COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2016–2017 Site Review Report

for

Foothills Behavioral Health Partners, LLC

April 2017

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), with revisions published May 2016, 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 FY 2016–2017 site review activities for the review period of January 1, 2016, through December 31, 2016. 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 three standard areas reviewed this year. Section 2 contains graphical representation of results for all standards reviewed over the past two three-year cycles. Section 3 describes the background and methodology used for the 2016–2017 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2015–2016 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 2016–2017 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

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 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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable/ To Be Determined	Score (% of Met Elements)
I. Coverage and Authorization of Services	31	28	25	3	0	3	89%
II. Access and Availability	10	10	10	0	0	0	100%
Totals	**41**	**38**	**35**	**3**	**0**	**3**	**92%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

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

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	62	57	5	38	92%
Totals	**100**	**62**	**57**	**5**	**38**	**92%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

FBHP delegated all authorization activities to Beacon Health Options (Beacon). Beacon had utilization management (UM) policies and procedures that addressed all major elements of authorization requirements. UM staff applied established level of care guidelines to determine medical necessity for all higher levels of care—e.g., inpatient, partial hospitalization, residential, and day treatment. UM staff referred all requests that did not meet criteria to an **FBHP** medical director or clinical peer advisor for final determination. Beacon conducted annual interrater reliability testing and audited clinical care managers and clinical peer advisors quarterly to ensure that criteria, available documentation, and reviewer interpretations were consistently applied among all UM staff. Beacon also used the list of covered BHO diagnoses to initially determine whether or not the services being requested applied to a diagnosis covered by the BHO. Staff members stated that UM staff contact the requesting provider when necessary to obtain additional information prior to making a UM decision. Notices of action sent to the member, with a copy to the requesting provider, included required content, were written in language easy to understand, and were available in English and Spanish or other languages upon request. Beacon updated the notices of action effective November 2016 to reflect the revised 60-day time frame for requesting a State fair hearing. The Medical Necessity Determinations policy accurately identified time frames for mailing notices of action. On-site denials record review confirmed the following:

- Denials record reviews included six new requests (one standard, four expedited, and one retrospective) and four retrospective claims reviews. No cases included an extension of the decision time frame.
- All 10 records demonstrated that **FBHP** mailed notices of action to the members and notified the requesting providers, qualified clinicians made denial decisions, and notices of action included required content.
- Nine of 10 records included notice of action (NOA) letters that were easy to understand; one case included content that was confusing or possibly inaccurate.
- Six of 10 records demonstrated that **FBHP** mailed notice of action letters within the required time frames.
- One case demonstrated consultation with the requesting provider prior to the authorization decision. (See recommendation following.)
- All cases denied for "not a covered service/diagnosis" informed the member how to obtain covered fee-for-service or wrap-around services. (See recommendation following.)

Policies, procedures, and provider and member materials accurately defined "emergency medical condition" and "services" and communicated that emergency services were available in or out of network without authorization. Policies and procedures also accurately addressed payment of emergency and poststabilization services, per requirements. Staff members stated that **FBHP** never questions emergency services based on medical necessity but that all emergency room (ER) claims are

retrospectively reviewed to ensure that the root cause of the emergency was related to a BHO-covered diagnosis.

Summary of Findings Resulting in Opportunities for Improvement

HSAG observed that **FBHP** frequently denied services for the reason "not a covered diagnosis"—seven of 10 records reviewed and 64 percent of all 2016 denials. Some of these denials included retrospective review of emergency service claims. Policies and procedures stated and staff members confirmed that **FBHP** never denies emergency services for medical necessity; however, an **FBHP** medical director reviews every ER claim to confirm that the emergency was related to a BHO-covered diagnosis. The medical director's determination is based on clinical review of information and notes available in the medical record. In four ER claims denial cases reviewed on-site, the medical reviewer had changed the primary diagnosis from what was submitted in the ER claim to a diagnosis found in the ER medical record notes or medical history after the emergency. The claim was then denied for reason of "not a covered diagnosis." Additionally, in two of four ER claims, HSAG noted that circumstances which appeared to be perceived by the member/family as an emergency medical condition were retrospectively denied due to "not a covered diagnosis." The frequency and circumstances related to **FBHP**'s denials for "not a covered diagnosis" raised some questions as to consistency and appropriateness of the covered diagnosis determinations. Nevertheless, these decisions are based on the clinical judgement of the medical director/peer advisor and as such are not within the scope of evaluation of compliance with federal and State regulations. Therefore, HSAG referred these cases to the Department for further evaluation and assigned a score of "To Be Determined" (TBD) for the following requirements:

- 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.
- 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.
- The Contractor may not deny payment for treatment obtained in situations which a prudent layperson who possesses an average knowledge of health and medicine would perceive as an emergency medical condition.

HSAG scored TBD as "not applicable" (NA) for purposes of the compliance audit.

FBHP defined "medical necessity" equivalent to the definition outlined in the contract. However, the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—included the addition of EPSDT-specific criteria. Therefore, **FBHP** is advised to immediately update the definition of "medical necessity" accordingly. HSAG recommends that **FBHP** refer to 10-CCR 2505-10 8.076.1.8 (a–g) and 8.7016.1.8.1 for guidance.

HSAG observed in the denial record reviews that in three cases **FBHP** retroactively denied services it had previously approved. HSAG noted that this practice may be out of compliance with Colorado Revised Statutes (CRS) 10-16-704(4): "When a treatment or procedure has been preauthorized by the

plan, benefits cannot be retrospectively denied except for fraud and abuse. If a health carrier provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person." While this finding is beyond the scope of the requirements reviewed in the compliance audit and therefore not reflected in compliance audit scoring, HSAG referred these cases to the Department for further evaluation.

Although **FBHP**/Beacon had a mechanism for consulting with providers prior to making authorization decisions, **FBHP** also employed a formal process for a post-denial consultation with the provider (the requesting provider may ask for reconsideration after **FBHP** denies an authorization request). HSAG cautions that a post-denial redetermination is an appeal and must be treated as such. Therefore, **FBHP** should ensure compliance with regulations concerning appeals (reviewed in another standard) when considering a post-denial redetermination. Furthermore, HSAG recommends that **FBHP** more assertively contact a provider *prior to* making a denial decision when in doubt about the information provided and in each case in which the clinical reviewer is considering denying services based on "not a covered diagnosis."

As observed in denial record reviews, NOA letters that deny services due to "not a covered diagnosis" included a statement directing members to call the Department's customer service line for help in determining whether or not the denied service was covered under another Health First Colorado health plan. As discussed with **FBHP** staff members during the on-site interview, the Department does not consider this an effective mechanism for assisting members with coverage under another health plan or with access to wrap-around services. (The Department's customer service personnel do not have access to the member's clinical information and are not trained to make such a determination.) In addition, this process does not meet **FBHP**'s care coordination requirements (reviewed in another standard). HSAG strongly recommends that **FBHP** modify its NOA language for denials due to "not a covered diagnosis/service" to direct members to call the BHO care managers/coordinators for assistance with any contacts with the Department or with referrals to other health plans or agencies. HSAG also recommends that the Department work with the BHOs to define appropriate procedures for BHO care coordinators to contact the Department concerning coverage for services that are covered under the State plan via fee-for-service or other Medicaid waiver programs.

HSAG observed during on-site denial record reviews that **FBHP** routinely sends a copy of any notice of action to the requesting provider unless the request was generated as a result of member assessment by a community mental health center (CMHC). In these cases, **FBHP** notifies the CMHC verbally. While this process is in compliance with federal and State requirements, HSAG recommends that **FBHP** also notify the requesting CMHC in writing so as to be consistent with procedures for notifying other providers and to ensure that all providers involved in the authorization request have documented results of the authorization decision.

The definition of "emergency medical condition" in **FBHP**'s Emergency and Poststabilization policy varied from the definition included in its member handbook and provider manual. Although the definition was compliant in all documents, HSAG recommends that **FBHP** use consistent language to define "emergency medical condition" in all documents and communications. Similarly, reviewers observed that the member handbook stated the member may obtain emergency services from any

hospital "in your area" and referred the member to a list of hospitals. HSAG recommends that **FBHP** consider simplifying the language in the member handbook to ensure that members clearly understand that they can access emergency services anywhere—in or out of network.

Summary of Findings Resulting in Required Actions

Notices of action to the member were written in a language and format easy to understand. However, one of the ten denial records reviewed on-site included a notice of action that described an action different than that noted in the denial file. The request was for a continued stay following previously approved days of admission. While the denial file was clear that specific days had been approved, the notice of action stated that the entire admission was denied. Staff members stated that they were unsure why the letter was written in this manner; therefore, the information in the notice of action was scored as confusing or possibly inaccurate. **FBHP** must develop mechanisms to ensure that the information in the notice of action to the member/provider accurately coincides with the determination of approved or denied days as noted in the denial record.

Staff members stated that it is **FBHP**'s policy to make a retrospective claim payment determination and send a notice of action within 30 days of receipt of the claim. The federal requirement is that the notice of action be mailed "at the time of any action affecting the claim." Four of five retrospective claim denials reviewed on-site demonstrated that **FBHP** failed to mail the notice of action within a reasonable time frame (within three days) after making the decision. **FBHP** must clarify its policies and procedures and ensure that it sends members and providers notices of action for denial of claims payment "at the time of any action affecting the claim"—interpreted by HSAG as on the date of denial or within three days of the decision.

UM policies and procedures clearly outlined Beacon's ability to extend the authorization decision time frame by 14 days based on member request or the need for additional information. In addition, the policy stated that Beacon may extend the time frame "due to matters justifiably beyond the control of the BHO," which staff described as an occurrence such as a natural disaster. Federal language clearly states that the Contractor may extend the authorization decision only if "there is a need for additional information and that the extension is in the member's best interest." **FBHP** must ensure that Beacon modifies the language in its policies and procedures accordingly.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

FBHP delegates the maintenance and monitoring of its provider network to Beacon. Beacon's Network Design and Access Standards policy described the processes Beacon uses to ensure **FBHP**'s members ready access to the full spectrum of covered services. Beacon provided **FBHP** quarterly and annually with reports that compared the number and location of members with the number, type, location, and languages spoken of contracted providers. Beacon monitored grievances related to members' abilities to access services and used various surveys to gauge member and provider perceptions of the availability of services.

FBHP staff members discussed recent efforts to improve network adequacy by improving the relationships between its independent provider network and the CMHCs. **FBHP**'s research indicated that members who sought services from an independent provider were less likely to engage in services and programs offered at CMHCs. By fostering relationships between independent providers and CMHCs, **FBHP** hopes to help independent providers understand the breadth of ancillary services available through the CMHCs and how to help members access those services.

FBHP's policies allowed members to seek a second opinion, and **FBHP** notified members of this right in the member handbook. **FBHP**'s policies also described the circumstances under which **FBHP** would provide members with access to out-of-network providers. **FBHP** readily employed single case agreements to ensure timely and appropriate access to needed services. Single case agreements included language that prohibited providers from billing members for covered services.

FBHP required its contracted providers and CMHCs to provide access to emergency services, maintain minimum hours of operation, and ensure the availability of covered services 24 hours a day, 7 days a week. **FBHP** provided evidence of having conducted regular monitoring to ensure compliance and appropriate follow-up with providers who failed to meet the standards.

FBHP's cultural competency plan delineated **FBHP**'s objectives and the departments responsible for implementing and monitoring a plan to ensure culturally and linguistically competent services. **FBHP** conducted an annual self-assessment that reviewed progress made toward meeting the objectives outlined in its plan and that identified new and/or revised objectives for moving forward. **FBHP**'s provider directory identified languages spoken by each provider as well as areas of social and cultural focus. **FBHP** used multiple mechanisms to ensure that members and providers know that member materials are available in alternative formats and languages and that members have access to free interpreter services. **FBHP** monitored its providers to ensure that all cultural considerations are noted in member records and offered training to help providers identify cultural considerations aside from language. **FBHP** recently updated training materials to help address some cultural issues commonly encountered by people in the lesbian, gay, bisexual, and transgender community. **FBHP** staff also addressed increased awareness of cultural issues encountered by its aging community.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no findings resulting in opportunities for improvement related to access and availability.

Summary of Required Actions

HSAG identified no required corrective actions for this standard.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

Summary of Strengths and Findings as Evidence of Compliance

FBHP delegated provider relations functions to Beacon. **FBHP** operated the EPSDT program as defined in policies and procedures originated by Beacon, **FBHP**, and **FBHP**'s partner CMHCs (Mental Health Partners [MHP] and Jefferson County Mental Health [JCMH]). Beacon developed a comprehensive EPSDT policy that addressed all components of the EPSDT requirements for the BHO and provided an overall foundation for implementing EPSDT requirements. **FBHP**'s EPSDT policy addressed the local BHO expectations related to EPSDT requirements, and MHP's and JCMH's EPSDT policies specified the provider-level expectations related to implementing BHO EPSDT responsibilities. During the on-site interview, staff members stated that **FBHP** assigned most responsibilities for implementing EPSDT to the CMHCs/providers. Staff members estimated that 80 percent of the BHO's members received behavioral health services through the two partner CMHCs. MHP's policy mimicked the **FBHP** policy; JCMH did not have an umbrella policy but addressed individual components of EPSDT within other policies (e.g., coordination of care). Staff members stated that JCMH was in process of developing a consolidated EPSDT policy which would coincide with the implementation of a new JCMH electronic health record that was being programmed to create an EPSDT care path to guide and document provider implementation of comprehensive EPSDT requirements. Policies, the provider manual, and provider trainings outlined the behavioral health providers' responsibilities related to EPSDT including: informing members of EPSDT services, determining whether or not screenings have been provided to members 20 years of age and under, linking members to primary care physicians (PCPs) to perform EPSDT screening, obtaining results of EPSDT screenings from PCPs, and providing assessment and treatment planning for any mental health/substance abuse issues identified through screening. Policies also addressed documentation requirements and sharing of protected health information (PHI) with Healthy Communities. **FBHP** monitored the CMHC's implementation of select components of the EPSDT program through periodic medical record audits and compliance audits.

FBHP notified members of the availability of EPSDT services using the Health First Colorado and **FBHP** member handbooks. **FBHP** policies also delegated responsibility for informing members about EPSDT services to the partner CMHCs. MHP provided a member intake packet which included

materials about EPSDT services and Healthy Communities and forms needed to request information from the member's PCP regarding the outcome of EPSDT screenings. Policies also required BHO practitioners to communicate periodically with individual members in treatment regarding well-child checks and other EPSDT screenings. The **FBHP** compliance checklist included monitoring of CMHC procedures to inform members of EPSDT benefits, including all components of information outlined in the requirement.

CMHC policies addressed the practitioner's responsibility to assist members with simple referrals, and staff stated that CMHC care coordinators were available to assist members with more complex needs. Staff members described that each CMHC was working with a partner federally qualified health center (FQHC)—MHP with Clinica; JCMH with Metro Community Provider Network (MCPN)—on implementing an integrated health home (i.e., physical health providers located in the CMHC), which included broadening all aspects of work flows to accommodate comprehensive mental health and physical health needs of members. **FBHP** also described evolving relationships with the Regional Care Collaborative Organization (RCCO) in the region as well as with county Healthy Communities organizations, to determine the best "lead" for coordinating various EPSDT services for members. Staff stated that **FBHP** is working on numerous projects to link information—especially related to children with complex needs—among various service providers in the system, but that these mechanisms are still evolving.

Despite the opportunities for improvement and recommendations outlined following, **FBHP** has made significant efforts over the past year to work with partner CMHCs and other community organizations to define and implement processes that address the BHO's responsibilities related to EPSDT.

Summary of Findings Resulting in Opportunities for Improvement

Although Beacon and **FBHP** have comprehensive policies regarding EPSDT, defined procedures for implementing the various requirements were limited, and evidence of compliance varied or appeared inconsistent. For example:

- The **FBHP** policy requires that the CMHCs also have an EPSDT policy. While MHP had an overall EPSDT policy, JCMH had no consolidated policy addressing EPSDT requirements but rather addressed some EPSDT components in other policies.
- While MHP produced an intake packet of EPSDT-related documents for members, **FBHP** provided no examples of JCMH processes to inform members of EPSDT services.
- While **FBHP** delegated most of the comprehensive EPSDT requirements to the provider CMHCs, provider expectations were primarily focused on one-to-one communications with members regarding well-child checks and other screenings, communicating with PCPs to obtain results of screenings, or referring members to PCPs to obtain necessary screenings. Provider communications and training materials related to EPSDT requirements were very high-level or limited in scope.
- CMHC monitoring tools included only select elements of EPSDT requirements: informing eligible members of EPSDT services and benefits, asking individual members if well-child checks had been performed, referring members for screenings as necessary, obtaining results of screenings from PCPs

(i.e., sending a coordination of care letter to the PCP annually), and logging notes reflecting coordination with other providers or agencies in the medical record.

