Fiscal Year 2017–2018 Site Review Report

for

Foothills Behavioral Health Partners, LLC

March 2018

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary 1-1
Summary of Results 1-1
Standard V—Member Information 1-3
Summary of Strengths and Findings as Evidence of Compliance 1-3
Summary of Findings Resulting in Opportunities for Improvement 1-3
Summary of Required Actions 1-3
Standard VI—Grievance System 1-4
Summary of Strengths and Findings as Evidence of Compliance 1-4
Summary of Findings Resulting in Opportunities for Improvement 1-5
Summary of Required Actions 1-6
Standard VII—Provider Participation and Program Integrity 1-8
Summary of Strengths and Findings as Evidence of Compliance 1-8
Summary of Findings Resulting in Opportunities for Improvement 1-9
Summary of Required Actions 1-9
Standard IX—Subcontracts and Delegation 1-10
Summary of Strengths and Findings as Evidence of Compliance 1-10
Summary of Findings Resulting in Opportunities for Improvement 1-10
Summary of Required Actions 1-10

2. Overview and Background 2-1
Overview of FY 2017–2018 Compliance Monitoring Activities 2-1
Compliance Monitoring Site Review Methodology 2-1
Objective of the Site Review 2-2

3. Follow-Up on Prior Year's Corrective Action Plan 3-1
FY 2016–2017 Corrective Action Methodology 3-1
Summary of FY 2016–2017 Required Actions 3-1
Summary of Corrective Action/Document Review 3-1
Summary of Continued Required Actions 3-1

Appendix A. Compliance Monitoring Tool A-1

Appendix B. Record Review Tools B-1

Appendix C. Site Review Participants C-1

Appendix D. Corrective Action Plan Template for FY 2017–2018 .... D-1

Appendix E. Compliance Monitoring Review Protocol Activities E-1

1. Executive Summary

The Code of Federal Regulations, Title 42—federal Medicaid managed care regulations, with revisions published May 6, 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 and Financing (the Department) has elected to complete this requirement for Colorado's behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to allow for implementation of new federal managed care regulations published May 2016, the Department determined that the review period for FY 2017–2018 was July 1, 2017, through December 31, 2017. This report documents results of the FY 2017–2018 site review activities for **Foothills Behavioral Health Partners, LLC** (**FBHP**). This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the four standard areas reviewed this year. Section 2 describes the background and methodology used for the 2017–2018 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2016–2017 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 appeals and grievances 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 2017–2018 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 **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	Score (% of Met Elements)
V. Member Information	12	11	8	3	0	1	73%
VI. Grievance System	27	27	13	14	0	0	48%
VII. Provider Participation and Program Integrity	13	13	11	2	0	0	85%
IX. Subcontracts and Delegation	4	4	4	0	0	0	100%
Totals	**56**	**55**	**36**	**19**	**0**	**1**	**65%**

*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 record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals	60	60	52	8	0	87%
Grievances	60	41	32	9	19	78%
Totals	**120**	**101**	**84**	**17**	**19**	**83%**

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

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

FBHP provided policies and procedures that described the processes for ensuring that all member materials are written at a sixth-grade reading level using a 12-point font size; are readily available in Spanish, alternative formats, and through the provision of auxiliary aids; and include large-print and Spanish taglines that describe how to request auxiliary aids, written translation, and oral translation. **FBHP** educated staff, providers, and members about the availability of these free services and how to access them.

FBHP's website included a wide range of information and resources targeted to members and their families. Available information included the Health First Colorado Member Handbook, provider directory, member rights and responsibilities, grievance and appeal processes, advance directives, how to detect and report suspected fraud, the Child Mental Health Treatment Act (CMHTA), local socioeconomic resources, and State and national resources related to mental health and advocacy. The information was well organized, and the website was easy to navigate. HSAG conducted an accessibility check on several **FBHP** Web pages using the Wave Web Accessibility Evaluation Tool and found no general accessibility errors.

Summary of Findings Resulting in Opportunities for Improvement

FBHP delegated the execution of website content and monitoring to its partner administrative services organization, Beacon Health Options (Beacon). Beacon had a policy that described the accessibility requirements (i.e., complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines) and submitted monthly reports to **FBHP** that delineated identified issues. HSAG recommends that **FBHP** develop a policy (or that Beacon update its policy) to describe the process and expected time frames for addressing compliance issues identified related to the website and its content.

HSAG reviewed various member materials available in PDF format; while the font appeared to be in an acceptable range, HSAG was unable to directly confirm the font size due to the PDF format. HSAG recommends that **FBHP** review all member documents to ensure that the general text of PDF versions of member materials is made available to members in at least a 12-point font.

Summary of Required Actions

Using a Flesch-Kinkaid readability test, HSAG tested several documents including the Grievance and Appeal (G & A) Guide and several template letters related to the grievance and appeal processes. Many of these documents scored well above the sixth-grade level. Additionally, during the record review, HSAG noted that several of the letters (most notably those used by **FBHP**'s partner community mental health center [CMHC], Mental Health Partners [MHP]) failed to include the large-print tagline. This tagline was also missing from **FBHP**'s grievance and appeal guide. **FBHP** must ensure that all member

information is written using easy-to-understand language and includes large-print taglines describing how to request auxiliary aids and services.

HSAG ran an accessibility check on several PDF documents available for download from the **FBHP** website (e.g., grievance and appeal guide, community resources handout, and provider directory). Through use of the Adobe Acrobat Pro accessibility checker, HSAG discovered accessibility errors within those PDF documents. Additionally, the website included no statement informing members that information is available in paper form without charge upon request. **FBHP** must develop a process to ensure that all information available for download from its website is readily accessible. **FBHP** must also add a statement to its website informing members that all information is available in print form, free of charge, by calling the **FBHP** customer service department.

FBHP's provider directory included the name, group affiliation, street address, telephone number, areas of specialty, and languages spoken for all providers accepting new patients. The directory included no information regarding a provider's website uniform resource locator (URL), cultural competency training, or accessibility for people with physical disabilities. **FBHP** must update its provider directory to include a provider's website URL (if available), indicate which providers have completed cultural competency training, and note which locations are accessible for people with physical disabilities.

Standard VI—Grievance System

Summary of Strengths and Findings as Evidence of Compliance

FBHP discussed the relationship between **FBHP** and is partner organizations—Beacon Health Options (Beacon), Jefferson Center for Mental Health (JCMH) and Mental Health Partners (MHP)—regarding processing of grievances and appeals. **FBHP** maintains responsibility for processing grievances, with the participation of JCMH and MHP in processing grievances received at the CMHCs. Beacon referred all grievances registered with Beacon staff to **FBHP** for resolution. Beacon processed all appeals on behalf of **FBHP**. **FBHP** referred all appeals received by **FBHP** to Beacon for processing. HSAG primarily considered documents from **FBHP**, JCMH, and MHP in review of compliance with grievance requirements and considered Beacon documents in review of compliance with appeals requirements. Policies and procedures and other documents adequately addressed many grievance and appeal compliance requirements, including new requirements for completing a Contractor-level appeal prior to requesting a State fair hearing (SFH), time frames for filing an appeal or SFH, provisions for who may file a grievance or appeal either orally or in writing, provision of assistance to members in the filing process, individuals appropriate for determining the outcome of a grievance or appeal, required content of resolution letters, effectuation of outcomes of an appeal, and maintaining a system for documentation and tracking of grievances and appeals. Despite circumstances in which written policies and procedures could be improved (as noted following), staff members were often able to verbally articulate understanding and implementation of federal and State requirements.

Summary of Findings Resulting in Opportunities for Improvement

Due to the interrelated partner activities for processing grievances and appeals, **FBHP** had numerous and varied policies and procedures and other documents related to compliance with grievance and appeal requirements, without a clearly outlined path of accountability or functions. HSAG recommends that **FBHP** organize policies and procedures or create flow charts that clearly demonstrate the relationship among the entities, accountabilities, and functions related to processing grievances and appeals for **FBHP** members.

HSAG identified several required actions attributed to inadequacies in grievance policies or processes performed by MHP or appeals policies and procedures performed by Beacon. As **FBHP** maintains responsibility for compliance with all grievance and appeal requirements, HSAG recommends that **FBHP** strengthen its oversight of functions performed by either MHP or Beacon. In addition, **FBHP** should perhaps also consider establishing well-defined delegation agreements between **FBHP** and its partner organizations regarding grievance or appeal processes and expectations.

In addition to the required actions following, HSAG noted additional opportunities for improvement in the MHP grievance policy: the policy does not define who may file a grievance; the policy states that MHP will resolve the grievance in 15 working days or extend the time frame, but does not specify that written notice must be sent to the member in that time frame; the policy does not specify the required content of the notice to the member; the policy does not specify the circumstances in which clinical expertise is required to review a grievance or that a grievance will be reviewed by an individual not previously involved in the incident. HSAG recommends that **FBHP** ensure that MHP address these elements in the update of its policy.

Staff members stated that the **FBHP** G & A Guide is included on the **FBHP** website as well as in both the grievance acknowledgement letter and the appeal acknowledgement letter to the member. The G & A Guide includes extensive information on the details of processing grievances, appeals, and SFHs, as well as lengthy adverse benefit determination (ABD) information. As such, HSAG finds that the G & A Guide contains too much general information to provide clear and applicable information to the member in an acknowledgement letter. HSAG suggests that **FBHP** customize information from the guide to include only grievance information in the grievance acknowledgement, appeal information in the appeal acknowledgement, and SFH information in the appeal resolution letter; and remove information regarding adverse benefit determination from all letters—the ABD process is irrelevant to grievances and precedes the filing of an appeal. If **FBHP** continues to publish the full G & A Guide on its website, HSAG suggests that **FBHP** update information so that the guide does not include the federal language for definition of "grievance" and does not state that the member may file a grievance if he/she disagrees with extension of a time frame for resolution of an appeal. Further, all corrections made to policies and procedures in response to this audit should similarly be incorporated into the G & A Guide.

HSAG noted several opportunities for improvement in the appeal information included in the ABD letter, including the need to clarify the template language regarding the time frame of a denied service—which implies the termination or reduction of currently existing services rather than denial of a request for services. HSAG also noted omission of several details related to processing of an appeal, which

might be important to communicate to the member. HSAG recommends that the BHO continue to work with the Department to determine potential improvements to the ABD letter and to appeals information included in the letter to members.

Although BHO staff members were able to verbally articulate processes that complied with regulations, the written Beacon Appeal Process policy did not specifically address several elements outlined in federal rules and regulations, including that:

- A member signature is required on the written appeal.
- A party to the appeal is the representative of a deceased member's estate.
- The member may provide documentation and testimony in the case of an expedited appeal (this *is* stated regarding a standard appeal).
- The BHO must provide records requested by the member *sufficiently in advance* of the resolution time frame.
- If the appeal resolution is adverse to the member and the member requested that services continue during the appeal or SFH, the BHO may recover the cost of continued services from the member.
- If the appeal reverses the original adverse benefit determination, the BHO will ensure that services are implemented *within 72 hours of the reversal determination*.

HSAG recommends that **FBHP** encourage Beacon to update its written Appeal Process policy to incorporate these elements.

The Beacon Appeal Process policy specified that the BHO cannot process an appeal without a written or electronic signature. HSAG shared that most managed care plans do process member-generated appeals despite lacking member signatures, to ensure that no needed services are delayed to members. HSAG recommends that Beacon consider re-evaluating its position on whether to proceed with processing unsigned appeals in cases wherein members may be waiting for services.

Summary of Required Actions

The JCMH grievance guide and MHP grievance policy defined "grievance" using language (i.e., "dissatisfaction about any matter related to provided services") that could be construed as dissatisfaction with an adverse benefit determination. **FBHP** must ensure that CMHCs clarify the definition of "grievance" as "dissatisfaction about any matter *other than an adverse benefit determination*."

The MHP grievance policy incorrectly stated that the member may file a grievance within 30 days of an incident. **FBHP** must ensure that MHP corrects its policy to state that a member may file a grievance *at any time*.

While the MHP Grievance policy stated that MHP may extend the time frame to respond to a grievance, the policy failed to specify the time frame for extensions and provided no procedures for informing the member of an extension. **FBHP** must ensure that MHP includes in its policies and procedures the 14-day time frame for extensions as well as the procedures for notifying members of extensions.

Three of eight grievance record reviews identified that the BHO failed to send an acknowledgement letter in the required "two working days" time frame. **FBHP** must ensure that all members are sent an acknowledgement letter within two working days of **FBHP**'s receipt of a grievance.

HSAG found in grievance record reviews that one member was not notified of the grievance resolution within the required time frame. In addition, five of nine record reviews included resolution letters that were difficult for the member to understand as one CMHC appeared to combine acknowledgement letter and resolution letter template language into one letter to the member. **FBHP** must ensure that CMHCs comply with requirements for sending resolution letters within the required 15 working days' time frame and write the notice to the member in a format and language that may be easily understood.

HSAG identified several compliance requirement deficiencies in the Beacon Appeal Process policy. **FBHP** must ensure that Beacon corrects these deficiencies in its Beacon Appeal Process policy and procedures as follows:

- Include "denial of a member's request to dispute a member financial liability" in the definition of "adverse benefit determination."
- Include the procedures for informing members of the limited time available to present evidence, in the case of an expedited appeal.
- Clarify expedited appeals procedures to include providing written notice to the member within 72 hours of receiving the appeal.
- Address continuation of previously approved services as required content of the appeal resolution letter, when applicable.
- Address the time frame for notifying the member in writing within two calendar days and giving the member prompt oral notice of a decision to deny a request for an expedited appeal.
- Include the accurate criteria, as specified in 42 CFR 438.420(a) and (b), for requesting continuation of benefits during an appeal or SFH.
- Remove the criterion, "the time period of the previous authorization of the services expires" from the definition of how long benefits will continue pending outcome of an appeal or SFH.

In on-site appeal record reviews, HSAG found that seven of 10 notices of appeal disposition included clinical content that HSAG deemed inappropriate to communicate to the member. **FBHP** must ensure that the description of the disposition includes only information appropriate to communicate to the member.

The **FBHP** Appeal Decision Letter template does not include information on the member's right to request continuation of services during an SFH when the services being appealed were previously approved and then terminated or reduced. The template letter also does not address the member's potential financial liability for continued services if the SFH upholds the ABD. **FBHP** must update the Appeal Decision Letter template language to include information regarding the continuation of previously authorized services during an SFH, when applicable.

The **FBHP** Appeal Decision Letter template includes two conflicting statements regarding the time frame for requesting an SFH. **FBHP** must modify the Appeal Decision Letter template to accurately inform the member that he or she may request an SFH within 120 calendar days from the date of the

notice of appeal resolution. **FBHP** must also ensure that staff members calculate the <listed date> from the date of the appeal resolution notice.

The sample **FBHP** expedited appeal request denial letter did not include the member's right to file a grievance if he or she disagrees with the decision. **FBHP** must ensure that the expedited appeal request denial letter informs the member of the right to file a grievance if he or she disagrees with the decision.

Information in the provider manual duplicates some of the inaccuracies in the details of grievance and appeal procedures, particularly related to continuation of benefits during an appeal and as noted in other elements in that standard. **FBHP** must ensure that all corrections implemented in response to recommendations or required actions in that standard are incorporated into the grievance and appeal information in the provider handbook.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

FBHP is responsible for the overall compliance program for the organization, although numerous provider-related responsibilities such as provider network management; credentialing and recredentialing; screening of providers for sanctions; and claims processing, screening, and payments were supported through functions delegated to Beacon. Beacon maintained a Network Development Plan to guide the recruitment and retention of providers and maintained thorough credentialing and recredentialing processes for network providers.

FBHP and Beacon have numerous policies and procedures related to compliance functions. The **FBHP** compliance program description addressed all required components of the organization-wide compliance program, which was overseen by the **FBHP** compliance officer, chief executive officer (CEO), and Board of Directors. Policies and procedures for monitoring fraud, waste, and abuse (FWA) were comprehensive; and staff members were able to verbalize understanding of the FWA requirements. **FBHP** conducted compliance program training for staff members, board members, and providers related to initial hire or contracting. The compliance officer also noted the educational programs and professional organizations through which she maintains ongoing training related to federal and State regulations regarding compliance and FWA. Documents clearly described processes for reporting suspected FWA, investigating of possible abuses, and disciplinary guidelines for employees and providers. Both **FBHP** and Beacon conducted initial and monthly screening of all employees, providers, owners, partners, directors, subcontracted entities, and the like against the US Department of Health and Human Services Office of Inspector General (HHS-OIG) databases to identify prohibited affiliations or any exclusions from participation in Medicaid.

Summary of Findings Resulting in Opportunities for Improvement

FBHP has a complex interrelationship with its partner, Beacon, to perform the various activities related to compliance requirements. As such, **FBHP** and Beacon both maintain and contributed multiple policies and procedures related to the performance of Provider Participation and Program Integrity activities. HSAG and staff members spent considerable time on-site discussing and locating information in various policies and procedures. Therefore, HSAG offers the following recommendation:

- **FBHP** should work with Beacon to either consolidate the numerous policies and procedures or provide clearly defined links between umbrella policies and the detailed procedures included in other polices to demonstrate a well-defined workflow among **FBHP**, Beacon Colorado, and Beacon corporate. Examples include: the **FBHP** compliance program plan could reference within the text the specific policies and procedures that support each major element of the compliance program. The **FBHP** Detection of Fraud, Waste, and Abuse policy and/or **FBHP** Investigation and Reporting of Fraud, Waste, and Abuse policy could include specific policy references or hyperlinks to related Beacon functional policies and procedures. HSAG advises that **FBHP** remain responsible for the overall compliance program of **FBHP**; therefore, **FBHP** policies should prevail, with oversight of any functions delegated to Beacon.

The Beacon Network Development Plan states that Beacon uses National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards; however, HSAG noted that the credentialing and recredentialing polices do not include this statement. HSAG recommends that Beacon include in its credentialing and recredentialing policies that Beacon complies with NCQA credentialing and recredentialing standards.

HSAG noted that the Beacon Practitioner Agreement is the only document that specifies that Beacon will not restrict providers from advising or advocating on behalf of members. HSAG recommends that Beacon strengthen its internal policies to include a policy statement as outlined in 42 CFR 438.102 (a)(1).

The member services verification plan outlines the process for sending letters to a sample of members to verify that they received services reported as delivered by providers. The process requests that the member contact Beacon if identified services are not received. The member response rate was reported as 1 percent. HSAG recommends that **FBHP**/Beacon explore other options such as more assertive outreach mechanisms, to increase the effectiveness of member services verification.

Summary of Required Actions

HSAG could not identify any written procedures for reporting to the Department disclosure of ownership and control within 35 days after any change in ownership or disclosure of any prohibited affiliation within five business days of discovery. **FBHP** must strengthen its written policies and procedures to define mechanisms for reporting to the Department any change in ownership or control or any discovery of prohibited affiliations, within the time frames specified in the requirement.

FBHP, through functions delegated to Beacon, had numerous policies and implemented procedures to identify, remedy, and report to the Department any potential fraud or overpayments. However, HSAG

identified no clearly defined mechanisms for a provider to report to **FBHP** or Beacon when it has received an overpayment and to return the overpayment within 60 calendar days. **FBHP** must develop and communicate to providers mechanisms for a provider to notify the BHO when it has received an overpayment and the reason for the overpayment as well as to return the overpayment to the BHO within 60 calendar days of identification.

Standard IX—Subcontracts and Delegation

Summary of Strengths and Findings as Evidence of Compliance

FBHP had a policy and procedure that described the processes and procedures related to subcontracts and delegation including performing pre-delegation assessments; having written agreements that delineate activities to be delegated and related reporting responsibilities; and requiring the subcontractor's compliance with all applicable State, federal, and Medicaid laws and regulations.

FBHP delegated grievance processing to its partner CMHCs and numerous operational functions to Beacon. The written agreements included (often by reference) delegated activities and obligations, reporting responsibilities, and specified remedies in instances of unsatisfactory performance. The written agreements required compliance with all applicable State, federal, and Medicaid laws and regulations and included the requirements related to the right for the State, CMS, HHS Inspector General, the Comptroller General, or their designees to audit. **FBHP**'s agreements with Beacon and the partner MHCs pre-dated the requirements related to pre-delegation assessments; therefore, **FBHP** performed no pre-delegation assessments.

FBHP provided a variety of documents that demonstrated ongoing and formal monitoring of delegated activities, including monthly reports and annual reviews. **FBHP**'s senior staff members reviewed delegation reports and audit results during its operations meetings. **FBHP** required no corrective actions of its delegates during the review period; however, the delegation policy described, and staff members articulated, the process for implementing and monitoring corrective actions, as needed.

