

Colorado Medicaid
Community Mental Health Services Program

FY 2012–2013 SITE REVIEW REPORT
for
**Northeast Behavioral Health
Partnership, LLC**

February 2013

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



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1. Executive Summary

for Northeast Behavioral Health Partnership, LLC

Overview of FY 2012–2013 Compliance Monitoring Activities

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct a periodic evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations and contractual requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the ninth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2012–2013 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

The BHO's administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable practitioners who had been credentialed or recredentialled in the previous 36 months. For the record review, the BHO received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal regulations was evaluated through review of the four standards. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2012–2013 site review activities for the review period—January 1, 2012, through December 31, 2012. Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Section 3 describes the extent to which the BHO was successful in completing corrective actions required as a result of the 2011–2012 site review activities. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing 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 process the BHO will be required to complete for FY 2012–2013 and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the BHO's contract requirements, NCQA Credentialing and Recredentialing Standards and Guidelines, and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key BHO personnel to determine compliance. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

The four standards chosen for the FY 2012–2013 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services (CMS) final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient BHOs (PIHPs)*. Appendix E contains a detailed description of HSAG's site review activities as outlined in the CMS final protocol.

Objective of the Site Review

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

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

Summary of Results

Based on the results from the compliance monitoring tool and conclusions drawn from the review activities, HSAG assigned each requirement within the standards in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any individual 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 enhancement for some elements, regardless of the score. Recommendations for enhancement for requirements scored as *Met* did not represent noncompliance with contract requirements or BBA regulations.

Table 1-1 presents the score for **Northeast Behavioral Health Partnership, LLC (NBHP)** for each of the standards. Details of the findings for each standard follow in Appendix A—Compliance Monitoring Tool.

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III Coordination and Continuity of Care	8	8	8	0	0	0	100%
IV Member Rights and Protections	5	5	5	0	0	0	100%
VIII Credentialing and Recredentialing	49	47	46	1	0	2	98%
X Quality Assessment and Performance Improvement	16	16	16	0	0	0	100%
Totals	78	76	75	1	0	2	99%

Table 1-2 presents the scores for **NBHP** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

Description of Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing Record Review	48	48	48	0	0	100%
Recredentialing Record Review	60	60	58	2	0	97%
Totals	108	108	106	2	0	98%

2. Summary of Performance Strengths and Required Actions

for Northeast Behavioral Health Partnership, LLC

Overall Summary of Performance

Northeast Behavioral Health Partnerships (NBHP) is a partnership between ValueOptions (VO), a national behavioral health provider and management organization, and local community mental health centers (CMHCs) providing behavioral health care throughout northeastern Colorado. Although VO is a partner in **NBHP**, **NBHP** has (at the request of the Department) entered into delegation agreements with VO, in addition to the Management Services Agreement, for the performance of specific activities required under the Colorado Medicaid Contract (e.g., management of care coordination and credentialing programs and maintenance of the Office of Member and Family Affairs [OMFA]).

For the four standards reviewed by HSAG, **NBHP** earned an overall compliance score of 99 percent. **NBHP** earned 100 percent in three of the four standards reviewed (Coordination and Continuity of Care, Member Rights and Protections, and Quality Assessment and Performance Improvement). **NBHP's** 98 percent score for the Credentialing and Recredentialing Standard related to a missing provision in the delegation agreement between VO and **NBHP**, which did not impact compliance with NCQA-required processes. **NBHP** demonstrated strong performance overall and a clear understanding of federal regulations and Medicaid contract requirements.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

NBHP requires the primary therapist to be responsible for coordination and continuity of care for each member. The **NBHP** primary therapist receives support from the VO care coordinators and discharge planners at each community mental health center (CMHC) for complex cases. **NBHP** used its care management authorization process to identify and monitor members in need of complex coordination. When required, **NBHP** engaged the medical director and a team of professionals to create a treatment plan and coordinate care among multiple providers and agencies.

NBHP presented three care coordination cases: one individual with complex medical and substance abuse needs and chronic homelessness, one youth with complex physical and behavioral health needs and Asperger's syndrome, and one individual with behavioral and physical health needs residing in a long-term nursing facility. These cases demonstrated active coordination of information and services among multiple providers and agencies; performance of a comprehensive assessment; and development of a treatment plan with goals, progress monitoring, and follow-up revisions to the plan.

NBHP monitored provider compliance with coordination of care requirements through treatment record audit using a comprehensive audit tool, which assessed all of the required components specified in the standard; however, the number and frequency of records **NBHP** reviewed was minimal. HSAG recommended that **NBHP** consider auditing a wider sample of provider treatment records to ensure that providers are consistently meeting the assessment, treatment planning, and coordination of care requirements.

Furthermore, case presentations did not clearly identify an assessment of the member's transportation needs. HSAG recommended that **NBHP** include a field in the assessment form (or elsewhere in the medical record, as appropriate) to document assessment of transportation needs. **NBHP** provided evidence that it maintains compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws in the conduct of coordination of care and other internal operations.

Summary of Strengths

NBHP delegated care coordination activities to VO. VO demonstrated extensive experience in care management, provided well-qualified staff to support **NBHP** members and mental health centers, and maintained well-defined systems and processes to support care coordination. The VO team demonstrated leadership and administrative skill in coordination of care for members with complex medical and behavioral health needs. Discharge planners located at each of the CMHCs facilitated continuity of care when members were transitioning from one level of care to another. Collectively, **NBHP** and its partners demonstrated depth of resources committed to coordination and continuity of care for members. The CMHC electronic health record, used in case demonstration, appeared well configured to document and track the elements of coordination of care.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

NBHP's and VO's member rights policies and procedures included all of the required content. The VO/NBHP provider manual described provider responsibilities for ensuring member rights and described the responsibilities of the NBHP Office of Member and Family Affairs (OMFA). Both of the VO provider contract templates informed providers that the list of member rights could be found in the provider manual and the expectation that providers take members' rights into account when furnishing services.

The NBHP/VO policies included the right to free exercise of rights that does not affect how providers or the BHO treat the member. This right was also listed in the member handbook. The member handbook and the NBHP Web site informed members about OMFA and its role to ensure member access to the grievance and appeals processes.

Summary of Strengths

NBHP demonstrated that its members are continuously encouraged by therapists and during member groups to access their rights and to use processes available to them, such as the grievance and appeals processes. Staff stated that OMFA advocates, located at each network CMHC, are visible to members and support providers in helping members access the grievance and appeal system. NBHP staff use business-sized "Compliment & Complaint Help" cards as handouts, placed throughout the CMHCs, which are available for providers to distribute to members. The cards have the OMFA advocate names and contact information and remind members of their right to provide feedback, positive or negative, to the CMHCs.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

VO, on behalf of **NBHP**, had several policies and procedures that thoroughly described the credentialing and recredentialing processes and demonstrated compliance with NCQA requirements. On-site review of credentialing and recredentialing records demonstrated that VO requires the Colorado standard credentials application, which included the required content and required the applicant to attest to the accuracy and completeness of the information provided. During the on-site record reviews, HSAG was also able to verify that VO verified licensure and queried the OIG database to verify eligibility to participate in federal health care programs.

NBHP provided an annual audit report completed by an independent contractor on behalf of **NBHP**. The audit evaluated all activities delegated to VO, including credentialing and recredentialing. The audit process included a file review for compliance with NCQA standards. Both the Management Services Agreement and the Delegation Agreement between **NBHP** and VO included the provision to require corrective action for inadequate performance of the delegated activities. **NBHP** provided evidence of having required corrective actions and following up until corrected.

Summary of Strengths

VO's corporate policies and processes bring extensive experience and knowledge of NCQA requirements to **NBHP**. VO's database for maintaining documents obtained for credentialing and recredentialing provides secure recordkeeping, while providing easy access to staff for processing and accessing provider files, as needed. VO's assignment of two credentialing specialists designated for Colorado provider applications ensured that Colorado-specific requirements were met.