To expand procedures for implementing requirements and to provide consistent evidence of compliance, HSAG recommends the following:

- JCMH should complete development of a comprehensive EPSDT policy as soon as possible.
- **FBHP** should enhance **FBHP** and/or CMHC procedures related to expectations and mechanisms for implementing comprehensive EPSDT requirements.
- CMHCs and/or **FBHP** might consider developing additional written materials (flyers, newsletters, posters) to periodically inform members of EPSDT benefits and services, and how to access them.
- **FBHP**'s monitoring of CMHC EPSDT responsibilities should include more comprehensive criteria.
- **FBHP** should develop more comprehensive and detailed provider education and training related to EPSDT service requirements.

The Beacon and **FBHP** EPSDT policies included the EPSDT definition of "medical necessity" and the criteria for approval of authorization requests as outlined in the requirement. However, **FBHP** should note that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—includes the EPSDT-specific criteria per 8.280.4.E. HSAG strongly recommends that the Beacon and **FBHP** EPSDT policies incorporate the definition of "medical necessity" for EPSDT services as outlined in the Findings section of Standard I, element 4, of the compliance monitoring tool.

HSAG encourages **FBHP** to work with the Department's EPSDT Administrator (Gina Robinson) to obtain guidance and trainings related to implementation of the Department's EPSDT requirements.

Summary of Findings Resulting in Recommendations

FBHP had mechanisms in place to attempt to ensure the provision of periodic health screens (assessments) to EPSDT beneficiaries. Policies clearly outlined the responsibility of the behavioral health provider to periodically discuss with individual members whether or not a well-child check has been performed by the member's PCP and to either refer the member to a PCP for necessary screenings or request a report of EPSDT screening results from the PCP. Both MHP and JCMH had a coordination of care letter used to request results of EPSDT screenings from the member's PCP. However, procedures were absent or unclear to ensure that providers would thoroughly complete this process. Missing aspects included addressing the provider's responsibility for follow-up in instances wherein the PCP did not respond to the request and/or expressing how actively the provider or care coordinators are expected to assist the member in obtaining EPSDT screening services. In addition, **FBHP** provided no evidence that the behavioral health providers were trained on all components of EPSDT screenings, and **FBHP**'s medical record audit tool did not include monitoring for documentation in the medical record of results of EPSDT screenings obtained from PCPs. HSAG recommends that **FBHP** enhance procedures, provider communications, and training to thoroughly address expectations and mechanisms

to ensure that EPSDT-eligible members receiving BHO services obtain all applicable components of periodic health screens.

Policies and procedures and the EPSDT provider training specifically stated that results of EPSDT screenings (obtained from the PCP or conducted by the BHO provider) must be documented in the medical record. However, neither the internal provider network (IPN) clinical audit tool nor the **FBHP** CMHC compliance checklist included monitoring the medical record for documentation of results of screenings or examinations. HSAG recommends that **FBHP** develop a mechanism to ensure that results of screenings (assessments) and examinations for members receiving BHO services are recorded in the members' medical records.

The **FBHP** UM Program Description stated that **FBHP** delegated UM functions to Beacon. Both Beacon's and **FBHP**'s EPSDT policies stated that the BHO would provide coverable medically necessary mental health services indicated through either screenings or referral to the behavioral health provider, "even if the service is not covered under the plan." Policies also stated that Beacon/**FBHP** would authorize any identified diagnostic or treatment services, including those related to substance abuse needs, that meet the definition of "medical necessity" and criteria for authorization specific to EPSDT, accurately outlining the EPSDT definition of "medical necessity" and criteria for authorization. However, Beacon's Quality Management/Utilization Management Program Description included no information specific to authorization of EPSDT-related services (e.g., the EPSDT definition of "medical necessity," clinical guidelines specific to EPSDT, or reference to the EPSDT policies). Therefore, it appeared that Beacon had not incorporated the expanded "medical necessity" definition related to EPSDT services into its UM practices or developed UM procedures to operationalize the EPSDT policy. HSAG recommends that **FBHP** modify or develop policies and procedures to demonstrate that UM staff members are using EPSDT-specific criteria and definitions of "medical necessity" when authorizing EPSDT-related services. The goal of these revisions is for the policies and procedures to reflect that **FBHP** ensures that its UM contractor (Beacon) more clearly aligns organizational UM procedures with the definition of "medical necessity" and authorization criteria outlined in the EPSDT policies.

The Beacon EPSDT policy stated and staff members confirmed that if a necessary EPSDT-related diagnostic or treatment service is not covered by the BHO benefit, the primary behavioral health provider is responsible for coordinating a referral to a provider who can deliver the service. In addition, the policy included the requirement for the BHO or contracted providers to coordinate necessary EPSDT services with outside agencies. These responsibilities were not described in **FBHP** or CMHC policies, but rather referred providers to an Internet link for referrals to Healthy Communities. **FBHP** also had no written procedures, provider training, or provider communications to provide evidence that behavioral health providers have the resources to successfully assist members with obtaining non-covered services, that coordination exists with other programs that may provide EPSDT services, or that BHO care coordinators assist providers in making such referrals. **FBHP** had no defined BHO care coordinator procedures related to providing referral assistance to providers or members for treatment not covered by the BHO, including coordination with other programs/agencies that may provide EPSDT-related services. In addition, HSAG observed in the on-site denial record reviews that notices of action to members eligible for EPSDT services referred the member to the Department's customer service line to determine whether or not the denied service was covered. **FBHP** did not appear to have a well-defined,

coordinated process for ensuring provision of EPSDT diagnostic services and treatment of all mental illnesses or conditions that "are not covered in the plan" or for coordinating services with external agencies. HSAG recommends that **FBHP** define a more cohesive mechanism for ensuring that treatment of mental health conditions related to EPSDT—but not covered under the BHO contract—are adequately addressed in procedures and clarify accountabilities for providing referral assistance to members, including coordinating with other programs that may provide EPSDT-related services. If developed, these procedures should address active involvement of BHO care coordinators (and/or documented responsibilities of affiliated organizations) to assist members and/or providers in order to obtain all documents needed to ensure access to non-covered services. These policies and procedures should also include, for members 20 years of age and under, processes for sending a notice of action letter that directs members and providers to contact BHO care coordinators—rather than the Department's customer service line—for assistance with accessing needed EPSDT-related services or Healthy Communities.

The Beacon EPSDT policy stated that if the provider is not licensed or equipped to render necessary treatment or further diagnosis, the provider shall refer the member to an appropriate practitioner or Healthy Communities. However, neither the provider manual nor provider training inform providers of this requirement or related processes. **FBHP**'s and MHP's policies address linking the member to an appropriate provider to furnish necessary *screenings* but do not address referring the member for diagnostic or treatment services when the BHO provider is not equipped to render necessary services. During on-site discussions, staff members stated that behavioral health providers make referrals to other providers as necessary—not specific to EPSDT diagnosis or treatment. HSAG recommends that **FBHP** develop procedures and/or enhance provider communications to clearly specify provider responsibilities for making referrals to appropriate practitioners or Healthy Communities for *necessary treatment or further diagnostic services* and define mechanisms for effectively doing so.

FBHP/Beacon incorporated the requirement to share PHI with Healthy Communities into the Beacon EPSDT policy verbatim. However, **FBHP** provided no evidence that it had incorporated the requirement into provider communications or internal operational procedures. HSAG recommends that **FBHP** develop mechanisms to communicate this requirement to providers and other pertinent staff members in order to fully operationalize the policy.

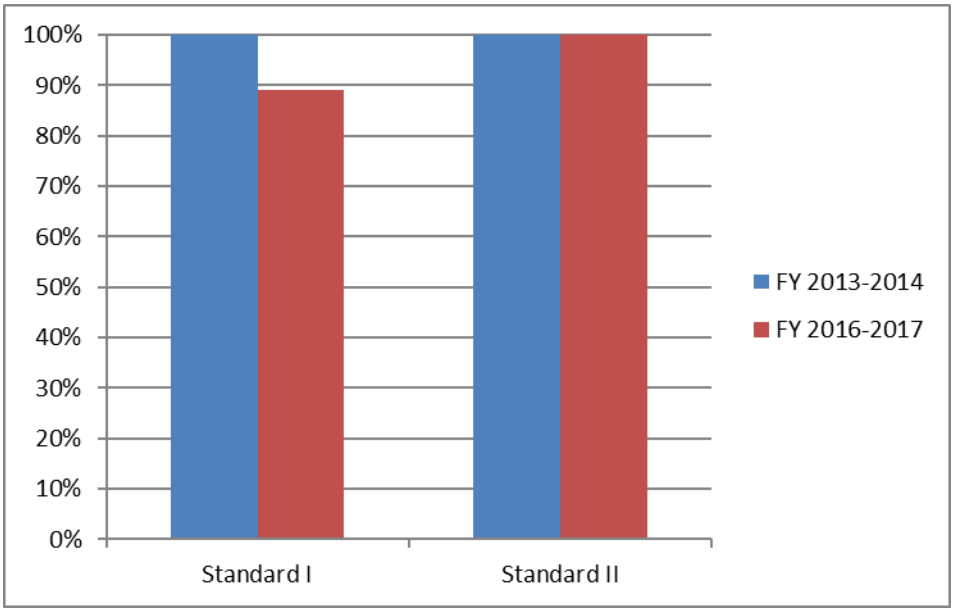
HSAG clarified during the on-site interviews that the requirement for "systematic" communications with the BHO's contracted providers regarding EPSDT requirements is the responsibility of the BHO—not the responsibility of behavioral health providers to communicate with PCPs. Staff members stated that **FBHP** has engaged CMHC providers in roundtable discussions concerning EPSDT requirements. While the **FBHP** website included EPSDT resources such as an overview of the Bright Futures periodicity schedule and links to Healthy Communities, it did not appear that **FBHP** directed providers to the website to obtain these resources. **FBHP** provided no evidence of comprehensive EPSDT-focused trainings, provider communications, or tools for BHO providers that represented "systematic" communication with BHO providers regarding EPSDT requirements. HSAG recommends that **FBHP** enhance provider communications and develop a mechanism for systematic (i.e., regular and periodic) communication with network providers regarding comprehensive EPSDT services and responsibilities.

Comparison of Results

Comparison of FY 2013–2014 Results to FY 2016–2017 Results

Figure 2-1 shows the scores from the FY 2013–2014 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.

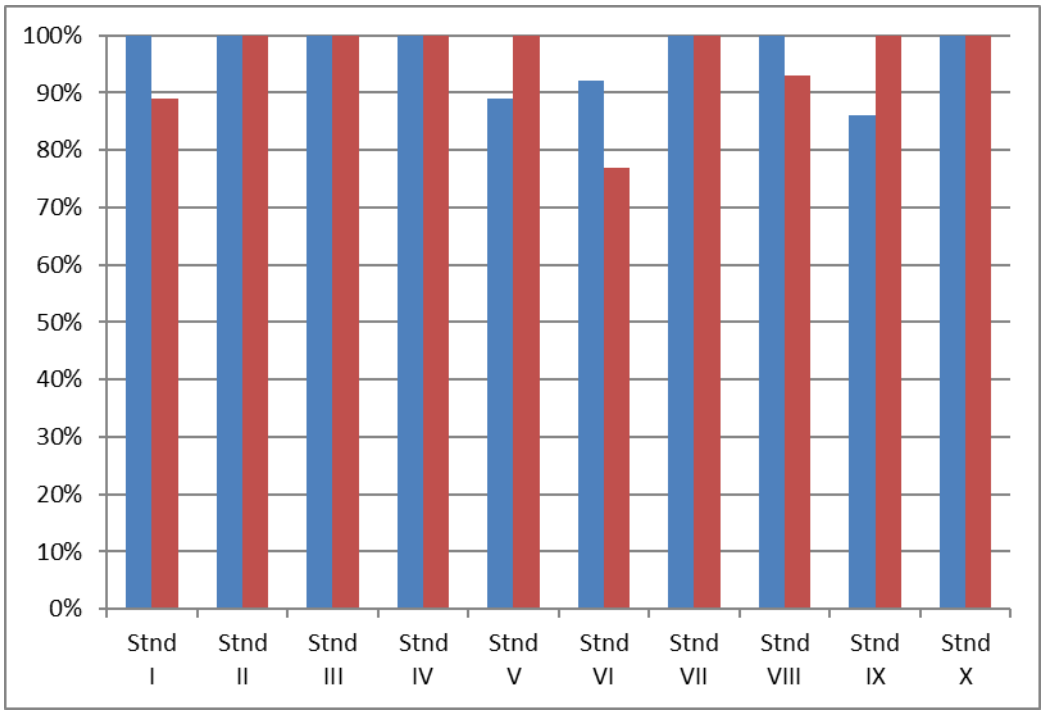
Figure 2-1—Comparison of FY 2013–2014 Results to FY 2016–2017 Results



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: Results shown in blue are from FY 2011–2012, FY 2012–2013, and FY 2013–2014. Results shown in red are from FY 2014–2015, FY 2015–2016, and FY 2016–2017.

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

Table 2-1—List of Standards by Review Year

Standard	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17
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	
XI—EPSDT Services						X

3. Overview and Background

Overview of FY 2016–2017 Compliance Monitoring Activities

For the fiscal year (FY) 2016–2017 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability.

HSAG reviewed an additional EPSDT standard for all BHOs during the FY 2016–2017 compliance site reviews. This standard was developed collaboratively by HSAG and the Department using federal EPSDT regulations and guidance in addition to State statutes that address EPSDT. The FY 2016–2017 findings for this standard can be found in Appendix A. A narrative summary of findings for this standard is also presented in the Executive Summary. During the on-site reviews, the Department identified that, while the BHO contracts require BHOs to comply with "all federal and State EPSDT regulations," the BHO contracts did not include the specificity delineated in the compliance monitoring tool. Therefore, the EPSDT findings will be used only to inform the development and implementation of EPSDT contracting provisions for the Regional Accountable Entities (RAEs) that will assume the capitated behavioral health contracts beginning in SFY 2018–2019. No corrective actions are required based on this compliance monitoring review. The State's EQRO vendor will review the EPSDT standard again in SFY 2019–2020.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued May 6, 2016. 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.

A sample of the BHO's administrative records related to Medicaid service and claims denials was 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 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid service and claims denials that occurred between January 1, 2016, and December 31, 2016. For the record review, the BHO received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each required element. 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.[3-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The three standards chosen for the FY 2016–2017 site reviews represent a portion of the Medicaid managed care requirements. The following 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 three areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the BHO into compliance with federal health care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, 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.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Aug 24, 2016.

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

FY 2015–2016 Corrective Action Methodology

As a follow-up to the FY 2015–2016 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 2015–2016 compliance monitoring site review.

Summary of FY 2015–2016 Required Actions

As a result of the FY 2015–2016 site review, **FBHP** was required to address three *Partially Met* items in the credentialing and recredentialing standard. **FBHP** was required to document the process it uses to determine which providers are allowed to submit credentialing applications. **FBHP** was also required to more strictly adhere to its recredentialing time frames for both individual and organizational providers.

Summary of Corrective Action/Document Review

FBHP submitted its proposed plan to HSAG and the Department in May 2016. Once HSAG and the Department had reviewed the plan, **FBHP** submitted documentation that demonstrated implementation. HSAG and the Department reviewed documents in August 2016 and determined that **FBHP** had completed all required actions.