Summary of Findings Resulting in Opportunities for Improvement

Although **FBHP** was compliant with the requirements related to delegation of grievance processing to its partner CMHCs, evidence of compliance was documented across several documents and written agreements. Furthermore, the agreements frequently referenced various documents such as policies and additional contracts and agreements. HSAG suggests that **FBHP** consolidate requirements related to delegation to its partner CMHCs into one or two written agreements, similar to its delegation agreement with Beacon. **FBHP** could also strengthen its delegation agreements by more specifically delineating the expectations of its subcontractors in the written agreements, as opposed to referencing additional documents.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2017–2018 Compliance Monitoring Activities

For the fiscal year (FY) 2017–2018 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the BHO's contract requirements and regulations specified by federal Medicaid managed care regulations published May 6, 2016. The Department determined that the Health First Colorado member handbook, as published and distributed by the Department, was the source of member handbook information and that BHOs were not accountable for compliance with member handbook federal requirements in 42 CFR 438.10(g). 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 appeals and grievances.

HSAG also reviewed a sample of the BHO's administrative records related to Medicaid appeals and grievances to evaluate implementation of federal healthcare regulations and managed care contract requirements as specified in 42 CFR 438 Subpart F and 10 CCR 2505-10, Section 8.209. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed). Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid appeals and grievances that occurred between July 1, 2017, and December 31, 2017. For the record review, the BHO received a score of *M* (met), *NM* (not met), or *NA* (not applicable) for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance System. HSAG also separately calculated a grievances record review score, an appeals record review score, and 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.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2017–2018 site reviews represent a portion of the Medicaid managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

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

[2-1] 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. https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2017.

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

FY 2016–2017 Corrective Action Methodology

As a follow-up to the FY 2016–2017 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 2016–2017 compliance monitoring site review.

Summary of FY 2016–2017 Required Actions

For FY 2016–2017, HSAG reviewed Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. HSAG found **FBHP** 100 percent compliant with the requirements in the access and availability standard. **FBHP** was required to develop a plan to address three issues related to coverage and authorization of services:

- 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.
- Clarify policies and procedures and ensure sending to members and providers, at the time of the actions affecting the claims, notices of action for denials of claims payments.
- Remove from policies and procedures language that allows **FBHP** to extend the authorization decision time frame "due to matters justifiably beyond the control of the BHO."

Summary of Corrective Action/Document Review

FBHP submitted a proposed plan of corrective action in May 2017 and evidence of having implemented its plan in September 2017. HSAG and the Department carefully reviewed all materials and determined in September 2017 that **FBHP** had addressed all required actions.

Summary of Continued Required Actions

No required actions were continued from the FY 2016–2017 site review activities.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood **and is readily accessible by members.** *(Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.)* *42 CFR 438.10(b)(1)* Contract Amendment 7: Exhibit A3—2.6.5.13.1	**Documents Submitted/Location Within Documents:** 1. IT302.2 508ComplianceofExternalWebSitesPolicy_2BHO, entire policy 2. 306LMemberMaterialsDevelopmentPolicy_2BHO-Page 1, IA-B, page 2 IIB 3. ScreenshotofNoDiscriminationonWebsite_FBHP-entire document 4. WebsiteCheck_FBHP-page 2 **Description of Process:** FBHP has delegated website management to Beacon Health Options. Beacon has IT302.2 508 Compliance of External Websites policy in place for websites, which addresses our website being readily accessible. Our electronic information complies with 508 guidelines and W3C's Web Content Accessibility Guidelines. Beacon regularly runs 508/WCAG scans for their websites to resolve accessibility issues they can control (they cannot control PDF content). The 508/WCAG reports are shared monthly so that everyone is aware of what needs to be resolved and so that accessible PDFs and content can be provided to remediate the issues. Please see Website Check_FBHP to review our automated compliance report. BEACON also follows 306L Member Materials Development Policy_2BHO which states in I A that Member materials will be easily understood, culturally relevant, and meaningful to Members and their families. In this same policy IB, Member materials are written at an appropriate reading level so that they are clear, concise and understandable to the representative population. In IIB, we describe our use of the Flesch-Kinkaid software which ascertains the minimum education level required to understand materials. We have attached our website screenshot addressing	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	discrimination to adhere to Section 504 of the Rehabilitation Act. See Screenshot of No Discrimination on Website_FBHP.	
2. **For consistency in the information provided to members, the Contractor uses the following as developed by the State:** • **Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.** • **Model member handbooks and member notices.** *42 CFR 438.10(c)(4)* Contract Amendment 7: Exhibit A3—2.2.6, 2.3.2, 3.1.7	**Documents Submitted/Location Within Documents:** 1. File: Managed Care Terminology.docx – Posted at http://www.fbhpartners.com/members/ link titled "Frequently Used Medical Definitions 2. ScreenshotOfManagedCareDefinitionsonWebsite_FBHP, entire document 3. ManagedCareTerminology2BHO, entire document 4. HealthFirstColoradoMemberHandbook_2BHO, page 63, 68 5. EvidenceofStateManagingMemberHandbook_2BHO, entire document 6. GrievanceandAppealGuide_FBHP, page 1 7. AppealDecisionLetter_FBHP, page 2 8. EvidenceofMemberHandbookonFBHPWebsite_FBHP, entire document **Description of Process:** FBHP understands the need for consistency in the information that is provided to our Members between the state and our BHO. FBHP has researched managed care definitions provided by Healthcare, Policy, and Financing in the Health First Colorado's (Colorado's Medicaid Program) Member Handbook and developed a Managed Care Terminology resource for our members (See Managed Care Terminology_FBHP). You can find these document by going to our website, www.fbhpartners.com. They are located under the Member tab. When you click on Managed Care Terminology, Members can access a PDF Document. Please see Health First Colorado's Member	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Handbook_2BHO on page 63 for consistency in the "appeal" definition which aligns with one of our definitions in the Managed Care Terminology documents. Please note that the state officially took over the Member Handbook on July 1, 2017 (Evidence of State Managing Member Handbook_2BHO). FBHP has adopted this handbook and loaded the Member handbook link on our website. See Evidence of Member Handbook on FBHP Website_FBHP FBHP sends out a Grievance and Appeal Guide_FBHP with any Notice of Adverse Benefit Determination letter. FBHP's Notice of Action letters were updated to Notice of Adverse Benefit Determination terminology to align with Amendment 7 changes to our contract. Please note the highlighted section on page one for the definition of "grievance." This definition is consistent with Health First Colorado's definition found in the Member Handbook on page 68. To demonstrate that we have updated our terminology to align with Amendment 7 changes, please see our definition of "medically necessary" in our Appeal Decision Letter_FBHP, page 2 (highlighted section). This wording was changed from medical necessity.	
Findings: HSAG is aware and the Department acknowledges that, for the 2017–2018 compliance review period, the State has neither developed nor communicated to health plan contractors a consensus list of managed care definitions to be used in information provided to members. HSAG has therefore scored this element *Not Applicable*. HSAG recommends that all contractors maintain awareness of this requirement and, when received, incorporate State-defined managed care definitions into all applicable member communications, as directed by the Department.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** • **All written materials for members must:** – Use easily understood language and format. – **Use a font size no smaller than 12 point.** – Be available in alternative formats **and through provision of auxiliary aids and services** that take into consideration the special needs of members **with disabilities** or limited English proficiency. – **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.** – Be available for immediate dissemination in that language.	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M8.4 Language Assistance – Entire document 2. Taglines are posted on FBHP website home page: See link titled "Services in Additional Languages". Site also has language translator, limited to web content. 3. DefinitionofPrevalentNonEnglishLanguageSpeakers_2BHO, page 8 4. DataUSAColorado_2BHO, page 28 5. EvidenceofMemberHandbookonFBHPWebsite_FBHP, entire document 6. HealthFirstColoradoMemberHandbookSpanish_2BHO, entire document 7. ScreenshotofReferralConnect_2BHO, entire document 8. ProviderDirectory_FBHP, page 1 9. AppealAcknowledgementLetter_FBHP, page 1 10. GrievanceAcknowledgementLetter_FBHP, page 1 11. GrievanceandAppealGuide_FBHP, page 1 12. FBHP_Appeal Guide_FY18_12-2-2017 SP – entire doc 13. NoticeofAdverseBenefitDeterminationLetter_FBHP, page 1 14. Notice of Adverse Benefit Determination-Final for Distribution_Spanish, entire document 15. LettertoMemberofProviderTerminating_FBHP, page 1 16. 306LMemberMaterialsDevelopmentPolicy_2BHO, page 1, I C,D,E; page 2, II B	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
42 CFR 438.10(d)(3) and (d)(6) Contract Amendment 7: Exhibit A3—2.6.5.13.1–3, 2.6.5.13.6.1–3, 2.6.5.13.7, 2.6.5.13.10.1–4	17. 311LHandlingCallsWithLimitedEnglishSpeakingMembersPolicy_2BHO-Entire Policy **Description of Process:** Beacon on behalf of FBHP researched the prevalent non-English language spoken in our region. According to Rule #MSB 17-01-18-A in the Revision to the Medical Assistance Rule Concerning Managed care, “prevalent” means a non-English language spoken by a significant number or percentage of members in the service area as identified by the state. According to Data USA, 17.2% of Colorado citizens are speakers of a non-English language which is lower than the national average of 21.5%. In 2015, the most common non-English language spoken in Colorado was Spanish. 10.7% of Colorado’s overall population are native Spanish speakers, followed by German at .46% and Chinese at .42%. Based on this information, the most prevalent non-English language in Colorado is Spanish. FBHP has taglines in large print and prevalent non-English language which describes how a Member can request auxiliary aids and services, written translation, or oral interpretation. We include our toll free and TTY/TDY customer service number and explain of the availability of materials in alternative formats at no charge to the member. We include this on our website under the Member Tab (see screenshot –need update). We have included several examples of materials that are critical for Members to obtain services including provider directories, a link to Health First Colorado’s Spanish Handbook on our website, appeal, grievance, notice of adverse benefit determination and letter to Member of provider terminating. See Appeal Acknowledgement Letter_FBHP, Grievance Acknowledgement Letter_FBHP, Notice of Adverse Benefit	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Determination_FBHP, and Letter to Member of Provider Terminating_FBHP. FBHP has uploaded a copy of Health First Colorado Member Handbook Spanish_2BHO on our website. This can be accessed under our Member tab on our website, www.fbhpartners.com. See Evidence of Member Handbook on FBHP website_FBHP. FBHP has a Member Material policy (306L Member Material Development) which we follow to ensure that Member materials are accurate, easily understood, culturally relevant, clear, available in other languages at no charge to the member and available in alternative formats. Beacon runs member materials through a Flesch-Kinkaid Score which is obtained through Microsoft Word. See 306L Member Materials Development Policy_2BHO on page 2 for readability testing guidelines. Beacon also has a policy (311L Handing Calls for Limited English Speaking Members) which guides FBHP callers who have limited English skills. We utilize Voiance® translation line which allows us to expediently connect Members with an interpreter in over 150 languages.	
Findings: FBHP provided policies and procedures that described the processes for ensuring that all member materials are written at a sixth-grade reading level using a 12-point font size; are readily available in Spanish, alternative formats, and through the provision of auxiliary aids; and include large-print and Spanish taglines that describe how to request auxiliary aids, written translation, and oral translation. HSAG tested readability of several documents including the G & A Guide and several template letters related to the grievance and appeal processes using a Flesch-Kinkaid readability test. Many of these documents presented reading levels above the sixth-grade level. Additionally, during the record		

<table>
<tr><th colspan="3">Standard V—Member Information</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the BHO</th><th>Score</th></tr>
<tr><td colspan="3">review, HSAG noted that several of the letters (most notably those used by Mental Health Partners) failed to include the large-print tagline. This tagline was also missing from the grievance and appeal guide.</td></tr>
<tr><td colspan="3">Required Actions:
FBHP must ensure that all member information is written using easy-to-understand language and includes large-print taglines describing how to request auxiliary aids and services.</td></tr>
<tr><td>4. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:
• The format is readily accessible (see definition of readily accessible above).
• The information is placed in a Web site location that is prominent and readily accessible.
• The information can be electronically retained and printed.
• The information complies with content and language requirements.
• The member is informed that the information is available in paper form without charge upon request, and is provided within five (5) business days.
42 CFR 438.10(c)(6)
Contract Amendment 7: Exhibit A3—2.6.5.3.6–8</td><td>Documents Submitted/Location Within Documents:
1. Member's page on FBHP website. http://www.fbhpartners.com/members/ (see "Tips and Recovery" link under Self Help Resources Section)
2. IT302.2 508ComplianceofExternalWebSites_Policy_2BHO-Entire Policy
3. WebsiteCheck_FBHP, page 2
4. ScreenshotofSubmittingWebUpdates_FBHP, entire document
5. 306LMemberMaterialsDevelopmentPolicy_Page 1, IA, B, D
6. ScreenshotofMemberInformationinProminentPlace_FBHP, entire document
7. ProviderDirectory_FBHP, entire document

Description of Process:
FBHP does make information available to our Members electronically on our website, http://www.fbhpartners.com /. FBHP has delegated the execution of website content to Beacon, however, maintains the monitoring of the website. Beacon has a policy to guide the requirements of being readily accessible. See IT302.2 508 Compliance of External Websites. Beacon regularly runs 508/WCAG scans for their websites to resolve accessibility issues they can control (they cannot control PDF content). The 508/WCAG reports are shared monthly so that everyone is aware of what needs to be resolved and so that accessible PDFs and content can be provided to remediate the issues. See Website Check_FBHP. FBHP reviews content on a</td><td>☐ Met
☒ Partially Met
☐ Not Met
☐ N/A</td></tr>
</table>

