COLORADO
Department of Health Care Policy & Financing

FY 2014–2015 Site Review Report Executive Summary

for

Foothills Behavioral Health Partners, LLC

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

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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 healthcare regulations and managed care contract requirements. The Department of Health Care Policy & 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 fiscal year (FY) 2014–2015 site review activities for the review period of January 1, 2014, through December 31, 2014. 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 four 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 2014–2015 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2013–2014 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 grievance and appeals 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 2014–2015 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 healthcare regulations.

Table 1-1 presents the scores for **Foothills Behavioral Health Partners, LLC** (**FBHP**) for each of the standards. Findings for all Met requirements 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)
V	Member Information	20	20	20	0	0	0	100%
VI	Grievance System	26	26	20	6	0	0	77%
VII	Provider Participation and Program Integrity	14	14	14	0	0	0	100%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals		**66**	**66**	**60**	**6**	**0**	**0**	**91%**

Table 1-2 presents the scores for **FBHP** for the grievances and appeals 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)
Grievances	50	36	36	0	14	100%
Appeals	48	48	44	4	0	92%
Totals	**98**	**84**	**80**	**4**	**14**	**95%**

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

Member materials, including the member handbook, were written in easy-to-understand language. The handbook was well organized and indexed to allow members to readily search for specific topics. **FBHP** translated numerous written materials into Spanish, which were available for dissemination. **FBHP** mailed all member materials within required time frames. **FBHP** maintained member mailing lists of Spanish- and English-speaking households and disseminated materials accordingly, which reportedly reduced the number of follow-up requests for translated materials. **FBHP** clearly communicated to providers the responsibility to distribute specific information to members at provider facilities. **FBHP** supported providers in this process, and the annual on-site provider audit included monitoring of availability of member materials. The **FBHP** website was easy to navigate and included much of the essential member information, with visible links to specific topics. The website included a Spanish conversion tab and provided access to some member materials in Spanish, including the member handbook. Staff members stated that they had objectives for further improving the website.

The member handbook and/or website included information on covered services, the Colorado Preferred Drug List (PDL), the Colorado Mental Health Treatment Act (CMHTA), community resources and national and local behavioral agencies and organizations, grievance and appeal procedures, member rights, trainings and newsletter information for members, the ombudsman, advance directives, emergency services, and other vital information. **FBHP** included in the member handbook a commendable description of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and a variety of Colorado waiver programs and how to access them. **FBHP** updated both the hard copy and searchable provider directory monthly. Other member communications included the annual member letter and privacy policy, and notices to members regarding any substantial change in services or provider termination. The member handbook stated that members do not have to pay for emergency or poststabilization services, and the website included a link to **FBHP**'s poststabilization policy.

Summary of Findings Resulting in Opportunities for Improvement

Although **FBHP** referenced CMHTA in relation to an appeal of denied residential treatment services, the member handbook did not provide any other information to explain CMHTA. HSAG recommends that **FBHP** expand information about CMHTA in the member handbook or on the **FBHP** website.

Access to care standards are required by contract to be posted on the BHO website. Although access to care standards are included in the member handbook, which is accessible on the website, HSAG recommends that **FBHP** create a visible link or otherwise direct the member to the section of the handbook that includes access to care standards. In addition, HSAG recommends that **FBHP** increase the number of pre-developed Spanish communications that are accessible through the

website, and that **FBHP** consider putting a message on the Spanish-translated pages of the website that informs members how to request other materials in Spanish.

The Member Information Requirements policy and the member handbook stated that members would be notified 15 days prior to a provider change. While this process might be timelier than the contract requirement stipulates, HSAG clarified that the requirement cites member notification 15 days from the provider's notice of termination, not 15 days prior to termination. HSAG recommends that **FBHP** clarify its policy and member handbook to be consistent with the requirement.

During on-site interviews, staff explained the differences between services accessible through the community mental health center (CMHC) model and the independent provider network (IPN). HSAG recommends that **FBHP** consider including a description in the member handbook explaining the differences between the two models of care (e.g., CMHC specialty programs and assignment of a therapist based on the member's intake assessment) to facilitate member choice in network providers.