NBHP's site visit tools and procedures for both individual practitioners and organizational providers were comprehensive and incorporated both NCQA and Colorado-specific requirements. **NBHP**'s credentialing committee, which served as the VO local credentialing committee, incorporated VO staff members and CMHC providers and included a variety of provider types.

Summary of Required Actions

Although the partnership (**NBHP**) included VO as a member of the partnership, there was a delegation agreement between the partnership and VO (as required by the Department). The delegation agreement did not include a provision that **NBHP** retains the right to approve, suspend, and terminate individual practitioners and providers. This provision was present in the delegation agreement submitted for the 2010 EQRO site visit, but it had been removed from the most recently signed agreement. **NBHP** must either revise the delegation agreement or use an addendum to include the required provision that **NBHP** retains the right to approve, suspend, and terminate individual practitioners and providers.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

NBHP had a comprehensive quality improvement (QI) program that incorporated a variety of mechanisms to monitor quality and appropriateness of care. Mechanisms included practice guidelines; performance improvement projects; and ongoing monitoring of performance measures, member satisfaction surveys, utilization patterns, and quality of care concerns. **NBHP** delegated performance of quality management activities to its partner organization, VO. The QI program was well documented through the annual program description, annual evaluation, and annual work plan, with review and oversight by the Quality Improvement/Utilization Management (QI/UM) Committee. HSAG reviewed evidence that corrective actions and focused QI projects were implemented, as needed. Well-developed health information systems collected pertinent information, had mechanisms to ensure accuracy of information, and produced numerous reports for utilization and quality monitoring. HSAG's on-site review identified opportunities for improvement resulting in recommendations, but no required actions.

HSAG recommended that **NBHP** more clearly identify the documentation of continued quality of care concerns and recommendations for the subsequent year's QI Work Plan in the annual QI Evaluation report to clarify ongoing areas for improvement from one year to another. In addition, **NBHP** should enhance documentation in the QI/UM Committee minutes to include more substantive discussion of conclusions and recommendations based on the reports and data submitted for review. **NBHP** should also ensure that there is a reporting mechanism in place for CMHCs to consistently report their findings back to the QI/UM Committee when information is referred to CMHCs for analysis.

HSAG recommended that the VO Colorado policy regarding clinical treatment guideline development incorporate all of the required elements from the VO corporate policy (of the same name) to ensure that the local policy includes all required elements. In addition, **NBHP** might consider more formally describing the local processes for ensuring that member information and benefit determinations are consistent with adopted practice guidelines.

Summary of Strengths

The **NBHP** staff was supported by the Colorado VO staff and systems, as well as the national VO organization, thereby enhancing the experience and expertise available to **NBHP** for QI activities. The QI process engaged many participating providers and departments in the component activities, as well as in the functions of the QI/UM Committee. The VO Health Information System was well developed and capable of producing numerous reports, which were used regularly to evaluate quality and appropriateness of care and to stimulate interventions and improvements. The **NBHP** medical director provided active leadership for the **NBHP** QI and UM programs.

Summary of Required Actions

There were no corrective actions required for this standard.

3. Corrective Action Plan Review Methodology for Northeast Behavioral Health Partnership, LLC

Methodology

As a follow-up to the FY 2011–2012 site review, each BHO that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the BHO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with **NBHP** until the BHO completed each of the required actions from the FY 2011–2012 compliance monitoring site review.

Summary of 2011–2012 Required Actions

As a result of the 2011–2012 site review, **NBHP** was required to address the following actions:

NBHP depicted the expedited appeal resolution time frame as three *working days* in its member handbook. Although three working days would meet compliance with federal regulations, **NBHP**'s policy was three calendar days. **NBHP** was required to revise its member handbook to ensure consistency between **NBHP** documents in describing the resolution time frame for expedited appeals.

The VO Appeal Process policy included the required content of appeal resolution letters; however, the content for letters regarding the request for continuation of previously authorized services and liability for cost if the adverse decision is upheld was listed as required content only if providers requested the appeal on behalf of the member. **NBHP** was required to revise its policy to clearly state that language regarding continuation of previously authorized services is required (if applicable) regardless of whether the member or the provider, acting as the DCR, requested the appeal.

The appeals resolution letter indicated that the filing time frame, if requesting continuation of previously authorized services, is 10 days from the notice of action (NOA). If the member has not yet requested the State fair hearing at the time of appeal resolution, the member would have until 10 days past the appeal resolution notice to request the State fair hearing with continuation of benefits. **NBHP** was required to revise member materials to clearly and accurately describe member rights related to the continuation of previously authorized services.

NBHP was required to revise its provider manual to specifically notify providers that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services if the final decision is adverse to the member.

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

Summary of Corrective Action/Document Review

NBHP submitted its CAP to HSAG and the Department in March 2012. HSAG and the Department determined that, if implemented as written, **NBHP** would achieve full compliance. **NBHP** submitted documents that demonstrated it had implemented its plan to HSAG and the Department in June 2012. HSAG and the Department carefully reviewed the documents and determined that **NBHP** had successfully completed all required actions. HSAG notified **NBHP** in August 2012 that its corrective actions were approved.

Summary of Continued Required Actions

NBHP had no required actions continued from FY 2011–2012.

Appendix A. **Compliance Monitoring Tool** *for* **Northeast Behavioral Health Partnership, LLC**

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by the BHO	Score
1. The Contractor has written policies and procedures to ensure timely coordination of the provision of Covered Services to its members and to ensure: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care to promote maintenance of health and maximize independent living. Contract: II.E.1.g.1	Documents Submitted/Location Within Documents: 1. MedicalNecessityPolicy_202L—Entire policy with particular emphasis on sections noted in narrative, below. 2. MedicalNecessityDeterminationLackofInformationandNotificationTimelinesPolicy_203L—Entire policy with particular emphasis on sections noted in narrative, below. 3. PrimaryTherapistResponsibofCCPolicy_262L—Entire policy 4. ProvisionofServicesbyanOutofNetworkProviderPolicy_274L— page 2, Section IV, number 3 and 9b. 5. ContinuityofCareAmongProvidersandLevelsofCarePolicy_254L—Entire policy Description of Process: “MedicalNecessityPolicy_202L” provides a standard definition for medical necessity (Section IV.A) which takes into account that services are provided at the most appropriate and least restrictive level of care and is intended to best maintain the member’s health. It describes the sources of information that are used in making medical necessity determinations (Section IV.B). This policy also describes the procedures for review by Clinical Care Managers (Sections V.A-F.).The focus of reviews for medical necessity is on individual needs of the member and determining the level of service appropriate to meet these needs. “MedicalNecessityDeterminationLackofInformationandNotificationTimelinesPolicy_203L” is a key document, which describes the Contractor’s procedures for making medical necessity determinations, the timeframes for these determinations, and the notifications to members. This policy is applicable in its entirety, yet the reviewer should particularly note the sections related to decision timeframes (Section V.C) and the definitions for urgent, routine and emergency services (Section IV). Timelines and monitoring of these timelines insure the accessibility of services to our members “PrimaryTherapistResponsibofCCPolicy_262L” defines the provider’s responsibility for coordinating care for Medicaid beneficiaries. This entire policy is applicable to this requirement and to the other coordination of care requirements in this Standard.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for Northeast Behavioral Health Partnership, LLC

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by the BHO	Score
	“ProvisionofServicesbyanOutofNetworkProviderPolicy_274L” describes how continuity of care is maintained for Medicaid members. Page 2, Section IV, number 3 and number 9-b describe how a new Medicaid member’s existing treatment can be continued through Medicaid coverage. VO Clinical Care managers work to facilitate timely communication to promote continuity of care when multiple providers are involved in care or a member is transitioning to different levels of care, and this is outlined in “ContinuityofCareAmongProvidersandLevelsofCarePolicy_254L.”	

Findings:

Coordination and Continuity of Care functions were delegated to ValueOptions (VO), a partner in Northeast Behavioral Health Partnership (NBHP). The ValueOptions—Colorado (VO-CO) Coordination of Care policy stated that it is the primary therapist’s responsibility to assess member needs, coordinate care among multiple providers and agencies, make referrals, and share information, as appropriate. The VO Coordination of Care with Physical Health Providers and the VO Continuity of Care Among Providers and Levels of Care policies further delineated the responsibility for communicating information between physical health and behavioral health providers, as applicable, as well as procedures for the case manager to facilitate the sharing of information among multiple providers. NBHP also submitted policies concerning the procedures for making timely decisions for authorization of medically necessary services.