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	monthly basis to update relevant information for our Members. We use Website Update tickets (WUTT) to keep the website current. See Screenshot of SubmittingWeb Updates_FBHP	
Findings: HSAG conducted an accessibility check on several FBHP Web pages using the Wave Web Accessibility Evaluation Tool. Through use of the tool, HSAG discovered no general accessibility errors. HSAG also ran an accessibility check on several PDF documents available for download from the FBHP website (e.g., grievance and appeal guide, community resources handout, and provider directory). Through use of the Adobe Acrobat Pro accessibility checker, HSAG discovered accessibility errors within these PDF documents. Additionally, the website included no statement informing members that information is available in paper form without charge upon request.		
Required Actions: FBHP must develop a process to ensure that all information available for download from its website is readily accessible (i.e., complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines). FBHP must also add a statement to its website telling members that all information is available in print form, free of charge, by calling its customer service department.		
5. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • **This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.** • The Contractor notifies members that **auxiliary aids and services are available upon request and at no cost for members with disabilities**, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)* Contract Amendment 7: Exhibit A3—2.6.5.13.7–9	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M8.4 Language Assistance-items II, III & V 2. FBHP website under “Treatment and Recovery” & “Rights and Advocacy” 3. FBHPartners Handbook 092517 – top of Page 16 4. FBHP-Cult-Comp-Plan-Update-7-1-16 – section 7.3 5. MHP_Admission_Registration – entire doc 6. MHP Client Rights PP – entire doc, training for providers on member rights 7. JCMH Client Rights from Book – item 16. **Description of Process:** FBHP has an organizational language policy and cultural competency plan (FBHP Policy M8.4 Language Assistance, FBHP-Cult-Comp-Plan-Update-7-1-16) that ensures that the member's rights for necessary accommodations are protected. In addition, the member's	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	rights are posted on the FBHP website and displayed/distributed to members when they engage in services.	
6. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from or was seen on a regular basis by the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 7: Exhibit A3—2.6.10.1	**Documents Submitted/Location Within Documents:** 1. MemberHandbook_FBHP- Page 14 2. PendingDisenrollmentReport_2BHO, entire document 3. LettertoMemberofProviderTerminating_FBHP, entire document 4. BeaconProviderTerminationWorkflow_2BHO, entire document **Description of Process:** FBHP has delegated Beacon Health Options' OMFA department to notify Members when Providers dis-enroll from the Network. Beacon makes a good faith effort to notify Members within 15 days upon receipt of the termination notice. Beacon's Knowledge Management and Reporting team developed an automatic Pending Disenrollment Report_2BHO outlining providers who are dis-enrolling or pending disenrollment from the network. This report is sent on a weekly basis via e-mail to OMFA, Provider Relations, and the Clinical team. The automated report includes the provider's name, date of disenrollment, and lists members who are currently seeing or have seen the provider in the last 6 months. Beacon's Provider Relations staff will verify if the provider is truly dis-enrolling prior to sending out notifications to Members. Providers may end up this report for several reasons such as: 1) Providers who have not returned re-credentialing paperwork; 2) Providers who have not re-validated with the State; 3) Providers who have not filed a change of address; 4) Providers who have not met other administrative requirements; 5) Providers who have had a serious violation; or 6) Providers who have informed Beacon that they	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	are voluntarily withdrawing from the Network. This report can be up to 90 days before a provider officially gets dis-enrolled. This time frame allows providers time to fulfill administrative requirements or to appeal a pending disenrollment decision. When a provider has exhausted all appeals, we receive a final report which contains Members who will need to have their care transitioned to a new provider. This is approximately 45 days before final disenrollment. However, there are times a provider moves, resigns from the network, or leaves the network in some other way. Provider Relations expediently informs OMFA when a provider is voluntarily dis-enrolling from the network. OMFA staff sends the Member a letter (see Letter to Member of Provider Terminating_FBHP) to any Member who had been seeing the dis-enrolled provider during the previous six months. The clinical team will review this list to identify any high-risk Members. A letter is sent within 15 days of dis-enrollment when possible. Situations where we would not inform members within the 15-day window would be when the provider informs us after they have closed their practice, or upon the death of a provider. In these cases, we inform members as soon as possible after we receive the information.	
7. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals**, pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:** • The provider's name and **group affiliation**, street address(es), telephone number(s), **Web**	**Documents Submitted/Location Within Documents:** 1. Screenshot Finding a Provider FBHP Site, entire document 2. ScreenshotofReferralConnect_2BHO- entire document 3. ReferralConnectSearchCriteria_2BHO, entire document 4. ScreenshotofProviderLanguageInformationforfromProviderConnect_2BHO-Section B, C, E 5. EvidenceofProviderDirectoryUploadedMonthly_2BHO-page 2	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
site URL, specialty (as appropriate), and whether the providers will accept new members. • **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.** • **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.)* *42 CFR 438.10(h)(1-3)* Contract Amendment 7: Exhibit A3—2.6.5.8.1–3	6. EvidenceofMonthlyDMATTupdate_FBHP , entire document 7. ProviderDirectory_FBHP, entire document, entire document 8. ExampleofProvideronHold_2BHO, entire document **Description of Process:** Beacon's Provider Relations Department makes information available regarding our contracted in-network physicians (including specialists and hospitals) available to members in paper or electronic form. This information can be found in FBHP's Provider Directory (See Provider Direcotry_FBHP). Members are able to obtain a copy our contracted providers through our website, fbhpartners.com. Once members select the Member tab, they will have two choices to find a provider. See Screenshot Finding a Provider FBHP Site. The first choice is Provider Directory where Members will find a list of in-network behavioral health providers and hospitals. Providers/Facilities' street address, telephone number, linguistic capabilities, and specialties are listed. The second option is Referral Connect. Members are able to search by specialty, American Sign Language and if there are accommodations for Members with physical disabilities. See Screenshot of Referral Connect_2BHO. This website address is: https://www.valueoptions.com/referralconnect/providerDirectory.do. In Referral Connect, Members can enter their address to obtain providers close to their home. Members can also request provider type, specialty, languages of provider, the age group that providers work with, gender of provider, the ethnicity of provider, and if they are handicapped accessible, have public transportation, or are accepting new patients. See Referral Connect Search Criteria_2BHO. Members can also obtain the mental health centers URL address. Please see Screenshot of URL sites on Website_CHP.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Many Members choose to call into FBHP's call center to request Health First Colorado providers in their vicinity. A Customer Service Assistant (CSA) will use our Referral Connect system to find providers near the Member. A CSA can search several fields including specialties, language, gender preference, and access for disabilities. Providers can update their information on Provider Connect. Updated information can be phone numbers, addresses, specialties, whether they are currently accepting new patients, or linguistic capabilities. Screenshot of Provider Language Information from Provider Connect_2BHO, See Section B, C, E. If a provider selects that they have accommodations for people with physical disabilities, Members are able to select this on Referral Connect. Providers notify Beacon when they are unable to accept new Members. Provider Relations staff will list their practice as full and remove these providers from the next provider directory upload. See Example of Provider on Hold_2BHO Beacon will use Providers' information to update the Provider Directory, including any of these changes on a monthly basis according to our Standard Operating Procedure. Information included in our paper provider directory is updated at least monthly, and electronic provider directories are updated no later than 30 calendar days after the Contractor receives updated provider information. See Evidence of Provider Directory Uploaded Monthly_2BHO.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Provider Relations has an automated monthly Data Management & Analysis Task Tracker (DMATT) ticket to update the provider directory on a monthly basis. Once this directory is updated, it is uploaded to our website. See Evidence of Monthly DMATT Update_FBHP.	
Findings: FBHP's provider directory included the name, group affiliation, street address, telephone number, areas of specialty, and languages spoken for all providers accepting new patients. The directory included no information regarding a provider's website URL, cultural competency training, or accessibility for people with physical disabilities.		
Required Actions: FBHP must update its provider directory to include a provider's website URL (if available), indicate which providers have completed cultural competency training, and note which locations are accessible for people with physical disabilities.		
8. **Provider directories are made available on the Contractor's Web site in a machine-readable file and format.** *42 CFR 438.10(h)(4)* Contract Amendment 7: Exhibit A3—2.6.5.8.4	**Documents Submitted/Location Within Documents:** 1. FBHP website on Member Services page: a. Link titled "Provider Directory" has a .pdf version of the most current provider listing. b. Link titled "Referral Connect" allows members to search for providers through a web based tool. 2. ScreenshotofReferralConnect_2BHO, entire document 3. Beacon Policy - PR 012 Provider Directory.pdf 4. EvidenceofMonthlyDMATTupdate_FBHP, entire document 5. ProviderDirectory_FBHP, entire document 6. IT302.2 508ComplianceofExternalWebSitesPolicy_2BHO Sections IA, III IV 1-11 7. WebsiteCheck_FBHP, page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: FBHP has delegated to Beacon the responsibility to ensure that Provider Directories are available on our website. There is an automated monthly DMATT report that updates providers who are current in our network. See Evidence of Monthly DMATT Update_FBHP. The information from this report is turned into our Provider Directory. See Provider Directoy_FBHP. According to Beacon's IT302.2 508 Compliance of ExternalWebsitesPolicy_2BHO, Beacon regularly runs 508/WCAG scans for their websites to resolve accessibility issues they can control (they cannot control PDF content). The 508/WCAG reports are shared monthly so that everyone is aware of what needs to be resolved and so that accessible PDFs and content can be provided to remediate the issues. Beacon Colorado is notified if there are any machine readable file and format issues with the Provider Directory. WebsiteCheck_FBHP.	
9. The Contractor provides other necessary information to members, including: • The Child Mental Health Treatment Act (CMHTA). • Community resources. Contract Amendment 7: Exhibit A3—2.6.7.3.1 and 2.6.7.3.3	**Documents Submitted/Location Within Documents:** 1. Community resources - FBHP website on Member Services page: a. Link titled "Click here to find reliable mental health and advocacy information on-line" 2. Health First Colorado's Members Handbook_2BHO entire document 3. Notice of Adverse Benefit Determination Letter_FBHP, page 7 4. CMHTALiaisonContactListfromState_2BHO, entire document 5. EvidenceofMemberHandbookonFBHPWebsite_FBHP, entire document 6. ProviderHandbook_2BHO, page 42	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: FBHP provides other necessary information to members including the Child Mental Health Treatment Act (CMHTA) and community resources. FBHP has information about the Child Mental Health Treatment Act (CMHTA) located on our website at: http://www.fbhpartners.com. There is a CMHTA "point person" at each community mental health center. See CMHTA Liason Contact List_2BHO. FBHP relies on the expertise of this "point person" to assist our Members. When a Member contacts the mental health center, they are directed to the CMHTA point person. FBHP also has Health First Colorado's Members Handbook link on our website where information about CMHTA can be found. Evidence of Member Handbook on FBHP Website_FBHP. When a child/adolescent has been denied residential treatment, we include information about CMHTA in the Notice of Adverse Benefit Determination letter (see Notice of Adverse Benefit Determination Letter_FBHP, page 7. Finally, information about CMHTA is found in Provider Handbook_2BHO, page 42. Providers are made aware of the Child Mental Health Treatment Act and can use this to provide information for Members.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. For any information provided to members by the Contractor, the Contractor ensures that information is consistent with federal requirements in 42 CFR 438.10. *42 CFR 438.10 (b)*	**Documents Submitted/Location Within Documents:** 1. 306LMemberMaterialsDevelopment_Policy_2BHO_ page 1, I A,B,C,D,E; page 2, II B, IV A iv, and IV D. 2. Evidence of Reading Level and Supervisor Proofing Materials_2BHO, page 18 and 19 3. EvidenceofReviewingMemberInformationwiththeState_2BHO- entire document **Description of Process:** Foothills Behavioral Health Partners has process in place to make sure that any information provided to members is consistent with federal requirements in 42 CFR 438.10. Beacon has a Member Material policy (See306L Member Materials Development Policy_2BHO) which we follow to ensure that Member materials are consistent with these requirements. Member materials are written at an appropriate reading level so that they are clear, concise and understandable. Beacon runs member materials through a Flesch-Kinkaid Score which is obtained through Microsoft Word. Beacon has a protocol to confirm that individual member letters are accurate, easily understood, and clear. Individual letters are reviewed by a supervisor prior to mailing to a member. As an example of this, we have loaded our Appeal Job Aid (see Evidence of Reading Level and Supervisor Proofing Materials_2BHO, page 18 and 19) to show our process of running appeal decision letters through Flesch-Kincaid and requiring supervisor approval. Member Materials are available in alternative formats for members who have communication disabilities. Alternative formats include large type and audio tape. Materials always have a tagline that	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	information is available in other languages at no charge to the member and available in alternative formats. When developing materials that may go to multiple Members, beacon reviews these materials with Healthcare Policy and Financing's contract manager for our region. For an example of this, please see Evidence of Reviewing Member Information with the State_2BHO. This shows that when we developed a form that would go to multiple Members, we sent it to our contract manager, Troy Peck, to review and approve. This is consistent with following our 306L Member Materials Development_Policy_2BHO. As present in EvidenceofReviewingMemberInformationwiththeState_2BHO the email chain provides evidence of reviewing member information with the state.	
11. **The Contractor provides member information by any of:** • **Mailing a printed copy of the information to the member's mailing address.** • **Providing the information by email after obtaining the member's agreement to receive the information by email.** • **Posting the information on the Contractor's Web site and advising the member in paper or electronic form that the information is available on the Internet and including the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.**	**Documents Submitted/Location Within Documents:** 1. AppealAcknowledgementLetter_FBHP, entire document 2. GrievanceAcknowledgementLetter_FBHP, entire document 3. NoticeofAdverseBenefitDeterminationLetter_FBHP, entire document 4. LettertoMemberofProviderTerminating_FBHP, entire document 5. AppealDecisionLetter_FBHP, entire document 6. GrievanceResolutionLetter_FBHP, entire document 7. EvidenceofPostage_2BHO, entire document **Description of Process:** FBHP provides member information through a variety of means. The predominant method is through mailings and our website. To demonstrate mailing a printed copy of information to a Member's mailing address, we have included copies of our grievance and appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• **Providing the information by any other method that can reasonably be expected to result in the member receiving that information.** *42 CFR 438.10(g)(3)*	acknowledgement letters, notices of adverse benefit determination letters, grievance resolution letter and appeal decision letters. See Appeal Acknowledgement Letter_FBHP, Grievance Acknowledgement Letter_FBHP, Notice of Adverse Benefit Determination Letter_FBHP, Letter to Member of Provider Terminating_FBHP, Appeal Decision Letter_FBHP, and Grievance Resolution Letter_FBHP. We use the mailing address from our Service Connect/Care Connect system (SC/CC). Eligibility files provided by HCPF with Member's address is downloaded into Beacon's SC/CC system. We provided the evidence of postage for OMFA for grievances and appeal under Evidence of Postage_2BHO. We post information on our website and inform members that they can access this information by going to the site. We provide FBHP's website link in letters. For evidence of this, see our Notice of Adverse Benefit Determination letter which directs members to our website to review our clinical care guidelines.	
12. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)*	**Documents Submitted/Location Within Documents:** 1. FBHP Utilization Management Attestation – entire doc 2. FBHP Policy Gifts, Gratuities, Meals & Expenses – entire doc **Description of Process:** FBHP attest annually to HCPF that it does not provide incentives for any staff based on utilization review decisions. All review decisions are based upon Medical Necessity, appropriate care, and benefit coverage. The FBHP policy on gifts also defines the organizational expectation that its employees and contractors will not give or accept gifts, payments, meals, entertainment or other benefits that might influence Member care, benefits or the decisions made on behalf of FBHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard V—Member Information							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	8
				Total Score ÷ Total Applicable		=	73%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. **The Contractor has established internal grievance procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The contractor must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them.** • **The Contractor may have only one level of appeal for members (or providers acting on their behalf).** • **A member may request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination has been upheld.** • **If the Contractor fails to adhere to required time frames for processing appeals, the member is deemed to have exhausted the Contractor's appeal process and the member may initiate a State fair hearing.** *42 CFR 438.400(a)(3)* *42 CFR 438.402(a-c)* *42 CFR 438.400(b)* Contract Amendment 7: Exhibit A3—2.6.4.1, 2.6.4.9.1, 2.6.4.9.3 10 CCR 2505-10—8.209.3.A, 8.209.4.A.2.c, 8.208.4.N, and 8.209.4.O	**Documents Submitted/Location Within Documents:** 1. GrievanceandAppealGuide_FBHP FY18 – items (2), (5, a), (8, a), (7,e) a. Document - Link titled "Grievance & Appeal Process" is posted at. http://www.fbhpartners.com/members/ b. FBHP Policy M3.8 Grievance System v1 – items (II, 1, a), (4, b, v), (6, g, v, 1) 2. MHP Policy Client Grievances – entire doc 3. JCMH Grievance Guide Eng 08 2017 – entire doc 4. 305LAppealProcessesPolicy_2BHO, Page 1 IA, B, Page 3, IIIE, Page 4, IV, A 3b 5. 303LGrievanceProcessPolicy_2BHO, Page 1, ID, Page 2, IIC 6. DCRForm_FBHP, entire document 7. ROIForm_FBHP, entire document 8. ProviderHandbook_2BHO, page 45, 48, 121 9. GrievanceDatabase_FBHP, entire document 10. ExampleofAppealLog_FBHP, entire document 11. AppealJobAid_2BHO, entire document 12. ExampleofCollectingAppealData_FBHP, entire document 13. NoticeofAdverseBenefitDeterminationLetter_FBHP, page 3, 6 14. ScreenshotofGrievanceandAppealProcessonWebsite_FBHP, entire document **Description of Process:** FBHP has established internal grievance procedures under which Members, Legal Guardians, or providers acting on Members' behalf, may challenge the denial of coverage of, or payment for, medical	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	assistance. FBHP has an appeal system in place to handle appeals of an adverse benefit determination and grievance system to resolve grievances. FBHP also has a process to collect and track information about appeals and grievances. Members can obtain information about the grievance and appeal process by following the link on our website. See Screenshot of Grievance and Appeal Process on Website_FBHP. To demonstrate that FBHP has established grievance and appeal guidelines in place, please see 305L Appeals Process Policy_2BHO and 303LGrievance Process Policy_2BHO. In these policies we state that either a Member, Legal Guardian, or a Designated Client Representative (DCR) can initiate an appeal or a grievance. A Member or their DCR may appeal an adverse benefit determination or file a grievance relating to any dissatisfaction about any matter other than an adverse determination. We send Members a Grievance and Appeal Guide_FBHP when there is an adverse benefit determination. In the guide it states that Members and/or Legal Guardians may ask someone other than themselves, including their service provider to file a complaint or appeal on their behalf. We explain that Members and/or Legal Guardians will need to fill out a Designated Client Representative (DCR) form to represent the Member, as well as a Release of Information form (ROI). Members also are informed that a representative can act on their behalf in the Notice of Adverse Benefit Determination Letter (See Notice of Adverse Benefit Determination Letter_FBHP). We have DCR and ROI forms located on our website under resources which can be downloaded (see Example of DCR Form_FBHP and Example of ROI Form_FBHP). Information about DCRs is also found in the Provider Handbook_2BHO.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	FBHP has a process to collect and track appeals. See Appeal Job Aid_2BHO for a detailed explanation of the processes we use to collect appeal information. All of this information is stored on our shared drive. Please see Example of Collecting Appeal Data_FBHP to demonstrate how all of the information is stored. Beacon's Knowledge Management and Reporting Team (KMAR) generates a quarterly report tracking all the appeals for the previous quarter. See Example of Appeal Log_FBHP for a copy of this report, Our 305L Appeals Process Policy_2BHO, Grievance and Appeal Guide_2BHO, and Notice of Adverse Benefit Determination letters (Notice of Adverse Benefit Determination_FBHP) explain that there is only one level of appeal for a member. There is detail in these three resources that Members/Legal Guardians/DCRs must go through the appeal process prior to requesting a State Fair Hearing. We also explain that if FBHP does not adhere to the required time frames for processing appeals, the Member is considered to have exhausted our appeal process and the Member may initiate a State Fair Hearing. FBHP has a process to collect and track grievances. There is a designated Advocate to take grievances directly from Members. Our goal has always been to address grievances promptly and expediently with Members. For an example of our grievance database where the information is collected, please see Grievance Database_FBHP.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. The Contractor defines "adverse benefit determination" as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • **The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).** • For a resident of a rural area with only one managed care plan, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network.	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – Definitions item 2 2. FBHPartners Handbook 092517 –page 30 3. ProviderMan_2BHO -page 49 a. FBHP Site, Providers page see link titled "The Colorado Beacon Health Options Provider Handbook" 4. 305LAppealProcessesPolicy_2BHO, page 3, C 1-6 5. 303LGrievanceProcessPolicy_2BHO, pages 2-3, E1-6 6. 274LOutofNetworkPolicy_2BHO, page 2, B 2a, c, page 3 B 4 7. AppealDecisionletter_FBHP, page 2 8. 202LMedicalNecessity_2BHO, page 2, II, A1-4 9. HealthFirstColoradoMemberHandbook_2BHO, page 63 10. GrievanceandAppealGuide_FBHP FY18, page 2 11. GrievanceandAppealTraining_2BHO, Slide 4 & 5 12. Evidence of Training_2BHO_entire document **Description of Process:** Foothill Behavioral Health Partners has the definition of an adverse benefit determination located in several places. FBHP has two policies that include this definition: See 305L Appeals Process Policy_2BHO, page 3 and 303L Grievance Process Policy_2BHO, page 2. We also send a Grievance and Appeal Guide_FBHP to Members when there is a notice of adverse benefit determination, or Members can find this guide on our website. The guide addresses the definition of an Adverse Benefit Determination on page 2. The specific definition of services which are medically necessary can be found in our policy, 202L Medical Necessity_2BHO on page 2 and in our Appeal Decision letter_FBHP on page 2. The policies guide our handling and	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– The provider is not part of the network but is the main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider. o If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* Contract Amendment 7: Exhibit A3—1.1.1.3 10 CCR 2505-10—8.209.2.A	disposition of grievances & appeals. The definition of an adverse benefit determination is located in the Provider Handbook_2BHO on page 50 to ensure that providers also know the correct terminology. FBHP also relies on Health First Colorado's Member Handbook_2BHO on the definition of an Adverse Benefit determination which can be found on page 63. The 274L Out of Network Policy_2BHO describes the single case agreement process. The policy describes the procedure we follow when Members request seeing an out-of-network provider and situations where a member may reside in a rural area and want to exercise their rights to obtain services outside of the network on pages 3 – 4. The policy addresses when Members need a provider with certain expertise or a rural provider who is not in network. Provider Relations staff will reach out to the provider and encourage them to become part of our network and approve single case agreements so the member can continue to see the provider. OMFA provided a training to Clinical staff to educate clinical staff members of the time frames to file grievances and appeals, review the definitions of grievances and appeals, and to discuss Members' rights to file grievances and appeals. See Grievance and Appeal Training_2BHO. OMFA had clinicians sign a training sign-in sheet for this training. Please see Evidence Grievance and Appeal Training_2BHO.	

<table>
<tr><th colspan="3">Standard VI—Grievance System</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the BHO</th><th>Score</th></tr>
<tr><td colspan="3">Findings:
The FBHP Grievances and Appeals policy accurately defined “adverse benefit determination (ABD),” including all elements. However, the Beacon Health Systems (Beacon) Appeal Process policy failed to include “denial of a member’s request to dispute a member financial liability” in its definition of ABD.</td></tr>
<tr><td colspan="3">Required Actions:
Beacon must update its Appeal Process policy to include all elements of the definition of “adverse benefit determination.”</td></tr>
<tr><td>3. The Contractor defines “Appeal” as “a review by the Contractor of an adverse benefit determination.”

42 CFR 438.400(b)
Contract Amendment 7: Exhibit A3—1.1.1.4
10 CCR 2505-10—8.209.2.B</td><td>Documents Submitted/Location Within Documents:
1. FBHP Policy M3.8 Grievance System v1 – Definitions item 3
2. 305LAppealProcessesPolicy_2BHO, page 2-3, B
3. 303LGrievanceProcessPolicy_2BHO, page 1, IIA
4. ManagedCareTerminology_2BHO, page 1
5. HealthFirstColoradoMemberHandbook_2BHO, page 63
6. GrievanceandAppealGuide_FBHP, page 2
7. GrievanceandAppealTraining_2BHO, Slide 4

Description of Process:
FBHP defines “Appeal” as an adverse benefit determination made by the BHO. This definition is explained in the policies and procedures which we follow. Please see 305L Appeals Process Policy_2BHO on page 2-3 and 303L Grievance Process Policy_2BHO on page 1. FBHP communicates this appeal definition to Members through our Managed Care Terminology_2BHO (located on our website, www.fbhpartners.com) and in our Grievance and Appeal Guide_FBHP FY18 on page 2. This definition is also located in Health First Colorado’s Member Handbook_2BHO on page 63 which is located on our website. Whenever a Member/Legal Guardian/DCR disagrees with an adverse benefit determination, this generates the Member’s appeal rights.</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ N/A</td></tr>
</table>