Summary of Continued Required Actions

FBHP had no required actions continued from FY 2015–2016.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Compliance Monitoring Tool
for Foothills Behavioral Health Partners, LLC

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor must ensure that the services provided are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished. • No less than the amount, duration, and scope furnished under fee-for-service Medicaid. *42 CFR 438.210(a)(3)(i)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.2.8, 2.2.7	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_2BHO –Entire policy 2. Member Handbook_FBHP pages 14- 15 *Misc 3. FBHP-Beacon Delegation Agreement effective 20151209 Fully Executed Section 3; Clinical and Utilization Management pg.9-11 **Description of Process:** This element is delegated to Beacon Health Options (Beacon) by Foothills Behavioral Health Partners (FBHP) and is defined in FBHP-Beacon Delegation Agreement effective 20151209 Fully Executed Section 3; Clinical and Utilization Management pg.9-11 (Document 3). Decisions regarding the amount, duration, or scope of services are limited only to whether or not they meet medical necessity criteria see policy 202L Medical Necessity_2BHO (Document 1). There are no limits if medical necessity criteria is met and therefore not less than the amount, duration and scope furnished under fee-for-service Medicaid. This is outlined for members in the FBHP member handbook (Member Handbook_FBHP pages 14- 15 *Misc).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Amendment 6, Exhibit A-2—2.2.9	**Documents Submitted/Location within Documents:** 1. LOC Guideline _23-Hour_Observation_2BHO - Entire document 2. LOC Guideline _Acute Inpatient Treatment_2BHO- Entire document 3. LOC Guideline _Acute_Treatment_Unit_Services_2BHO - Entire document	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ TBD

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	4. LOC Guideline _Adult_Residential_Treatment_Services_2BHO - Entire document 5. LOC Guideline _Advocacy_Svcs_2BHO - Entire document 6. LOC Guideline _Alternative outpatient services_2BHO - Entire document 7. LOC Guideline _Alternative_Family_Care_2BHO - Entire document 8. LOC Guideline _Case_Management_Services_2BHO - Entire document 9. LOC Guideline _Child_Adol_Day_Treatment_Services_2BHO - Entire document 10. LOC Guideline _Community_Support_Programs_2BHO - Entire document 11. LOC Guideline_Client_Operated_Services_Adult_2BHO 12. LOC Guideline _Intensive_Outpatient_Programs_Adult_2BHO - Entire document 13. LOC Guideline _IOP_ChildAdol_Sex_Disorder_TX_2BHO - Entire document 14. LOC Guideline _Outpatient_Crisis_Intervention_Services_2BHO - Entire document 15. LOC Guideline _Parameters_for_Treating_Children_Under_5_2BHO - Entire document 16. LOC Guideline _Partial_Hospitalization_2BHO - Entire document	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	17. LOC Guideline _Peer_Support_Services_2BHO - Entire document 18. LOC Guideline _Psychological-Neuropsychological_Testing_2BHO - Entire document 19. LOC Guideline _Residential_Treatment_Children-Adolescents_2BHO - Entire document 20. LOC Guideline _Respite_Care_Services_2BHO - Entire document 21. LOC Guideline _Wrap_Around_Services_2BHO - Entire document 22. 202L Medical Necessity_2BHO – Page 2, Section II, B; Page 3, Section IV, C and D 23. 303L Peer Advisor Adverse Determinations_2BHO – Entire policy 24. Exhibit D-2_Covered Behavioral Health Diagnoses_2BHO-Entire Document 25. Rounds Log Nov 2015 thru 100516-entire document 26. FBHP Policy M2.0 Medical Management Higher LOC_ Entire Document **Description of Process:** This element is delegated to Beacon Health Options (Beacon) by Foothills Behavioral Health Partners (FBHP). Beacon staff refer to FBHP's medical necessity policy (202L Medical Necessity_2BHO; document 23), the list of covered diagnoses (Exhibit D-2_Covered Behavioral Health Diagnoses, document 24) FBHP Policy M2.0 Medical Management Higher LOC_ Entire Document (Document 26)	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	and the clinical level of care criteria (documents 1-21) 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 (303L Peer Advisor Adverse Determinations_2BHO; document 23). Variables such as the member's situation and other care available are also taken into account in each individual situation as demonstrated by the Rounds Log Nov 2015 thru 100516_2BHO (document 25). 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. Beacon staff refers cases for possible adverse clinical decisions to the Medical Director/Peer Advisor for review (202L Medical Necessity_2BHO document 23).	

Findings:
FBHP had extensive and well-defined level of care criteria applied by UM staff when making authorization decisions related to medical necessity. In addition, FBHP's UM process required that UM staff consider the list of covered BHO diagnoses when making authorization decisions. UM staff referred all questions related to whether or not the member had a covered diagnosis to the clinical peer advisors/medical directors, whose determination of covered diagnosis logically prevailed over the application of medical necessity criteria. HSAG observed in the denial record reviews that medical directors used information available in the medical record to make decisions regarding the primary diagnosis. However, in some cases where multiple diagnoses were listed, the medical director determined that a non-covered diagnosis was the primary reason for needed treatment. This made it unclear whether or not the Contractor arbitrarily denied a required service "solely because of diagnosis." In addition, the frequency with which FBHP assigned "not a covered diagnosis" as the denial reason—7 of 10 denial record reviews and 64 percent of all 2016 denials—raised questions as to the appropriateness of these determinations. Nevertheless, the decision of "not a covered diagnosis" is based on the clinical judgment of the medical director/peer advisor and, as such, is outside the scope of the compliance audit. Therefore, HSAG referred these cases to the Department for further evaluation. For purposes of this compliance audit, HSAG marked this requirement as "To Be Determined" (TBD) and will score it as "Not Applicable."

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor may place appropriate limits on a service: • 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 purposes. *42 CFR 438.210(a)(4)(i) and (ii)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.2.10	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_2BHO – Page 2, Section II. A. 2. LOC Guideline_23-Hour_Observation_2BHO- Entire document 3. LOC Guideline _23-Hour_Observation_2BHO - Entire document 4. LOC Guideline _Acute Inpatient Treatment_2BHO- Entire document 5. LOC Guideline _Acute_Treatment_Unit_Services_2BHO - Entire document 6. LOC Guideline _Adult_Residential_Treatment_Services_2BHO - Entire document 7. LOC Guideline _Advocacy_Svcs_2BHO - Entire document 8. LOC Guideline _Alternative outpatient services_2BHO - Entire document 9. LOC Guideline _Alternative_Family_Care_2BHO - Entire document 10. LOC Guideline _Case_Management_Services_2BHO - Entire document 11. LOC Guideline _Child_Adol_Day_Treatment_Services_2BHO - Entire document 12. LOC Guideline _Community_Support_Programs_2BHO - Entire document 13. LOC Guideline_Client_Operated_Services_Adult_2BHO 14. LOC Guideline _Intensive_Outpatient_Programs_Adult_2BHO - Entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	15. LOC Guideline _IOP_ChildAdol_Sex_Disorder_TX_2BHO - Entire document 16. LOC Guideline _Outpatient_Crisis_Intervention_Services_2BHO - Entire document 17. LOC Guideline _Parameters_for_Treating_Children_Under_5_2BHO - Entire document 18. LOC Guideline _Partial_Hospitalization_2BHO - Entire document 19. LOC Guideline _Peer_Support_Services_2BHO - Entire document 20. LOC Guideline _Psychological-Neuropsychological_Testing_2BHO - Entire document 21. LOC Guideline _Residential_Treatment_Children-Adolescents_2BHO - Entire document 22. LOC Guideline _Respite_Care_Services_2BHO - Entire document 23. LOC Guideline _Wrap_Around_Services_2BHO - Entire document 24. Exhibit D-2_Covered Behavioral Health Diagnoses_2BHO-Entire Document 25. FBHP Policy M2.0 Medical Management Higher LOC_ Entire Document **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). FBHP also monitors the requests for	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	higher levels of care. See FBHP Policy M2.0 Medical Management Higher LOC_ Entire Document The Medical Necessity policy incorporates the elements of the State's definition for Medical Necessity (202L Medical Necessity_2BHO – Page 2, Section II. A). Covered Diagnoses lists are stipulated by contract (Exhibit D-2_Covered Behavioral Health Diagnoses_2BHO). The level of Care Guidelines provide the basis for any limits placed on services authorized to control utilization and focus it on the members who will benefit from services and achieve their goals. (Documents 2-22). 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.	
4. The Contractor specifies what constitutes "medically necessary services" in a manner that: • Is no more restrictive than that used in the State Medicaid program. – Is in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care. – Is reasonably necessary for the diagnosis or treatment of a covered behavioral health disorder or to improve, stabilize, or prevent	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_2BHO –Entire policy 2. 223LTreatmentPlanning_Policy_2BHO-Entire Policy 3. Exhibit D-2_Covered Behavioral Health Diagnoses_2BHO-entire document 4. LOC Guideline _23-Hour_Observation_2BHO - Entire document 5. LOC Guideline _Acute Inpatient Treatment_2BHO- Entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
deterioration of functioning resulting from such a disorder. – Is clinically appropriate in terms of type, frequency, extent, site, and duration. – Is furnished in the most appropriate and least restrictive setting where services can be safely provided. – Cannot be omitted without adversely affecting the member's behavioral health and/or physical health conditions associated with the member's covered behavioral health diagnosis or the quality of care rendered. • 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. *42 CFR 438.210(a)(5)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—1.1.1.34	6. LOC Guideline _Acute_Treatment_Unit_Services_2BHO - Entire document 7. LOC Guideline _Adult_Residential_Treatment_Services_2BHO - Entire document 8. LOC Guideline _Advocacy_Svcs_2BHO - Entire document 9. LOC Guideline _Alternative outpatient services_2BHO - Entire document 10. LOC Guideline _Alternative_Family_Care_2BHO - Entire document 11. LOC Guideline _Case_Management_Services_2BHO - Entire document 12. LOC Guideline _Child_Adol_Day_Treatment_Services_2BHO - Entire document 13. LOC Guideline _Community_Support_Programs_2BHO - Entire document 14. LOC Guideline_Client_Operated_Services_Adult_2BHO 15. LOC Guideline _Intensive_Outpatient_Programs_Adult_2BHO - Entire document 16. LOC Guideline _IOP_ChildAdol_Sex_Disorder_TX_2BHO - Entire document 17. LOC Guideline _Outpatient_Crisis_Intervention_Services_2BHO - Entire document 18. LOC Guideline _Parameters_for_Treating_Children_Under_5_2BHO - Entire document	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	19. LOC Guideline _Partial_Hospitalization_2BHO - Entire document 20. LOC Guideline _Peer_Support_Services_2BHO - Entire document 21. LOC Guideline _Psychological-Neuropsychological_Testing_2BHO - Entire document 22. LOC Guideline _Residential_Treatment_Children-Adolescents_2BHO - Entire document 23. LOC Guideline _Respite_Care_Services_2BHO - Entire document 24. LOC Guideline _Wrap_Around_Services_2BHO - Entire document 25. 104L Developing and Updating Clinical Criteria_Level of Care Criteria_2BHO – Entire Policy **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Medically necessary services are needed for the diagnosis or treatment of health impairments and also to prevent deterioration in functioning as a result of a covered mental health disorder (202L Medical Necessity_2BHO –Entire policy, especially Section IV.A, document 1). Our treatment planning policy (223LTreatmentPlanning_Policy_2BHO document 2) outlines the focus of treatment by starting with an individualized assessment of the member, starting with the DSM V diagnosis. The assessment 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	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	functioning level. The policy notes that treatment goals need to be focused and measurable to address these identified problems. FBHP's 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 _Child_Adol_Day_Treatment_Services_2BHO (Document 12, above) focuses on the current academic impairment in the admission and discharge criteria. Similarly, the LOC Guideline _Adult_Residential_Treatment_Services_2BHO (document 7) also 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. All of our LOC guidelines are written with these principles in mind. Beacon policies are based on the State Medicaid Program's definition for medical necessity and the covered diagnoses (Exhibit D-2_Covered Behavioral Health Diagnoses_2BHO, document 3) provides the scope of covered diagnoses that we are responsible to treat. The level of care guidelines also undergo annual review and revision (as indicated)	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	by various committees (104L Developing and Updating Clinical Criteria_Level of Care Criteria_2BHO, (document 26).	

Findings:

FBHP defined "medical necessity" equivalent to the definition outlined in this requirement. However, the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—included the addition of EPSDT-specific criteria. Therefore, FBHP is advised to immediately update the definition of "medical necessity" accordingly. Please reference 10-CCR 2505-10 8.076.1.8 (a–g) and 8.7016.1.8.1 for guidance:

8.076.1.8. Medical necessity means a Medical Assistance program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.
b. Is provided in accordance with generally accepted professional standards for health care in the United States.
c. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
e. Is delivered in the most appropriate setting(s) required by the client's condition.
f. Is not experimental or investigational.
g. Is not more costly than other equally effective treatment options.

8.076.1.8.1 For EPSDT-specific criteria, see 10 C.C.R. 2505-10, Section 8.280.4.E.

"For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living; and meets the criteria set forth in Section 8.076.1.8(b–g)."