Required Actions:

None.

2. The Contractor has policies and procedures that address, and the Contractor provides for the coordination and provision of Covered Services in conjunction with: ◆ Any other MCO or PIHP. ◆ Other behavioral health care providers. ◆ Physical health care providers. ◆ Long term care providers. ◆ Waiver services providers. ◆ Pharmacists. ◆ County and State agencies. ◆ Other provider organizations that	Documents Submitted/Location Within Documents: 1. PrimaryTherapistResponsibofCCPolicy_262L—Section II.D.1-10 (p.2) 2. 2012AuditToolTemplate_3BHO, Sections C8 and F1-F5 *MISC Description of Process: “PrimaryTherapistResponsibofCCPolicy_262L” defines the purposes for coordination of care and the specific groups that should be included in coordination of care activities. The specific entities are listed in Section II.D.1-10 (p.2). Providers are monitored on compliance with this policy through existing audit procedures. Please see “2012AuditToolTemplate_3BHO”, Sections C8 and F1-F5.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by the BHO	Score
provide wraparound services. ♦ The Single Entry Point (SEP) care manager, as applicable. <i>42CFR438.208(b)(2)</i> Contract: II.E.1.g.1—3		
Findings: The VO-CO Coordination of Care policy identified the primary therapist (or designated care coordinator) as being responsible to coordinate services and share relevant information, as clinically appropriate, among all of the entities listed in the requirement. The Audit Tool template (used for auditing medical records for compliance with requirements) included an element to verify that the provider documented services provided by other providers/agencies involved in the member’s care and that the provider coordinated care with these providers. Staff stated that the audit tool is used to monitor providers for compliance with coordination of care policies and medical record requirements. Sample audit tools provided evidence that records of a sample of independent network providers were audited quarterly. Given that VO audits two medical records for each provider within the sample, and that the sample is relatively small, a small number of records are reviewed quarterly. HSAG recommends that NBHP consider auditing a wider sample of provider treatment records to ensure that providers are consistently meeting the assessment, treatment planning, and coordination of care requirements. During the on-site interview, staff stated that members who are transferring from one level of care to another are identified through the initial authorization process and followed by care management throughout their treatment within higher levels of care such as inpatient, residential, or long-term care. Staff stated that care managers hold weekly rounds with community mental health center (CMHC) discharge planners, and special staffings with residential programs, as needed, to coordinate follow-up care for members approaching discharge. Staff members also reported a recently developed VO position of field care manager, whose responsibility it is to coordinate services for members with particularly complex needs receiving services from multiple providers. During on-site interviews, staff presented three care coordination cases: one individual with chronic homelessness and complex medical and substance abuse issues, one youth with Asperger’s Syndrome and both physical and behavioral health care needs, and one individual with behavioral and physical health care needs residing in a long-term nursing facility. These cases demonstrated active coordination of information and services with each of the providers and organizations involved, as appropriate.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	Evidence as Submitted by the BHO	Score
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary (behavioral health) care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. Contract: None.	Documents Submitted/Location Within Documents: 1. PrimaryTherapistResponsibofCCPolicy_262L—Section II.E (p.3) 2. CoordinationofCarewithPrimaryHealthProviderPolicy_278L—Entire policy 3. ServiceforDeafandHardofHearingClientsPolicy_238L—Entire policy 4. 2012AuditToolTemplate_3BHO, Sections C8 and F1-F5 *MISC 5. InpatientATUConcurrentReviewProcess_workflow_2010OCT14_CL—Entire document Description of Process: “PrimaryTherapistResponsibofCCPolicy_262L” defines the purposes for coordination of care and the specific groups that should be included in coordination of care activities. The requirement that each member has an ongoing source of primary care is addressed in Section II.E (p.3). Additionally, the Coordination of Care with Primary Health Provider Policy [CoordinationofCarewithPrimaryHealthProviderPolicy_278L] addresses this requirement specifically. The entire policy is applicable. Member’s individual needs are taken into account in referrals to care, making sure the care is appropriate to his or her needs and the following policy is an example of how this is accomplished for deaf and hard of hearing members: “ServiceforDeafandHardofHearingClientsPolicy_238L” Providers are monitored on compliance with this requirement through existing audit procedures. Please see “2012AuditToolTemplate_3BHO”, Sections C8 and F1-F5. When members are admitted to higher level of care services, coordination of care to insure that appropriate sources of behavioral health care are in place to assist the member with their recovery and ongoing treatment becomes even more important and the VO Care Managers work closely with hospitals and CMHC staff to make sure plans are in place. This is demonstrated in the following document: “InpatientATUConcurrentReviewProcess_workflow_2010OCT14_CL” which is utilized in training VO Care Managers, Hospitals and CMHC staff about the required process of communication to coordinate care.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by the BHO	Score
Findings: The VO-CO Coordination of Care policy stated that the primary therapist (or designated staff care coordinator) is responsible for care coordination when multiple providers are involved with the member. In addition, the primary therapist is responsible to ensure that all members have an ongoing source of primary medical care. NBHP provided multiple policies and procedures that outlined mechanisms for coordination between the behavioral health and physical health provider, as well as integration of care for members with complex behavioral health needs receiving higher levels of care. The Audit Tool template (used for auditing medical records for compliance with requirements) included an element to verify that the BHO provider made a referral to a primary care physician (PCP) for a medical exam, obtained a release of information for communication with the PCP, and notified the PCP of the member’s diagnosis, medications, and participation in treatment. During on-site review, staff provided a review of care coordination treatment records of three cases, which documented that each member had an assigned primary therapist and PCP.		
Required Actions: None.		
4. Contractor ensures that each member accessing services receives an individual mental health assessment and individual needs assessment. The mental health assessment addresses: ◆ Member demographics. ◆ Cultural and racial affiliations. ◆ Language and reading proficiency. ◆ Personal and family health history. ◆ Self-perceived health status to predict the member’s likelihood of experiencing the most common mental illnesses. ◆ Personal health characteristics, including but not limited to: • Mental illness. • Alcohol consumption. • Substance use disorders.	Documents Submitted/Location Within Documents: 1. 2012AuditToolTemplate_3BHO-- Sections B1-B20 *MISC 2. TreatmentPlanning_Policy223L—Entire policy 3. EQROProviderManual_2012Sept_PR-- pages 86-88 *MISC Description of Process: The Provider Audit Tool, “2012AuditToolTemplate_3BHO” addresses this requirement for an individual mental health assessment. See Sections B1-B20. Treatment planning for our members must be done after an individualized assessment for each member, as outlined in “TreatmentPlanning_Policy223L.” Providers are required to follow the requirements of the Provider Manual, and Section 17, Medical Records Requirements listed in “EQROProviderManual_2012Sept_PR” pages 86-88 outlines that these elements of assessment are required parts of the treatment record for each member.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by the BHO	Score
The individual needs assessment evaluates: ◆ Special transportation needs. ◆ Cultural and linguistic needs. 42CFR438.208(c)(2) Contract: II.F.7		

Findings:

The VO-CO Treatment Planning policy stated that the treatment plan is based on a thorough assessment of the member's needs, including each of the required elements. The medical record documentation standards included in the provider manual stated that each treatment record would include an assessment which included the elements outlined in the Treatment Planning policy. The Audit Tool template, used for monitoring provider treatment records, included verification of the required assessment components. During the on-site interview, staff provided evidence that records of a sample of independent network providers were audited quarterly. In addition, staff stated that the CMHCs perform similar routine audits of a representative sample of CMHC medical records.

The on-site presentation of care coordination cases demonstrated that all of the requirements were addressed, with the exception of transportation needs. Although NBHP staff were able to describe how therapists worked with members and were aware of members' methods of transportation (e.g., Medicaid vendor, facility van, family), an assessment of transportation needs was not documented in the files. HSAG recommends that NBHP include a field in the assessment form (or elsewhere in the medical record, as appropriate) to document assessment of transportation needs.