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	OMFA provided a training to Clinical staff to educate clinical staff members of the time frames to file grievances and appeals, review the definitions of grievances and appeals, and to discuss Members' rights to file grievances and appeals. See Grievance and Appeal Training_2BHO. OMFA had clinicians sign a training sign-in sheet for this training. Please see Evidence of Training_2BHO.	
4. The Contractor defines "grievance" as "an expression of dissatisfaction about any matter other than an **adverse benefit determination**." Grievances may include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the member's rights **regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.** *42 CFR 438.400(b)* Contract Amendment 7: Exhibit A3—1.1.1.27, 2.6.4.5.8.1.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – items (III, 6), 2. FBHPartners Handbook 092517 –page 30 3. 303LGrievanceProcessPolicy_2BHO, page 2, IID 4. 305LAppealProcessesPolicy_2BHO, page 6 IV C 5Bi 3bullet 5. GrievanceandAppealTraining_2BHO - slide 16 6. EvidenceofGrievanceandAppealTraining_2BHO-Entire document 7. ExpeditedAppealRequestDenialLetter _FBHP, entire document 8. HCPFGrievanceCategoriesDefined_2BHO, entire document 9. GrievanceandAppealGuide_FBHP, page 1 **Description of Process:** FBHP defines "grievance" as "an expression of dissatisfaction about any matter other than an adverse benefit determination. This definition can be found in our 303L Grievance Process Policy_2BHO on page 2 and 305L in our Appeals Process Policy_2BHO. Members can find the definition of a grievance in the Grievance and Appeal Guide_FBHP on page 1. Members can find out that they can file a grievance if they disagree with FBHP's decision to extend the time frame to review their appeal authorization decision. See page 2 in	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Appeal Delay Letter_FBHP. We also notify Members that they can file a grievance if there request for an expedited appeal is denied (See Expedited Appeal Request Denial Letter_FBHP) and Grievance and Appeal Guide_FBHP on page 5 We also provide training to internal staff and community mental health center staff. Please see our GrievanceandAppealTraining_2BHO and Evidence of Grievance and Appeal Training_2BHO. HCPF provided definitions for grievance categories that we use as guides to record the grievance in the correct fields (see HCPF Grievance Categories Defined_2BHO).	
Findings: The FBHP Grievances and Appeals policy defines "grievance" per the language of the requirement. However, the Jefferson Center for Mental Health (JCMH) grievance guide and Mental Health Partners (MHP) grievance policy defined "grievance" using broader language: "dissatisfaction about your service provider" and "dissatisfaction about provider services," respectively. Dissatisfaction about services could be construed as dissatisfaction with an ABD (which would be an appeal).		
Required Actions: FBHP must ensure that community mental health centers (CMHCs) that identify and process grievances on behalf of FBHP clarify the definition of "grievance" as "dissatisfaction about any matter *other than an adverse benefit determination*."		
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *42 CFR 438.402(c)*	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessesPolicy_2BHO, Page 2, item C 2. 303LGrievanceProcessPolicy_2BHO, (Page 2, item F), (Page 4, section IV, item A) 3. FBHP Policy M3.8 Grievance System v1 – item 3, n 4. GrievanceandAppealGuide_FBHP FY18 – page 1 a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Contract Amendment 7: Exhibit A3—2.6.4.4.1, 2.6.4.4.4, 2.6.4.6.3, 1.1.1.17 10 CCR 2505-10—8.209.3.B.1, 8.209.3.B.2, 8.209.2.C	**Description of Process:** FBHP has established internal grievance procedures under which Members, Legal Guardians, or providers acting on Members' behalf, may file a grievance. To demonstrate that FBHP has established grievance and appeal guidelines in place, please see FBHP Policy M3.8 Grievance System v1 , 305L Appeals Process Policy_2BHO and 303LGrievance Process Policy_2BHO. In these policies we state that either a Member, Legal Guardian, or a Designated Client Representative (DCR) can initiate an appeal or a grievance. A Member or their DCR may appeal an adverse benefit determination or file a grievance relating to any dissatisfaction about any matter other than an adverse determination. We send Members a Grievance and Appeal Guide_FBHP FY18 when there is an adverse benefit determination. In the guide it states that Members and/or Legal Guardians may ask someone other than themselves, including their service provider to file a complaint or appeal on their behalf. We explain that Members and/or Legal Guardians will need to fill out a Designated Client Representative (DCR) form to represent the Member, as well as a Release of Information form (ROI). Members also are informed that a representative can act on their behalf in the Notice of Adverse Benefit Determination Letter (See Notice of Adverse Benefit Determination Letter_FBHP). We have DCR and ROI forms located on our website under resources which can be downloaded (see Example of DCR Form_FBHP and Example of ROI Form_FBHP). Information about DCRs is also found in the Provider Handbook_2BHO.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
6. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.D	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (III, 6), (5, a) 2. FBHPartners Handbook 092517 –page 32 3. 305LAppealProcessesPolicy_2BHO, page 1 item A 4. 303LGrievanceProcessPolicy_2BHO, pages 2 item D 5. GrievanceandAppealGuide_FBHP FY18 – item (4, f) a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html **Description of Process:** To demonstrate that FBHP has established grievance and appeal guidelines in place, please see FBHP Policy M3.8 Grievance System v1 , 305L Appeals Process Policy_2BHO and 303LGrievance Process Policy_2BHO. These policies clearly define that the member has the right to file a grievance orally or in writing. The Grievance and appeal guide FHP FY 18, which is distributed to members when they receive an adverse benefits determination letter, also informs the member of the process and the means by which they can file a grievance.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.A	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (5, a) 2. GrievanceandAppealGuide_FBHP FY18 – item (4, f) a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html **Description of Process:** FBHP has clearly defined in its grievance system policy and grievance and appeal guide that there is no statute of limitations imposed on the	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	member's rights to file a grievance. The Grievance and appeal guide FHP FY 18, which is distributed to members when they receive an adverse benefits determination letter, also informs the member of the process and the means by which they can file a grievance.	
Findings: The FBHP Grievances and Appeals policy and the Beacon Grievance Process policy state that a member may file a grievance at any time. However, the MHP grievance policy incorrectly stated that the member may file a grievance within 30 days of an incident.		
Required Actions: FBHP must ensure that MHP, which processes CMHC grievances on behalf of FBHP, corrects its policy to state that a member may file a grievance *at any time*.		
8. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.B	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (5, b) 2. GrievanceandAppealGuide_FBHP FY18 – item (4, f) a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 3. MHP Policy Client Grievances – item 2 4. JCMH Grievance Guide Eng 08 2017 – page 1 5. M'cd Griev Ack Letter Template 6-29-15 – entire doc 6. 303LGrievanceProcessPolicy2BHO- page 6, IV 5 7. HealthFirstColoradoMemberHandbook_2BHO, page 68 8. GrievanceContactRecord_2BHO, entire document 9. GrievanceAcknowledgementLetter_FBHP-Entire Document 10. GrievanceFlowChart_2BHO-Entire Document **Description of Process:** Foothills Behavioral Health Partnerships sends Members a written acknowledgement letter within two (2) working days of the receipt of	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	the grievance. FBHP follows our 303L Grievance Process Policy_2BHO which states that we will send out an acknowledgement letter within two working days on page 5. This two-day requirement to send out an acknowledgement letter is also in our Grievance Flow Chart_2BHO. The date the grievance is received sets the clock for the two-day turnaround time to send an acknowledgment letter. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. This date is logged in the Member's Grievance Contact Record_2BHO. If the grievance is filed with the Engagement Center, the date is entered into the FBHP grievance data base. If the date is filed with a community mental health center Advocate or at a local OMFA office, the date is also logged into the FBHP grievance data base. Members are made aware that they will receive an acknowledgement letter within two business days from Health First Colorado Member Handbook_2BHO on page 68. FBHP has attached the acknowledgement letter that we send to Members within this two day time frame. See Grievance Acknowledgment Letter_FBHP.	
Findings: All FBHP, Beacon, and CMHC policies and procedures accurately addressed this requirement. However, three of eight applicable grievance record reviews failed to send an acknowledgement letter in the required time frame.		
Required Actions: FBHP must ensure that all members are sent acknowledgement letters within two working days of FBHP's receipt of a grievance.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and **within 15 working days of when the member files the grievance.** • Notice to the member must be in writing in the format established by the Department. • **Notice to the member must be in a format and language that may be easily understood by the member.** *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract Amendment 7: Exhibit A3—2.6.4.5.5, 2.6.4.5.5.1, 2.6.5.13.1 10 CCR 2505-10—8.209.5.D.1, 8.209.5.F	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (5, c, iii), (5, c, iv) 2. GrievanceandAppealGuide_FBHP FY18 – item (4, g) a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 3. Mcd Griev Dec Letter Template 6-29-15 – entire doc 4. 303LGrievanceProcessPolicy_2BHO, page 6 IV 11 5. 306LMemberMaterialsPolicy_2BHO, page 1 I A,B,C,D,E, Page 2 II B 6. GrievanceFlowChart_2BHO, entire document 7. HealthFirstColoradoMemberHandbook_2BHO, page 68 8. GrievanceAcknowledgementLetter_FBHP, entire document 9. GrievanceResolutionLetter_FBHP-Entire Document **Description of Process:** Foothills Behavioral Health Partnerships aims to resolve each grievance and provides notice to the Member of the resolution of their grievance as expeditiously as possible. This resolution time frame is within 15 working days from the receipt of the grievance. There are times that this time frame may need to be extended either by Member request, or because more time is required to resolve the grievance. FBHP follows 303 L Grievance Process Policy_2BHO which aligns with state and federal regulations for grievance resolution deadlines. FBHP follows the time frames as indicated in Grievance Flow Chart_2BHO. Members are made aware of the time frame to resolve their grievance through a variety of ways. The information that their grievance will be	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	resolved within 15 working days is listed in Health First Colorado Member Handbook_2BHO on page 68 and in the Grievance and Appeal Guide_FBHP FY18 on page 2. Both of these two resources are found on our website (www.fbhpartnerships.com). Members also receive this information in the Grievance Acknowledgement Letter_FBHP. In the Grievance Acknowledgement Letter_FBHP, we insert the date that the grievance will be resolved which is 15 working days of receipt of the grievance. The date the grievance is received establishes the clock for investigating and resolving the grievance. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. The 15 working days is used to gather facts, consult with others, review policies and make assessments about the Member's complaint. When a reasonable resolution is found, the person handling the grievance notifies the member by letter, using the state-approved template GrievanceResolutionLetter_FBHP. FBHP uses their 306L Member Materials Policy_2BHO to guide the content in the Grievance Resolution Letter_FBHP. The Grievance Resolution Letter_FBHP is written at an appropriate reading level and in a format to be easily understood by Members.	
Findings: HSAG found in grievance record reviews that one member was not notified of the grievance resolution within the required time frame. In addition, five of nine record reviews included resolution letters that were difficult for the member to understand; one CMHC appeared to combine acknowledgement letter and resolution letter template language into one letter to the member, resulting in a letter that could not be easily understood.		
Required Actions: FBHP must ensure that CMHCs which process grievances on behalf of FBHP comply with requirements for sending resolution letters within the required 15 working days' time frame and write the notice to the member in a format and language that may be easily understood.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract Amendment 7: Exhibit A3—2.6.4.5.5.2 10 CCR 2505-10—8.209.5.G	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (5, c, iv) 2. GrievanceResolutionLetter_FBHP, Entire Document **Description of Process:** FBHP's Grievance Resolution Letter_FBHP includes the results of the disposition, the resolution process, and the date it was completed. We follow our 303L Grievance Process Policy_2BHO which has specific information that needs to be included in the resolution letter including the process of the resolution and the date it was completed. FBHP uses the State department approved Grievance Resolution Letter_FBHP. The letter contains the date the investigation and resolution was completed and the disposition of the grievance. The facts of the resolution are described in the body of the letter in enough detail that the member understands the resolution and is written in lay person language at a low grade reading level. Please see one of FBHP's resolution letter Example of Grievance Resolution Letter_FBHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, **auxiliary aids and services upon request**, as well as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)*	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (3, L-Q) 2. 305LAppealProcessesPolicy_2BHO, page 1 item c, page 2 item H, page 4 item 3a, 3. 303LGrievanceProcessPolicy_2BHO, Page 1 item e, 4. GrievanceandAppealGuide_FBHP FY18 – item (3) a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Contract Amendment 7: Exhibit A3—2.6.4.3 10 CCR 2505-10—8.209.4.C	**Description of Process:** FBHP and Beacon have clearly defined in its grievance system policies and grievance and appeal guide that there is assistance available to members during this process. The Grievance and appeal guide FHP FY 18, which is distributed to members when they receive an adverse benefits determination letter, also informs the member of their right to ask for assistance with this process.	
12. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. • **Take into account all comments, documents, records, and other information submitted by the member or their representative without**	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (5,c,ii), (6 a) 2. FBHPartners Handbook 092517 –page 32 3. GrievanceandAppealGuide_FBHP FY18 – items (4, f), (7) a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 4. 305LAppealProcessesPolicy_2BHO, page 2 I F, page 3, II D1-4 page 5 C 5. 303LGrievanceProcessPolicy_2BHO, Page 6 ,#10, 6. ExpeditedAppealWorkflow_2BHO, entire document 7. HealthFirstColoradoMemberHandbook_2BHO, page 68 8. NoticeofAdverseBenefitDeterminationLetter_FBHP, page 4 9. AppealDecisionLetter_FBHP, page 1 10. ExpeditedAppealRequestDenialLetter_FBHP-entire document 11. ExampleofCollectingAppealData_FBHP, entire document 12. Appeal Acknowledgement Letter_FBHP_entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* Contract Amendment 7: Exhibit A3—2.6.4.5.4, 2.6.4.6.10, 2.6.4.6.6.1, 2.6.4.7.1.1, 2.6.4.7.1.2 10 CCR 2505-10—8.209.5.C, 8.209.4.E	**Description of Process:** FBHP ensures that the individuals who make decisions on grievances and appeals are people who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual. FBHP follows our 305L Appeal Process Policy_2BHO which defines a Peer Advisor as a health professional employed or contracted with the BHO. The Peer Advisor has a current and active, unrestricted license to practice medicine or a health profession. The Peer Advisor is board certified and in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment and is not the individual who made the original non-certification nor the subordinate of one who made decision. Peer advisors are the individuals who review denial decisions. The way that we enforce this procedure is in our Appeal Decision Letter_FBHP. There is a standard paragraph with an attestation that the Peer Advisor was not involved in FBHP's original determination and states the scope of the Peer Advisor's licensure. To demonstrate that FBHP takes into account all comments, documents, records and other information submitted by the Member or their representative without regard if this information was submitted or considered in the initial adverse benefit determination, see Example of Collecting Appeal Data_FBHP. FBHP's Appeal Coordinator compiles all information received from Member/DCR into a secure shared drive. This information is sent to the Peer Advisor. Also, in our Appeal Acknowledgement Letter_FBHP, we have standard wording to show what information was used in making the appeal decision.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	FBHP follows our 303L Grievance Process Policy_2BHO which states that the staff person investigating the grievance shall ensure that the individual who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the client's condition if deciding a grievance that involves clinical issues. Our Expedited Appeal Workflow_2BHO demonstrates our process when we receive a request for an expedited appeal. FBHP's Appeal Coordinator will review the request with the medical director to see if the request meets criteria for an expedited request. If the medical director does not believe that it meets requirements, the member will receive an Expedited Appeal Request Denial Letter_FBHP. In this letter, the Member is informed of the qualifications for the person who reviewed the request for the expedited appeal and the Member's right to file a grievance about the denied request. Members are made aware that those who make decisions on grievances and appeals are people who were not involved in any previous level of review or decision-making for the Member. This can be found in Health First Colorado Member Handbook_2BHO, GrievanceandAppealGuide_FBHP FY18 found on our website, (www.fbhpartners.com), and Notice of Adverse Benefit Determination Letter_FBHP	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
13. A member may file an appeal with the Contractor **within 60 calendar days** from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* Contract Amendment 7: Exhibit A3—2.6.4.6.3.1 10 CCR 2505-10—8.209.4.B	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (6,b) 2. GrievanceandAppealGuide_FBHP FY18 – item (6, a) a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 3. 305LAppealProcessPolicy_2BHO, page 1 IA, page 4, IV 2 4. HealthFirstColoradoMemberHandbook_2BHO, page 63 5. NoticeofAdverseBenefitDeterminationLetter_FBHP, page 4 **Description of Process:** FBHP allows Members/Legal Guardians/DCRs to file an appeal with us within 60 calendar days from the date on the Adverse Benefit Determination Letter_FBHP. Members are made aware of this in the Notice of Adverse Benefit Determination Letter_FBHP, through our GrievanceandAppealGuide_FBHP FY18 which is found on our website at www.fbhpartners.com, or through Health First Colorado's Members Handbook_2BHO on page 63. FBHP follows state regulations for appeal filing deadlines. The "appeal clock" starts on the date the Notice of Adverse Benefit Determination_FBHP is mailed. Our appeal policy, 305L Appeal Process Policy_2BHO directs the process for handling appeals within the 60 calendar days.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
14. The member may file an appeal either orally or in writing and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406(b)(3)* Contract Amendment 7: Exhibit A3—2.6.4.6.3.2 10 CCR 2505-10—8.209.4.F	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (6,a) 2. FBHPartners Handbook 092517 –page 33 3. GrievanceandAppealGuide_FBHP FY18 – item (6, a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 4. 305LAppealProcessesPolicy_2BHO, Page 1, IA, Page 4 IV 2 5. NoticeofAdverseBenefitDeterminationLetter_FBHP, page 4 6. AppealChecklist_2BHO, entire document 7. ExpeditedAppealWorkflow_2BHO, entire document 8. AppealJobAid¬_2BHO, page 15 **Description of Process:** Foothill Behavioral Health Partners allows Members to file an appeal either orally or in writing. FBHP informs Members that any oral standard appeal request needs to be followed up in writing. Members are notified of their ability to request an appeal orally or in writing in the GrievanceandAppealGuide_FBHP FY18 which is located on our website, www.fbhpartners.com. This information is also communicated in the Notice of Adverse Benefit Determination letter_FBHP. FBHP follows state regulations for accepting appeals from Members/Guardians/DCRs. In our appeal policy, 305L Appeal Process Policy_2BHO, we indicate that Members can request an appeal either verbally or in writing. It is our procedure to request that any appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	requested verbally be followed up in writing for a standard appeal. FBHP has created an internal document, Appeal Checklist_2BHO to ensure that we have the necessary documentation to process an appeal. If the member/ guardian / DCR request an expedited appeal, there is no requirement for the member to follow up in writing. OMFA staff follow our Expedited Appeal Workflow_2BHO where it is stated that no written letter is required for expedited appeal requests. Also, in our Appeal Job Aid_2BHO, on page 15, it is indicated that the appeal clock starts as soon as we have an expedited request and no written letter is required	
15. The Contractor sends the member written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract Amendment 7: Exhibit A3—2.6.4.1 10 CCR 2505-10—8.209.4.D	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (6,g,i) 2. FBHPartners Handbook 092517 –page 34 3. GrievanceandAppealGuide_FBHP FY18 – item (6, a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 4. 305LAppealProcessesPolicy_2BHO, page 5, IV A 4 5. HealthFirstColoradoMemberHandbook_2BHO, page 65 6. AppealAcknowledgementLetter_FBHP, entire document **Description of Process:** Foothills Behavioral Health Partnerships sends the Member a written acknowledgement of an appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. FBHP follows state and federal regulations for acknowledging appeals and keeping within deadlines for appeals. We follow 305L Appeal Process Policy_2BHO which states that we will send an acknowledgement letter within two (2) working days from the date that we received the requested appeal. The date the appeal is	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	received sets the clock for the appeal. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. For expedited appeals, the time is also noted. Since appeals can be filed orally, but must be followed with a written appeal for standard appeals, the date of first contact is the date that starts the "appeal clock." If an oral appeal is filed, the date is when the member/guardian/DCR orally filed. This date is logged in the appeals file for tracking purposes. FBHP sends an approved Appeal Acknowledgement Letter_FBHP to Members. This template is used to provide written acknowledgement of the receipt of an appeal. We try to send the appeal acknowledgment letter by close of business on the day we receive the appeal. If a Member is requesting an expedited appeal, we will send Expedited Appeal Acknowledgment Letter_FBHP. Members are informed about two (2) day turnaround to receive an acknowledgment letter in Health First Colorado Member Handbook_2BHO on page 65 and in the GrievanceandAppealGuide_FBHP FY18 on page 4. Both of these documents are located on our website at www.fbhpartnerships.com.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
16. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date), and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • The member a reasonable opportunity, in person and in writing, to present evidence **and testimony** and make legal and factual arguments. **(The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.)** • The member and his or her representative the member's case file, including medical records, other documents and records, and **any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame.** • That included, as parties to the appeal, are: − The member and his or her representative. − The legal representative of a deceased member's estate.	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 –item (2, d, ii), (2, d, iv), (6, g, iv, 1), (4, b, ix) (3, o) 2. FBHPartners Handbook 092517 –page 33-35 3. GrievanceandAppealGuide_FBHP FY18 – item (6, a) See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 4. 305LAppealProcessesPolicy_2BHO a. Page 1, I, A and E b. Page 2, I, F, G c. Page 4, IV A2 d. Pages 5 IV A 3c, d 5. HealthFirstColoradoMemberHandbook_2BHO, page 64, 65 6. NoticeofAdverseBenefitDeterminationLetter_FBHP, page 3 7. ExpeditedAppealWorkFlow_2BHO, entire document 8. AppealJobAid_2BHO, page 15 9. RecordsRequest_2BHO, entire document **Description of Process:** Foothills Behavioral Health Partnerships Appeal process provides for Members/Guardians/DCRs to request an appeal verbally once they have been notified of an Adverse Benefit Determination. FBHP follows state and federal regulations to ensure that Members/ Guardians/DCR's can exercise all of their rights in the appeal process and that members have all access to appropriate files, can present evidence to substantiate their appeal, and that oral inquiries will be treated as an appeal to establish the earliest filing date. FBHP's designated Appeal Coordinator explain all of the rights to the Member when they call to request an appeal. The Appeal Coordinator	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
42 CFR 438.406(b)(3-5) Contract Amendment 7: Exhibit A3—2.6.4.6.4, 2.6.4.6.5, 2.6.4.6.7, 2.6.4.6.8, 2.6.4.6.9 10 CCR 2505-10—8.209.4.F, 8.209.4.G, 8.209.4.H, 8.209.4.I	communicates to the Member/Guardian/DCR of the limited time frames in making an appeal decision. The Appeal Coordinator follows the Appeal Job Aid_2BHO. On page 15, we discuss our protocol to notify the Member/DCR of the time frames that they have if they want to include additional information for their appeal. This protocol is both for standard and expedited requests. The Office of Member and Family Affairs (OMFA) staff are guided by 305L Appeal Process Policy_2BHO. On page 1, I A and page 4 IV A2, the policy states that a Member/Guardian/DCR can verbally request an appeal. Once the verbal appeal request is made, the Appeal Coordinator starts the 'appeal clock." On page 1, IE states that Members/Guardians/DCRs have the right to be informed that they can request an expedited appeal in situations where the life, safety, or fullest recovery of the Member would be put at risk. On page 2, I F and page 5 3Ac, the policy states that Members/Guardians/DRS have to the right to submit any information in a timely manner that they would like considered in an appeal. On page 2 IG and page 5, 3Ad we state that Members/Guardians/DCRS have the right to request copies of the information used in making an appeal. FBHP sends a GrievanceandAppealGuide_FBHP FY18 to members with the Notice of Adverse Benefit Determination Letter_FBHP and makes the guide available on our website at www.fbhpartnerships.com. In the GrievanceandAppealGuide_FBHP FY18, on page 3, we inform Members that they can request an appeal verbally, however, this oral request needs to be followed up in writing if it is for a standard appeal. We inform members that they can provide any information they think would be helpful in making a decision	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	about their appeal. When records are requested, we send a Records Request_2BHO to the facility to obtain the records at no charge to the Member. We also inform members that they can request to see any review any records that were used in making a decision, free of charge. In the Notice of Adverse Benefit Determination Letter_FBHP, on page 3, Members are informed that they can ask FBHP for a complete copy of their file, including medical records to use for their appeal and that they can receive this free of charge. In our ExpeditedAppealWorkFlow _2BHO, we have a process in place to help members with their expedited appeals. We do not require a signed letter when the request is for an expedited appeal. Members can learn about their appeals rights through Health First Colorado Member Handbook_2BHO. On Page 64 the handbook explains that Members can ask their health plan for a complete copy of their medical records and that they can receive this free of charge. On page 65, Members are made aware of the ability to request an expedited appeal.	
Findings: The Beacon Appeal Process policy adequately addressed most elements of this requirement. However, the policy included no procedures for informing the member of the limited time available in expedited appeals to present evidence and arguments related to the appeal.		
Required Actions: In the case of expedited appeals, FBHP must ensure that Beacon includes in its appeals policies the procedures for informing members of the limited time available to present evidence or arguments.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
17. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • For expedited resolution of an appeal and notice to affected parties, **within 72 hours** after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)&(3)&(d)(2)* *42 CFR 438.10* Contract Amendment 7: Exhibit A3—2.6.4.7.1, 2.6.4.7.3.2, 2.6.4.7.3.5, 2.6.5.13.1 10 CCR 2505-10—8.209.4.J, 8.209.4.L	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (6, g, ii), (6, g, iii) 2. GrievanceandAppealGuide_FBHP FY18 – item (6, c), (7, c) a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 3. 305LAppealProcessesPolicy_2BHO, page 1, I, E, Page 7, C7, D1a,c 4. Time framesforAppealsandGrievances_2BHO, entire document 5. HealthFirstColoradoMemberHandbook_2BHO, page 65, 66 6. ProviderHandbook_2BHO, page 51 7. AppealAcknowledgementLetter_FBHP, entire document 8. ExpeditedAppealWorkFlow_2BHO, entire document 9. StandardAppealWorkFlow__2BHO, entire document 10. AppealDecisionLetter_FBHP, entire document 11. AppealJobAid_2BHO, page 19 **Description of Process:** FBHP resolves each appeal and provides written notice of the disposition as expeditiously as the Member's health condition requires. We follow state and federal regulations for resolving and making decisions about the appeal and informing the member/guardian/DCR. OMFA staff follows the 305 L Appeal Process Policy_2BHO to ensure that we are meeting regulations. On page 1 ID and E and page 7 we outline the policy that Members have a right to resolution of a standard appeal within ten (10) working days and for an Expedited Appeal within seventy-two (72) hours. On page 7, we state that verbal notification for inpatient services and expedited appeals will be given the same day as the decision. We also use Time frames for Appeals and Greivances_2BHO as a guide of timeliness standards. In our	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Appeal Job Aid_2BHO on page 19, we outline the process for the readability testing to ensure that the letter can be easily understood by the Member. All letters are reviewed by a supervisor to ensure that they are in a language and format that the Member could easily understand. FBHP also follows the Expedited Appeal Work Flow_2BHO and Standard Appeal Work Flow_2BHO to follow timelines. Members can learn about the time frames that they can expect to receive a decision about their appeal. This information can be found on our website, www.fbhpartners.com in Health First Colorado Member Handbook_2BHO and GrievanceandAppealGuide_FBHP FY18. Providers can learn about these time frames in the Provider Handbook_2BHO on page 51. When a Member requests either a standard or expedited appeal, we send them an acknowledgement letter letting them know the time frame for making a decision. See Appeal Acknowledgement Letter_FBHP and Expedited Appeal Acknowledgement Letter_FBHP. Members will be sent an Appeal Decision Letter_FBHP within 10 working days of filing the appeal. Members will receive an Appeal Decision Letter_FBHP within 72 hours of an approved expedited appeal request.	
Findings: The Beacon Appeal Process policy incorrectly defined the time frame for providing notice to the member for an expedited appeal. The policy stated that "the timeframe for resolution of an expedited appeal is 72 hours for verbal notification to be provided to the member or requesting party, to be followed by written notification within two (2) calendar days." Regulations require written appeal resolution notice to the member within 72 hours of receipt of an expedited appeal, and reasonable efforts to orally inform the member. The appeal record reviews indicated that the member was notified of disposition within the required time frames. However, seven of 10 notices of disposition included clinical content that HSAG deemed inappropriate to communicate to the member—e.g., alleging member's alcohol or substance		