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. The Contractor has in place written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.9	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_2BHO, Section I, H; Section II, A 2. 203LMedicalNecessityDetermination_2BHO – Section IV, F, 1-5 and IV, G, 1-5 Pages 8-11. 3. 204LIntakeDataCollectInitialAuthHLOC_2BHO- entire policy 4. 206LDataCollectionContinuedAuthHLOC_ 2BHO- entire policy **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon policies clearly define and outline the procedures and information needed for each type of authorization- initial and continuing authorizations in policies (documents 3 and 4). The first step in the process is to gather the data and determine if Medical Necessity is being met (202L Medical Necessity_2BHO and 203LMedicalNecessityDetermination_2BHO – Section IV, F, 1-5 and IV, G, 1-5 Pages 8-11, documents 1 and 2 respectively). The process for reviewing initial authorization of care is reflected in 2014L_IntakeDataCollectInitial Auth HLOC_2BHO, document 3). If addition services are requested, the process for conducting continuing reviews is reflected in 206L_DataCollectionContinuted AuthHLOC, (document 4).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
6. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure consistent application of review for authorizing decisions. *42 CFR 438.210(b)(2)(i)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.15	**Documents Submitted/Location within Documents:** 1. 408L Care Management Documentation Audit_2BHO – entire document 2. CCM Doc Audit Tool Conc Rvw_2BHO 3. CCM Doc Audit Tool Initial Rvw_2BHO **Description of Process:** Beacon has a policy and procedure in place that outlines the process to ensure consistent application of the review for authorizing decisions (408L Care Management Documentation Audit_2BHO, document 1). Beacon clinical care managers complete quarterly peer audits utilizing a web-based audit tool that focuses on the content of documentation for UM decision making (CCM Doc Audit Tool Conc Rvw_2BHO and CCM Doc Audit Tool Initial Rvw_2BHO, documents 2 and 3). The audit reviews inpatient and ATU admissions that occurred the previous quarter. Each CCM has 2 admissions per month randomly selected, then their peers review the documentation in Care Connect. The cases are selected by either the Clinical Services Supervisor or the Clinical Director, and distributed to the CCM team to complete. The web-based tool calculates the scoring for the documentation audit, which includes timeliness of decision making as well. If the results of the audit are below standard (85%), corrective action training is taken to improve staff knowledge. The results are reported to the team and to the CHP board, through submission of a written report.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *4 2CFR 438.210(b)(2)(ii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.16	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_2BHO – Section IV, G, page 3 2. 203LMedicalNecessityDetermination_2BHO – Section IV, M., pages 13-14 3. 303L Peer Advisor Adverse Determinations_2BHO– Entire Document **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon policies direct staff to contact the provider, when necessary, for a review determination (policy 203L Peer Advisor Adverse Determinations_2BHO, document 3). In addition, Beacon 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 Determinations_2BHO). Authorizations or denials of services involve immediate telephonic notification of providers. (203L Medical Necessity Determination_Policy_2BHO – Document 2) If providers fail to request additional services, Beacon staff will 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_2BHO – Document 1). Attempts are made to contact the requesting provider for reconsideration/peer to peer review before finalizing any adverse clinical decisions (203L_203LMedicalNecessityDetermination_2BHO, IV.A.6, page 4, document 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor's UM program ensures that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease. *42 CFR 438.210(b)(3)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.15.3	**Documents Submitted/Location within Documents:** 1. FY16_UM Program Description_FBHP, page 19 *Misc 2. 303L Peer Advisor Adverse Determinations_2BHO – Entire Document 3. Dr. Fine Resume –FBHP- Entire Document 4. FBHP Medical Director job description- Entire Document **Description of Process:** The FY 16_UM Program Description_FBHP (page 19, document 1) describes the processes in place to ensure that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested is make by a healthcare professional who has appropriate clinical expertise in treatment the member's condition or disease. The Medical Director is available to review decisions and has the appropriate expertise (Document 3_Dr. Fine Resume –FBHP- Entire Document; Document 4_ FBHP Medical Director job description_ Entire Document). This is also reinforced via Policy 303L Peer Advisor Adverse Determinations_2BHO (Document 2).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor has in place 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). *42 CFR 438.210(c)*	**Documents Submitted/Location within Documents:** 1. 203LMedicalNecessityDetermination_2BHO– IV, D.4/5. page 6; IV, E.4/5, pages 7-8; IV, F 4/5; G 4/5; H-5, page 12; I, pages 12-13 2. Denial_NOA_Appeal Process_2BHO- Entire Document 3. FBHP-Beacon Delegation Agreement effective 20151209 Fully Executed Section 3; Clinical and Utilization Management pg.10; Items I & J.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Contract: Amendment 6, Exhibit A-2—2.6.5.5.1 10 CCR 2505-10 8.209.4.A	**Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP), as identified in Document 3 (FBHP-Beacon Delegation Agreement effective 20151209 Fully Executed Section 3; Clinical and Utilization Management pg.10; Items I & J). Beacon 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, refer to policy 203LMedicalNecessityDetermination_2BHO sections listed below: • **Section IV.D.4/5** 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 IV.E.4/5** outlines the same notification guidelines indicated above for urgent concurrent reviews; • **Section IV.F4/5** outlines the same notification guidelines indicated above for routine initial reviews; • **Section IV.G.4/5** outlines the same notification guidelines indicated above for routine concurrent reviews. • **Section IV.H.5** outlines the notification guidelines indicated above for retrospective reviews. In addition the clinical staff have available to them a workflow that outlines these requirements and timeframes (Denial_NOA_Appeal Process_2BHO, document 2).	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The Contractor provides notice of standard authorization decisions as expeditiously as the member's health condition requires and not to exceed 10 calendar days from receipt of the request for service. *42 CFR 438.210(d)(1)* Contract: Amendment 6, Exhibit A-2—2.5.15.1 10CCR2505—10, Sec 8.209.4.A.3.c	**Documents Submitted/Location within Documents:** 1. 203LMedicalNecessityDetermination_ 2BHO-Entire Policy 2. FBHP Policy M2.0 Medical Management Higher LOC_ Entire Document **Description of Process:** This element is Delegated to Beacon Health Options by Foothills Behavioral Health Partners and is supported by FBHP Policy M2.0 Medical Management Higher LOC_ Entire Document in addition to following Policy 203LMedicalNecessityDetermination_ 2BHO 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 IV, F.5 pages 9) • For denial of payment (such as for retro reviews), at the time of the action affecting the claim (Section IV, H.5, page12) • All authorization decisions are made as expeditiously as the member's health condition requires (Section IV, A.2, page 3) • For standard service authorization decisions that deny or limit services- within 10 calendar days of the receipt of request for service (Sections IV.G.5, pages 10 and 11) • For service authorization decisions not reached within the required timeframes, on the date timeframes expire (Section IV, G.2, pages 9 and 10) • For expedited decisions, letters are mailed no later than 3 calendar days from the receipt of request for services (Section IV.D.5, page 6; IV.E.5, pages 7 and 8)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11. For cases in which a provider indicates, or the Contractor determines, that the standard authorization time frame could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not to exceed 3 working days from receipt of the request for service. *42 CFR 438.210(d)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.15.2	**Documents Submitted/Location within Documents:** 12. 203LMedicalNecessityDetermination_2BHO-Entire Policy **Description of Process:** Policy 203LMedicalNecessityDetermination_2BHO outlines the timeframes for Notices of Action: • All authorization decisions are made as expeditiously as the member's health condition requires (Section IV, A.2, page 3) • For expedited decisions, letters are mailed no later than 3 calendar days from the receipt of request for services (Section IV.D.5, page 6; IV.E.5, pages 7 and 8)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days 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. *42 CFR 438.210(d)(1)(2)* Contract: Amendment 6, Exhibit A-2—2.5.15.1 and 2.5.15.2.1	**Documents Submitted/Location within Documents:** 1. 203LMedicalNecessityDetermination_2BHO Pages 7-10, Sections IV.D2 and 3 and IV.E2 and pages 13-15 Sections IV.F.3 and IV.E.3 **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon rarely extends decision timeframes, however when extensions are made, policy 203LMedicalNecessityDetermination_2BHO 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 given due to lack of information to make any decision or if the member requests an extension.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	• **Section IV.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 IV.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 IV.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 IV.F.2-3 and IV.G2-.3** notes a 14 calendar day extension is available if there is a lack of information to make an authorization decision, or if the member requests an extension for initial or concurrent authorization decisions. • **Section IV.F.3** notes a 14-day extension is available if there are circumstances beyond the control of Beacon.	
Findings: Policies and procedures clearly outlined FBHP's ability to extend the authorization decision time frame by 14 days based on member request or the need for additional information. In addition, the policy stated that FBHP may extend the time frame "due to matters justifiably beyond the control of the BHO," which staff described as an occurrence such as a natural disaster. Federal language clearly states that the Contractor may extend the authorization decision only if "there is a need for additional information and that the extension is in the member's best interest."		
Required Actions: FBHP must modify the language in its policies and procedures to remove "due to matters beyond the control of the BHO" as a reason for extending the authorization decision time frame.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
13. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.6.5.5 10CCR2505—10, Sec 8.209.4.A.1	**Documents Submitted/Location within Documents:** 1. 306LMemberMaterials_Development_2BHO-I.A-E 2. Notice of Action Standard Non Covered Diagnosis_Spanish_FBHP- entire document 3. Notice of Action Standard Not Mtg Med Nec_Spanish_FBHP- entire document 4. Notice of Action Standard Service Not Covered_Spanish_FBHP- entire document 5. Notice of Action Standard Non Covered Diagnosis_FBHP – entire document 6. Notice of Action Standard- Not Mtg Med Nec Form_FBHP – entire document 7. Notice of Action Standard Service Not Covered_FBHP – entire document **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon follows our 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. We recognize that a large proportion of Medicaid enrollees have low health literacy, so we follow guidelines developed by CMS in developing the Beacon member materials policy for low literacy readers. For example, when we present 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 we are prepared to translate it into other languages should a member request this. We test our 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**
	We continue to use templates specific to the denial reason: Notice of Action Standard Non Covered Diagnosis_FBHP, Notice of Action Standard- Not Mtg Med Nec Form_FBHP and Notice of Action Standard Service Not Covered_FBHP .	
Findings: Notices of action to the member were written in a language and format easy to understand. However, one of the ten denial records reviewed on-site included a notice of action that described an action different than what was noted in the denial file. The request was for a continued stay following previously approved days of admission. While the denial file was clear that specific days had been approved, the notice of action stated that the entire admission was denied. Staff members stated that they were unsure why the letter was written in this manner; therefore, the information in the notice of action was scored as confusing or possibly inaccurate.		
Required Actions: FBHP must develop mechanisms to ensure that the information in the notice of action to the member/provider accurately coincides with the determination of approved or denied days as noted in the denial record.		
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 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 request 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.	**Documents Submitted/Location within Documents:** 1. Notice of Action Standard Non Covered Diagnosis_FBHP-Entire Document 2. Notice of Action Standard Service Not Covered_FBHP-Entire Document 3. Notice of Action Standard- Not Mtg Med Nec Form_FBHP-Entire Document 4. GrievanceAppeal_Guide_FBHP-Entire Document *Misc **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon ensures that members receive Notices of Action which contain all of the required elements. In our effort to only include elements in the letter which pertain specifically to the member in question, we include our separate	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• 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). *42 CFR 438.404(b)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.6	Grievance and Appeal Guide (GrievanceAppeal_Guide_FBHP) which we mail with every Notice of Action.	
15. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except: – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and	**Documents Submitted/Location within Documents:** 1. 203LMedicalNecessityDetermination_ 2BHO-Entire Policy **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Policy203LMedicalNecessityDetermination_ 2BHO 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 IV.I. pages 12-13) • For denial of payment (such as for retro reviews), at the time of the action affecting the claim (Section IV.H.5, page 12) • All authorization decisions are made as expeditiously as the member's health condition requires (Section IV.A.2, page 3)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
indicates that the member understands that service termination or reduction will occur. o The member has been admitted to an institution in which the member is ineligible for Medicaid services. o The member's address is determined unknown based on returned mail with no forwarding address. o The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. o A change in the level of medical care is prescribed by the member's physician. o The notice involves an adverse determination with regard to preadmission screening requirements. o The transfer or discharge from a facility will occur in an expedited fashion. • 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 expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services.	• For standard service authorization decisions that deny or limit services- within 10 calendar days of the receipt of request for service (Sections IV.F.4, page 9 and IV.G.5, page 10-11) • For service authorization decisions not reached within the required timeframes, on the date timeframes expire (Section IV. A.5, page 3-4) • For expedited decisions, letters are mailed no later than 3 calendar days from the receipt of request for services (Section IV.D.5, page 6 and IV.E.5, pages 7-8)	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the time frame, as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR 438.210 (d) *42 CFR 438.404(c)* *42 CFR 431.211,431.213, and 431.214* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5 10CCR2505—10, Sec 8.209.4.A (3) (a-c)		
Findings: Staff members stated that it is FBHP's policy to make a retrospective claim payment determination and send a notice of action within 30 days of receipt of the claim. The federal requirement is that the notice of action be mailed "at the time of any action affecting the claim." Four of five retrospective claim denials reviewed on-site demonstrated that FBHP failed to mail the notice of action within a reasonable time frame (within three days) after making the decision.		
Required Actions: FBHP must clarify its policies and procedures to ensure that it sends members and providers notices of action for denial of claims payment "at the time of any action affecting the claim"—interpreted by HSAG as on the date of denial or within three days of the decision.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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. *42 CFR 438.404(c)(4)(i)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5.5.2 10CCR2505—10, Section 8.209.4.A.3.c (i)	**Documents Submitted/Location within Documents:** **1.** 203L MedicalNecessityDetermination_ 2BHO – Sections IV.D.3.a , IV.E.3.a, IV.F.2-3 and IV.G.2-3 **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon 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 Beacon Colorado 203LMedicalNecessityDetermination_ 2BHO in the following locations: • IV.D.3.a, page 5-6 • IV.E.3.a, page 7 • IV.F.2-3, page 8-9 • IV.G.2, pages 9 • IV.G.3, page 10 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: • IV.D.1, page 5 • IV.E.1, pages 6-7 • V.F.1, page 8 • IV.G.1, page 9	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
17. The Contractor provides that compensation to individuals or entities that conduct utilization management (UM) activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Amendment 6, Exhibit A-2—2.5.15.4	**Documents Submitted/Location within Documents:** 1. C421Obj in clin dec mkg CSNT 117.1_2BHO -entire policy 2. New_Hire_and_Annual_Attestation_2BHO, page 3 3. Code of conduct_Copy of Certificate_2BHO-Entire Document 4. Code of Conduct_Annual Training_2BHO-entire document **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon 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. (C421Obj in clin dec mkg CSNT 117.1_2BHO -entire policy, document 1). New employees as well as on an annual basis, Beacon staff receives training regarding conflict of interest and employee code of conduct, including signing an annual attestation (New_Hire_and_Annual_Attestation_2BHO, page 3, document 2; Code of Conduct_Annual Training_2BHO, document 4 and Code of Conduct, Copy of certificate_2BHO, document 3) 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 layperson 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. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.20	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices_Policy_2BHO – Page 2-3, Section II.A defines Emergency Medical Condition. 2. Provider Manual_2BHO– Section 4- Utilization Management Procedures, page 21 *Misc 3. Member Handbook_FBHP_*Misc, page 14 and 15 **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon 270L Emergency and PostStabilization Services policy defines emergency medical conditions that coincide with the State's definition of Medical Necessity (document 1). Members receive information in the member handbook (Member Handbook_FBHP) about what defines an emergency or crisis and how to obtain emergency services (document 3). Beacon staff assists members and directs them to the nearest facility/ER when there is any question of an emergency medical condition. The definition of emergency medical condition is identified in the Member Handbook (document 3, pages 14 and 15) and the Provider Handbook (document 2, page 21).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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 needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.21	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices_Policy_2BHO – Pages 3, Section II.C. 2. Provider Maual_BHO– Section 4- Utilization Management Procedures, page 21-22.*Misc **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon 270L Emergency and PostStabilizationServices_Policy_2BHO policy provides this exact definition of Emergency Services This definition is also given to providers in the Provider Maual_2BHO.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.1	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices_Policy_2BHO – Page 1, Section I.A. 2. Colorado Reference Guide _2BHO- #22, page 12 **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Policy 270L Emergency and PostStabilizationServices_2BHO (document 1) provides an overview of how emergency services are covered and reimbursed. Beacon Colorado ER claims procedures indicates members can access these services without prior authorization (Colorado Reference Guide_2BHO, document 2 page 12). This procedure document states that claims for emergency services are accepted and paid for to any provider, regardless of network status.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
21. The Contractor informs members that prior authorization is not required for emergency services. *42 CFR 438.10(f)(6)(viii)(B)* Contract: Amendment 6, Exhibit A-2—2.6.11.1.13.4	**Documents Submitted/Location within Documents:** 1. Member Handbook_FBHP – Page 13-14 *Misc 2. Provider Manual_2BHO– Section 4- Utilization Management Procedures, pages 21-22 *Misc 3. Colorado Reference Guide _2BHO- #22, page 12 **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon informs members via the Member Handbook (document 1) that prior authorization is not required for emergency services. In addition, Providers are made aware that emergency services do not require prior authorization (Provider Manual_2BHO, page 21). As Members are not responsible for payment of any emergency service claims, the Claims Processors follow the guidance established in the Colorado Reference Guide_2BHO, page 12 in addressing such claims.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor may not deny payment for treatment obtained under the following circumstances: • A member had an emergency medical condition, as defined in 42 CFR 438.114(a) (see #18 above). • Situations which a prudent layperson who possesses an average knowledge of health and medicine 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	**Documents Submitted/Location within Documents:** 1. 270L Emergency PostStabilizationServices – Policy_2BHO- Pages 1-, Section I.B.1 2. Colorado Reference Guide _2BHO-entire document 3. Member Handbook_FBHP – Page 14 *Misc 4. Provider Manual_2BHO– Section 4- Utilization Management Procedures, page 21 *Misc **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon 270L Emergency PostStabilizationServices – Policy_2BHO clearly outlines that	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ TBD

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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. *42 CFR 438.114(c)(ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.1, 2.2.4.3.4.2	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 (Colorado Reference Guide_2BHO, document 2). Members and Providers are also informed of this requirement through the Provider and Member handbooks (Member Handbook_FBHP, page 14 and Provider Manual_2BHO Sect 4, page 21).	

Findings:
Policies and procedures and member and provider communications clearly stated that FBHP would pay for all emergency services without authorization, and staff stated that emergency services are assumed to be medically necessary. However, two of ten denial records reviewed on-site were cases which appeared to be perceived by the member/family as an emergency medical condition but were retrospectively denied due to "not a covered diagnosis." While not technically out of compliance for FBHP to determine that the reason for the member's ER admission was not a covered diagnosis, these cases presented questions regarding "the Contractor may not deny payment for treatment in situations which a prudent layperson who possesses an average knowledge of health and medicine would perceive as an emergency medical condition." However, the decision of "not a covered diagnosis" is based on the clinical judgement of the medical director/peer advisor and, as such, is outside the scope of the compliance audit. HSAG referred these cases to the Department for further evaluation. For purposes of this compliance audit, HSAG marked this requirement as "To Be Determined" (TBD) and scored it as "Not Applicable."