Required Actions:

None.

5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. 42CFR438.208(b)(3) Contract: II.F.7.g	Documents Submitted/Location Within Documents: 1. PrimaryTherapistResponsibofCCPolicy_262L—Section II.C, D and F. Description of Process: "PrimaryTherapistResponsibofCCPolicy_262L" defines the purposes for coordination of care and the specific groups that should be included in coordination of care activities. The purposes are specifically noted in Sections II.C, D, and F.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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Findings:

The VO-CO Coordination of Care policy required the primary therapist to share the results of his or her assessment with other providers to prevent duplication of services and reduce the potential for fraud, waste, and abuse. The policy outlined the procedures for obtaining a release of information and for sharing information with other involved providers and the primary care provider. The policy stated that it was applicable to all BHO members.

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by the BHO	Score
One of the three care coordination cases presented on-site demonstrated sharing of pertinent assessment information (lab results) with another provider. Staff stated that information sharing is selective based on the “need to know” policies in response to the Health Insurance Portability and Accountability Act (HIPAA) and other Colorado privacy laws concerning behavioral health information. Staff stated that, during the authorization process, care management staff members review current authorization requests as well as previous authorizations and communicate with the requesting providers to prevent duplication of services. Required Actions: None.		
6. Each member has an individualized service plan (treatment plan/care plan) that includes: ◆ Measurable goals. ◆ Strategies to achieve the stated goals. ◆ Mechanism for monitoring and revising the service plan as appropriate. The service plan is developed by the member, the member’s designated client representative (DCR) and the provider/treatment team and is signed by the member. (If a member chooses not to sign his/her service plan, documentation shall be provided in the member’s medical record stating the member’s reason for not signing the plan.) Service planning shall take place annually or if there is a change in the member’s level of functioning and care needs. <i>42CFR438.208(c)(3)</i> Contract: II.F.9	Documents Submitted/Location Within Documents: 1. TreatmentPlanningPolicy_223L—Entire policy 2. 2012AuditToolTemplate_3BHO, Sections C1-C14 *MISC 3. Member Handbook_NBHP-pages. 8, pp. 18-19*MISC 4. EQROProviderManual_2012Sept_PR” p.87 *MISC Description of Process: “TreatmentPlanningPolicy_223L” addresses this requirement and is applicable in its entirety. Sections V.A-D describes the procedures related to this requirement. Providers are monitored on compliance with this policy through existing audit procedures. Please see “2012AuditToolTemplate_3BHO”, Sections C1-C14. Members are educated about their role in treatment planning through our Member Handbook in the following documents: NBHP: Member Handbook_NBHP-pages. 8, pp. 18-19 Involvement of the member/DCR in treatment planning is outlined in “EQROProviderManual_2012Sept_PR” p.87	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by the BHO	Score
Findings: The VO-CO Treatment Planning policy stated that the treatment plan is based on the individual needs assessed and includes the goals, relevant therapies, and involvement of pertinent providers/agencies. The policy required that the treatment plan be revised regularly and be monitored periodically by the primary therapist. The policy defined “member” and “designated client representative,” described provider involvement in care planning, and described the process to obtain the member’s signature on the care plan (or to note the reason for not signing). The member handbook and provider manual addressed member involvement in treatment planning. The Audit Tool template verified that the treatment plan is audited for all of the required elements, including signatures of members and providers, and review or revision of the plan every six months, as needed. During the on-site review, staff provided evidence of provider treatment record audits of the independent provider network and summary results of record audits performed by the CMHCs. CMHC treatment record audits also included criteria for a written treatment plan with client and provider signatures. The three care coordination cases presented during the on-site interview demonstrated that each member had a treatment plan with measurable goals, related interventions, a member signature, and follow-up or reassessment every six months.		
Required Actions: None.		
7. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. In all other operations as well the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. 42CFR438.208(b)(4) 42CFR438.224 Contract: II.E.1.g.1, VII.S	Documents Submitted/Location Within Documents: 1. PrimaryTherapistResponsibofCCPolicy_262L—Section II.F 2. ContinuityofCareAmongProvidersandLevelsofCarePolicy_254L Section V, A, 1 and 2 Description of Process: “PrimaryTherapistResponsibofCCPolicy_262L” defines the purposes for coordination of care and the specific groups that should be included in coordination of care activities. Member privacy protection is addressed in Section II.F (p.3). In communications with providers to insure continuity of care, VO Care Managers protect member rights under HIPAA. This is addressed in the following policy: “ContinuityofCareAmongProvidersandLevelsofCarePolicy_254L.”, Section V, A, 1 and 2.”	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by the BHO	Score
Findings: NBHP submitted several VO-CO Care Coordination policies that addressed the need for communication of pertinent information among providers involved in a member’s care. The policies addressed the need to ensure that communications with other providers are protected in accordance with federal (i.e., HIPAA) and State requirements regarding release of protected health information (PHI). The policies delineated the procedures for obtaining a signed consent for release of information. During the on-site interview, staff stated that therapists shared pertinent assessment information with medical and other providers contingent on a release of information signed by the member. Information was shared based on the “need to know” in response to HIPAA and other Colorado privacy laws concerning behavioral health information. Staff provided evidence of annual VO employee training concerning HIPAA privacy and security, which included job-related access and use of PHI, disclosure of PHI, physical and electronic security of information, and related penalties and disciplinary actions.		
Required Actions: None.		
8. The Contractor may require nursing facility residents who are able to travel to a service delivery site to receive their mental health services at a service delivery site. The Contractor shall arrange for transportation for the member between the nursing facility and the service delivery site, but shall not be responsible for the cost of transportation. However, the Contractor shall provide medically necessary mental health services on-site in the nursing facility if transportation cannot be arranged. Contract: II.E.3	Documents Submitted/Location Within Documents: 1. SvcsForResidentsNursingFacilityPolicy_275L—Entire policy Description of Process: “SvcsForResidentsNursingFacilityPolicy_275L” addresses this requirement. The entire policy is applicable to this requirement.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO-CO Services for Residents in Nursing Facilities policy described the provision of mental health services for residents of nursing facilities, including the arrangement for transportation for members traveling to a CMHC for services.		

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by the BHO	Score
One of the care coordination cases presented during the on-site interview demonstrated coordination of services for a resident in a nursing facility, which demonstrated that mental health services were provided on-site at the nursing facility, and the member was transported to physical health appointments outside of the facility, although the means of transportation was not documented.		
Required Actions: None.		

Results for Standard III—Coordination and Continuity of Care

Total	Met	=	<u>8</u>	X	1.00	=	<u>8</u>
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>
Total Applicable		=	<u>8</u>	Total Score	=	<u>8</u>	

Total Score ÷ Total Applicable	=	<u>100%</u>
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Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for Northeast Behavioral Health Partnership, LLC

Standard IV—Member Rights and Protections

Requirement	Evidence as Submitted by the BHO	Score
1. The Contractor has written policies and procedures regarding member rights. <i>42CFR438.100(a)(1)</i> Contract: II.F.3.a	Documents Submitted/Location Within Documents: 304LMemberRandR_Policy_VOCO -Entire Policy 310LNonDiscrimination_Policy_VOCO-Entire Policy Description of Process: The Member Rights and Responsibilities Policy, 304LMemberRandR_Policy_VOCO and the Non-Discrimination Policy, 310LNonDiscrimination_Policy_VOCO are two policies that guide our position on protecting member rights. The Non-Discrimination policy is the foundation for all member rights policies. The Members Rights and Responsibilities policy meets all state and federal regulations and contract requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: NBHP delegated distribution of member materials and maintenance of policies and procedures related to member rights and protections to VO. The VO Member Rights and Responsibilities policy included each of the rights at 42CFR438.100 and as described in the Colorado Medicaid Managed Care contract. The policy also described the procedures for notifying members of these rights. VO also had policies that described how member materials, which included explanation of member rights, were distributed to members.		
Required Actions: None.		
2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members. <i>42CFR 438.100(a)(2)</i> Contract: II.F.3.a	Documents Submitted/Location Within Documents: - FacilityContract_VOCO– Section Page 27 of 28, G.1 (n); Page 7 of 28 - 5.4 (a) - IPN_Contract_VOCO – Section 5.4 (a); page 26 of 27, G.1 (n) - ProviderHandbook_Section15_OMFA_VOCO- paragraph 1, 3, 5, 12, bullet 3 - Provider_Training_Presentation_3BHO- Pages 67-71 - MemberHandbook_NBHP - Pages 16-19 *Misc Description of Process: There are a variety of methods in place to ensure that network and affiliated providers and staff are knowledgeable about member rights and responsibilities and the requirement to uphold those rights. Both FacilityContract_VOCO - and the IPN_Contract_VOCO describe providers' or facilities responsibility for upholding and respecting member rights. Providers are encouraged to post the downloadable member rights poster in the provider handbook is encouraged to be posted in providers' offices and given to members. ProviderHandbook_Section15_OMFA_VOCO references member rights, how members contact an advocate if member has a grievance or how to access other	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections

Requirement	Evidence as Submitted by the BHO	Score
	OMFA services that are offered. ValueOptions does a minimum of four face-to-face provider forums where an overview of member rights is presented in the Provider_Training_Presentation_3BHO member handbooks are made available to providers. MemberHandbook_NBHP is available to be distributed to members at intake or when member rights and responsibilities are discussed.	

Findings:

The VO/NBHP provider manual described provider responsibilities for ensuring member rights, and described the responsibilities of the NBHP Office of Member and Family Affairs (OMFA). Both of the VO provider contract templates informed providers that the list of member rights could be found in the provider manual and the expectation that providers take members' rights into account when furnishing services. The contract templates included the provider's responsibility for informing members of their rights. The online provider manual included a downloadable member rights poster. During the on-site interview, NBHP staff reported that providers are asked to either post the member rights poster (in CMHCs and larger offices) or distribute the list of rights during the first treatment session. Provider forums were developed for the target audience of independent network providers and included member rights and OMFA information. NBHP staff also described community forums conducted during the review period that were open to the public and included presentations by OMFA staff. NBHP staff reported that each CMHC has an OMFA representative responsible for training staff and providers at its CMHC. VO, as the partner responsible for provider and network monitoring, conducted annual on-site monitoring of the CMHCs that included reviewing evidence of training (e.g., agendas, sign-in sheets). CMHC training related to member rights was required at initial employee orientation and annually.

Required Actions:

None.

3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate	Documents Submitted/Location Within Documents: Bullet Point 1: Members are given information in accordance with the requirements stated in 42CFR438.10. 1. ScreenShot_OMFA_MemberRight_NBHP http://www.nbhpartnership.com/members/mbr_omfa.htm 2. MHC_contract_compliance_audit_tool_NBHP – item 1 3. ProviderHandbook_Section15_OMFA_VOCO http://www.nbhpartnership.com/providers/handbook/Section_15_Office_of_Member_and_Family_Affairs.pdf for NBHP 4. 306LMemberMaterials_Policy_VOCO-sections III.A-E; IV.B; V.A.1-4 5. 307LMemberInfoReq_Policy_VOCO- Entire Policy *MISC Description of Process: Members are given information in accordance with the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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Standard IV—Member Rights and Protections

Requirement	Evidence as Submitted by the BHO	Score
to the member’s condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment, and the right to a second opinion. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). Additional member rights, include the right to: ◆ Have an independent advocate. ◆ Request that a specific provider be considered for inclusion in the provider network. ◆ Receive a second opinion. ◆ Receive culturally appropriate and competent services from participating providers. ◆ Receive interpreter services for members with communication disabilities or for non-English-	requirements stated in 42CFR438.10. In the ScreenShot_OMFA_MemberRights_NBHP, this document contains all of the various member rights, including policies, complaints and grievances, non-discrimination and other rights protections. Furthermore, MHC_contract_compliance_audit_tool_NBHP item 1 review NBHP mental health centers for their policies on member rights. Moreover, ProviderHandbook_Section15_OMFA_VOCO instructs providers of their requirement to uphold member rights, and what is required to be posted. Finally, policies 306LMemberMaterials_Policy_VOCO III.A-E; IV-b; V.A.1-5- describes requirements in developing and distributing member materials to make them consistent with 42CFR438.10 and policy 307LMemberInfoReq_Policy_VOCO- entire policy describes all of the content required to be included in member materials according to 42CFR438.10 Bullet Point 2: Be treated with respect and with due consideration for his or her dignity and privacy 1. 304LMemberRandR_Policy_VOCO -section III.A.3, 5 2. MemberHandbook_NBHP–Inside cover, pages 18-26; page 17 *Misc Description of Process: The Members Rights and Responsibilities policy, 304LMemberRandR_Policy_VOCO - III.A.3, 5, is the policy that guides our position on protecting member rights. All NBHP members receive an annual member handbook, MemberHandbook_NBHP-inside cover, pages 18-26; page 17, where it explains what action members can take if they feel their rights have not been respected, as well as confidentiality and how member’s personal health information is protected. Bullet Point 3: Receive information on available treatment options and alternatives presented in a manner appropriate to the member’s condition and ability to understand. 1. 304LMemberRandR_Policy_VOCO –section III.A.7 2. MemberHandbook_NBHP– Pages 9 & 10 *Misc Description of Process: Members Rights and Responsibilities policy, 304LMemberRandR_Policy_VOCO – III.A.7 discusses the right of members to participate in discussion with their provider(s) regarding appropriate or medically necessary treatment	

Standard IV—Member Rights and Protections

Requirement	Evidence as Submitted by the BHO	Score
speaking members. ◆ Prompt notification of termination or changes in services or providers. ◆ Express an opinion about the Contractor’s services to regulatory agencies, legislative bodies, or the media without the Contractor causing any adverse effects upon the provision of Covered Services. 42CFR438.100(b)(2) and (3) Contract: II.F.1, II.F.4.j.3	options. MemberHandbook- Pages 9 & 10 talk about developing a treatment plan collaboratively, and how to ask for alternative treatments and what to do if a member has a disability. Bullet Point 4: Participate in decisions regarding his or her healthcare, including the right to refuse treatment, and the right to a second opinion. 1. 304LMemberRandR_Policy_VOCO–section III.A.14 2. MemberHandbook_NBHP - page9, 14 *Misc 3. ScreenShot_LevelofCareGuidelines_NBHP-Entire Document 4. ScreenShot_AchieveSolutions_NBHP-Entire Document Description of Process: Members Rights and Responsibilities policy, 304LMemberRandR_Policy_VOCO– III.A.14. states that members have the right to a second opinion. Member rights to a second opinion are also described in Members rights to a second opinion and contact information to do so are described in MemberHandbook_NBHP - page 14. MemberHandbook_NBHP_EntireDocument - page 9, describes how decisions are made about care and how a member can get copies of level of care guidelines which explains medical necessity. Members are offered easy access to level of care and clinical guidelines through ScreenShot_LevelofCareGuidelines_NBHP, which are used to help make informed care decisions. ScreenShot_AchieveSolutions_NBHP is a member and provider education tool that is available to our membership and offers a variety of topics on mental health, services, help to make decisions and offers other tools that enable members to take part in their care decisions. Bullet Point 5: Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, 1. 304LMemberRandR_Policy_VOCO –section III.A. 19 Description of Process: Members Rights and Responsibilities Policy, 304LMemberRandR_Policy_VOCO – .III.A. 19, defines members right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.	