The EPSDT services description in the member handbook stated that EPSDT services apply to children aged 20 years and younger and women who are pregnant. While information about EPSDT services should perhaps be communicated to women who are pregnant, the actual services are only applicable to children who are 20 years old and younger. Therefore, HSAG recommends that **FBHP** clarify the language referencing pregnant women in this section of the handbook.

Summary of Required Actions

There were no required actions for this standard.

Standard VI—Grievance System

Summary of Strengths and Findings as Evidence of Compliance

FBHP's policy and procedures, as well as various member and provider communications, clearly substantiated that **FBHP** had a well-defined, robust process for the processing of member grievances and appeals that included definitions of a grievance and an appeal, procedures and time frames for processing grievances and appeals, and thorough member communications regarding the resolution of grievances and appeals. Grievances were investigated and resolved through the **FBHP** Office of Member and Family Affairs (OMFA) staff and the delegated partner CMHCs. All appeal procedures were executed through ValueOptions (VO). **FBHP** OMFA staff tracked and reported grievance time frames and outcomes in the VO grievance database. Because **FBHP** OMFA did not have access to the VO appeals database, staff members documented and tracked appeals in an **FBHP** appeals database. Grievance records reviewed demonstrated 100 percent compliance with all required elements, and appeal records reviewed scored 92 percent overall compliance with the required elements. With the exception of some confusion regarding timely filing requirements and continuation of benefits, all grievance and appeal procedures were accurately defined in multiple documents. The **FBHP** and VO OMFA staff were actively involved in assisting members with

grievances, appeals, and State fair hearings (SFHs) and efficiently achieving resolution. The Grievance and Appeal policy and Grievance and Appeal Guide stated that an appeal decision will be made within the required time frames for standard and expedited appeals. The **FBHP** time frame for processing expedited appeals was three calendar days instead of three working days according to URAC requirements. All submitted documents stated that OMFA will attempt to reach the member by telephone, as well as in writing, regarding expedited appeal decisions. The appeal decision template letter included the date the appeal was received and the date of the appeal decision. Members and providers were informed of all applicable grievance and appeal procedures in the member handbook and provider manual, respectively. Appeal and grievance resolution letters included applicable dates, reviewer credentials, thorough descriptions of disposition, and alternatives for next steps. During the on-site interview, **FBHP** staff members demonstrated that they were very knowledgeable and conscientious with regard to the appropriate processing of grievances and appeals.

Summary of Findings Resulting in Opportunities for Improvement

The member handbook erroneously stated that the appeal decision would be made within 10 calendar days, rather than 10 working days. HSAG recommends that **FBHP** correct the member handbook to be consistent with **FBHP** policies for resolution of standard appeals within 10 working days.

HSAG recommends that several areas of member communications be clarified to avoid confusion related to appeals and SFH, including the following:

- The member handbook and the *Decision on Appeal of Previously Authorized Services* letter both stated that the member may have to pay for services continued during an appeal if the appeal is upheld at SFH. Since all appeals do not go to SFH, **FBHP** should clarify that the member may have to pay for services continued during an appeal if the **FBHP** appeal upholds the original denial, and may have to pay for services continued during a SFH if the SFH upholds the denial.
- The *Decision on Appeal of Previously Authorized Services* letter communicated the member's right to request continuation of benefits during an **FBHP** appeal or SFH. However, this appeal resolution letter is sent to the member when the **FBHP** appeal has already concluded. **FBHP** should consider eliminating information regarding the appeal process in any appeal resolution letter and limiting information in this letter to applicable SFH processes.

Grievance record reviews included two cases in which the CMHC required the member to sign a release of information (ROI) before a grievance could be resolved. In both cases, the members withdrew their grievances because they refused to sign the ROI. There is no requirement or applicability of a ROI for investigating and resolving a member grievance. **FBHP** should ensure that grievances are processed without requesting a ROI from the member.