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. *42 CFR 438.114(d)(1)(i) and (ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.3	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices_Policy_2BHO –Page 1, Section I.C.1-2 2. Colorado Reference Guide _2BHO-entire document **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon 270L Emergency PostStabilizationServices – 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, Beacon staff pays these claims, without the need for an authorization. Providers are not required to notify Beacon of ER services or request authorizations to obtain reimbursement (Colorado Reference Guide_2BHO, document 2)	☒ 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. • For *practitioner* emergency room claims for members with a primary substance use or mental health disorder diagnosis. (The Contractor is not financially responsible for outpatient emergency room services for members with a primary	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices – Policy_2BHO- Page 1, Section I.A, C.1 2. Colorado Reference Guide _2BHO- #22, page 12 **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon 270L Emergency and PostStabilization Services policy indicates that Beacon is responsible to pay for ER services when the primary diagnosis is psychiatric in nature, even if the ER services also included some	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ TBD

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
substance use disorder diagnosis or when the primary diagnosis is medical in nature.) Contract: Amendment 6, Exhibit A-2—2.2.4.3.11, 2.2.4.3.12, 2.2.4.3.13	procedures to treat a secondary medical diagnosis. During claims processing, Beacon staff allows for payment of these claims, without the need for an authorization. (Colorado Reference Guide_2BHO, document 2)	
Findings: The Emergency and Poststabilization Services policy addressed the BHO's responsibility to pay for emergency services when the primary diagnosis is psychiatric in nature. Several denial records reviewed on-site illustrated instances in which the emergency services claim documented a primary behavioral health diagnosis but FBHP's medical director believed the root cause of the behaviors was related to a non-covered diagnosis such as substance use or autism and denied the claim. It was unclear whether or not the Contractor appropriately authorized payment "when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis." However, the decision of "not a covered diagnosis" is based on the clinical judgement of the medical director/peer advisor and, as such, is outside the scope of the compliance audit. HSAG referred these cases to the Department for further evaluation. For purposes of this compliance audit, HSAG marked this requirement as "To Be Determined" (TBD) and scored it as "Not Applicable."		
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. *42 CFR 438.114(d)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.5	**Documents Submitted/Location within Documents:** 1. DelegationAgreement_FBHP - Entire policy *Misc 2. 270L Emergency and PostStabilizationServices – Policy_2BHO -Page 1, Section I.D. 3. Member Handbook_FBHP –Page 14 &15 *****Misc **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon 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

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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. *42 CFR 438.114(d)(3)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.6	**Documents Submitted/Location within Documents:** 1. DelegationAgreement_FBHP - Entire policy *Misc 2. 270L Emergency and PostStabilizationServices – Policy_2BHO-Page 2, Section I..E **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon 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
27. The Contractor defines "poststabilization care services" as covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.47	**Documents Submitted/Location within Documents:** 1. DelegationAgreement_FBHP - Entire policy *Misc 2. 270L Emergency and PostStabilizationServices – Policy_2BHO-Page 3, Section II.D. **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon 270L Emergency and PostStabilization Services policy clearly defines post stabilization care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.7	**Documents Submitted/Location within Documents:** **1.** 270L Emergency and PostStabilizationServices – Policy_2BHO-Page 2, Section I.D **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon is financially responsible for post stabilization care services obtained within or outside the network that have been pre-approved by a plan provider or other organization representative. Policy 270 L Section I. D. clearly states this financial 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 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	**Documents Submitted/Location within Documents:** 1. 270L PostStabilizationServices –Policy_2BHO-Page 2, Section I.G. 2-4 **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon is financially responsible for post stabilization 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 stabilize the member's condition in several circumstances. Policy 270 L Section I. G.2-4 clearly states this financial responsibility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii) and (iii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.8, 2.2.4.3.8.1, 2.2.4.3.8.2, 2.2.4.3.8.3		
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. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.9	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices – Policy_2BHO-Page 3-4, Section IV.A-C **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon policy details the additional circumstances by which Beacon maintains financial responsibility for provided services and details when this responsibility ends. Policy 270 L, Section IV.A-C outline when the financial responsibility for Beacon 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. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.8.4	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices – Policy_2BHO-Page 1, Section I. D. 2. Member Handbook_FBHP-Page 11*Misc **Description of Process:** This element is delegated to Beacon by Foothills Behavioral Health Partners (FBHP). Beacon policy details the additional circumstances by which Beacon maintains financial responsibility for provided services. Policy 270 L states that members are not charged for these services regardless of whether the services are obtained through Beacon or not. The member handbook also lets members know that they are not responsible to pay for any Medicaid covered services. Members are not charged for these services regardless of whether they go through Beacon or not.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	25	X	1.00	=	25
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable/ To Be Determined	=	3	X	NA	=	NA
Total Applicable		=	28	**Total Score**		=	25

Total Score ÷ Total Applicable	=	89%

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 and monitors a network of providers sufficient to provide access to all covered behavioral health and substance use disorder services. *42 CFR 438.206(b)(1)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.1, 2.5.9	**Documents submitted:** 1. PR302 NetworkDesignAndAccessStandard_2BHO-Entire Policy 2. IPN_EmergencyAccessToCare_Q4FY16_Calls_FBHP-EntireDocument 3. Access_To_Care_FINAL_QTR4FY16_FBHP -Entire Document 4. Q4 FY16 NWAdequacy Report – 20160706_2BHO-Entire Document 5. FY 2016 Annual Needs Assessment_052016_2BHO-Entire Document 6. FBHP Provider Directory Lang Update-2016-09-14-14-56-20_FBHP-Entire Document 7. L604_Policy FBHP LCC –Colorado FBHP LCC Review Standards_FINAL_FBHP-Entire Policy **Description of Process:** This element is delegated to Beacon Health Options by Foothills Behavioral Health Partners (FBHP). Beacon Health Options has several policies that describe the activities involved to assess and maintain a comprehensive provider network to serve the needs of eligible Health First Colorado (Medicaid) members as noted in the local (L604_Policy FBHP LCC –Colorado FBHP LCC Review Standards_FINAL_FBHP) and national policy (PR302 NetworkDesignAndAccessStandard_2BHO). In addition to policies, Beacon Health Options conducts a variety of provider monitoring activities to assure providers are meeting the needs of	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	BHO Health First Colorado (Medicaid) members. These activities include monitoring of accessibility and availability (Access_To_Care_FINAL_QTR4FY16_FBHP) and (IPN_EmergencyAccessToCare_Q4FY16_Calls_FBHP). The BHO maintains other network reports that monitor the number and mix of the providers included in the network to serve member needs based on expected utilization and population (Q4 FY16 NWAdequacy Report – 20160706_2BHO), (FY 2016 Annual Needs Assessment_052016_2BHO-Entire Document), and (FBHP Provider Directory Lang Update-2016-09-14-14-56-20_FBHP).	
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 healthcare needs of specific Medicaid populations represented in the Contractor's service area. • The numbers, types, and specialties of providers required to furnish the contracted Medicaid services. • The number of network providers accepting/not accepting new Medicaid members. • The geographic location of providers in relationship to where Medicaid members live, considering distance, travel time, and means of transportation used by members. – Members have access to a provider within 30 miles or 30 minutes' travel time, whichever is	**Documents submitted:** 1. PR302 NetworkDesignAndAccessStandard_2BHO-Entire Policy 2. FY 2016 Annual Needs Assessment_052016_2BHO-Entire Document 3. FBHP Provider Directory Lang Update-2016-09-14-14-56-20_FBHP-Entire Document 4. Q4 FY16 NWAdequacy Report – 20160706_2BHO-Entire Document 5. Provider Manual_2BHO –Page 30 *Misc 6. L604_Policy FBHP LCC –Colorado FBHP LCC Review Standards_FINAL_FBHP-Entire Policy 7. FBHP_Specific_BHONetDevPlan_FY17_FBHP-Entire Document This element is delegated to Beacon Health Options by Foothills Behavioral Health Partners (FBHP). Beacon Health Options reviews the network adequacy for FBHP regularly as per our local (L604_Policy FBHP LCC –Colorado FBHP LCC Review	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
larger, to the extent such services are available. • Physical access to locations for members with disabilities. *42 CFR 438.206(b)(1)(i) through (v)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.9.1; 2.5.9.2; 2.5.8.1.4	Standards_FINAL_FBHP) and national (PR302 NetworkDesignAndAccessStandard_2BHO) policies to ensure Health First Colorado (Medicaid) members have a range of providers that are available to serve their needs. Our Network Development Plan (FBHP_Specific_BHONetDevPlan_FY17_FBHP) gives details on the specific needs FBHP has in provider recruitment. Review of the network includes the number of providers, specialties, languages, locations, and accessibility. As notes in our Network Reports (FY 2016 Annual Needs Assessment_052016_2BHO Document) and (Q4 FY16 NWAdequacy Report – 20160706_2BHO), Beacon Health Options monitors the availability of providers quarterly and annually. The monitoring completed by Beacon Health Options includes an assessment of member needs and expected utilization. Members are provided choice in providers across the FBHP region (Provider Manual_2BHO) and (FBHP Provider Directory Lang Update-2016-09-14-14-56-20_FBHP) which 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. Information is provided of member ability to choose providers that are available in the network, or the right to request a provider be added to the network in our member materials.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain one outside the network, at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Amendment 6, Exhibit A-2—2.5.8.2	**Documents submitted:** 1. Policy 257L – Request for Second Opinion_2BHO-section IA, IVA1,2 2. Second Opinion Workflow_2BHO– Entire document 3. SecondOpinion_ProviderChangeRequest_2016FBHP-Entire Document 4. Member Handbook_FBHP –Page 19 and 21*Misc 5. FBHP Policy M6.5 Second Opinions_Entire Document **Description of Process:** Beacon provides any assistance to Foothills Behavioral Health Partners (FBHP) with the standard to ensure that Members know that they have access to a second opinion without any cost to the Member. In order to ensure that Members know that they have access to a second opinion, we have made this information known internally through FBHP Policy M6.5 Second Opinions_Entire Document257LRequestforSecondOpinion_Policy_2BHO, which is Beacon's policy for requesting a second opinion, through the Member handbook (Member Handbook_FBHP) as well as made this information available at the FBHP website, http://www.fbhpartners.com/ The number of requests that we receive each year requesting a second opinion is relatively low. In the instances a request is received, staff members follow the Second Opinion policy and workflow (SecondOpinionworkflow_2BHO). This can be through the Clinical Department or the Office of Member & Family Affairs. SecondOpinion_ProviderChangeRequest_2016_2BHO is	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	a form for Providers and Members alike, which was developed to help facilitate this process to ensure the reason for the second opinion is considered in finding a provider. If a network provider is not qualified to help with a second opinion (for instance in treating Members with eating disorders), we would go outside of our network at no cost to the Member. The process is further outlined in Beacon's 257LRequestforSecondOpinion_ _I.Policy.A_2BHO. As noted in the policy, it is necessary to determine the medical necessity and appropriateness of the mental health services that are provided to our Members; thus, allowing a need for a second consultation or opinion from a qualified mental health clinician or a Board Certified Psychiatrist. Members learn about their rights to a second opinion through the member handbook (Member Handbook_FBHP) which includes the member rights and responsibilities statements. Members are informed that this second opinion is at no cost to them.	
4. 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 for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Amendment 6, Exhibit A-2—2.5.9.5	**Documents submitted:** 1. SCALetter_Practitioner_2015DEC22_PR_2BHO-Entire Document 2. SCALetter_Facilities_2015DEC22_PR_2BHO-Entire Document 3. Provider Manual_2BHO-page 30 *Misc 4. MemberHandbook_FBHP-Page 8,22 *MIsc 5. Policy 257L – Request for Second Opinion_2BHO-section IA, IVA1,2 6. FBHP Policy M6.5 Second Opinions_Entire Document **Description of Process:** This element is delegated to Beacon Health Options by Foothills Behavioral Health Partners (FBHP). Foothills Behavioral Health	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Policy FBHP Policy M6.5 Second Opinions_Entire Document (Document 6) identifies how a member can request a second opinion at no cost. Beacon Health Options' Policy 257L – Request for Second Opinion describes services not available through an in-network provider may be accessible to members through an out-of-network provider at no cost to the member and that all timeframes for authorization decisions must be upheld. Policies outline the approval process and situations in which Single Case Agreements are approved for member services outside of the provider network. Providers are sent individual contracts (SCALetter_Practitioner_2015DEC22_PR_2BHO) and (SCALetter_Facilities_2015DEC22_PR_2BHO) which indicate that the BHO Provider Handbook (Provider Manual_2BHO) notes that members cannot be billed for behavioral health services. In the Member Handbook_FBHP, members are informed that they can ask to see a provider who may not be listed in the provider directory. The provider handbook outlines the member's rights regarding choice of providers.	