Appendix A. **Colorado Department of Health Care Policy and Financing**
FY 2012–2013 Compliance Monitoring Tool
for **Northeast Behavioral Health Partnership, LLC**

Standard IV—Member Rights and Protections		
Requirement	Evidence as Submitted by the BHO	Score
	Bullet Point 6: Request and receive a copy of his or her medical records and request that they be amended or corrected. 1. 304LMemberRandR_Policy_VOCO –section III.A. 21-27 2. Notice_of_Privacy_Practices_Spanish_NBHP – Entire Document 3. Notice_of_Privacy_Practices_NBHP – Entire Document 4. LC400MemberPrivacyRights_Policy_VOCO; Section V.B.1., V.C.1., V.D.1., V.E.1., V.F.1. Description of Process: Member Rights and Responsibilities Policy, 304LMemberRandR_Policy_VOCO – .III.A. 21-27, informs members of their right to get a copy of their protected health information subject to certain limitations. Members are also informed through, Notice_of_Privacy_Practices_Spanish_NBHP– Entire Document, Document, Notice_of_Privacy_Practices_NBHP on how they can request to see and get copies of their medical records and make changes or additions to their record. MemberPrivacyRights_VO; section V.B.1., V.C.1., V.D.1., V.E.1., V.F.1 Bullet Point 7: Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). 1. 304LMemberRandR_Policy_VOCO –page 4,10,11,12,13,14,15 2. ProviderHandbook_Section3_Provider_Assistance_and_Referrals_VOCO– pages 3-6 3. MemberHandbook_NBHP - page 4, 5 *Misc 4. ProviderDirectory_2012SEP_3BHO - Entire Document http://www.nbhpartnership.com/members/resources/Provider_Directory.pdf 5. ScreenShot_ReferralConnect_NBHP-Entire Document 6. N201_Practitioner Credentialing _Process_Policy_VOCO-Entire Policy Description of Process: 304LMemberRandR_Policy_VOCO – 4,10,11,12,13,14,15 is the guiding policy for ensuring health care services are furnished in accordance with requirements for access and quality of services (42CFR438.206 and 42CF438.210). ProviderHandbook_Section3_Provider_Assistance_and_Referrals_VOCO pages 3-6, describes access standards for providers; that providers cannot provide different hours or a	

Standard IV—Member Rights and Protections		
Requirement	Evidence as Submitted by the BHO	Score
	different standard of service for Medicaid members than for other clients; requirements for routine, urgent and emergency services and follow up. MemberHandbook_NBHP-page 4, 5 explain access standards for mental health services. ProviderDirectory_2012SEP_3BHO - Entire Document is distributed to all new enrollees in hard copy format and is downloadable from the NBHP website at: http://www.nbhpartnership.com/members/resources/Provider_Directory.pdf Members can use the on-line tool, ScreenShot_ReferralConnect_NBHP, to find providers with specific characteristics. Furthermore, N201_Practitioner Credentialing_Process_Policy_VOCO describes the credentialing process all providers are subject to ensure they meet the rigorous credentialing standards. Once in the network a member can select a provider by viewing online provider directory using the referral connect tool on the web site or by calling a clinical services assistant. Bullet Point 8: Have an independent advocate. 1. 304LMemberRandR_Policy_VOCO - .III.A. 9 2. MemberHandbook_NBHP– page 6, 18, 19, 20 *Misc 3. SCREENSHOT_ADVOCACY_NBHP–Web Pages Describes how to reach advocates Description of Process: Member Rights and Responsibilities Policy, 304LMemberRandR_Policy_VOCO - .III.A. 9, specifies that members can be represented by a person of their choosing in their interactions with ValueOptions Colorado. MemberHandbook_NBHP– page 6, describes the fact that members can have an independent advocate to help them in their service planning and pages 18, 19 & 20 describe how to use an advocate in the grievance and appeal process. Member can have an advocate in any dealings with the BHO or their provider. SCREENSHOT_ADVOCACY_NBHP are web pages that describe how to reach advocates. Bullet Point 9: Request that a specific Provider be considered for inclusion in the Provider network 1. 304LMemberRandR_Policy_VOCO–III.A.13 2. MemberHandbook_NBHP - page 16 *Misc 3. ProviderHandbook_Section5_ClientChoice_of_Providers_NBHP	

Standard IV—Member Rights and Protections		
Requirement	Evidence as Submitted by the BHO	Score
	Description of Process: Value Options Members Rights and Responsibilities policy, 304LMemberRandR_Policy_VOCO –III.A.13 is the guiding policy that ensures members can request that a specific Provider be considered for inclusion in the Provider network. The list of member rights are in handbooks, MemberHandbook_NBHP- page 16, which include that a specific Provider be considered for inclusion into the Provider network, as well as included in ProviderHandbook_Section5_ClientChoice_of_Providers_NBHP Bullet Point 10: receive a second opinion 1. 304LMemberRandR_Policy_VOCO – III.A. 14 2. MemberHandbook_NBHP– page 14 *Misc 3. ProviderHandbook_Section6_SecondOpinion_NBHP-Entire Document Description of Process: As noted in requirement four above, a member has the right to request a second opinion from a network provider. Bullet Point 11: Receive culturally appropriate and competent services from participating providers 1. 304LMemberRandR_Policy_VOCO – III.A.15 2. 304LMemberRandR_Policy_VOCO– III. A. 20 Description of Process: As noted in the provider handbook, we expect providers to consider cultural factors in their care of the member. OMFA conducts webinars and can provide training in cultural competence, as noted in ProviderHandbook_Section_15_OMFA, Page 2. The NBHP Cultural Competence Plan is posted on http://www.nbhpartnership.com/members/resources/Cultural_Competence_Plan.pdf Bullet Point 12: Receive interpreter services for members with communication disabilities or for non-English speaking members 1. ProviderHandbook_Section15_OMFA_VOCO – paragraph 2 2. MemberHandbook_NBHP_EntireDocument – page 8, 10 *Misc	

Standard IV—Member Rights and Protections		
Requirement	Evidence as Submitted by the BHO	Score
	Description of Process: Members have the right to get interpreter services if needed. We have a list of interpreters and are constantly expanding the list of qualified interpreters. A member, advocate or family member can request an interpreter. We will make arrangements for the interpreter to be present at the therapy sessions. We will coordinate the appointment so that the interpreter, the therapist and the member are present. In no case do we allow family members or friends to act as interpreters when a member is getting clinical services. Bullet Point 13: Prompt notification of termination or changes in services or providers 304LMemberRandR_Policy_VOCO – III. A. 16 - ProviderTermination_Letter_Template_NBHP - MemberHandbook_NBHP-Page 8 *MISC Description of Process: The service center has policies and procedures to ensure we notify members when a provider terminates from the network. This includes voluntary termination, involuntary termination, or any other reason the provider stops seeing members. The OMFA Department receives notice from provider relations that a provider will be disenrolled from the network. This notification comes to us between 40-50 days of the termination date. The OMFA Department gets a list of all members the provider is currently seeing, or has seen in the last 6 months. We send each member a letter informing the member that the provider is being terminated, the date of the termination, and how to reach the service center to find another provider. The member may ask us to find a provider, or may just ask for a list of providers and will look for themselves. Bullet Point 14: Express an opinion about the Contractor’s services to regulatory agencies, legislative bodies or the media without the Contractor causing any adverse effects upon the provision of Covered Services 304LMemberRandR_Policy_VOCO – III. A.17 Description of Process: Members are informed about their rights through a variety of mechanisms. Member rights are contained in the member handbook, the welcome letter,	