During appeal record reviews, HSAG noted that an unusually high number of appeals (6 of 14 appeal records) were filed directly with the administrative law judge rather than filing an internal **FBHP** appeal. (HSAG also observed that the SFH process was requiring up to six months for scheduling a hearing). While regulation allows members or designated client representatives (DCRs) to request a SFH instead of an internal appeal, **FBHP** may want to further evaluate whether

any internal processes may be contributing to the number of appeals that are referred directly to SFH.

In one appeal record reviewed, 35 days lapsed between the verbal appeal and receipt of the written appeal, and the appeal review process was not initiated until the written appeal was received. This resulted in all of the required time frames being scored as "not met." HSAG recommends that **FBHP** evaluate whether staff are expediently assisting members/DCRs with timely submission of a written appeal following a verbal appeal.

The Grievance and Appeal policy and the member handbook stated that if the appeal resolution time frame was extended, the member would be informed of the reason and why it was in the member's best interest. The appeal extension letter (as observed in record reviews) routinely stated, "more time is needed to review additional documentation" as the reason for the extension. HSAG recommends that **FBHP** expand this explanation to specify why it is in the member's best interest to extend the time frame.

Regarding the effectuation of appeal resolution, the Grievance and Appeal policy and member communications noted that **FBHP** may recover the cost of services continued during an appeal if the SFH officer upholds the denial, but this documentation did not address the ability of the health plan to recover the cost of continued services during the **FBHP** appeal process. Staff stated that **FBHP** rarely, if ever, has attempted to recover the cost of continued services from the member. HSAG recommends that **FBHP** include a statement in the Grievance and Appeal policy that clearly confirms **FBHP**'s policy regarding recovery of costs of services continued during an **FBHP**-level appeal, when **FBHP** upholds the original denial.

Summary of Required Actions

The Grievance and Appeal policy, member handbook, provider manual, and Grievance and Appeal Guide described an action, an appeal, and the 30-calendar-day time frame for filing. However, all documents inaccurately stated that an appeal of reduction, suspension, or termination of previously approved services must be filed in 10 days. The reduced 10-day time frame for filing an appeal applies only when the member is requesting continuation of previously approved services during the appeal. **FBHP** must ensure that members may appeal an action to reduce, suspend, or terminate previously approved services within 30 calendar days of the notice of action, unless the member is requesting continuation of benefits during the appeal.

The Grievance and Appeal policy, member handbook, and Grievance and Appeal Guide all accurately addressed the provision of an acknowledgement within two working days of receiving the appeal. The Appeal Acknowledgement letter informed the member of the date the appeal was received. However, only six out of eight appeal records reviewed (75 percent) included an acknowledgement letter sent within the required time frame. **FBHP** must ensure that all appeals are acknowledged in writing within two working days of receiving the appeal.

One out of eight appeal record reviews included an appeal disposition letter sent outside the required time frame. (In this case, it appeared that the written appeal was received more than one month after a verbal appeal was received by the member, and the appeal was not processed until the

written appeal was received.) **FBHP** must ensure that standard appeals are resolved within 10 working days (plus 14 calendar days if extended) of the initial receipt of the appeal (verbal or written).

Seven out of eight appeal records reviewed included resolution letters with the required content. One resolution letter did not inform the member of the right to continue benefits during a SFH and the potential financial implications for doing so. **FBHP** must ensure that the appeal resolution letter for all appeals not resolved wholly in favor of the member informs the member of the right to continue previously approved benefits during a SFH and that the member may be held liable for the cost of these benefits if the hearing decision upholds the contractor's action.

The *Decision on Appeal of Previously Authorized Services* letter, the member handbook, the provider manual, and the Grievance and Appeal Guide all inaccurately communicated that the time frame for requesting a SFH for reduction, suspension, or termination of previously authorized services was 10 days. (The 10 day filing requirement applies only when the member is requesting continuation of previously authorized services pending outcome of the SFH.) **FBHP** must correct member and provider materials to clarify that members may request a SFH for reduction, suspension, or termination of previously authorized services within 30 calendar days of the notice of action, unless the member is requesting continuation of benefits pending the SFH decision.