<table>
<tr><th colspan="3">Standard VI—Grievance System</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the BHO</th><th>Score</th></tr>
<tr><td colspan="3">abuse, describing the member’s emotional problems, or including other clinical personal health information (PHI)—and were therefore scored “not easy to understand.”</td></tr>
<tr><td colspan="3">Required Actions:
FBHP must ensure that Beacon’s expedited appeals procedures provide for written notice to the member within 72 hours of receiving the appeal. FBHP must also ensure that the description of the disposition includes only information that is appropriate to communicate to the member.</td></tr>
<tr><td>18. The contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days:
• If the member requests the extension; or
• If the Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member’s interest.
• If the Contractor extends the time frames, it must—for any extension not requested by the member:
– Make reasonable efforts to give the member prompt oral noice of the delay.
– Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision.
– Resolve the appeal as expeditiously as the member’s health condition requires and no later than the date that the extension expires.
• If the Contractor fails to adhere to the notice and timing requirements for extension of the</td><td>Documents Submitted/Location Within Documents:
1. FBHP Policy M3.8 Grievance System v1 –item (5, c, iii), (6, g, iii)
2. FBHPartners Handbook 092517 –page 35
3. GrievanceandAppealGuide_FBHP FY18 – item (4, g), (6, c), (7, c)
a. See link titled “Grievance & appeals Process” http://www.fbhpartners.com/members/index.html
4. 305LAppealProcessesPolicy_2BHO page 1, C,E, page 2 E1, Page 6, 5 a-b
5. 303L_GrievanceProcessPolicy_2BHO , page 7 , 13
6. HealthFirstColoradoMemberHandbook_2BHO, page 65
7. GrievanceandAppealGuide_FBHP FY18, page 2, 4, 5
8. NoticeofAdverseBenefitDeterminationLetter_FBHP, page 5, 6
9. GrievanceDelayLetter_FBHP, entire document
10. AppealDelayLetter_FBHP, entire document

Description of Process:
FBHP can extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days when a Member requests the extension or when FBHP believes that there is a need for additional information and that the delay in making a decision would be in the Member’s best interest.</td><td>☐ Met
☒ Partially Met
☐ Not Met
☐ N/A</td></tr>
</table>

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
appeal resoultion time frame, the member may initiate a State fair hearing. *42 CFR 438.408(c)* Contract Amendment 7: Exhibit A3—2.6.4.7.2, 2.6.4.7.2.1, 2.6.4.7.8, 2.6.4.7.3.3, 2.6.4.5.8.1.2, 2.6.4.9.3, 2.6.4.6.2.5.2.3 10 CCR 2505-10—8.209.4.J, 8.209.4.O	FBHP follows all state and federal guidelines for extending time frames for resolution of grievances and appeals (both expedited and standard) by 14 calendar days. FBHP's 303L Grievance Process Policy_2BHO shows on page 7 that we can extend the time frame for the resolution of a grievance by up to 14 calendar days if the Member requests the extension or if there is a need for additional information and that the delay is in the Member's best interest. FBHP notifies the Member within 2 business days when there has been a request for an extension and attempt to contact the Member on the phone. We send out a letter to the member to notify them. See Grievance Delay Letter_FBHP. In the body of the letter, we document why it is in the Member's best interest to delay the grievance. FBHP's 305L Appeal Process Policy_2BHO_ provides the protocols we follow when either a Member requests an extension, or when we believe it would be in the Member's best interest to have additional time to make a decision. We send the Member written notification when the time frame is extended. The policy states on page 6 that we will include the reason for the extension, the date by which FBHP will make a final determination, and the notification of Member's rights to file a grievance if the Member disagrees with the extension. We send this letter to Member within 2 business days. See Appeal Delay Letter_FBHP. In the body of the letter, we document why it is in the Member's best interest to delay the appeal. Please see Example of Standard Delay Letter_FBHP for content that is embedded in the letter with the reason for filing extension as well as the right to file a grievance if there is a disagreement about the extension.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Members are made aware of the ability to delay either a grievance or appeal by up to fourteen (14) calendar days by accessing the GrievanceandAppealGuide_FBHP FY18 on our website, www.fbhpartners.com. In our GrievanceandAppealGuide_FBHP FY18, on page 2, 4 and 5, we outline for Members this right to delay an appeal or grievance. Members are also alerted about this ability to delay a grievance or appeal decision in the Notice Of Adverse Benefit Determination Letter_FBHP on page 5, 6. In Health First Colorado Member Handbook_2BHO, Members are alerted to the fact that they may request a State Fair Hearing if the BHO does not follow the timelines for appeals.	
Findings: Both the FBHP and Beacon policies regarding grievances and appeals accurately addressed the time frames and member notification requirements for extension of the resolution of an appeal or grievance. While the MHP Grievance policy stated MHP may extend the time frame to respond to a grievance, the policy failed to specify the 14-calendar day time frame for extensions and provided no procedures for informing the member of an extension.		
Required Actions: FBHP must ensure that MHP, which processes CMHC grievances on behalf of FBHP, includes in its policies and procedures the 14-day time frame for extensions as well as the procedures for notifying members of extensions.		
19. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: − The right to request a State fair hearing, and how to do so.	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – items (5, c, iv), (6, c), (6, e), (6, f, iv, 4) 2. FBHPartners Handbook 092517 –page 33-34 3. GrievanceandAppealGuide_FBHP FY18 – items (8), (9) a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 4. 305LAppealProcessPolicy_2BHO. Page 7, E1, 3b, 4a-b 5. HealthFirstColoradoMemberHandbook_2BHO, page 66, 67	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– The right to request that benefits/services continue* while the hearing is pending, and how to make the request. o That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract Amendment 7: Exhibit A3—2.6.4.7.4, 2.6.4.7.5 10 CCR 2505-10—8.209.4.M	6. AppealDecisionLetter_FBHP, entire document 7. NoticeofAdverseBenefitDeterminationLetter_FBHP, page 8 **Description of Process:** FBHP documents in the appeal decision letter the results of the resolution process and the date it was completed. FBHP's OMFA staff follows 305L Appeal Process Policy_2BHO. On page 7, our policy states that the written notice includes the results of the determination/resolution process and the date it was completed. The letter will specify the information that was reviewed in making the decision. This section also includes our policy that Members/Guardians/DCRs can request a State Fair Hearing in the determination was not wholly in favor of the Member. See Appeal Decision Letter_FBHP. Members can find out about their right to request a State Fair Hearing if the appeal decision was not wholly in their favor. On page 5 of the Grievance and Appeals Guide_FBHP, Members are instructed on how they can request a State Fair Hearing. Members are made aware on page 19 that they may be liable to pay for services if the appeal was not in their favor. In Health First Colorado Member Handbook_2BHO, Members are made aware on page 66 that they can request a State Fair Hearing. In Health First Colorado Member Handbook_2BHO on page 67 and in the Notice of Adverse Benefit Determination Letter_FBHP on page 8, Members are made aware that they can request to keep their services during an appeal. Members are also made aware that if they lose their appeal, they may be liable to pay back the cost of any services that they received during their appeal.	

<table>
<tr><th colspan="3">Standard VI—Grievance System</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the BHO</th><th>Score</th></tr>
<tr><td colspan="3">Findings:
The Beacon Appeal Process policy did not address continuation of previously approved services as required content of appeal resolution notices when the resolution is not in favor of the member.

The FBHP Appeal Decision Letter template did not include information on the member's right to request continuation of services during a State fair hearing when the services being appealed were previously approved and then terminated or reduced. The template letter also does not address the member's potential financial liability for continued services if the State fair hearing upholds the ABD. Template issues are global; therefore, HSAG did not consider continued benefit language in the scoring of the content of letters in individual appeal record reviews. It was unclear whether the submitted template letter was intended for use in appeal resolution related to the termination, suspension, or reduction of previously authorized services. FBHP did not; however, provide evidence that it used a specific template that included the required language for situations in which such applied.</td></tr>
<tr><td colspan="3">Required Actions:
FBHP must ensure that Beacon updates its Appeal Process policy and updates the Appeal Decision Letter template language to include information regarding the continuation of previously authorized services during a State fair hearing when applicable. FBHP could add language to its existing template (making it clear whether this applies to the current appeal). Alternatively, FBHP could consider developing a specific template to be used when the appeal resolution is not in favor of the member and relates to a decision to terminate, suspend, or reduce previously authorized services.</td></tr>
<tr><td>20. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.
• If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing.
• The parties to the State fair hearing include the Contractor as well as the member and his or her</td><td>Documents Submitted/Location Within Documents:
1. FBHP Policy M3.8 Grievance System v1 – items (6, g, iii, 3, a), (6, g, v)
2. FBHPartners Handbook 092517 –page 35
3. GrievanceandAppealGuide_FBHP FY18 – items (7, c), (7, e), (8)
a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html
4. 305LAppealProcessesPolicy_2BHO, page 1, I 33, IV A 3b, 4b
5. AppealDecisionLetter_FBHP, page 2
6. NoticeofAdverseBenefitDeterminationLetter_FBHP, page 5
7. ALJJobAid_2BHO, page 2, 3</td><td>☐ Met
☒ Partially Met
☐ Not Met
☐ N/A</td></tr>
</table>

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
representative or the representative of a deceased member's estate. • The Contractor shall participate in all State fair hearings regarding appeals. *42 CFR 438.408(f)(1) and (2) and (3)* Contract Amendment 7: Exhibit A3—2.6.4.9.1, 2.6.4.9.3, 2.6.4.9.2, 2.6.4.9.5 10 CCR 2505-10—8.209.4.N, 8.209.4.O, 8.209.4.H	**Description of Process:** Foothill Behavioral Health Partnerships inform Members that they can request a State Fair Hearing after receiving notice that FBHP is upholding the adverse benefit determination. We inform Members that they may request this within 120 calendar days from the date of the notice of resolution. In our 305LAppealProcessPolicy_2BHO, page 1, we have a procedure that Members can request a State Fair Hearing if we do not adhere to the notice and timing requirements. At this time, the Member is deemed to have exhausted the appeal process. In our GrievanceandAppealGuide_FBHP FY18, we inform members that they can request a State Fair Hearing within 120 days from the adverse appeal decision. We inform members that they may represent themselves at the hearing, bring an Advocate, or have someone else represent them. In the Notice of Adverse Benefit Determination Letter_FBHP on page 6 and I the Appeal Decision Letter page 2, Members are informed that they can request a State Fair Hearing within 120 days from the adverse appeal decision. In the Grievance and Appeals Guide on page 8, Members are informed that they have either have an Advocate, a representative, or they can represent themselves at the State Fair Hearing. FBHP has an ALJJobAid_2BHO which we use to guide the process and ensure that we are represented in the State Fair Hearing. This	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	process includes setting the hearing date and blocking out this time in the Medical Director's calendar to ensure that FBHP participates.	
Findings: The FBHP Appeal Decision Letter template includes two statements regarding request for a State fair hearing: one statement correctly informs the member that he or she may request a State fair hearing within 120 days from the adverse appeal decision; the other statement incorrectly states that the <listed date> is 120 days from the notice of adverse benefit determination. Template issues are global; therefore, HSAG did not consider this discrepancy in the scoring of the content of letters in individual appeal record reviews.		
Required Actions: FBHP must modify the Appeal Decision Letter template to accurately inform the member that he or she may request a State fair hearing within 120 calendar days from the date of the notice of appeal resolution (i.e., remove conflicting statement, "from the notice of adverse benefit determination"). FBHP must also ensure that staff members calculate the <listed date> from the date of the appeal resolution notice.		
21. The Contractor maintains an expedited review process for appeals for when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the Contractor denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution. – **Make reasonable efforts to give the member prompt oral notice of the denial**	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (6, g, iv) 2. FBHPartners Handbook 092517 –page 35 3. GrievanceandAppealGuide_FBHP FY18 – item (6, c) See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 4. 305LAppealProcessesPolicy_2BHO, page 1 IE, page 3 IIF, page 7 IV C6 5. HealthFirstColoradoMemberHandbook_2BHO, page 65,66 6. ExpeditedAppealRequestDenialLetter_FBHP, entire document, 7. ExpeditedAppealWorkflow_2BHO, entire document 8. NoticeofAdverseBenefitDeterminationLetter_2BHO, page 3, 5 **Description of Process:** Foothills Behavioral Health maintains an expedited review process for appeals for when we determine or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410* Contract Amendment 7: Exhibit A3—2.6.4.7.3, 2.6.4.7.3.1, 2.10.17.2 10 CCR 2505-10—8.209.4.Q, 8.209.4.R, 8.29.4.S	In our 305L Appeal Process Policy_2BHO, we follow the procedure that Members/Guardians or their DCRs have the right to be informed that they may also request an Expedited Appeal in situations where the life, safety, or fullest recovery of the member would be put at risk by an appeal resolution that is within the standard time frames. On page 7, our policy states that no punitive action may be taken against a provider acting as a DCR who requests an expedited resolution or supports a Member's appeal. Our ExpeditedAppealWorkflow _2BHO reflects that the appeal will be transferred to the time frame of a standard resolution if an expedited request is denied. Members are notified by letter when their request for an expedited appeal is denied. See Expedited Appeal Request Denial Letter_FBHP. In this letter we explain that we will transfer the appeal to the time from for standard resolutions and that they can file a grievance if they are in disagreement with the denial to expedite their appeal. For an example of a sent letter in which we document the date the Member was contacted via phone, see Example of Expedited Appeal Request_FBHP. In our GrievanceandAppealGuide_FBHP FY18, on page 4, we inform Members that they can request an expedited appeal if they believe that waiting for a decision will be harmful to their health. We explain that the Medical Director will decide if their request will be approved or denied and that we will attempt to call them on the phone to inform them of our decision. We also let member know if their request for an Expedited Review is denied, that we will send them a notice within two (2) calendar days. The notice will explain why the request was	

<table>
<tr><th colspan="3">Standard VI—Grievance System</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the BHO</th><th>Score</th></tr>
<tr><td></td><td>denied and that it will be transferred to standard time frames. In the Notice of Adverse Benefit Determination Letter_FBHP, on page 3 it is explained that Members can request a quick appeal if they or their health care provider believe that waiting ten (10) business days for FBHP to decide their appeal would put their health at risk. On page 5, we inform Members that if we do not agree with their request for a quick appeal, we will inform them within 10 business days of the appeal decision. We will also attempt to call the Member when the request is denied.