Standard IV—Member Rights and Protections

Requirement	Evidence as Submitted by the BHO	Score
	posted on the web site and listed. Providers and staff are informed about their responsibility to uphold member rights through the provider contracting process, in the provider handbook, provider forums and provider webinars. Staff is instructed about member rights during their staff orientation. Value Options also highlights in their staff training the fact that members should not be retaliated against if and when they file a grievance. As part of Value Options recovery training members are encouraged to advocate for themselves whether it be to providers, legislatures or other decision makers. Value Options also monitors the grievance process to determine whether or not members' rights have been violated as a result of members voicing complaints.	
Findings: The VO Member Rights and Responsibilities policy included each of the member rights. The list of member rights was available on the NBHP Web site under both the provider and member tabs. NBHP provided evidence of monitoring VO for compliance with requirements related to member rights. The provider manual included each of the member rights and described provider responsibilities related to member rights.		
Required Actions: None.		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. <i>42CFR438.100(c)</i> Contract: II.F.1.h	Documents Submitted/Location Within Documents: 1. ProviderHandbook_Section15_OMFA_VOCO- pages 1-3 2. MemberHandbook_NBHP- page 24 & throughout the member handbook *Misc 3. Screenshot_OMFA_Description_RightsProtection_NBHP-Entire Document 4. 304LMemberRandR_Policy_VOCO–section III. A.17 Description of Process: The Office of Member and Family Affairs (OMFA) is tasked with the responsibility to uphold member rights without retaliation to the member. This is done through member and provider education and through the grievance process. 304LMemberRandR_Policy_VOCO is the guiding policy to ensure members rights and responsibilities are upheld. ProviderHandbook_Section15_OMFA_VOCO discusses member rights and responsibilities and the importance of members being able to exercise those rights. The MemberHandbook_NBHP_EntireDocument explains to members how they can exercise their rights without retaliation through the grievance process as well as, Screenshot_OMFA_Description_RightsProtection_NBHP. Value Options recovery training encourages members to advocate for themselves.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections

Requirement	Evidence as Submitted by the BHO	Score
Findings: The VO Member Rights and Responsibilities policy included the right to free exercise of rights that does not affect how providers or the BHO treat the member. This right was also listed in the member handbook. The member handbook and the NBHP Web site informed members about the OMFA and the role of OMFA to ensure member access to the grievance and appeals processes. The provider manual informed providers that filing a grievance or an appeal should not restrict or compromise member access to mental health services. During the on-site interview, NBHP staff reported that members are encouraged, on an ongoing basis, by therapists and during member groups such as member advisory groups to access their rights and use processes available to them, such as the grievance and appeals processes. Staff stated that OMFA advocates, on-site at each network CMHC, are visible to members and support providers in helping members access the grievance and appeal system. NBHP staff use business-sized “Compliment & Complaint Help” cards as handouts, placed throughout the CMHCs, which are available for providers to distribute to members. The cards have the OMFA advocate names and contact information and remind members of their right to provide feedback, positive or negative, to the CMHCs.		
Required Actions: None.		
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. 42CFR438.100(d) Contract: VII.T	Documents Submitted/Location Within Documents: 310LNonDiscrimination_Policy_VOCO – entire policy 304LMemberRandR_Policy_VOCO -section III.A.4 - Member Handbook_NBHP– inside cover *MISC Description of Process: Members are informed of our non-discrimination policy in the member handbook under the listing of member rights and on inside cover of the NBHP Member Handbook. This information is also clearly detailed in policies and procedures, 310LNonDiscrimination_Policy_VOCO and 304LMemberRandR_Policy_VOCO. Rights violations are monitored through the grievance process. Value Options nondiscrimination policy was developed based on federal regulations which address discrimination.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Nondiscrimination policy described the rights associated with each of these legislations. The policy described examples and forms of discrimination and the process for using the grievance system tracking to detect possible discrimination. Nondiscrimination was on the list of rights in the member handbook, and a statement of nondiscrimination and related rights was found on the inside cover of the handbook. Staff reported that these nondiscrimination legislations were addressed in new employee orientation and in annual training at the VO service center as well as at the CMHCs.		
Required Actions: None.		



Appendix A. **Colorado Department of Health Care Policy and Financing**
FY 2012–2013 Compliance Monitoring Tool
for **Northeast Behavioral Health Partnership, LLC**

Results for Standard IV—Member Rights and Protections									
Total	Met	=	<u>5</u>	X	1.00	=	<u>5</u>		
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>		
Total Applicable		=	<u>5</u>		Total Score	=	<u>5</u>		

Total Score ÷ Total Applicable	=	<u>100%</u>
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Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. NCQA CR1	Documents Submitted/Location Within Documents: 1. N101_Overview_of_National_Networks_Policy – Entire policy 2. N201_PractitionerCredentialing_Process_Policy_VOCO – Entire policy 3. N203_Facility_Provider_Credentialing_Process – Entire policy 4. N501_Practitioner_Recredentialing_Process – Entire policy 5. N502_Facility_Program_Clinic_Recredentialing_Process – Entire policy Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions carefully evaluates the credentials of each applicant seeking network participation based on uniform, objective criteria detailed in our credentialing and primary source verification processes and policies as listed in the above documents.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

VO, on behalf of NBHP, had several policies and procedures that thoroughly described the credentialing and recredentialing processes and demonstrated compliance with NCQA requirements. During the on-site interview, VO/NBHP staff reported that VO had applied to obtain credentialing verification organization (CVO) status through NCQA and was scheduled for an NCQA site visit.

Required Actions:

None.

2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include psychiatrists, psychologists, clinical social workers,	Documents Submitted/Location Within Documents: 1. N301_Development_of_Credentialing_Criteria – pg. 1 2. N205_Discipline_Specific_Credentialing_Criteria_for_Practitioners – Entire Policy Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions maintains a network of mental health providers. The delegate has specific policies (N301) and procedures that detail the types of mental health (non-physician) practitioners and medical practitioners it will credential.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
psychiatric nurse specialists, and or licensed professional counselors.) 42CFR438.214(a) NCQA CR1—Element A1		
Findings: The Discipline Specific Credentialing Criteria for Practitioners policy described each type of practitioner credentialed for NBHP.		
Required Actions: None.		
2.B. The verification sources used. NCQA CR1—Element A2	Documents Submitted/Location Within Documents: - N401_Primary_Source_Verification_Policy – Entire policy - N401A_Sample_Primary_Source_Verification_Report Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions requires potential and current providers to provide specific information to meet the minimal criteria for inclusion in the provider network. This information is detailed in the N401 Primary Source Verification policy and procedure.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The primary verification sources described in the VO policy met NCQA requirements. VO (on behalf of NBHP) used primary sources such as the Colorado Department of Regulatory Agencies (DORA) to verify State licenses, and the federal OIG database to verify eligibility to participate in federal health care programs.		
Required Actions: None.		

Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for Northeast Behavioral Health Partnership, LLC

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	Documents Submitted/Location Within Documents: 1. N205_Discipline_Specific_Credentialing_Criteria_for_Practitioners – Entire Policy 2. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Entire Policy 3. N501_Practitioner_Recredentialing_Process – Entire policy 4. N502_Facility_Program_Clinic_Recredentialing_Process – Entire policy Description of Process: As described in the attached policies, ValueOptions maintains specific criteria for credentialing and recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The VO Discipline Specific Credentialing Criteria for Practitioners policy described the credentialing criteria for each type of practitioner that VO credentials and recredentials on behalf of NBHP.

Required Actions:

None.

2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	Documents Submitted/Location Within Documents: 1. N101_Overview_of_National_Networks_Policy – Entire policy 2. N201_Practitioner_Credentialing_Process – Entire policy 3. N501_Practitioner_Recredentialing_Process - Entire policy 4. N203_Facility_Provider_Credentialing_Process – Entire policy 5. N502_Facility_Program_Clinic_Recredentialing_Process – Entire policy 6. N601_Role_of_National_Credentialing_Committee– Entire policy 7. N604_Role_of_Local_Credentialing_Committee – Entire policy Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions has policies that detail the credentialing and recredentialing decision process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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Findings:

The VO Practitioner Credentialing Process and the VO Practitioner Recredentialing Process policies described VO's processes for making credentialing and recredentialing decisions and delineated the roles of national VO and local NBHP staff members. During the on-site interview, VO staff stated that the credentialing specialist, who performs primary source verification and manages the applicant's file, is located at VO's national office. Staff reported that two specific credentialing specialists are assigned to Colorado applications and are provided a spreadsheet that includes specific Colorado requirements and processes.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor’s established criteria. NCQA CR1—Element A5	Documents Submitted/Location Within Documents: 1. N202_Organization_of_Practitioner _Credentialing_ &_ Recredentialing_ File – Entire policy Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions has a policy and procedure that clearly outlines the management and organization of credentialing and recredentialing files. All of these files are maintained electronically and include a minimum set of information on all providers who submit an application to be included in the provider network.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The processes used for managing NBHP provider credentialing and recredentialing files, as described in VO policies, met NCQA requirements. On-site review of credentialing and recredentialing records demonstrated compliance with VO policies and procedures and NCQA standards and guidelines.