5. 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. *42 CFR 438.206(b)(5)* Contract: Amendment 6, Exhibit A-2—none	**Documents submitted:** 1. SCALetter_Practitioner_2015DEC22_PR_2BHO-Entire Document 2. SCALetter_Facilities_2015DEC22_PR_2BHO-Entire Document 3. Provider Manual_2BHO-Page 53 *Misc **Description of Process:** This element is delegated to Beacon Health Options by Foothill Behavioral Health Partners (FBHP). Single Case Agreements require that out-of-network providers coordinate with Beacon	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Health Options with respect to payment (SCALetter_Practitioner_2015DEC22_PR_2BHO) and (SCALetter_Facilities_2015DEC22_PR_2BHO). Referenced in these individual single case contracts is reference to the Provider Manual (Provider Manual_2BHO) which also indicates that members cannot be billed for behavioral health services.	
6. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.9	**Documents submitted:** 1. Access_To_Care_FINAL_QTR4FY16_FBHP- Entire Document 2. Provider Manual_2BHO-Pages-12 and 38 *Misc. 3. 210L_ MemberRequestRoutine_2BHO-Page 1 Section 1 4. 211LMemberRequestUrgent_2BHO-Page 1 Section 1 A-C 5. CarlsonS_Fail_EmergencyResponseTesting_FBHP-Entire Document 6. HuntoonS_IPN_PASS_EmergencyResponseTesting_FBHP-Entire Document 7. SUD Provider After Hours Availability Requirement_2BHO-Entire Document 8. eNewsletter_2016_Aug-2BHO-Page 7 9. IPN_EmergencyAccessToCare_Q4FY16_Calls_FBHP-Entire Document 10. FBHP 3rd Qtr QI report 2016_pages 3-4 11. JCMH Access To Services 12. SUD Documentation Training PPT_2015June_QM_slide 12. 13. FBHP Policy Q12.1 Access for member with TBI_page 1 section 1.A 14. 2015PractionerContract-2BHO 15. SUD Provider After Hours Availability Requirement_2BHO-Entire Document 16. eNewsletter_2016_Aug-2BHO-Page 7	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	17. IPN_EmergencyAccessToCare_Q4FY16_Calls_FBHP-Entire Document 18. FBHP_FY16_Annual Quality Report_Attachment_ACF_NCF_Client survey report_page3 19. FBHP Policy Q3.6 Access to Services_page 2 20. FBHP MHC compliance checklist 2016__Access to services, page 2 **Description of Process:** In order to ensure that covered services are available 24 hours a day, 7 days a week when medically necessary Foothills Behavioral Health Partnership (FBHP) maintains policies which establishes standards to ensure that, "contract-required services are available 24 hours a day, seven days a week, when medically necessary" FBHP Policy Q3.6 Access to Services_ (Document 19)_ 210L_MemberRequestRoutine_2BHO (Document 3) and 211LMemberRequestUrgent_2BHO_Document 4). FBHP Policy Q12.1 Access for member with TBI_page 1 section 1.A (Document 13) 2015PractionerContract-2BHO (Document 14) also states that the provider will, "make available to MCD Members those Medically Necessary Covered Services provided by Provider within the scope of his/her/its professional license, registration and or certification twenty-four (24) hours a day, seven (7) days a week. FBHP provides training to providers regarding availability of services 24/7/365 utilizing SUD Documentation Training PPT_2015June_QM_slide 12 (Document 12).	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	In addition, FBHP ensures that providers are meeting the standards set forth in the contract by conducting regular monitoring. Access_To_Care_FINAL_QTR4FY16_FBHP demonstrates quarterly monitoring surrounding access standards. The details of this report are shared at the CAUMC/QISC committee on a regular basis. FBHP also tracks performance through our quarterly report, and the providers have written policies regarding access standards (Document 11-JCMH Access To Services). Furthermore, the emergency responsiveness of the IPN provider network is monitored regularly through ongoing testing (CarlsonS_Fail_EmergencyResponseTesting_Document 5; FBHP, HuntoonS_IPN_PASS_EmergencyResponseTesting_FBHP_Document 6), SUD Provider After Hours Availability Requirement_2BHO, eNewsletter_2016_Aug-2BHO). During the test calls the IPN providers are phoned to assess the validity of their emergency instructions contained within their voicemail and to test their responsiveness in returning calls within the 15 minute requirement. Likewise, Beacon also monitors the perceptions surrounding access to care of the members we serve through the semiannual Fact Finders report Document 1 (Access_To_Care_FINAL_QTR4FY16_FBHP). The Provider Manual_2BHO (Document 2) also provides detail on standards for coverage of service.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid fee-for-service if the provider serves only Medicaid members. • Minimum hours of provider operation shall include service coverage from 8 a.m. to 5 p.m. Mountain Time, Monday through Friday. • Extended hours of operation and service coverage shall be provided at least 2 days per week at clinic treatment sites, which may include additional morning, evening, or weekend hours. • Emergency coverage 24 hours a day, 7 days a week. *42 CFR 438.206(c)(1)(ii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.2, 2.5.8.1.3	**Documents Submitted/Location within Documents:** 1. Provider Manual_2BHO-pages 11-12 *Misc 2. FBHP Policy Q3.6 Access to Services_entire document 3. JCMH Extended Office Hours 2015 4. MHP Locations and hours of Operation 5. FBHP MHC compliance checklist 2016_Access to services **Description of Process:** This element is shared between Beacon Health Options and Foothills Behavioral Health Partners (FBHP). The Provider Manual (Provider Manual_2BHO) is incorporated into each providers' contract as a participating Beacon Health Options/BHO provider. Providers are required to offer hours of operation that are not less than that offered to any other client/member that has other coverage including self-pay as required in FBHP Policy Q3.6 Access to Services and monitored (JCMH Extended Office Hours 2015-(Document 3) and MHP Locations and hours of Operation-(Document 4). This element is reviewed annually in the contract compliance audit as noted in audit tool FBHP MHC compliance checklist 2016 (Document 5). Our providers are aware of this requirement and grievances or survey results may also be used for monitoring as applicable.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. 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 1 hour of contact in urban and suburban areas. – In person within 2 hours of contact in rural and frontier areas. • Urgently needed services are provided within 24 hours of 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.) • Routine outpatient appointments following intake/initial assessment shall occur at least 3 times within 45 days. • Outpatient follow-up appointments shall occur within 7 business days after discharge from an inpatient psychiatric hospitalization or residential facility.	**Documents submitted:** 1. Access_To_Care_FINAL_QTR4FY16_FBHP- Entire Document 2. IPN_EmergencyAccessToCare_Q4FY16_Calls_FBHP-Entire Document 3. CarlsonS_Fail_EmergencyResponseTesting_FBHP-Entire Document 4. HuntoonS_IPN_PASS_EmergencyResponseTesting_FBHP-Entire Document 5. SUD Provider After Hours Availability Requirement_2BHO-Entire Document 6. eNewsletter_2016_Aug-2BHO-Entire Document 7. Provider Manual_2BHO-Pages 10, 11 and 49 *Misc 8. JeffersonCtr_ProvMontioring_FBHP-Entire Document 9. IPAuditTool_final_2BHO-Instructions tab,cell 59C 10. SUD Committee MeeetingMinutes_2016APR27-2BHO-Item VII 11. FBHP Policy Q3.6 Access to Services_Entire document 12. JCMH Access To Services_Entire Document 13. JCMH Emer Serv flyer 14. MHP BRIEF URGENT CARE_page 1 15. MHPAccess to Care_Entire Document 16. FBHP MHC compliance checklist 2016_Access to services, page 2 17. Access Standards for Medicaid Consumers_entire document 18. FBHP_FY17_Quality Improvement Plan_pages 6-9; 12-13 19. FBHP 3rd Qtr QI report 2016_pages 3-5; 8-10	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Ongoing mental health and substance use disorder services shall be scheduled and continually provided for within 2 weeks from an initial assessment or intake appointment. (Ongoing services include but are not limited to assignment to a therapist and individual/group outpatient therapy.) *42 CFR 438.206(c)(1)(i)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.1—2.5.8.1.11.6	**Description of Process:** This element is shared between Beacon Health Options and Foothills Behavioral Health Partners (FBHP). The emergency responsiveness of the IPN provider network is monitored regularly through ongoing testing (CarlsonS_Fail_EmergencyResponseTesting_FBHP, HuntoonS_IPN_PASS_EmergencyResponseTesting_FBHP), SUD Provider After Hours Availability Requirement_2BHO, eNewsletter_2016_Aug-2BHO and IPN_EmergencyAccessToCare_Q4FY16_Calls_FBHP. During the test calls the IPN providers are phoned to assess the validity of their emergency instructions contained within their voicemail and to test their responsiveness in returning calls within the 15 minute requirement. Beacon Health Options conducts various monitoring activities to ensure compliance with contractual language and standards (2015PractionerContract-2BHO). In order to monitor access to services Beacon regularly monitors access to care standards quarterly (Access_To_Care_FINAL_QTR4FY16_FBHP). Results are shared with providers through the use of JeffersonCtr_ProvMontioring_FBHP. FBHP monitors through Quality Assurance Program as noted through FBHP_FY17_Quality Improvement Plan_pages 6-9; 12-13(Document 18) and evidenced in FBHP 3rd Qtr QI report 2016_pages 3-5; 8-10 (Document 19). FBHP and its partner mental health centers follow all required time frames as identified in FBHP Policy Q3.6 Access to Services_entire document (Document 11), Access Standards for	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Medicaid Consumers (Document 17) and monitors through quality checks and the annual contract compliance audit (FBHP MHC compliance checklist 2016_Access to services, page 2; Document 16).	
9. 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. *42 CFR 438.206(c)(1)(iv) through (vi)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.8	**Documents submitted:** 1. Access_To_Care_FINAL_QTR4FY16_FBHP-Entire Document 2. JeffersonCtr_ProvMontioring_FBHP-Entire Document 3. IPN_EmergencyAccessToCare_Q4FY16_Calls_FBHP 4. FBHP MHC compliance checklist 2016_Access to services_Items 14-20 5. FBHP_FY16_Annual Quality Report_page 7 6. FBHP 3rd Qtr QI report 2016_pages 3-5; 8-10 7. FBHP Policy Q5.5 Provider Monitoring_Entire document **Description of Process:** This element is delegated to Beacon Health Options by Foothills Behavioral Health Partners (FBHP). Beacon Health Options maintains mechanisms in order to ensure compliance with timely access. Access_To_Care_FINAL_QTR4FY16_FBHP and IPN_EmergencyAccessToCare_Q4FY16_Calls_FBHP Foothills Behavioral Health Partners also monitors through the QI program, as identified in FBHP Policy Q5.5 Provider Monitoring_Entire document. FBHP MHC compliance checklist 2016_Access to services demonstrate various access monitoring activities which occur through the year. Furthermore, on an annual basis Beacon Health Options conducts formal monitoring with its providers	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	(JeffersonCtr_ProvMontioring_FBHP). The formal monitoring is a comprehensive review of key area of performance. The performance measures are reviewed with QI team and monitored to ensure compliance with standards (FBHP_FY16_Annual Quality Report_page 7) and FBHP 3rd Qtr QI report 2016_pages 3-5; 8-10 (Document 6).	
10. 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 and diverse cultural and ethnic backgrounds. (Includes a written cultural competency plan, policies, and training) *42 CFR 438.206(c)(2)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.12.1—2.5.12.3	**Documents submitted:** 1. CulturalCompetenceTrainingSlideDeck_2BHO– entire document 2. Referral_Connect_2BHO – Entire Document 3. Provider Handbook_2BHO –Pages 30, 115 and 121*Misc. 4. ProviderDirectory2BHO-Entire Document 5. 311L Handling Calls for Limited English Speaking Members_2BHO-Entire Document 6. 306L_Member Materials Policy _2BHO-Entire Document 7. MemberHandbook_FBHP Pages 10, 14 *Misc 8. FBHP Attendance Sheet CultComp Training 2015_Entire document 9. FBHP Cultural Competency M2 6 executed 2016_Entire document 10. FBHP Cult Comp Plan 7-1-2016_Entire document 11. FBHP Cultural Competency Self Assessment 2015_Entire document 12. JCMH Intake Assessments Including Culture and Transportation for FBHP 2015_page 2 13. FBHP Policy M4.7 Member Information_Entire document 14. FBHP Policy M8.4 Language Assitance4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: Beacon provides any support to Foothills Behavioral Health Partners (FBHP) in relation to this Cultural Comptency requirement. This support is offered across vartious platforms. FBHP also has cultural components addressed through the identified policies (Document 8; FBHP Cultural Competency M2 6 executed 2016), and the culutural compentency plan (Document 9; FBHP Cult Comp Plan 7-1-2016_Entire document) which is reviewed annually based on self assessment (Document 10; FBHP Cultural Competency Self Assessment 2015_Entire document). Annual training is also provided through OMFA Director (Document 7; FBHP Attendance Sheet CultComp Training 2015_Entire document). The provider directory includes languages spoken by each of the providers listed. ReferralConnect, which is available on our website, can be used to find providers with language or cultural expertise. The user can select a provider using several fields in the data base, including languages spoken or specialty. Providers are required to include cultural and social factors when doing their initial assessment, per Section 17 in the provider handbook. Assessing cultural factors is a component of the clinical assessment and is incorporated into the service plan when appropriate. The provider handbook explains the requirements for medical record documentation (pages 85-87). As part of the initial assessment, providers should assess social and cultural factors that may be important to the member/family as evidenced by JCMH	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Intake Assessments Including Culture and Transportation for FBHP 2015_page 2 (Document 10). FBHP provides access to interpreter services free of charge. Members are informed of this right in the member handbook (MemberHandbook_FBHP page 10, 14; Document 6). Providers are also made aware of this in the provider handbook (Provider Handbook_2BHO; Document 6). All required materials are available in English and Spanish. When distributing information through the mail, we identify members who speak Spanish, as noted on their eligibility application form, and send them information in Spanish so that they don't have to call to request the information. When telephonic oral interpretation is requested by a member who speaks a language other than English or Spanish, we use the Voiance® language line, which is accessed by following policy 311L Handling Calls for Limited English Speaking Members and FBHP Policy M8.4 Language Assitance4. If a provider is needed for a face to face interaction, we select interpreters from professional language service providers, or use the interpreters authorized to provide interpretation for the court system. ASL and sign language interpreters who are used are certified. We do not use family or friends for interpreter services, unless a member requests we do so. All member materials are written at a 6th grade reading level and are available in English or Spanish. Materials are tested using internet available tools such as the Fleisch-Kinkaid test. Materials are also submitted to the Department for approval prior to distribution. Policy 306LMemberMaterials_Policy_2BHO and FBHP Policy M4.7 Member Information_Entire document	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	explains the cultural factors that should be considered when developing member materials. Culturally specific information that should be considered includes language (limited English proficiency) and disability (visual or auditory impairments, disabilities that impact communication). An example of materials in Spanish includes the member handbook. FBHP provides their own cultural competency trainings. Beacon has provided training information for Cultural Competency with an updated training slide deck – Cultural Competency Training slide deck which incorporated material on Lesbian, Gay, Bisexual and Transgender concerns. This slide deck was made available to FBHP (CulturalCompetenceTrainingSlideDeck_2BHO). This slide deck has incorporated material on Lesbian, Gay, Bisexual and Transgender concerns.	