Members can also learn about their right to request an expedited appeal in the Health First Colorado Member Handbook_2BHO on page 66-67.</td><td></td></tr>
<tr><td colspan="3">Findings:
Neither the Beacon Appeal Process policy nor the Beacon Expedited Appeal Workflow specified the time frame for notifying the member orally or in writing of the decision to deny a member's request for an expedited appeal. In addition, the sample FBHP expedited appeal request denial letter did not include the member's right to file a grievance if he or she disagrees with that decision.</td></tr>
<tr><td colspan="3">Required Actions:
FBHP must ensure that Beacon policies and procedures address notifying the member in writing within two calendar days and giving the member prompt oral notice of a decision to deny a request for an expedited appeal. FBHP must ensure that the expedited appeal request denial letter informs the member of the right to file a grievance if he or she disagrees with the decision.</td></tr>
<tr><td>22. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if:
• The member files timely* for continuation of benefits—defined as on or before the later of the following:
– Within 10 days of the Contractor mailing the notice of adverse benefit determination.</td><td>Documents Submitted/Location Within Documents:
1. Document - FBHP Policy M3.8 Grievance System v1 – item (6, d), (6, e)
2. Document - FBHPartners Handbook 092517 –page 34
3. Document - GrievanceandAppealGuide_FBHP FY18 – item (6, b)
See link titled “Grievance & appeals Process”
http://www.fbhpartners.com/members/index.html</td><td>☐ Met
☒ Partially Met
☐ Not Met
☐ N/A</td></tr>
</table>

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 calendar days of the notice of adverse benefit determination. **This definition of "timely filing" only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* Contract Amendment 7: Exhibit A3—2.6.4.8.1 10 CCR 2505-10—8.209.4.T	4. 305LAppealProcessesPolicy_2BHO page 5 item B, **Description of Process:** As defined the FBHP and Beacon policies and grievance and appeals guide, FBHP members have the right to request a continuation of services during the resolution of the appeal process. Step by step instructions on the members rights during this process are clearly identified in GrievanceandAppealGuide_FBHP FY18 – item (6, b).	
Findings: The Beacon Appeal Process policy includes inaccuracies in the criteria for requesting continued benefits during an appeal or State fair hearing as follows: • The policy states that the member must file the *appeal* on or before the time frames specified. The member must rather *request continued benefits* in these time frames, not file the appeal.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• The policy states that the member must make the request on or before the latter of the following: "within 10 days of the intended date of the proposed adverse benefit determination." The correct criterion is on or before the intended effective date of the adverse benefit determination, not within 10 days of that date. (Note: The policy correctly states "within 10 days of the mailing the notice of adverse benefit determination.")		
Required Actions: FBHP must ensure that Beacon appeal policies and procedures include the accurate criteria, as specified in the requirement, for requesting continuation of benefits during an appeal or State fair hearing. Beacon must correct the inaccuracies as noted in the Findings.		
23. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract Amendment 7: Exhibit A3—2.6.4.8.2 10 CCR 2505-10—8.209.4.U	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 –item (6, f) 2. FBHPartners Handbook 092517 –page 34 3. GrievanceandAppealGuide_FBHP FY18 – page (6, a), (6, b), (6, d) See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 4. 305LAppealProcessesPolicy_2BHO page 5 item B4 **Description of Process:** As defined the FBHP and Beacon policies and grievance and appeals guide, FBHP members have the right to request a continuation of services during the resolution of the appeal process. Step by step instructions on the members rights during this process are clearly identified in GrievanceandAppealGuide_FBHP FY18 – item (6, b&d).	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Beacon Appeal Process policy included an additional criterion, "the time period of the previous authorization of the services expires"—for how long benefits will continue pending outcome of an appeal or State fair hearing. Per the language of the requirement, this is not a criterion for how long benefits will continue.		
Required Actions: FBHP must ensure that Beacon corrects its appeals policy to remove this criterion as a definition for how long benefits will continue pending outcome of an appeal or State fair hearing.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
24. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* Contract Amendment 7: Exhibit A3—2.6.4.8.3 10 CCR 2505-10—8.209.4.V	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – items (6, f, iv, 1) 2. FBHPartners Handbook 092517 –page 35 3. GrievanceandAppealGuide_FBHP FY18 – page 4 a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 4. ProviderHandbook_2BHO, page 50 **Description of Process:** FBHP's Provider Handbook_2BHO, on page 50 states If the BHO's decision on a member's appeal is adverse to the member, and the member has not filed for a State Fair Hearing, the BHO may recover the cost of the services furnished to the member while the appeal is pending, if the reason why the services were furnished was solely because of the requirements of this section.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than **72 hours** from the date it receives notice reversing the determination. • If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M3.8 Grievance System v1 – item (6, f, iv, 2) 2. FBHPartners Handbook 092517 –page 35 3. GrievanceandAppealGuide_FBHP FY18 – item (9) a. See link titled "Grievance & appeals Process" http://www.fbhpartners.com/members/index.html 4. 305LAppealProcessesPolicy_2BHO, page 8 5. ProviderHandbook_2BHO, page 50 6. ALJJobAid_2BHO, page 4 7. ALJSettlement_FBHP, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Contractor must pay for those services, unless State policy and regulations provide for the State to cover the cost of such services. *42 CFR 438.424* Contract Amendment 7: Exhibit A3—2.6.4.8.4, 2.6.4.8.5 10 CCR 2505-10—8.209.4.V, 8.209.W	**Description of Process:** Foothills Behavioral Health Partners follows our 305L Appeal Process Policy_2BHO which states on page 8, Section G: Implementation of Final Resolution Results states if the designated Reviewer or Administrative Law Judge upholds the appeal, the Grievance and Appeals Coordinator will ensure that disputed service or resolution is authorized or implemented expeditiously. The Provider Handbook_2BHO, page 50 states if the BHO's decision on a member's appeal upholds the member's appeal and the member has not filed for a State Fair Hearing, the BHO must pay for the services that were furnished while the appeal is pending, if the reason why the services were furnished was solely because of the requirements listed above. Similarly, if the State Fair Hearing decision upholds the member's appeal and services were furnished while the Hearing was pending, the BHO must pay for the services that were furnished solely because of the requirements listed above. If the services were not provided, the BHO must provide the services as quickly as possible. FBHP follows the ALJ Job Aid_2BHO. On page 4, we state that when we receive notification, the OMFA department will notify the clinical team to update the authorization when an appeal has been overturned. The process is to send the information to the Clinical Director. The clinical team will overturn the authorization and send to claims so that they can pay the authorization.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	In some circumstances the decision is made to settle out of court. We have submitted two documents, ALJ Settlement_FBHP as evidence that services overturned by appeal process were paid.	
26. The Contractor maintains records of all grievances and appeals. **The records must be accurately maintained in a manner accessible to the State and available on request to CMS**. **The record of each grievance and appeal must contain, at a minimum, all of the following information:** • **A general description of the reason for the grievance or appeal.** • **The date received.** • **The date of each review or, if applicable, review meeting.** • **Resolution at each level of the appeal or grievance.** • **Date of resolution at each level, if applicable.** • **Name of the person for whom the appeal or grievance was filed.** *42 CFR 438.416* Contract Amendment 7: Exhibit A3—2.9.6.2 10 CCR 2505-10—8.209.3.C	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, page 8, H1-5, I 2. 303LGrievanceProcessPolicy_2BHO, page 8, C 2, 3 3. GrievanceDatabase_FBHP, entire document 4. ExampleofAppealLog_FBHP, entire document 5. FBHP_FY17_Q1_Member Grievance and Appeals Analysis Report 6. FBHP_FY17_Q2_Member Grievance and Appeals Analysis Report 7. FBHP_FY17_Q3_Member Grievance and Appeals Analysis Report 8. FBHP_FY17_Q4_Member Grievance and Appeals Analysis Report **Description of Process:** FBHP maintains records of all grievances and appeals. These records are accurately maintained in a manner accessible to the State and available upon request to CMS. In our 305L Appeal Process Policy_2BHO, on page 8, we have a section entitled Monitoring and Reporting by the Grievance and Appeals Coordinator. Each appeal is logged upon receipt and assigned expeditiously to an appropriate reviewer with notification to the reviewer of the timeline for a resolution.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	FBHP's 303LGrievanceProcessPolicy_2BHO, page 8, #2 states that we will review our grievance tracking reports quarterly. In the same policy, #3 states that our Grievance and Appeals Coordinator will complete a report specifying the numbers and types of grievances reported and resolved quarterly and submit to the Department of Health Care Policy and Financing by the last day of the month following each quarter. An annual report of grievances will be submitted to the Department of Health Care Policy and Financing the month following the end of the fiscal year as required by contract. All documentation is maintained by the Grievance and Appeals Coordinator. FBHP maintains a Grievance database where all relevant information regarding grievances are recorded. This security enabled database is accessible to the BHO, OMFA staff, including local mental health center Advocates, via log in and password. Data recorded includes, but is not limited to, the date the grievance is received, who filed the grievance and contact information, nature of the grievance, resolution, and date of grievance resolution. The FBHP OMFA staff enters all of the data for each grievance as it arrives. For the reporting capabilities of our database, please see Grievance Database_FBHP. At the end of the quarter, OMFA staff compiles the database information and submits the required quarterly reports to the Department within the required time frames. Please see: These quarterly reports also include information required to report on appeals. Management and Reporting Department compiles a report for	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	all of the Appeals and ALJ's which come in during the quarter. See Example of Appeal Log_FBHP. In this report is the members name id #, the date the appeal/alj was received, the contact source, the contact category, the date the acknowledgement letter was sent, the date the resolution letter was sent, and if it was upheld or overturned. The data is used to develop the state Grievance and Appeals reports, which are submitted to the Department 45 days after the end of the quarter. Grievance and Appeals reports are provided for FY 2017. File names are: 1. FBHP_FY17_Q1_Member Grievance and Appeals Analysis Report 2. FBHP_FY17_Q2_Member Grievance and Appeals Analysis Report 3. FBHP_FY17_Q3_Member Grievance and Appeals Analysis Report 4. FBHP_FY17_Q4_Member Grievance and Appeals Analysis Report	
27. The Contractor provides the information about the grievance appeal and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal	**Documents Submitted/Location Within Documents:** 1. ProviderHandbook_2BHO, page 45, 46, 48, 49, 121 2. NoticeofAdverseBenefitDeterminationLetter_FBHP, page 3, 4, 5, 6, 7,8 **Description of Process:** FBHP makes the following information know to Providers through the Provider Handbook_2BHO and in the Notice of Adverse Benefit Determination Letter_FBHP. When services to a provider are denied,	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
which is adverse to the member, including how members obtain a hearing, and the representation rules at a hearing. • The availability of assistance in the filing processes. • The toll-free number to file orally. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. • Appeals process available under the Child Mental Health Treatment Act (CMHTA), if residential services are denied. • Any State-determined provider's appeal rights to challenge the failure of the organization to cover a service. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract Amendment 7: Exhibit A3—2.6.4.4 10 CCR 2505-10—8.209.3.B	the provider also receives a receipt of the Notice of Adverse Benefit Determination Letter_FBHP. • The Members' right to file grievances and appeals: Provider Handbook_2BHO pages 45, 48, and 121 for appeals and page 121 for grievances. Notice of Adverse Benefit Determination Letter_FBHP, Page 3 for appeals and page 5 for Grievances. • The requirements and time frames for filing grievances and appeals: Provider Handbook_2BHO, page 48 for appeal time frame, page 49 for state fair hearing time frame. Notice of Adverse Benefit Determination Letter_FBHP, Page 4 for Appeals, page 6 for State Fair Hearing • The right to a State Fair Hearing after the BHO has made a decision on an appeal which is adverse to the Member, including how members obtain a hearing and the representation rules at a hearing. Provider Handbook_2BHO, page 48. Notice of Adverse Benefit Determination Letter_FBHP, page 3, 6 • The availability of assistance in the filing process. Provider Handbook_2BHO on pages 46, 49, 121. Notice of Adverse Benefit determination Letter_FBHP, page 3 • The toll free number to file orally: Provider Handbook_2BHO on page 48. Notice of Adverse Benefit Determination Letter_FBHP, page 4 and 5 • Continuation of Services: Provider Handbook_2BHO on page 49 and Notice of Adverse Benefit Determination Letter_FBHP, page 7-8 • Member may be required to pay: Notice of Adverse Benefit Determination Letter_FBHP, page 8	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	• Appeals process under the CMHTA act, see Notice of Adverse Benefit Determination Letter_FBHP, page 7 • State-determined provider's appeal rights to challenge the failure to cover a service, Provider Handbook_2BHO,page 45	
Findings: The Beacon provider handbook included thorough information on processing of appeals and grievances, including elements specified in the requirement. However, information in the provider manual duplicates some inaccuracies in the details of grievance and appeal requirements (as noted in other elements in this Standard), particularly related to continuation of benefits during an appeal.		
Required Actions: FBHP must ensure that all corrective actions implemented in response to recommendations or required actions in this Standard are included in the grievance and appeal information in the provider handbook.		