The provider manual stated that when members are requesting continuation of benefits, members must file an appeal within 10 days of the notice of action or *10 days before* the intended date of the action. As outlined in the requirement, the member must file an appeal or SFH request within 10 days of the notice of action or before the intended effective date of the proposed action (not 10 days before), whichever is later. **FBHP** must clarify the provider manual and any related communications to ensure that the member may request continuation of benefits pending the outcome of an appeal or SFH by filing on or before the later of 10 days after mailing of the notice of action or the intended effective date of the action.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

FBHP had a complex structure for meeting the requirements of the Provider Participation and Program Integrity standard. Many of the requirements, including provider credentialing, were delegated to VO, a partner owner as well as a management services organization (MSO) subcontractor. However, **FBHP**'s corporate compliance officer assumed responsibility for the compliance program, and the chief quality officer and her staff assumed responsibility for the monitoring of quality, appropriateness, member access, most reporting requirements, medical record requirements, and contract compliance. **FBHP**'s OMFA was responsible for the advance directives requirement. Signal Behavioral Health Network (Signal), **FBHP**'s other subcontractor, was delegated responsibilities related to the substance use disorder (SUD) provider network (as outlined in Standard IX).

FBHP staff presented flowcharts that detailed the VO credentialing process for both facilities and practitioners. **FBHP** staff provided evidence of a very comprehensive system for monitoring provider and subcontractor performance; demonstrated that corrective actions were taken, well-documented, and tracked; and provided a VO corrective action plan for review. During on-site interviews, staff stated that **FBHP** implemented a comprehensive audit oversight plan intended to improve **FBHP**/VO coordination of audit/investigation procedures and communications.

FBHP established a thorough process to protect against fraud and abuse. The corporate compliance program was comprehensive and addressed leadership and structure, standards and procedures, training and education, communication, auditing and monitoring, and enforcement of standards. The corporate compliance officer had direct access to the Boards of Managers and Directors. **FBHP**'s Code of Conduct specifically outlined **FBHP**'s commitment to the prevention and identification of fraud, waste, and abuse and was applicable to all employees, board members, providers, and contractors. A compliance hotline ensured anonymous reporting of any potential violations of the compliance program, a prompt response to any suspected violations, and appropriate disciplinary response.

FBHP maintained policies and procedures concerning advance directives and developed a PowerPoint presentation to train providers on advance directives and member rights. **FBHP** reminds members annually about their rights, including those regarding advance directives.

Summary of Findings Resulting in Opportunities for Improvement

FBHP met all requirements of this standard. There were no additional opportunities for improvement identified for this standard.

Summary of Required Actions

There were no required actions for this standard.

Standard IX—Subcontracts and Delegation

Summary of Strengths and Findings as Evidence of Compliance

FBHP had two subcontractors: VO and Signal. **FBHP** delegated the following functions to VO: claims processing, clinical and utilization management services, credentialing, health information systems and reporting, and provider network management. **FBHP** delegated the following functions to Signal: recruitment and maintenance of the SUD provider network, recommendation of providers for inclusion in the VO/**FBHP** provider network, grievance functions, SUD provider education, quarterly and annual network adequacy reporting, and medical record and claims audits. **FBHP** had a written delegation agreement with each subcontractor that incorporated all of the required elements. **FBHP**'s relationship with VO pre-dated some of the federal and State regulations regarding delegation. **FBHP** initiated the delegation agreement with Signal within the past year and provided evidence of a pre-delegation evaluation of Signal's capabilities, an action plan for Signal to improve performance in several areas, and a mechanism for tracking Signal's progress and completion of the action plan.

FBHP implemented a comprehensive system to monitor subcontractor performance on an ongoing basis. To ensure impartiality, **FBHP** contracted with an independent auditor to conduct a full audit of the delegates' performance every three years. **FBHP** also conducted annual audits for credentialing requirements and follow up of corrective action plans from the previous year. **FBHP**'s *VO Delegation Full Audit FY 2014* document detailed a comprehensive assessment of VO's delegated functions, as well as the process used to notify the subcontractor of any deficiencies and the follow up needed to obtain resolution of the problem.

Summary of Findings Resulting in Opportunities for Improvement

FBHP met all requirements of this standard. There were no additional opportunities for improvement identified for this standard.

Summary of Required Actions

There were no required actions for this standard.