Results for Standard II—Access and Availability							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	10	**Total Score**		=	10

Total Score ÷ Total Applicable	=	100%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The Contractor must comply with the following requirements based on 42 CFR 441.50 to 441.62 effective October 1, 2015, and Code of Colorado Regulations 10 CCR 2505-10 8.280 effective April 30, 2016. References Contract: Amendment 6, Exhibit A-2—2.5.13.5 The Contractor shall comply with all federal (441.50 to 441.62) and state (10 CCR 2505-10 8.280) EPSDT regulations. Contract: Amendment 6, Exhibit A-2—2.2.1 The Contractor shall provide or arrange for the provision of all medically necessary covered services and diagnoses and procedures, including *services* identified under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, 42 CFR Sections 441.50 to 441.62. (Includes informing, screening, diagnosis, treatment, discretionary services, referral/care coordination, and transportation and scheduling assistance.) Additional Resources State Medicaid Manual/Section 5 offers further detailed instructions and guidance regarding the various components of the EPSDT Program.		
1. The Contractor must have written policies and procedures for providing EPSDT services to members age 20 and under. • The definition of EPSDT services includes informing, screening (assessment), diagnosis, treatment, discretionary services (e.g. medically necessary wrap-around services), referral and care coordination, and transportation and scheduling assistance. 10 CCR 2505-10 8.280.2 and 8.280.8A	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. FBHP Policy EPSDT_Entire document 3. IPN ClinicalAuditTool revised_Section F_Items 69-74. 4. FBHP MHC compliance checklist 2016_Access to services_item A20 **Description of Process:** The BHO delegates utilization management and provider relations functions to Beacon Health Options, which includes management of the call center and independent provider network training. In addition, FBHP closely monitors and works with their providers to ensure the written policies are in place for members as noted FBHP MHC compliance checklist 2016_item A20. Beacon's	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	policy, 248L_EPSDT_2BHO-Entire Policy, supports processes to ensure that independent provider network providers are aware of EPSDT services and identifies how members are made aware. IPN ClinicalAuditTool revised_Section F_Items 69-74 monitors the IPN providers policies, FBHP MHC compliance checklist 2016_Access to services_item A20 monitors to ensure policies and procedures are in place. In managing these functions for FBHP, Beacon abides by the FBHP EPSDT policy in their interactions with providers as well as referring members for services. FBHP monitors both CMHCs and IPN providers adherence to the policy as well through routine medical record audits and compliance audits. Beacon has established a comprehensive EPSDT policy and a variety of other resources to support members and providers in understanding and accessing this benefit. Policy **248L_EPSDT_2BHO-Entire Policy** and **FBHP Policy EPSDT _Entire document** are the foundational documents for this standard. They are relevant in their entirety, but the "Definitions" section in **248L_EPSDT_2BHO-Entire Policy** II.A includes the specific language identified in this element. Although the EPSDT screenings and most medical services may be delivered typically in primary care settings, the BHO and its contracted behavioral health providers are responsible for coordinating with primary care providers and assisting members to access the recommended services, regardless of whether the service is covered by the BHO. For example, the EPSDT screening completed by the primary care physician may indicate a need for developmental disability services. The BHO and/or its	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	behavioral health provider is then responsible for referring the member/family to the community centered board (CCB) or other resource for identification and provision of the necessary services.	
2. The Contractor must notify members age 20 and under of the benefits and options for children and adolescents under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and is responsible for ensuring that children and their families are able to access the services appropriately. The Contractor must— • Provide a combination of written and oral methods to inform all eligible members (or their families) about the EPSDT program within 60 days of enrollment and annually thereafter. – Member communications must effectively inform those individuals who are blind or deaf or who cannot read or understand the English language. • Using clear and nontechnical language, provide information about the following— – The benefits of preventive healthcare. – The services available under the EPSDT program and where and how to obtain those services; (includes physical, mental, oral and substance abuse, as well as services that may have limits or services not covered in the state plan).	**Documents submitted:** 1. Member_Handbook_FBHP-EPSDT Section –Page 33*Misc 2. CO-HF-Handbook_2BHO-pages 16-20 3. JCMH Coordination of Care Letter EPSDT_page 2 4. MHP English EPSDT packet_Entire document 5. MHP EPSDT letter to providers Espanol_entire document 6. JCMH Coordination and Continuity of Care Policy and Procedure_Section C_page 2 7. FBHP MHC compliance checklist 2016_Access to services_A20 **Description of Process:** The BHO uses a variety of mechanisms to communicate with its members about the EPSDT program and how to access services. Providers are monitored for member communications regarding EPSDT. See FBHP MHC compliance checklist 2016_item A20. Members are informed about the EPSDT program through the Health First Colorado Member Handbook, which is mailed to all new members upon enrollment and annually thereafter. Please see CO-HF-Handbook_2BHO (Document 2). This handbook also is available to member on the Health First Colorado website. BHO members who are seen by a PMHC are educated regarding EPSDT benefits as evidenced by MHP English EPSDT packet_Entire document (Document 4), JCMH Coordination of Care Letter EPSDT_page 2 (Document 3).	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– That the services under the EPSDT program are provided without cost to members 20 and under. – That necessary transportation and scheduling assistance for EPSDT services is available to members upon request, and the process to make a request. *42 CFR 441.56 (a)(1)—(4)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.9.1; 2.5.9.2; 2.5.8.1.4	The Member_Handbook_FBHP-EPSDT Section (Document 1) contains detailed information about the EPSDT benefit. It uses non-technical language to describe the purposes of the EPSDT program and who is eligible. This section also explains the purpose of well-child check-ups (i.e., preventive healthcare). Providers also include information to members who are requesting services as noted in JCMH Coordination of Care Letter EPSDT_Entire document (Document 3). This section also explains how to access a Family Health Coordinator and how to locate additional information about the program on the state EPSDT website. Members are encouraged to call the BHO's Office of Member and Family Affairs (OMFA) or the Access to Care Line to get additional assistance or to have their questions answered about EPSDT. The Member Handbook is available to all members on the BHO's website in addition to additional information: http://fbhpartners.com/members/files/FBHPartners-Member-Handbook.pdf . Members who need EPSDT information in oral form or in a language other than English can obtain the information by contacting the OMFA office or the BHO's Access to Care Line to arrange translation or interpretation services (see p. 12 of the Member Handbook for details). For members who do not speak English, we will find a provider who speaks the member's native language, or we will provide an interpreter. If the member is deaf or hard of hearing, we will find a provider who signs or will arrange for an interpreter. The Member Handbook is available in Spanish upon request and EPSDT information can be provided in Spanish (Document 5; MHP EPSDT letter to providers Espanol_page 2). There is no fee for any of these services. We use	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Relay Colorado or a TTY line to communicate effectively with deaf members and use Voiance Language Line telephone interpreters, if we do not have a staff person who speaks the member's language.	
3. The Contractor must reasonably ensure the provision of all applicable components of periodic health screens (assessments) to EPSDT beneficiaries who are receiving BHO services or referred to a BHO provider. *42 CFR 441.56 (b), 441.59 (b)* 10 CCR 2505-10 8.280.8.C; 8.280.4.A.3 (d) and (h), and 8.280.4.A (4) Contract: Amendment 6, Exhibit A-2—2.5.13.2.1	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. FBHP EPSDT Policy_Entire document 3. JCMH Coordination and Continuity of Care Policy and Procedure_Section C_page 2 4. MHP- EPSDT Policy 10.16_Entire Document 5. FBHP MHC compliance checklist 2016_Access to services_item A20 **Description of Process:** The BHO makes every effort to reasonably ensure the provision of all applicable components of periodic health screens to EPSDT beneficiaries who are receiving BHO services or are referred to a BHO contracted provider. Please see 248L_EPSDT_2BHO-Entire Policy (Document 1)for details and FBHP MHC compliance checklist 2016_item A20 for compliance monitoring. Section IV, "Procedures" (all subsections), specifically outlines what is expected when a BHO member has a primary care physician, and when they do not. If a member does not have a primary care physician or pediatrician, Beacon call center staff can assist the member in identifying a health care provider through the State's enrollment broker. This referral also can be completed by the behavioral health provider, if the client/family has directly accessed behavioral health services with a treatment provider FBHP EPSDT Policy_Procedures_page 2. Once the member becomes established with the primary care physician, the behavioral health provider must coordinate with the	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	PCP to complete any applicable health screenings and arrange for or provide the identified services as identified in FBHP EPSDT Policy an documented through JCMH Coordination and Continuity of Care Policy and Procedure_Section C_page 2 (Document 3) MHP-EPSDT Policy 10.16_Entire Document (Document 4). For members who already have an established PCP, the behavioral health provider must coordinate care with that physician and assist the member in accessing any recommended services. If the EPSDT assessment reveals that the member needs a BHO-covered service that cannot be provided by the initial behavioral health provider (e.g., a neuropsychological assessment), the behavioral health provider must contact the BHO to help coordinate this service.	
Findings: Policies clearly outlined the responsibility of the behavioral health provider to periodically discuss with individual members whether or not a member's PCP performed a well-child check and to either refer the member to a PCP for necessary screenings or request screening results from the PCP. Both MHP and JCMH used a template letter to request results of EPSDT screenings from the member's PCP. However, procedures were absent or unclear regarding the provider's responsibility for follow-up if the PCP did not respond to the request and/or how actively the provider or care coordinators were expected to assist the member in obtaining EPSDT screening services. In addition, FBHP provided no evidence that the behavioral health providers were trained on all components of EPSDT screenings and the medical record audit failed to monitor for documentation of the results of EPSDT screenings obtained from the PCP. Therefore, it appeared that FBHP *attempted* to ensure the provision of periodic health screens (assessments) to EPSDT beneficiaries, but did not have procedures to thoroughly complete the process.		
Recommendations: HSAG recommends that FBHP enhance procedures, provider communications, and training to clarify expectations and mechanisms for assisting EPSDT-eligible members receiving BHO services with obtaining all applicable components of periodic health screens.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. Results of screenings (assessments) and examinations for members receiving BHO services shall be recorded in the child's medical record. Documentation shall include, at a minimum, identified problem and negative findings and further diagnostic studies and/or treatments needed and the date ordered. 10 CCR 8.280.4.A (5)	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. FBHP EPSDT Policy_Entire document 3. EPSDT Provider Training Slides_2BHO—Slide 5 4. IPN ClinicalAuditTool revised_Section F_Items 69-74. 5. MHP- EPSDT Policy 10.16_page 2_ items 6-11 **Description of Process:** The BHO's contracted behavioral health providers are responsible for documenting the results of all screenings, assessments and examinations for members receiving BHO services. This requirement is stated in the **248L_EPSDT_2BHO-Entire Policy**, specifically in section IV. J and **FBHP EPSDT_Procedures, page 3 item 10**: "The behavioral health provider must record the results of all screenings and examinations in the child's medical record. Documentation shall include, at a minimum, identified problem(s) and negative findings and further diagnostic studies and/or treatments needed, and the date(s) ordered." Providers are instructed about this requirement in their onboarding training, which includes specific information about EPSDT. See **EPSDT Provider Training Slides_2BHO—Slide 5**.Providers' compliance with this requirement is assessed through the BHO's quality audit mechanisms utilizing **IPN ClinicalAuditTool revised_ Section F_Items 69-74.** Providers will identify if a screening has or has not occurred, and document linkage or service provision within the medical record. **See MHP- EPSDT Policy 10.16_ page 2 items 6-11.**	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: Policies and procedures and the EPSDT provider training specifically stated that results of EPSDT screenings obtained from the PCP or conducted by the BHO provider must be documented in the medical record. However, neither the IPN clinical audit tool nor the FBHP MHC compliance checklist included monitoring for documentation in the medical record of results of screenings or examinations.		
Recommendations: HSAG recommends that FBHP develop a mechanism to ensure that results of screenings (assessments) and examinations for members receiving BHO services are recorded in the members' medical records.		
5. The Contractor must ensure the delivery of EPSDT Contractor-covered services. 10 CCR 2505-10 8.280.8A	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. FY16_UM Program Description_FBHP—Section IV [pp. 10-25] 3. FBHP Policy EPSDT_Entire document 4. JCMH Coordination of Care Letter EPSDT_entire document 5. MHP English EPSDT packet_page 1 **Description of Process:** The BHO is responsible for authorizing and ensuring the delivery of all contract-covered services identified as medically necessary for EPSDT-eligible members. **See FBHP Policy EPSDT_Entire document and 248L_EPSDT_2BHO-Entire Policy** (Section IV.M, p. 6) MHP English EPSDT packet_ Page 1 and JCMH Coordination of Care Letter EPSDT_entire document. This notes how BHO covered services can be provided by PCMHC. The BHO has existing UM processes for meeting this requirement. The operation of the FBHP UM program is outlined in the **FY16_UM Program Description_FBHP—Section IV** [pp. 10-25]. Contracted behavioral health providers can deliver many outpatient services, such as individual or family therapy, without obtaining prior authorization and without any limit to the number	Information Only

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	of units. Other services, such as psychological evaluations or higher levels of care (e.g., residential or inpatient), may require prior authorization and ongoing reviews to determine continued medical necessity. Out-of-network providers can obtain authorizations through a robust Single Case Agreement process. Providers can request authorization for any covered service. Traditional outpatient services, such as individual and family therapy, are typically authorized for a period of six months at a time. Other services may be authorized for a defined purpose (e.g., psychological evaluation) with a specified number of units, or for a defined episode of care. If the authorized units are exhausted or the specified time period expires, the provider can request additional units or time. A member or his/her family or designated client representative also can request covered services directly by contacting the BHO or by making their request known to the BHO's community behavioral health center partner. For example, if residential treatment is being recommended by the EPSDT assessor, the member may contact the CBHC partner's RTC Liaison to arrange a mental health needs assessment. The CMHC's RTC Liaison will then coordinate the review of that assessment by the BHO and authorization of services, if appropriate.	
Findings: Both the Beacon and FBHP EPSDT policies stated that the BHO would provide coverable medically necessary mental health services indicated through screenings or referral to the BH provider, "even if the service is not covered under the plan." The MHP and JCMH EPSDT coordination of care letter to PCPs included language to remind PCPs that children who need mental health services as a result of EPSDT screenings should be referred to the CMHC.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Policies also stated that Beacon/FBHP would authorize any identified diagnostic or treatment services, including those related to substance abuse needs, that meet the definition of "medical necessity" and criteria for authorization specific to EPSDT, accurately outlining the EPSDT definition of "medical necessity" and criteria for authorization. However, the FBHP UM Program Description and Beacon's Quality Management/Utilization Management Program Description included no information specific to authorization of EPSDT-related services (e.g., the EPSDT definition of "medical necessity," clinical guidelines specific to EPSDT, or reference to the Beacon EPSDT policy). FBHP provided no evidence of development or implementation of UM procedures to operationalize the EPSDT policy.		
Recommendations: HSAG recommends that FBHP modify or develop policies and procedures to demonstrate that UM staff members are using EPSDT-specific criteria and definitions of "medical necessity" when authorizing EPSDT-related services. The goal of these revisions is for the policies and procedures to reflect that FBHP ensures that its UM contractor (Beacon) more clearly aligns organizational UM procedures with the definition of "medical necessity" and authorization criteria outlined in the EPSDT policies.		
6. The Contractor must ensure that BHO providers provide diagnostic services in addition to treatment of all mental illnesses or conditions (includes substance abuse) discovered by any screening and diagnostic procedure—even if the services are not covered in the plan. *42 CFR 441.56 (c)* 10 CCR 2505-10 8.280.4.A (3) (e); 8.280.4.C (3) Contract: Amendment 6, Exhibit A-2—2.5.13.2.5	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. FBHP Policy EPSDT_Entire document 3. MHP- EPSDT Policy 10.16_Entire document **Description of Process:** The BHO is responsible for ensuring that all diagnostic services in addition to treatment of all mental illnesses or conditions (including substance use disorders) discovered by any screening and diagnostic procedure, even if the services are not covered by the BHO's benefit plan. See **248L_EPSDT_2BHO-Entire Policy** (Section IV.O, pp. 6-7) **FBHP Policy EPSDT_(page 1; Medical Necessity)** As noted in #5 above, a provider or member can request authorization for any BHO covered service that is medically necessary, according to the EPSDT medical necessity definition. If the necessary service is covered, but cannot be delivered by the primary behavioral health provider because of training or	Information Only

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	licensure limitations, the provider must coordinate with the BHO to refer the member to an appropriate provider for this service. If the necessary service is not covered by the BHO benefit, the primary behavioral health provider is responsible for coordinating a referral to a provider who can deliver the service. For example, if a member is identified as needing autism-specific services (e.g., a functional behavioral assessment for applied behavioral analysis), which would be uncovered by the BHO, the provider must assist the member in obtaining services through the community-centered board or another qualified provider. For covered and uncovered services, the process is identified in PMHC Policy **MHP- EPSDT Policy 10.16_page 1_medical necessity and number 9.**	

Findings:
The FBHP, Beacon, and MHP EPSDT policies stated that the BHO provides all medically necessary EPSDT-related services, even if the service is not covered under the plan. The Beacon EPSDT policy stated the BHO must provide referral assistance to members for diagnosis or treatment services not covered by the plan. Staff members stated that if the necessary service is not covered by the BHO benefit, the primary behavioral health provider is responsible for coordinating a referral to a provider who can deliver the service. However, this responsibility was not described in FBHP's or the CMHC's policies. FBHP also had no written procedures, provider training, or other information to provide evidence that behavioral health providers had the resources to successfully assist members with obtaining non-covered services or that BHO care coordinators would assist providers in making such referrals. As evidenced in the on-site denial record reviews, notices of action to members eligible for EPSDT services referred the member to the Department's customer service line to determine if the denied service is covered under Medicaid fee-for-service. FBHP did not appear to have a coordinated process for ensuring provision of EPSDT diagnostic services and treatment of all mental illnesses or conditions "not covered in the plan."

Recommendations:
HSAG recommends that FBHP develop more detailed procedures and a cohesive mechanism for ensuring that treatment of mental health conditions related to EPSDT but not covered under the BHO contract are adequately addressed.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. If the provider is not licensed or equipped to render necessary treatment or further diagnosis, the provider shall refer the individual to an appropriate practitioner or facility or to the Outreach and Case Management Office (Healthy Communities) for assistance in finding a provider. 10 CCR 2505-10 8.280.4.C.2 Contract: Amendment 6, Exhibit A-2—2.5.13.1.1	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. FBHP Policy EPSDT_Entire document 3. MHP English EPSDT packet **Description of Process:** This requirement is specifically defined in **248L_EPSDT_2BHO-Entire Policy** [section IV.N]. If the primary therapist or other provider is not able to render the EPSDT identified services, they shall refer the member to a provider who is able to provide that screening, diagnosis or treatment as defined in **MHP English EPSDT packet(page 2-11)**. The behavioral health provider can obtain referral assistance from the BHO by calling the Access to Care Line or by contacting the Healthy Communities office in their area.	Information Only
Findings: The Beacon EPSDT policy included this requirement verbatim and stated that the BHO provider may contact BHO care coordinators or Health Communities for assistance with referrals. However, neither the provider manual nor provider training inform providers of this requirement or related processes. The FBHP and MHP policies address linking the member to an appropriate provider to furnish necessary screenings, but do not address referring the member for diagnostic or treatment services that the BHO provider is not equipped to render. Both MHP and JCMH had a mechanism to furnish members general information on Healthy Communities, but that information does not fulfill this requirement. During on-site discussions, staff members stated that behavioral health providers make referrals to other providers as necessary—not specific to EPSDT diagnosis or treatment.		
Recommendations: HSAG recommends that FBHP develop procedures and/or enhance provider communications to clearly specify provider responsibilities for making referrals to appropriate practitioners or to Healthy Communities for necessary treatment or further diagnostic services and define mechanisms for effectively doing so.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor defines "Medical Necessity for EPSDT Services" as: • A service that is found to be equally effective treatment among other less conservative or more costly treatment options; • Meets one of the following criteria: – The service is expected to prevent or diagnose the onset of an illness, condition, or disability. – The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. – The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability. – The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living. • May be a course of treatment that includes observation or no treatment at all. – The Contractor's UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements: o The service is medically necessary. o The service is in accordance with generally accepted standards of medical practice.	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. FBHP Policy EPSDT_Entire document 3. MHP English EPSDT packet_page 5 **Description of Process:** **Beacon has some delegated functions of this standard. Beacon Health Options** has defined medical necessity for EPSDT services in its EPSDT policy, **248L_EPSDT_2BHO-Entire Policy;** FBHP has the same definition defined in **FBHP Policy EPSDT page 1,** and identified at PMHC through **MHP English EPSDT packet_page 5**. Please see Section II. D (pp. 3-4) for this medical necessity definition, and see Sections IV.M through IV.O (pp. 6-7) for the UM processes related to the authorization of covered versus non-covered medically necessary services.	Information Only