Results for Standard VI—Grievance System							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	14	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	27	**Total Score**		=	13
				Total Score ÷ Total Applicable		=	48%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* Contract Amendment 7: Exhibit A3—2.9.7.1.1	**Documents Submitted/Location Within Documents:** 1. Amended Delegation Agreement FY17 Executed 10.16.17 (Pages 19, 21-22) 2. Network Development Plan_FY2018_FBHP-Page 1, 5 and 6 3. L604_LCC_FBHP-Pages 3 and 4 4. Annual Needs Assessment_2BHO – Entire Spreadsheet, see all tabs. 5. BHO_Blank_LPAC_Confidentiality Agreement_2017March – entire doc 6. FBHP_LPAC_2017July28_PR– entire doc 7. FBHP_Template_CLCCCompleteDenialPreAppFBHP_Ltr_2017July14– entire doc 8. LPAC Timeline-general– entire doc 9. Policy LPAC- FBHP_FINAL– entire doc **Description of Process:** Per document "Amended Delegation Agreement FY17 Executed 10.16.17", FBHP delegates this function to Beacon Health Options. Beacon Health Options and FBHP has policies in place to select provider (L604_LCC_FHP & Policy LPAC- FBHP_FINAL) and develops annual Network Development Plan_FY2018_FBHP that outlines the strategies for selection and retention of providers. The plan is based on the Annual Needs Assessment_2BHO which has reports of providers and facilities based on counties (See Tabs "Network IPN Report" & "Facilities") and their specialties including language availability (See Tab "Specialty Information").	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. The Contractor follows a documented process for credentialing and re-credentialing that complies with the State's policies for credentialing. • The Contractor uses National Committee for Quality Assurance (NCQA) credentialing and re-credentialing standards and guidelines as the uniform and required standards for all contracts. • The Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. *42 CFR 438.214(b) and (e)* Contract Amendment 7: Exhibit A3—2.9.7.1.1, 2.9.7.2.1.1–2, and 2.9.7.2.3.1	**Documents Submitted/Location Within Documents:** 1. FBHP Policy D3.5 Delegation Credentialing Re-credentialing_ Executed (Entire Document) 2. N_CR202.03_Overview_2BHO-Entire Document 3. N_CR203.03_PracCredentialing_2BHO-Entire Document 4. N_CR217.02_FacCredentialing_2BHO -Entire Document 5. N_CR209.03_PracRe-credentialing _2BHO -Entire Document 6. N_CR219.03_FacRe-credentialing _2BHO -Entire Document 7. N_CR218.03_CredCriteria_Facility_2BHO – Page 3 **Description of Process:** This function is delegated to Beacon Health Options. The (FBHP Policy D3.5 Delegation Credentialing Re-credentialing_ Executed) policy defines the areas of oversight and monitoring as it relates to the delegation of this task. Beacon Health Options reviews providers upon initial credentialing (N_CR203.03_PracCredentialing_2BHO and N_CR217.02_FacCredentialing_2BHO) and then again upon re-credentialing in order to evaluate providers who participate in the Health First Colorado network. Policy N_CR202.03_Overview_2BHO is an overview which establishes and maintains a functional area at the corporate level that develops and manages a national network of practitioners and organizational providers to meet the clinical needs of its members, based on objective, non-discriminatory criteria. Re-credentialing per N_CR209.03_PracRe-credentialing _ 2BHO and N_CR219.03_FacRe-credentialing _2BHO occurs on a 3 year, or 36-month cycle. Beacon Health Options meets NCQA guidelines for	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	meeting credentialing criteria. All policies are reviewed annually to ensure compliance. N_CR218.03_CredCriteria_Facility_2BHO evidences that Beacon Health Options, on behalf of BHO, ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.	
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* Contract Amendment 7: Exhibit A3—2.5.14.1 and 2.9.7.1.3	**Documents Submitted/Location Within Documents:** 1. FBHP_Policy_Q6_Provider_Network_Delegation_Executed (Entire Document) 2. N_CR206.05_PrimSourceVerif_2BHO-Entire Document 3. N_CR202.03_Overview_2BHO- See Highlighted Section Pg. 1 4. PractitionerAgreement_2BHO- Page 8 and 30 **Description of Process:`** This function is delegated to Beacon Health Options. Beacon Health Options does not discriminate as per PractitionerAgreement_2BHO against providers for acting within the scope of their license or providing services to members that require costly treatment. Policy N_CR202.03_Overview_2BHO states that non-discriminatory is defined as, "Non-Discriminatory – Not on the basis of attributes such as applicant's race, ethnic/national identity, gender, age, sexual orientation, or the type of procedure or patient in which the practitioner specializes." Policy N_CR206.05_PrimSourceVerif_2BHO indicates how non-discriminatory primary source data is used to make decisions about network participation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* Contract Amendment 7: Exhibit A3—2.5.14.1	**Documents Submitted/Location Within Documents:** 1. Amended Delegation Agreement FY17 Executed 10.16.17 (Pages 19, 21-22) 2. FBHP_Policy_Q6_Provider_Network_Delegation_Executed (Entire Document) 3. CLCCDenialLetter_2017_FBHP-Entire Document 4. Network Development Plan_FY2018_FBHP – Page 2 **Description of Process:** This function is delegated to Beacon Health Options. As demonstrated in above document, FBHP uses the Network Development Plan_FY2018_FBHP to ensure that have the appropriate number of providers needed for its members and maintain a fair cost-based reimbursement practice. Beacon Health Options notifies providers, in writing, of any decision to deny inclusion of individual or groups of providers in the network and the reason for the denial. They are informed of their rights to appeal the decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, provider, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participation in federal healthcare programs. • The Contractor shall not employ or contract with any individual or entity who has been	**Documents Submitted/Location Within Documents:** 1. Amended Delegation Agreement FY17 Executed 10.16.17 (Pages 19, 21-22) 2. Ownership or Control Disclosures Report 2017 – entire doc 3. FBHP_Policy_Q6_Provider_Network_Delegation_Executed (Entire Document documents FBHP procedures to monitor impermissible affiliations and employees.)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
excluded from participation in Medicaid by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). • The Contractor has procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity. • The Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of its employees and contractors against the HHS-OIG's List of Excluded Individuals (LEIE) to determine whether they have been excluded from participation in Medicaid. • The Contractor has procedures to provide to the Department written disclosure of any prohibited affiliation within five (5) business days of discovery. *42 CFR 438.214(d)* *42 CFR 438.610(a-c)* *42 CFR 438.608(c)(1-2)* Contract Amendment 7: Exhibit A3—2.9.7.3.3.2, 2.9.7.3.3.7, 2.9.10.9, 2.10.5.2, 2.10.5.3.7.2	4. FBHP_Policy C_Excluded Individuals or Organizations_Executed (page 1 documents FBHP procedures to monitor impermissible affiliations and employees.) 5. FBHP_Policy_C- Conflict of Interest with Contracted Services_Executed (page 1) 6. FBHP_Policy_C v1.1 Conflict of Interest_Executed (entire document - documents procedures for monitoring impermissible affiliations and employees specific to conflict of interest.) 7. Conflict of Interest FBHP Board 2017 (entire doc: form used to monitor Board conflict of interest) 8. Conflict of Interest FBHP Employee 2017 (entire doc; form used to monitor employee conflict of interest) 9. N_CR206.05_PrimSourceVerif_2BHO-Entire Document 10. FBHP OIG Report Nov2017 – entire doc 11. March 2017 Vendor Supplier Attestation-Entire Document **Description of Process:** This function is delegated to Beacon Health Options. An OIG check (FBHP OIG Report Nov2017) is done on a monthly basis to make sure that this requirement is met and is provided to FBHP with all Board and Staff identified. Beacon Health Options does this through the PSV process for providers. Beacon Health Options does this for all employees and Beacon Health Options Colorado does this for employees and board members on a monthly basis. See March 2017 Vendor Supplier Attestation for an example of the vendor/supplier attestation that is processed on a monthly basis to ensure that all vendors and suppliers are not on an exclusion list.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: While FBHP, supported by Beacon, had policies, procedures, and implemented processes to conduct screening of individuals and entities at all levels of the organization, HSAG could not identify any written procedures for reporting to the Department disclosure of ownership and control within 35 days after any change in ownership or disclosure of any prohibited affiliation within five business days of discovery.		
Required Actions: FBHP must strengthen its written policies and procedures to define mechanisms for reporting to the Department within the time frames specified in the requirement any change in ownership or control or any discovery of prohibited affiliations.		
6. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care, or treatment options—including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* Contract Amendment 7: Exhibit A3—2.10.17.1	**Documents Submitted/Location Within Documents:** 1. Amended Delegation Agreement FY17 Executed 10.16.17 (Pages 19, 21-22) 2. FBHP_Policy_Q6_Provider_Network_Delegation_Executed (Entire Document) 3. PractitionerAgreement_2BHO- Pages 8, 15 and 30 4. ProviderMan_2BHO - Pages 124 and 129 5. N_CR202.03_Overview_2BHO- Pages 124 and 129 **Description of Process:** This function is delegated to Beacon Health Options. As stated in PractitionerAgreeement_2BHO and N_CR202.03_Overview_2BHO, Beacon Health Options does not discriminate against providers who act within the scope of his/her license for advising or acting on the behalf of members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* Contract Amendment 7: Exhibit A3—2.10.18.1 and 2.10.18.3	**Documents Submitted/Location Within Documents:** 1. FBHP Policy M7.4 Non Discrimination (entire doc) 2. 310L NonDiscrimination_OMFA_2BHO -Entire Document **Description of Process:** Beacon Health Options and FBHP do not object to providing a service on moral or religious grounds. The full policies, 310L_NonDiscrimination_OMFA_2BHO and FBHP Policy M7.4 Non Discrimination, affirms our position on non-discrimination with a clear statement on pages 1 of both polies that it does not "discriminate against members because of race, religion, gender, age, disability, health status or sexual orientation, in the context of receiving care and services from Beacon Health Options Colorado and its providers".	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse, and which includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices to ensure compliance with requirements of the contract and who reports directly to the CEO and Board of Directors.	**Documents Submitted/Location Within Documents:** 1. FBHP Corporate Compliance Program 4.0_2017 (entire doc; describes compliance plan/program) 2. **FBHP Policies & Procedures** (4a-j docs below are compliance program policies that articulate FBHP commitment to applicable federal and state standards) a. FBHP_Policy_C- Anti Kick-back Statute_Executed (entire doc; procedures for complying with Federal kick-back statute) b. FBHP_Policy_C- False Claims_Executed (entire doc; procedures for preventing false claims) c. FBHP_Policy_C- Detection of Fraud and Abuse_Executed (pg 2 #2 procedures for employee training; #3 procedures for auditing and monitoring; #4 lines of communication)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• The establishment of a compliance committee of the Board of Directors and at the senior management level, charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* Contract Amendment 7: Exhibit A3—2.9.3.1, 2.9.3.1.1.1–2, 2.9.3.1.3–7	d. FBHP_Policy_C- Investigation and Reporting of Fraud and Abuse_Executed (entire doc; procedures for investigating and reporting fraud and abuse) e. FBHP_Policy_Q10_Monitoring_of_Encounter_Record_Accuaracy_Executed (Sec I; schedule of auditing; Sec III procedures for response to offenses) f. FBHP_Policy C_Excluded Individuals or Organizations_Executed (page 1, procedures for complying with federal and state standards) g. FBHP_Policy_C- Criminal Background Check_Executed (entire doc; procedures for complying with federal and state standards) h. FBHP Policy Response to Corporate Compliance Program Violations.pdf (entire doc; procedures for enforcement of standards through disciplinary guidelines) i. FBHP_Policy_C- Gifts, Gratuities, Meals and Expenses_Executed (entire doc; policy & procedure for complying with federal and state standards, e.g. kickback statute) j. FBHP_Policy_C- Exit Interviews_Executed (entire doc; additional mechanism for identifying fraud/abuse) 3. FBHP Compliance Work Plan FY17 – entire doc 4. FBHP Audit Plan FY17 (entire doc; annual audit plan for internal compliance monitoring & auditing) 5. FBHP_Member_Services_Verification_2017 - entire doc; procedures for detecting fraud, waste & abuse, in particular services never rendered or inflated bills	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	6. FBHP MSV Results 2017 – entire doc; member services verification report 7. FBHP Board Compliance Training - entire power point; example of compliance training/education for Board 8. FBHP Staff Compliance Training – entire doc 9. Relias Training Course Completion – entire doc 10. Compliance Training – Initial – entire doc 11. FBHP PP Exit Interview V1.0 – entire doc 12. N_CO119A_COPSD_FWA_2BHO-Entire Document 13. N_CO101_ComplianceProgramActivities_2BHO -Entire Document 14. N_CO310Compliance with FWA Laws_2BHO -Entire Document 15. Beacon Code of Conduct_2BHO-Entire Document 16. N_CO119_Program Integrity Activities_2BHO -Entire Document 17. CTO_ChartAuditResults_FBHP – Entire Document **Description of Process:** Beacon Health Options has written policies and procedures, as indicated above, that clearly describe compliance with federal and state standards; designated compliance officer and committee who are accountable to the senior management; and delineate training and education for the compliance officer and FBHP's employees. Communication between the compliance officer and employees can occur through the hotline or by contacting the compliance officer directly. Procedures are in place for monitoring and auditing which includes audits of claims/encounters and clinical record reviews. Specific procedures are in place for investigating and reporting fraud and abuse. If fraud is suspected the Beacon Health Options Special Investigation Unit will investigate as well.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	FBHP is required to immediately reports indications or suspicions of fraud by giving a verbal report to our Contract manager. FBHP then investigates its suspicions and submit its written findings to the contract manager within 3 business days of the verbal report. If the investigation is not complete within 3 business days, FBHP continues to investigate and submit a final report within 15 business days of the initial notification. If FBHP needs an extension, we contact our Contract Manager to ask for an extension. We also report the appropriate law enforcement agencies. Our Contract Manager reports indications or suspicions of fraud, waste or abuse to the Medicaid Fraud and Control Unit.	
9. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit and any potential fraud to the State Medicaid Fraud Control Unit. Contractor provides to the Department: – Verbal report immediately. – Written report in three (3) business days.	**Documents Submitted/Location Within Documents:** 1. FBHP_Policy_C- False Claims_Executed (item 3) 2. FBHP_Policy_C- Investigation and Reporting of Fraud and Abuse_Executed (entire doc) 3. FBHP Corporate Compliance Program 4.0_2017 (entire doc; describes compliance plan/program) 4. N_CO119A_COPSD_FWA_2BHO-Entire Document 5. N_CO310Compliance with FWA Laws_2BHO -Entire Document 6. N_CO101_Compliance Program Activities_2BHO-Entire Document 7. QM16D_ColoradoSpringECAddendum_2BHO **Description of Process:** Beacon Health Options has written policies and procedures, as indicated above, that clearly describe compliance with federal and state standards including the Fraud Waste and Abuse Act. Communication between the compliance officer and employees can	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud. *42 CFR 438.608(a)(6-8)* Contract Amendment 7: Exhibit A3—2.12.1, 2.9.3.2.1–2, 2.9.3.4.1, 2.9.3.4.4	occur through the hotline or by contacting the compliance officer directly. Procedures are in place for monitoring and auditing which includes audits of claims/encounters and clinical record reviews. This is demonstrated in QM16D_ColoradoSpringECAddendum_2BHO. Specific procedures are in place for investigating and reporting fraud and abuse. If fraud is suspected the Beacon Health Options Special Investigation Unit will investigate as well. Per our Compliance Plan we are required to immediately reports indications or suspicions of fraud by giving a verbal report to our Contract manager. FBHP then investigates its suspicions and submit its written findings to the contract manager within 3 business days of the verbal report. If the investigation is not complete within 3 business days, FBHP continues to investigate and submit a final report within 15 business days of the initial notification. If FBHP needs an extension, we contact our Contract Manager to ask for an extension. We also report the appropriate law enforcement agencies. Our Contract Manager reports indications or suspicions of fraud, waste or abuse to the Medicaid Fraud and Control Unit.	
10. The Contractor's compliance program includes: • Provision for prompt notification to the Department about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program,	**Documents Submitted/Location Within Documents:** 1. OMFA 101 Member Demographic Changes_2BHO-Entire Document 2. N_CR208.03_Integrity Provider Data_2BHO-Entire Document 3. N_CR216.04_Provider Disenrollments_2BHO-Entire Document 4. PR_012 Provider Directory_2BHO-Entire Document 5. Quarterly Disenrollment Report_FBHP – Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
including termination of the provider agreement with the Contractor. *42 CFR 438.608(a)(3-4)* Contract Amendment 7: Exhibit A3—2.9.3.2.1–2, 2.10.15.2	**Description of Process:** Beacon Health Options, on behalf of the BHOs, facilitates communication between members or family members with the State on changes in member circumstances that may affect the member's eligibility. Additionally, Beacon notifies Contract Manager of the demographic change, as noted in the OMFA 101 Member Demographic Changes_2BHO. Beacon Health Options maintains and updates provider data and directories when changes in provider's circumstances change that affect their ability to participate in Medicaid as noted in N_CR208.03_Integrity Provider Data_2BHO and N_CR216.04_Provider Disenrollments_2BHO. Beacon reports these changes to the State through quarterly as disenrollment report and updated monthly Provider Directory as noted in PR_012 Provider Directory_2BHO. This is evidenced by an example of Disenrollment Quarterly Report_FBHP.	
11. The Contractor's compliance program includes provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • The Contractor screens all provider claims, collectively and individually, for potential fraud, waste, or abuse— including mechanisms to identify overpayments to providers and to report suspected instances of up-coding, unbundling of services, services that were billed for but never rendered, and inflated bills for services and goods provided.	**Documents Submitted/Location Within Documents:** 1. FBHP_Policy_Q10_Monitoring_of_Encounter_Record_Accuarac y_Executed (items I & III documents the interval of monitoring and the actions taken on the findings) 2. FBHPartners Compliance Hotline – entire doc 3. N_CO119A_COPSD_FWA_2BHO-Entire Document 4. N_CO310Compliance with FWA Laws_2BHO -Entire Document 5. N_CO101_Compliance Program Activities_2BHO -Entire Document 6. Beacon Code of Conduct_2BHO –Entire Document 7. ProviderMan_2BHO – page 109, overpayment recovery 8. Member_services_verification_plan	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• The Contractor has procedures for provision of a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. – The Contractor provides individual notices to all or a sample of members who received services to verify and report whether services billed by providers were actually received by members. • The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor has procedures to identify to the Department within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(a)(5), (c)(3), and (d)(2) and (3)* Contract Amendment 7: Exhibit A3—2.9.3.1.8, 2.9.3.1.1.3–9, 2.9.3.2.1–2, and 5.2.1.1	9. FBHP WAF Report October 2017.xlsx – entire doc 10. 2017 SUD PROVIDER FORUM-Final – entire doc 11. Beacon Payment Recovery Report – entire doc **Description of Process:** Beacon Health Options has written policies and procedures that clearly describe compliance with federal and state standards of Fraud, Waste and Abuse Act. Requirement's bullet point 2 is evidenced by Section III of N_CO119_COPSD_FWA_2BHO. It outlines the procedures for identification, potential fraud and/or abusive billing practices, and review with time frames. Supplemental policies, N_CO310Compliance with FWA Laws_2BHO and N_CO101_Compliance Program Activities Section II C definition of Claims Billing Audits The BHO's presented a SUD forum (2017 SUD PROVIDER FORUM-Final) for all providers in the State at OBH on May 9, 2017. Included in this was a review of 42 CFR Part 2 and Fraud, Waste , and Abuse. 1. The Beacon Code of Conduct_2BHO requires all staff or its affiliates to follow the federal and state requirements on billing, and report any potential or suspected cases of improper billing practices. The FBHP Corporate Compliance Program 4.0_2017 (entire doc; describes compliance plan/program) also has a code of conduct which requires the reporting of suspected fraud, waste, or abuse. For individuals who are reported, they are monitored on a monthly basis for updates or investigative outcomes as identified in FBHP WAF Report (October 2017).xlsx. Beacon monitors and requests follow up from the Medicaid Program Integrity Unit routinely.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	2. The members are sent a letter to confirm services annually. In the event there is a return, follow up is completed with the provider and the member to identify if services did or did not occur. See Member_services_Verification_ plan for the complete process. 3. Beacon Health Options has written policies on the reporting of overpayments as evidenced in N_CO119 Program Integrity Activities_2BHO. On page 2 and 3, Beacon staff, providers and all entities are required to report any suspicion of potential fraud, waste and abuse which includes overpayments.	
Findings: FBHP, through functions delegated to Beacon, had numerous policies and implemented procedures to identify, remedy, and report to the Department any potential fraud or overpayments. However, HSAG identified no clearly defined mechanisms for a provider to report when it has received an overpayment and to return the overpayment within 60 calendar days.		
Required Actions: FBHP must develop and communicate to providers mechanisms for a provider to notify the Contractor when it has received an overpayment and the reason for the overpayment as well as to return the overpayment to the Contractor within 60 calendar days of identification.		
12. The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of the State. *42 CFR 438.608(b)* Contract Amendment 7: Exhibit A3—2.5.9.12	**Documents Submitted/Location Within Documents:** 1. N_CR206.05_PrimSourceVerif_2BHO-Entire Document 2. PR_011_Medicaid Enrollment Verfication_2BHO-Page 1 3. FBHP OIG Report Nov2017 – entire doc **Description of Process:** Beacon Health Options conducts a check of providers to make sure that they meet all requirements consistent with the provider disclosure, screen and enrollment requirements. An OIG check is done on a monthly basis to make sure that this requirement is met. This is in FBHP OIG Report Nov2017, Beacon Health Options does this through the PSV process for providers as noted in the N_CR206.05_PrimSourcesVerif_2BHO. Starting March 1, 2017,	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Beacon Health Options, on behalf of the BHO, added process to ensure all providers are enrolled with the state as Medicaid provider. This includes providers already in the network, submitted claims or requested interest in joining the network (see PR_011_Medicaid Enrollment Verficiation_2BHO).	
13. The Contractor provides that Medicaid members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the healthcare provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* Contract Amendment 7: Exhibit A3—2.2.3, 2.10.14.2	**Documents Submitted/Location Within Documents:** 1. Amended Delegation Agreement FY17 Executed 10.16.17 (pg 2 Sec 2.02, item e, indicating delegation of Provider Network to Beacon) 2. FBHP_Policy_Q6_Provider_Network_Delegation_Executed (entire doc; policy indicating delegation of provider network management to VO) 3. ProviderMan_2BHO-Page 16 4. PractitionerAgreement_2BHO-Page 11 **Description of Process:** Beacon Health Options provider agreements and provider handbook clearly state members cannot be held liable for payments for covered services or for the Contractor's debts.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	11
				Total Score ÷ Total Applicable		=	85%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. **Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.** The Contractor must: • Evaluate the prospective subcontractor's ability to perform the activities to be delegated. • Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. • Identify deficiencies or areas for improvement, and ensure that the subcontractor takes corrective action. *42 CFR 438.230(b)(1)* Contract Amendment 7: Exhibit A3—3.1.5, 3.1.5.1, 3.1.5.3–4	Note—This does not apply to provider agreements (unless provider contracted to perform responsibilities other than services to members). **Documents Submitted/Location Within Documents:** 1. FBHP Policy D1.5 Delegation of BHO Responsibilities – entire document 2. FBHP Policy D2.6 Monitoring of Delegates - Page 1, Items I & II 3. Beacon Delegation Audit Review_2017 – entire document **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities **or obligations** and related reporting responsibilities. • **That the subcontractor agrees to perform the delegated activities and reporting responsibilities** • Provision for revocation of the delegation of activities or obligation or **specify other remedies in instances where the State or Contractor determines** that the subcontractor has not performed satisfactorily. *42 CFR 438.230(b)(2) and (c)(1)* Contract Amendment 7: Exhibit A3—3.1.5.1.2	**Documents Submitted/Location Within Documents:** 1. Amended Delegation Agreement FY17 Executed 10.16.17 – entire document 2. Response_FBHP_CAP_ITServices_July2016_Revised07172017 3. FBHP IT CAP Aug 2016 **Description of Process:** FBHP captures the obligations and reporting requirement in exhibits A & B of the delegation agreement.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • **The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.** *42 CFR 438.230 (c)(2)* Contract Amendment 7: Exhibit A—6.A	**Documents Submitted/Location Within Documents:** 1. Amended Delegation Agreement FY17 Executed 10.16.17 – article IV **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The written agreement with the subcontractor includes: • **The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.** – **The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems related to Medicaid members.** – **The right to audit will exist through 10 years from the final date of the contract period or from**	**Documents Submitted/Location Within Documents:** 1. Amended Delegation Agreement FY17 Executed 10.16.17 – article VI **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
the date of completion of any audit, whichever is later. – **If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.** *42 CFR 438.230(c)(3)* Contract Amendment 7: Exhibit A3—2.9.9.5		

Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	4	**Total Score**		=	4
				Total Score ÷ Total Applicable		=	100%

Appendix B. Record Review Tools

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Foothills Behavioral Health Partners, LLC

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	January 11, 2018
Reviewer:	Rachel Henrichs
Participating Health Plan Staff Member:	Patty Viles and Lynne Bakalyan

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	****	10/22/17	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: The provider who filed this appeal was not authorized to do so (no signed designated client representative [DCR] form). HSAG removed the file from the sample.											
2	****	11/30/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	12/13/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
3	****	11/27/17	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This appeal was filed after the allowed 60-day time frame. HSAG removed the file from the sample.											
4	****	11/15/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	11/29/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The appeal resolution letter included clinical details inappropriate for an appeal resolution letter.											
5	****	11/15/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	11/29/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The appeal resolution letter included clinical details inappropriate for an appeal resolution letter.											
6	****	11/08/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	11/21/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The appeal resolution letter included clinical details inappropriate for an appeal resolution letter.											
7	****	10/23/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	11/03/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The appeal resolution letter included clinical details inappropriate for an appeal resolution letter.											
8	****	10/11/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/19/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The appeal resolution letter included clinical details inappropriate for an appeal resolution letter.											
9	****	10/09/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/17/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The appeal resolution letter included clinical details inappropriate for an appeal resolution letter.											
10	****	09/07/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☒ No ☐	10/04/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The DCR requested an extension to allow for collection of additional materials. On September 15, 2017, FBHP mailed an extension letter that included all required content.											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Foothills Behavioral Health Partners, LLC

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS1	****	09/16/17	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/29/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: FBHP mailed the acknowledgement letter on September 21, 2017. The appeal resolution letter included clinical details inappropriate for an appeal resolution letter.											
OS2	****	09/11/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/15/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
OS3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**10**	**10**	**10**				**10**	**10**	**10**
Column Subtotal of Compliant (M) Elements			**9**	**10**	**10**				**10**	**10**	**3**
Percent Compliant (Divide Compliant by Applicable)			**90%**	**100%**	**100%**				**100%**	**100%**	**30%**

Key: M = Met; N = Not Met
N/A = Not Applicable

Total Applicable Elements	**60**
Total Compliant (M) Elements	**52**
Total Percent Compliant	**87%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Foothills Behavioral Health Partners, LLC

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	January 11, 2018
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member:	Patty Viles and Jaime Davila

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	****	07/28/17	Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments: OMITTED from sample. Should have been originally processed as a denial followed by appeal. Does not fit definition of grievance.										
2	****	08/17/17	Y ☐ N ☒ N/A ☐	08/22/17	3	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐
Comments: Acknowledgement and resolution included in one letter on same day (outside of acknowledgement time frame). Content of letter was confusing as it included language from both the acknowledgement template and the resolution template letters.										
3	****	08/17/17	Y ☐ N ☒ N/A ☐	09/22/17	27	Y ☐ N ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐
Comments: Acknowledged August 23. Decision to discharge member from care. Content of letter was confusing as it included information applicable to both acknowledgement and resolution, including both past and future tense language.										
4	****	09/14/17	Y ☐ N ☒ N/A ☐	09/28/17	10	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐
Comments: Acknowledged September 26. Letter confusing, as there was mixed acknowledgement and resolution language in letter.										
5	****	09/20/17	Y ☒ N ☐ N/A ☐	09/22/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: Acknowledgement and resolution same day.										
6	****	09/20/17	Y ☒ N ☐ N/A ☐	09/29/17	7	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: Acknowledged September 22.										
7	****	09/21/17	Y ☒ N ☐ N/A ☐	09/25/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐
Comments: Acknowledged September 22. Content of letter was confusing as it included language from both the acknowledgement template and the resolution template letters.										
8	****	09/22/17	Y ☒ N ☐ N/A ☐	09/28/17	5	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
9	****	09/25/17	Y ☐ N ☐ N/A ☒	09/27/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐
Comments: No acknowledgement letter, but resolution notice in two days. Plan sent two resolution letters on same day. First letter included incorrect information (confusing to member) and required clarification in second letter.										
10	****	10/16/17	Y ☒ N ☐ N/A ☐	11/03/17	15	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Foothills Behavioral Health Partners, LLC

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS 1			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**8**			**9**	**3**	**3**	**9**	**9**
Column Subtotal of Compliant (Yes) Elements			**5**			**8**	**3**	**3**	**9**	**4**
Percent Compliant (Divide Compliant by Applicable)			**63%**			**89%**	**100%**	**100%**	**100%**	**44%**

Key: Y = Yes; N = No
N/A = Not Applicable

Total Applicable Elements	**41**
Total Compliant (Yes) Elements	**32**
Total Percent Compliant	**78%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2017–2018 site review of **FBHP**.