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Requirement	**Evidence as Submitted by the BHO**	**Score**
o The service is clinically appropriate in terms of type, frequency, extent, and duration. o The service provides a safe environment or situation for the child. o The service is not for the convenience of the caregiver. o The service is not experimental and is generally accepted by the medical community for the purpose stated. *42 CFR 441.57* 10 CCR 2505-10 8.280.1, 8.280.4.D and E		
Findings: The Beacon and FBHP EPSDT policies included the EPSDT definition of "medical necessity" and the criteria for approval of authorization requests as outlined in the requirement. However, FBHP should note that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—includes the EPSDT-specific criteria per 8.280.4.E. HSAG strongly recommends that the Beacon and FBHP EPSDT policies incorporate the definition of "medical necessity" as outlined in the Findings section of Standard I, element 4, of this tool. The FBHP UM Program Description did not address use of different medical necessity criteria for reviewing or approving EPSDT-related services, but stated that UM functions are delegated to Beacon. Beacon's Quality Management/Utilization Management Program Description included no EPSDT-specific authorization procedures, no EPSDT medical necessity criteria, and no EPSDT-related review criteria or clinical guidelines. During on-site interviews, staff members confirmed no additional UM policies and procedures specific to processing requests for services for members ages 20 and under. Therefore, it appeared that the expanded "medical necessity" definition related to EPSDT services was isolated in EPSDT policies and that Beacon had not incorporated this definition into UM policies and procedures or operations.		
Recommendations: HSAG recommends that FBHP ensure that the UM contractor (Beacon) establishes a link between the EPSDT "medical necessity" definition and criteria for authorization described in EPSDT policies and UM operational practices.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor must provide referral assistance to members receiving BHO services for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening (assessment) and diagnosis. • The Contractor must coordinate with other programs that may provide EPSDT-related services: State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Health Care Program for Children with Special Needs), other public health, mental health, and education programs and related programs such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC). – Includes Child Find, Early Intervention Colorado, and the Accountable Care Collaborative. • Contractors are encouraged to refer children and their families to the Healthy Communities program in their area for community services and medical referrals, transportation information, appointment assistance, and administrative case management. – Contractors are encouraged to contact Healthy Communities for assistance in locating families who may have excessively missed appointments.	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. FBHP Policy EPSDT_Entire document 3. MHP English EPSDT packet_page 3 4. JCMH Coordination and Continuity of Care Policy and Procedure **Description of Process:** The BHO and/or its contracted behavioral health providers are responsible for coordinating services identified during the screening and diagnosis processes, even when these services are not included in the BHO's covered benefits. This requirement is detailed in **248L_EPSDT_2BHO-Entire Policy** [Section IV.O, p. 6]. For example, if the EPSDT assessment reveals that the member needs nutritional supports, the member or guardian would be referred to the Special Supplemental Food Program for Women, Infants and Children (WIC) or any other identified need. See **MHP English EPSDT packet_**page 3 **and JCMH Coordination and Continuity of Care Policy and Procedure_**entire document. JCMH Coordination and Continuity of Care Policy and Procedure identifies the different programs or referrals they may be able to provide, in addition to their routine services. Both demonstrate how individuals may be referred to additional services.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• The Contractor must have a process to ensure that medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action. *42 CFR 441.61 and 441.62* 10 CCR 2505-10 8.280.8.D (5) Contract: Amendment 6, Exhibit A-2—2.5.13.1		

Findings:
The Beacon EPSDT policy required the BHO or contracted providers to coordinate necessary EPSDT services with outside agencies. The FBHP policy and MHP policy included no requirements or procedures for coordinating services with external agencies, but rather referred providers to the Internet link for referrals to Healthy Communities. The JCMH Coordination of Care policy stated that on assessment members will receive information about Healthy Communities but included no specific expectations related to coordinating care with external programs/agencies and providing referral assistance to members for treatment not covered by the BHO. Neither the provider manual nor other provider communications addressed the responsibility of the BHO provider to coordinate with other programs that may provide EPSDT services. As evidenced in the on-site denial record reviews, notices of action to members eligible for EPSDT services referred the member to the Department's customer service line to determine whether or not the denied service was covered.

During on-site interviews, staff members stated that FBHP expected providers to assist members with simple referrals to needed EPSDT services or providers and that CMHC care coordinators assisted members/families with more complex needs. However, FBHP had no defined BHO care coordinator procedures related to providing referral assistance to providers or members for treatment not covered by the plan, including coordination with other programs/agencies that may provide EPSDT-related services. FBHP staff also described evolving relationships with the RCCO in the region as well as with county Healthy Communities organizations, to determine who is the best "lead" for coordinating various EPSDT services for members.

Recommendations:
HSAG recommends that FBHP develop procedures and clarify accountabilities for providing referral assistance to members receiving BHO services for treatment not covered by the plan, including coordinating with other programs that may provide EPSDT-related services. If developed, these procedures should address active involvement of BHO care coordinators (and/or documented responsibilities of affiliated organizations) to assist members and/or providers in order to obtain all documents needed to ensure access to non-covered services. These policies and procedures should also include, for members 20 years of age and under, processes for sending a notice of action letter that directs members and providers to contact BHO care coordinators—rather than the Department's customer service line—for assistance with accessing needed EPSDT-related services or Healthy Communities.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The Contractor must share PHI with the Department's EPSDT outreach and case management agencies (Healthy Communities) as allowable under HIPAA for treatment, payment and operations purposes, without requiring any special releases or other permission from the member. • The Contractor shall have either written consent from a member or a qualified service organization (QSO) agreement with a substance abuse organization to share member information regarding substance abuse disorder treatment with the Department's EPSDT outreach and case management agencies (Healthy Communities). Contract: Amendment 6, Exhibit A-2—2.5.13.3, 2.5.13.4	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. FBHP Policy EPSDT_page 3 item 10 **Description of Process:** The BHO and its beahavioral health providers must share PHI with the Department's outreach and case management agencies (Healthy Communities). Such communication is allowable under HIPAA without additional consent from the member to release information, except in the case of SUD treatment. This information is detailed in **248L_EPSDT_2BHO-Entire Policy** [Section IV.P (p. 7)] and **FBHP Policy EPSDT**_page 3 item 10 .	Information Only
Findings: FBHP/Beacon incorporated the requirement to share PHI with Healthy Communities into the Beacon EPSDT policy verbatim. However, FBHP provided no evidence that it had incorporated the requirement into provider communications or internal operational procedures.		
Recommendations: HSAG recommends that FBHP develop mechanisms to communicate this requirement to providers and other pertinent staff members in order to fully operationalize the policy.		
11. The Contractor facilitates provision of components of periodic health screens (assessments) for members receiving BHO services through systematic communication with network providers regarding the Department's EPSDT requirements. 10 CCR 2505-10 8.280.8.D (3) and (4)	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. EPSDT_Provider_Training_2BHO-Enitre Document 3. FBHP Policy EPSDT_Entire document 4. MHP English EPSDT packet_page 3 5. JCMH Coordination and Continuity of Care Policy and Procedure_ page1_procedure	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: This requirement is stated in the BHO's EPSDT policy, **248L_EPSDT_2BHO-Entire Policy** [IV.F (p. 4-5)], **FBHP Policy EPSDT_specifically pages 2-3 items 1-10.** Providers are instructed on this requirement during EPSDT training and compliance is monitored through the BHO's usual auditing mechanisms. See **EPSDT_Provider_Training_2BHO.** Providers follow EPSDT guidelines and specifically note the referral system through policy and educational materials. See **MHP English EPSDT packet_page 3, JCMH Coordination and Continuity of Care Policy and Procedure_ page 1_Procedure.** Additional information, including a periodicity table, can be found on FBHP website: http://www.fbhpartners.com/members/files/EPSDT-Periodicity-Schedule.pdf	
Findings: FBHP submitted documents that emphasized the need for the behavioral health provider to communicate with the PCP regarding EPSDT findings and requirements. During the on-site interview, HSAG clarified that this requirement is related to the BHO's responsibility to communicate "systematically" with the BHO's contracted providers regarding EPSDT requirements. Staff members stated that FBHP engaged CMHC providers in roundtable discussions concerning EPSDT requirements. The FBHP website included EPSDT resources such as an overview of the Bright Futures periodicity schedule and links to Healthy Communities; however, HSAG did not see that FBHP directed providers to the FBHP website to obtain these resources. In addition, FBHP provided no evidence of comprehensive EPSDT-focused trainings, provider communications, or tools for BHO providers that represented "systematic" communication with BHO providers regarding EPSDT requirements.		
Recommendations: HSAG recommends that FBHP enhance provider communications and develop a mechanism for systematic (i.e., regular and periodic) communication with network providers regarding comprehensive EPSDT services and responsibilities.		

Appendix B. Record Review Tool

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Foothills Behavioral Health Partners, LLC

Review Period:	January 1, 2016—November 30, 2016
Date of Review:	December 15, 2016
Reviewer:	Kathy Bartilotta
Participating Plan Staff Member:	Tami Ballard, Steve Coen, Alan Fine

Requirements	File 1	File 2	File 3	File 4	File 5
Member	DM	JG	AD	HP	BS
Date of initial request	10/04/16	09/06/16	07/11/16	04/08/16	03/18/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	CL	CL	NR	NR	NR
Standard (S), Expedited (E), or Retrospective (R)	R	R	R	E	E
Date notice of action sent	11/03/16	10/05/16	08/08/16	04/08/16	03/21/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	30	29	28	1	3
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	NC	NC	NC	C	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	C
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, NC, or N/A)	C	C	NA	N/A	C
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	TBD	TBD	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	NC	C
Total Applicable Elements	**6**	**6**	**6**	**6**	**8**
Total Compliant Elements	**5**	**5**	**5**	**5**	**8**
Score (Number Compliant / Number Applicable) = %	**83%**	**83%**	**83%**	**83%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business **TBD** = To Be Determined (scored NA, referred to Department for additional review)

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Foothills Behavioral Health Partners, LLC

Requirements	File 6	File 7	File 8	File 9	File 10
Member	HK	SD	WJ	KH	TP
Date of initial request	06/05/16	09/09/16	01/07/16	10/10/16	08/25/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	CL	NR	NR	CL
Standard (S), Expedited (E), or Retrospective (R)	E	R	S	E	R
Date notice of action sent	06/06/16	10/06/16	01/07/16	10/13/16	09/22/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	1	27	1	3	28
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	NC	C	C	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
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, NC, or N/A)	C	C	NA	C	C
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	TBD	TBD	C	TBD	TBD
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	**6**	**6**	**6**	**6**	**6**
Total Compliant Elements	**6**	**5**	**6**	**6**	**6**
Score (Number Compliant / Number Applicable) = %	**100%**	**83%**	**100%**	**100%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business **TBD** = To Be Determined (scored NA, referred to Department for additional review)

Total Record Review Score	Total Applicable Elements: 62	Total Compliant Elements: 57	Total Score: 92%

Notes:

File #1— Retrospective review of emergency room claim (30 days from receipt). The claim was denied due to "not a covered diagnosis" ("primary" diagnosis determined to be alcohol withdrawal). Notice of action mailed six days after decision made.

File #2—Retrospective review of emergency room claim (30 days from receipt). The claim was denied due to "not a covered diagnosis" ("primary" diagnosis determined to be alcohol-induced mood disorder). Member expressed suicidal ideation but could not be evaluated by CMHC team unless sober. Notice of action mailed 13 days after decision made.

File #3—Member was not Medicaid eligible when admitted—determination of eligibility was retroactive. Review was retrospective. Notice of action mailed 24 days after decision made.

File #4—Member received initial approval from April 2 through April 8. FBHP's continued stay review conducted on April 8 denied additional days going forward; however, the notice of action stated that the *admission was being retroactively denied to date of admission*. The notice of action was confusing or possibly inaccurate.

File #5—Member was already inpatient when request received. Prior to denial, medical director consulted with provider, who agreed that primary reason was medical rather than behavioral diagnosis. The claim was denied due to "not a covered diagnosis."

File #6— The claim was denied due to "not a covered diagnosis" ("primary" diagnosis determined to be alcohol-induced mood disorder).

File #7—Retrospective review of emergency room claim (30 days from receipt). Emergency room claim included numerous diagnoses. Member presented with violent mood swings and threatening behavior to family—hospitalized for uncontrolled behavior. Due to inpatient information retrospectively reviewed, medical director determined that medical history was primary reason for behavioral issues. *Both ER and hospitalization denied retroactively* due to "not a covered diagnosis" ("primary" diagnosis was medical not behavioral diagnosis). Member was 10 years old (potential EPSDT). Notice of action mailed 11 days after decision made.

File #8—Member was 17 years old (potential EPSDT). Notice of action included customized recommendations for additional services.

File # 9—Initially approved for two days. On October 12, FBHP's medical director received additional information (not apparent in initial review) and *retroactively denied previously approved days* due to not a covered diagnosis ("primary" diagnosis determined to be autism).

File #10—Retrospective review of emergency room claim (30 days from receipt). The claim was denied due to "not a covered diagnosis" ("primary" diagnosis was medical, not behavioral diagnosis). Notice of action mailed two days after decision made.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **FBHP**.

Table C-1—HSAG Reviewers and FBHP and Department Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
FBHP Participants	**Title**
Alan Fine	Medical Director, FBHP
Alyssa Rose (telephonic)	Director, Network Strategy
Bob Dyer	Chief Executive Officer, FBHP
Diana Maier	Director, Network Performance Improvement, FBHP
Jaime Davila	Director, Member Services, FBHP
James Bonk (telephonic)	Vice President of Operations, Beacon Health Options
Jill McFadden	Director of Quality and Project Management, Mental Health Partners
Kari Snelson	Compliance, FBHP
Kiara Kuenzler	Chief Operations Officer, FBHP
Marilyn Hejny	Director, Provider Services, FBHP
Patty Vines	Manager, Office of Member and Family Affairs, FBHP
Steve Coen	Clinical Peer Advisor, Beacon Health Options
Tami Ballard	Director, Utilization Management, Beacon Health Options
Department Observers	**Title**
Ben Harris	ACC Contract Manager and Performance Specialist
Danielle Culp	Quality and Compliance Specialist
Gina Robinson	Program Administrator
Michael Lott-Manier (telephonic)	Contract Manager

Appendix D. Corrective Action Plan Template for FY 2016–2017

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	Action
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 email or through the file transfer protocol (FTP) site, with an email 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 email 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 email or the FTP site, with an email 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.

Step	Action
Step 6	**Documentation substantiating implementation of the plan 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 healthcare regulations and managed care contract requirements.

The CAP template follows.

Table D-2—FY 2016–2017 Corrective Action Plan for FBHP

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
12. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days 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. *42 CFR 438.210(d)(1)(2)* Contract: Amendment 6, Exhibit A-2—2.5.15.1 and 2.5.15.2.1	Policies and procedures clearly outlined FBHP's ability to extend the authorization decision time frame by 14 days based on member request or the need for additional information. In addition, the policy stated that FBHP may extend the time frame "due to matters justifiably beyond the control of the BHO," which staff described as an occurrence such as a natural disaster. Federal language clearly states that the Contractor may extend the authorization decision only if "there is a need for additional information and that the extension is in the member's best interest."	FBHP must modify the language in its policies and procedures to remove "due to matters beyond the control of the BHO" as a reason for extending the authorization decision time frame.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
13. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.6.5.5 10CCR2505—10, Sec 8.209.4.A.1	Notices of action to the member were written in a language and format easy to understand. However, one of the ten denial records reviewed on-site included a notice of action that described an action different than what was noted in the denial file. The request was for a continued stay following previously approved days of admission. While the denial file was clear that specific days had been approved, the notice of action stated that the entire admission was denied. Staff members stated that they were unsure why the letter was written in this manner; therefore, the information in the notice of action was scored as confusing or possibly inaccurate.	FBHP must develop mechanisms to ensure that the information in the notice of action to the member/provider accurately coincides with the determination of approved or denied days as noted in the denial record.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. The notices of action must be mailed within the following time frames: • For denial of payment, at the time of any action affecting the claim.	Staff members stated that it is FBHP's policy to make a retrospective claim payment determination and send a notice of action within 30 days of receipt of the claim. The federal requirement is that the notice of action be mailed "at the time of any action affecting the claim." Four of five retrospective claim denials reviewed on-site demonstrated that FBHP failed to mail the notice of action within a reasonable time frame (within three days) after making the decision.	FBHP must clarify its policies and procedures to ensure that it sends members and providers notices of action for denial of claims payment "at the time of any action affecting the claim"—interpreted by HSAG as on the date of denial or within three days of the decision.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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 email 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 three 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, 2016, and December 31, 2016. 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.

For this step,	HSAG completed the following activities:
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. • 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 2016–2017 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 draft 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.