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

HSAG Review Team	Title
Katherine Bartilotta, BSN	Associate Director
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
FBHP Participants	**Title**
Alan Fine	Medical Director
Alma Mejorado	Director, Provider Relations
Amy Turner	Manager, Administrative Services
Bob Dyer	Chief Executive Officer
Jaime Davila	Director, Member Services
Kari Snelson	Chief Operating Officer and Compliance Officer
Lynne Bakalyan	Director, Office of Member/Family Affairs
Mandi Strickland	Director, Performance Improvement and Quality
Patty Viles	Manager, Office of Member/Family Affairs
Department Observers	**Title**
Patricia Connally	HCPF—Quality Compliance Specialist
Russ Kennedy	HCPF—Quality Specialist

Appendix D. Corrective Action Plan Template for FY 2017–2018

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 and HSAG will: • Approve the planned interventions and instruct the BHO to proceed with implementation, or • Instruct the BHO to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the CAP, the BHO will have a time frame of six months to complete proposed actions and submit documents. The BHO will submit documents as evidence of completion one time only on or before the six-month deadline for all required actions in the CAP. (If necessary, the BHO will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the health plan within the intervening time frame.)

Step	Action
Step 5	**Technical assistance**
	HSAG will schedule with the BHO a one-time, interactive, verbal consultation and technical assistance session during the six-month time frame. The session may be scheduled at the health plan's discretion at any time the health plan determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the BHO as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the six-month deadline will result in assignment as a delinquent corrective action that will be continued into the following compliance review year. (HSAG will list delinquent actions in the annual technical report and in the health plan's subsequent year's compliance site review report.)

The CAP template follows.

Table D-2—FY 2017–2018 Corrective Action Plan for FBHP

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
3. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** • **All written materials for members must:** – Use easily understood language and format. – **Use a font size no smaller than 12 point.** – Be available in alternative formats **and through provision of auxiliary aids and services** that take into consideration the special needs of members **with disabilities** or limited English proficiency. – **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral**	FBHP provided policies and procedures that described the processes for ensuring that all member materials are written at a sixth-grade reading level using a 12-point font size; are readily available in Spanish, alternative formats, and through the provision of auxiliary aids; and include large-print and Spanish taglines that describe how to request auxiliary aids, written translation, and oral translation. HSAG tested readability of several documents including the G & A Guide and several template letters related to the grievance and appeal processes using a Flesch-Kinkaid readability test. Many of these documents presented reading levels above the sixth-grade level. Additionally, during the record review, HSAG noted that several of the letters (most notably those used by Mental Health Partners) failed to include the large-print tagline. This tagline was also missing from the grievance and appeal guide.	FBHP must ensure that all member information is written using easy-to-understand language and includes large-print taglines describing how to request auxiliary aids and services.

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. – Be available for immediate dissemination in that language. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit A3—2.6.5.13.1–3, 2.6.5.13.6.1–3, 2.6.5.13.7, 2.6.5.13.10.1–4		
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 V—Member Information		
Requirement	**Findings**	**Required Action**
4. **If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:** • **The format is readily accessible (see definition of readily accessible above).** • **The information is placed in a Web site location that is prominent and readily accessible.** • **The information can be electronically retained and printed.** • **The information complies with content and language requirements.** • **The member is informed that the information is available in paper form without charge upon request, and is provided within five (5) business days.** *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit A3—2.6.5.3.6–8	HSAG conducted an accessibility check on several FBHP Web pages using the Wave Web Accessibility Evaluation Tool. Through use of the tool, HSAG discovered no general accessibility errors. HSAG also ran an accessibility check on several PDF documents available for download from the FBHP website (e.g., grievance and appeal guide, community resources handout, and provider directory). Through use of the Adobe Acrobat Pro accessibility checker, HSAG discovered accessibility errors within these PDF documents. Additionally, the website included no statement informing members that information is available in paper form without charge upon request.	FBHP must develop a process to ensure that all information available for download from its website is readily accessible (i.e., complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines). FBHP must also add a statement to its website telling members that all information is available in print form, free of charge, by calling its customer service department.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
7. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, **pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:** • The provider's name and **group affiliation**, street address(es), telephone number(s), **Web site URL, specialty (as appropriate)**, and whether the providers will accept new members. • **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.** • **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.)*	FBHP's provider directory included the name, group affiliation, street address, telephone number, areas of specialty, and languages spoken for all providers accepting new patients. The directory included no information regarding a provider's website URL, cultural competency training, or accessibility for people with physical disabilities.	FBHP must update its provider directory to include a provider's website URL (if available), indicate which providers have completed cultural competency training, and note which locations are accessible for people with physical disabilities.

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
42 CFR 438.10(h)(1-3) Contract Amendment 7: Exhibit A3—2.6.5.8.1–3		
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
2. The Contractor defines "adverse benefit determination" as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • **The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).** • For a resident of a rural area with only one managed care plan, the denial of a Medicaid member's request to exercise his or her rights to obtain services	The FBHP Grievances and Appeals policy accurately defined "adverse benefit determination (ABD)," including all elements. However, the Beacon Health Systems (Beacon) Appeal Process policy failed to include "denial of a member's request to dispute a member financial liability" in its definition of ABD.	Beacon must update its Appeal Process policy to include all elements of the definition of "adverse benefit determination."

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network but is the main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider. o If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* Contract Amendment 7: Exhibit A3—1.1.1.3 10 CCR 2505-10—8.209.2.A		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
4. The Contractor defines "grievance" as "an expression of dissatisfaction about any matter other than an **adverse benefit determination**." • Grievances may include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the member's rights **regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.** *42 CFR 438.400(b)* Contract Amendment 7: Exhibit A3—1.1.1.27, 2.6.4.5.8.1.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	The FBHP Grievances and Appeals policy defines "grievance" per the language of the requirement. However, the Jefferson Center for Mental Health (JCMH) grievance guide and Mental Health Partners (MHP) grievance policy defined "grievance" using broader language: "dissatisfaction about your service provider" and "dissatisfaction about provider services," respectively. Dissatisfaction about services could be construed as dissatisfaction with an ABD (which would be an appeal).	FBHP must ensure that community mental health centers (CMHCs) that identify and process grievances on behalf of FBHP clarify the definition of "grievance" as "dissatisfaction about any matter *other than an adverse benefit determination*."
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
7. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.A	The FBHP Grievances and Appeals policy and the Beacon Grievance Process policy state that a member may file a grievance at any time. However, the MHP grievance policy incorrectly stated that the member may file a grievance within 30 days of an incident.	FBHP must ensure that MHP, which processes CMHC grievances on behalf of FBHP, corrects its policy to state that a member may file a grievance *at any time*.
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
8. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.B	All FBHP, Beacon, and CMHC policies and procedures accurately addressed this requirement. However, three of eight applicable grievance record reviews failed to send an acknowledgement letter in the required time frame.	FBHP must ensure that all members are sent acknowledgement letters within two working days of FBHP's receipt of a grievance.
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
9. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and **within 15 working days of when the member files the grievance.** • Notice to the member must be in writing in the format established by the Department. • **Notice to the member must be in a format and language that may be easily understood by the member.** *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract Amendment 7: Exhibit A3—2.6.4.5.5, 2.6.4.5.5.1, 2.6.5.13.1 10 CCR 2505-10—8.209.5.D.1, 8.209.5.F	HSAG found in grievance record reviews that one member was not notified of the grievance resolution within the required time frame. In addition, five of nine record reviews included resolution letters that were difficult for the member to understand; one CMHC appeared to combine acknowledgement letter and resolution letter template language into one letter to the member, resulting in a letter that could not be easily understood.	FBHP must ensure that CMHCs which process grievances on behalf of FBHP comply with requirements for sending resolution letters within the required 15 working days' time frame and write the notice to the member in a format and language that may be easily understood.
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
16. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date), and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • The member a reasonable opportunity, in person and in writing, to present evidence **and testimony** and make legal and factual arguments. **(The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.)** • The member and his or her representative the member's case file, including medical records, other documents and records, and **any new or additional documents considered, relied upon, or generated by the Contractor in connection with the**	The Beacon Appeal Process policy adequately addressed most elements of this requirement. However, the policy included no procedures for informing the member of the limited time available in expedited appeals to present evidence and arguments related to the appeal.	In the case of expedited appeals, FBHP must ensure that Beacon includes in its appeals policies the procedures for informing members of the limited time available to present evidence or arguments.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. • That included, as parties to the appeal, are: – The member and his or her representative. – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3-5)* Contract Amendment 7: Exhibit A3—2.6.4.6.4, 2.6.4.6.5, 2.6.4.6.7, 2.6.4.6.8, 2.6.4.6.9 10 CCR 2505-10—8.209.4.F, 8.209.4.G, 8.209.4.H, 8.209.4.I		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

<table>
<tr><th colspan="3">Standard VI—Grievance System</th></tr>
<tr><th>Requirement</th><th>Findings</th><th>Required Action</th></tr>
<tr><td>17. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires, but not to exceed the following time frames:
• For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal.
Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.
• For expedited resolution of an appeal and notice to affected parties, within 72 hours after the Contractor receives the appeal.
• For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution.
• Written notice of appeal resolution must be in a format and language that may be easily understood by the member.

42 CFR 438.408(b)(2)&(3)&(d)(2)
42 CFR 438.10</td><td>The Beacon Appeal Process policy incorrectly defined the time frame for providing notice to the member for an expedited appeal. The policy stated that "the timeframe for resolution of an expedited appeal is 72 hours for verbal notification to be provided to the member or requesting party, to be followed by written notification within two (2) calendar days." Regulations require written appeal resolution notice to the member within 72 hours of receipt of an expedited appeal, and reasonable efforts to orally inform the member.

The appeal record reviews indicated that the member was notified of disposition within the required time frames. However, seven of 10 notices of disposition included clinical content that HSAG deemed inappropriate to communicate to the member—e.g., alleging member's alcohol or substance abuse, describing the member's emotional problems, or including other clinical personal health information (PHI)—and were therefore scored "not easy to understand."</td><td>FBHP must ensure that Beacon's expedited appeals procedures provide for written notice to the member within 72 hours of receiving the appeal. FBHP must also ensure that the description of the disposition includes only information that is appropriate to communicate to the member.</td></tr>
</table>

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
Contract Amendment 7: Exhibit A3—2.6.4.7.1, 2.6.4.7.3.2, 2.6.4.7.3.5, 2.6.5.13.1 10 CCR 2505-10—8.209.4.J, 8.209.4.L		
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
18. The contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days: • If the member requests the extension; or • If the Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. • If the Contractor extends the time frames, it must—for any extension not requested by the member: − Make reasonable efforts to give the member prompt oral noice of the delay. − **Within two (2) calendar days**, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. − Resolve the appeal as expeditiously as the member's health condition requires and no later than the date that the extension expires. • **If the Contractor fails to adhere to the notice and timing requirements**	Both the FBHP and Beacon policies regarding grievances and appeals accurately addressed the time frames and member notification requirements for extension of the resolution of an appeal or grievance. While the MHP Grievance policy stated MHP may extend the time frame to respond to a grievance, the policy failed to specify the 14-calendar day time frame for extensions and provided no procedures for informing the member of an extension.	FBHP must ensure that MHP, which processes CMHC grievances on behalf of FBHP, includes in its policies and procedures the 14-day time frame for extensions as well as the procedures for notifying members of extensions.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
for extension of the appeal resoultion time frame, the member may initiate a State fair hearing. *42 CFR 438.408(c)* Contract Amendment 7: Exhibit A3—2.6.4.7.2, 2.6.4.7.2.1, 2.6.4.7.8, 2.6.4.7.3.3, 2.6.4.5.8.1.2, 2.6.4.9.3, 2.6.4.6.2.5.2.3 10 CCR 2505-10—8.209.4.J, 8.209.4.O		
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
19. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. o That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract Amendment 7: Exhibit A3—2.6.4.7.4, 2.6.4.7.5 10 CCR 2505-10—8.209.4.M	The Beacon Appeal Process policy did not address continuation of previously approved services as required content of appeal resolution notices when the resolution is not in favor of the member. The FBHP Appeal Decision Letter template did not include information on the member's right to request continuation of services during a State fair hearing when the services being appealed were previously approved and then terminated or reduced. The template letter also does not address the member's potential financial liability for continued services if the State fair hearing upholds the ABD. Template issues are global; therefore, HSAG did not consider continued benefit language in the scoring of the content of letters in individual appeal record reviews. It was unclear whether the submitted template letter was intended for use in appeal resolution related to the termination, suspension, or reduction of previously authorized services. FBHP did not; however, provide evidence that it used a specific template that included the required language for situations in which such applied.	FBHP must ensure that Beacon updates its Appeal Process policy and updates the Appeal Decision Letter template language to include information regarding the continuation of previously authorized services during a State fair hearing when applicable. FBHP could add language to its existing template (making it clear whether this applies to the current appeal). Alternatively, FBHP could consider developing a specific template to be used when the appeal resolution is not in favor of the member and relates to a decision to terminate, suspend, or reduce previously authorized services.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
20. **The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.** • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. • The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. • The Contractor shall participate in all State fair hearings regarding appeals. *42 CFR 438.408(f)(1) and (2) and (3)* Contract Amendment 7: Exhibit A3—2.6.4.9.1, 2.6.4.9.3, 2.6.4.9.2, 2.6.4.9.5 10 CCR 2505-10—8.209.4.N, 8.209.4.O, 8.209.4.H	The FBHP Appeal Decision Letter template includes two statements regarding request for a State fair hearing: one statement correctly informs the member that he or she may request a State fair hearing within 120 days from the adverse appeal decision; the other statement incorrectly states that the <listed date> is 120 days from the notice of adverse benefit determination. Template issues are global; therefore, HSAG did not consider this discrepancy in the scoring of the content of letters in individual appeal record reviews.	FBHP must modify the Appeal Decision Letter template to accurately inform the member that he or she may request a State fair hearing within 120 calendar days from the date of the notice of appeal resolution (i.e., remove conflicting statement, "from the notice of adverse benefit determination"). FBHP must also ensure that staff members calculate the <listed date> from the date of the appeal resolution notice.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
21. The Contractor maintains an expedited review process for appeals for when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the Contractor denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution. – **Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision.**	Neither the Beacon Appeal Process policy nor the Beacon Expedited Appeal Workflow specified the time frame for notifying the member orally or in writing of the decision to deny a member's request for an expedited appeal. In addition, the sample FBHP expedited appeal request denial letter did not include the member's right to file a grievance if he or she disagrees with that decision.	FBHP must ensure that Beacon policies and procedures address notifying the member in writing within two calendar days and giving the member prompt oral notice of a decision to deny a request for an expedited appeal. FBHP must ensure that the expedited appeal request denial letter informs the member of the right to file a grievance if he or she disagrees with the decision.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
42 CFR 438.410 Contract Amendment 7: Exhibit A3—2.6.4.7.3, 2.6.4.7.3.1, 2.10.17.2 10 CCR 2505-10—8.209.4.Q, 8.209.4.R, 8.29.4.S		
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
22. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 calendar days of the notice of adverse benefit determination. ***This definition of "timely filing" only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The**	The Beacon Appeal Process policy includes inaccuracies in the criteria for requesting continued benefits during an appeal or State fair hearing as follows: • The policy states that the member must file the appeal on or before the time frames specified. The member must rather request continued benefits in these time frames, not file the appeal. • The policy states that the member must make the request on or before the latter of the following: "within 10 days of the intended date of the proposed adverse benefit determination." The correct criterion is on or before the intended effective date of the adverse benefit determination, not within 10 days of that date. (Note: The policy correctly states "within 10 days of the mailing the notice of adverse benefit determination.")	FBHP must ensure that Beacon appeal policies and procedures include the accurate criteria, as specified in the requirement, for requesting continuation of benefits during an appeal or State fair hearing. Beacon must correct the inaccuracies as noted in the Findings.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
provider may not request continuation of benefits on behalf of the member.) *42 CFR 438.420(a) and (b)* Contract Amendment 7: Exhibit A3—2.6.4.8.1 10 CCR 2505-10—8.209.4.T		
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
23. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract Amendment 7: Exhibit A3—2.6.4.8.2 10 CCR 2505-10—8.209.4.U	The Beacon Appeal Process policy included an additional criterion, "the time period of the previous authorization of the services expires"—for how long benefits will continue pending outcome of an appeal or State fair hearing. Per the language of the requirement, this is not a criterion for how long benefits will continue.	FBHP must ensure that Beacon corrects its appeals policy to remove this criterion as a definition for how long benefits will continue pending outcome of an appeal or State fair hearing.
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
27. The Contractor provides the information about the grievance appeal and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member, including how members obtain a hearing, and the representation rules at a hearing. • The availability of assistance in the filing processes. • The toll-free number to file orally. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair	The Beacon provider handbook included thorough information on processing of appeals and grievances, including elements specified in the requirement. However, information in the provider manual duplicates some inaccuracies in the details of grievance and appeal requirements (as noted in other elements in this Standard), particularly related to continuation of benefits during an appeal.	FBHP must ensure that all corrective actions implemented in response to recommendations or required actions in this Standard are included in the grievance and appeal information in the provider handbook.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
hearing is pending, if the final decision is adverse to the member. • Appeals process available under the Child Mental Health Treatment Act (CMHTA), if residential services are denied. • Any State-determined provider's appeal rights to challenge the failure of the organization to cover a service. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract Amendment 7: Exhibit A3—2.6.4.4 10 CCR 2505-10—8.209.3.B		
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 VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
5. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, provider, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participation in federal healthcare programs. • The Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). • The Contractor has procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity. • The Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of its employees and contractors against the HHS-OIG's List of Excluded Individuals (LEIE) to determine whether they have been excluded from participation in Medicaid. • The Contractor has procedures to provide to the Department written	While FBHP, supported by Beacon, had policies, procedures, and implemented processes to conduct screening of individuals and entities at all levels of the organization, HSAG could not identify any written procedures for reporting to the Department disclosure of ownership and control within 35 days after any change in ownership or disclosure of any prohibited affiliation within five business days of discovery.	FBHP must strengthen its written policies and procedures to define mechanisms for reporting to the Department within the time frames specified in the requirement any change in ownership or control or any discovery of prohibited affiliations.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
disclosure of any prohibited affiliation within five (5) business days of discovery. *42 CFR 438.214(d)* *42 CFR 438.610(a-c)* *42 CFR 438.608(c)(1-2)* Contract Amendment 7: Exhibit A3—2.9.7.3.3.2, 2.9.7.3.3.7, 2.9.10.9, 2.10.5.2, 2.10.5.3.7.2		
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 VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
11. The Contractor's compliance program includes provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • The Contractor screens all provider claims, collectively and individually, for potential fraud, waste, or abuse—including mechanisms to identify overpayments to providers and to report suspected instances of up-coding, unbundling of services, services that were billed for but never rendered, and inflated bills for services and goods provided. • The Contractor has procedures for provision of a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. – The Contractor provides individual notices to all or a sample of members who received services to verify and report whether services billed by providers were actually received by members. • The Contractor has a mechanism for a network provider to report to the Contractor when it has received an	FBHP, through functions delegated to Beacon, had numerous policies and implemented procedures to identify, remedy, and report to the Department any potential fraud or overpayments. However, HSAG identified no clearly defined mechanisms for a provider to report when it has received an overpayment and to return the overpayment within 60 calendar days.	FBHP must develop and communicate to providers mechanisms for a provider to notify the Contractor when it has received an overpayment and the reason for the overpayment as well as to return the overpayment to the Contractor within 60 calendar days of identification.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor has procedures to identify to the Department within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(a)(5), (c)(3), and (d)(2) and (3)* Contract Amendment 7: Exhibit A3—2.9.3.1.8, 2.9.3.1.1.3–9, 2.9.3.2.1–2, and 5.2.1.1		
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 appeals and grievances that occurred between July 1, 2017, and December 31, 2017. 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 appeals and grievances. • 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 2017–2018 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.