Required Actions:

None.

2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	Documents Submitted/Location Within Documents: All of the below referenced documents are located in the Evidence folder for Standard VIII, unless otherwise noted: * 1. ProviderPolicies_NBHP_Entire Document 2. Final NBHP Management Services Agreement_NBHP_2011September01_COM – entire policy 3. DelegationAgree2011_NBHP-Entire Document *Misc Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions (ProviderPolicies_NBHP_Entire Document and the Final NBHP Management Services Agreement_NBHP_2011September01_COM).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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Findings:

The NBHP Credentialing and Recredentialing Delegation policy described processes for delegation and delegation oversight of VO in performing credentialing and recredentialing of NBHP practitioners.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes). NCQA CR1—Element A7	Documents Submitted/Location Within Documents: 1. N101_Overview_of_National_Networks_Policy – Pg. 2, Section IV, B and C 2. BiAnnual_Audit_2012_Sample Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N101 clearly states that credentialing and recredentialing decisions are made in a non-discriminatory manner.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Nondiscrimination practices described in VO's policies included audits to ensure nondiscrimination and processes to respond to audit findings or any complaints received. NBHP provided an example of a completed nondiscrimination audit. During the on-site interview, NBHP/VO staff members reported that the audit provided as an example did not necessarily include Colorado providers, as the sampling was taken from the national provider database to evaluate VO processes in general. The sample for this type of audit is not weighted by state.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
2.H. The process for notifying practitioners if information obtained during the Contractor’s credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	Documents Submitted/Location Within Documents: 1. N207_Practitioner_Rights_and _Notification_ Policy – Page 3, Section V.B. Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N207 states that providers are notified if staff identify discrepancies during the credentialing or recredentialing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The Practitioner Rights and Notification policy included the process for clarifying discrepancies in information gathered for the credentialing and recredentialing process.

Required Actions:

None.

2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee’s decision. NCQA CR1—Element A9	Documents Submitted/Location Within Documents: 1. N201_PractitionerCredentialing_Process_Policy_VOCO – Page 1, Section V, G 1, 2b 2. N601_Role_of_National_Credentialing_Committee – Page 2, Section V, F1 Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N201 and N601states that practitioners are notified of the credentialing/recredentialing decision within 60 days.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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Findings:

The Practitioner Credentialing and Recredentialing Process policy described processes for notifying applicants within 5 days of adverse decisions, and within 60 days of the decisions to include the applicant in the provider network.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
2.J. The medical director’s or other designated physician’s direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	Documents Submitted/Location Within Documents: - N601_Role_of_National_Credentialing_Committee - Page 3, Section V, F1 - N604_Role_of_Local_Credentialing_Committee – Page 2, Section V, B, C, E Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policies on the National and Local Credentialing Committees state that the Chief Medical Officer or the designated Medical Director has direct credentialing responsibilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: VO’s policies stated that the local medical director (i.e., the NBHP medical director) is the chair of the local credentialing committee (LCC) and that the medical director may sign off on clean files that meet VO’s criteria for participation in the network. During the on-site interview, VO staff members clarified VO’s process. Staff reported that the medical director sign-off refers to the VO national medical director; and although the policy indicates that the medical director may sign off on clean files, the local medical director makes a recommendation and sends a report with recommendations to the national credentialing committee (NCC). The NCC approval is the credentialing date. Required Actions: None.		
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law. NCQA CR1—Element A11	Documents Submitted/Location Within Documents: N409_Confidentiality_of_Provider_Other_Credentialing Information – Entire Policy Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N409 indicates that all information that is provider-specific in the provider’s credentialing file is confidentially maintained. Furthermore, it is ValueOptions policy that any information in the provider’s credentialing file will not be released without explicit consent from the provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Procedures for confidentiality described in the policies included limited electronic and physical access based on job category and need for the information. Need for the information was related to completion of the credentialing/recredentialing process. Limited physical access included hard copy applications arriving in a locked mail room, and scanning documents directly from the mailroom. Electronic security included password protections based on job category. Other processes described included staff training and attestation/agreement to maintain confidentiality for staff members involved in the credentialing process. Staff reported that VO performs an annual review of staff electronic access based on job category to ensure appropriate access. Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	Documents Submitted/Location Within Documents: 1. N412 Provider Directory & Other Enrollee Information – Page 1, Section III Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy indicates that any information listed in the provider directory comes directly from the provider credentialing database. Information in the provider credentialing database may not be altered and is quality-checked by the credentialing specialist and/or the credentialing manager.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

VO's policies stated that provider directories are printed directly from the credentialing database. The policies also described the process to update the database as changes occur. On-site, staff members reported that provider directories for member eligibility mailings are printed monthly. Only the number of directories needed are printed to ensure that the most recent information is sent to new members. Staff members reported that the online searchable database has updated provider information within 48 hours of a change to the national provider database. Staff also reported that the .pdf copy of the provider directory placed on the NBHP Web site is updated monthly when the hard copy provider directories are printed for member mailings.

Required Actions:

None.

2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request. NCQA CR1—Element B1	Documents Submitted/Location Within Documents: 1. N207_Practitioner_Rights_and_Notification_Policy – Page 2, Section V, A Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N207 states that practitioners have the right to review information submitted to support their credentialing application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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Findings:

The VO Practitioner Rights and Notification policy described the process for providing information to applicants upon request. Staff members reported that applicants are provided the toll-free provider support number with application materials; therefore, requests are handled at the VO national office. If applicants call the Colorado VO service center, a warm transfer can be accomplished.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
2.N. The right of practitioners to correct erroneous information. NCQA CR1—Element B2	Documents Submitted/Location Within Documents: 1. N207_Practitioner_Rights_and _Notification_ Policy – Page 3, Section V.B. Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N207 states that practitioners have the right to correct erroneous information in their credentialing application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Rights and Notification policy addressed the applicant’s right to correct erroneous information.		
Required Actions: None.		
2.O. The right of practitioners, upon request, to receive the status of their application. NCQA CR1—Element B3	Documents Submitted/Location Within Documents: 1. N207_Practitioner_Rights_and _Notification_ Policy – Page 4, Section V.C Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N207 states that practitioners have the right to request information regarding the status of their credentialing application and be provided that information.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Rights and Notification stated that applicants may request and receive the status of their application either verbally or in writing.		
Required Actions: None.		
2.P. The right of applicants to receive notification of their rights under the credentialing program. NCQA CR1—Element B4	Documents Submitted/Location Within Documents: 1. N207_Practitioner_Rights_and _Notification_ Policy – Page 4, Section V.D Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N207 states that practitioners who have submitted a credentialing application are to be notified of their rights to review information in their credentialing application, correct erroneous information, and to request information about the status of their application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
Findings The policy stated that applicants are notified via a welcome packet, which describes how to obtain the provider manual online or in hard copy. The provider manual included applicant rights under the credentialing program. In addition, the Colorado standard provider application informed applicants of their rights under the credentialing program.		
Required Actions: None.		
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: - Collecting and reviewing Medicare and Medicaid sanctions. - Collecting and reviewing sanctions or limitations on licensure. - Collecting and reviewing complaints. - Collecting and reviewing information from identified adverse events. - Implementing appropriate interventions when it identified instances of poor quality related to the above.	Documents Submitted/Location Within Documents: - N710_Ongoing_Monitoring_of_Provider_Sanctions – Entire Policy - Sanction_Review_Log_2012 - N703_Involuntary_Suspension_Quality_of_Care – Entire Policy - Q314_Identification_and_Monitoring_of_Potential_Quality_of_Care_Issues_and_Tr ends – Pages 4-6 - Q317_Investigation_of_Adverse_Incidents – Pages 3-4 - NCC_Minutes_012412 – Sample - CLCC_Minutes_2012Aug_PR – Page 2; New Issues - CLCC_AdvisoryForum_2012AUG_PR – Entire Document Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. Monitoring of sanctions, complaint and adverse events occurs locally for the initial review and recommendations; these issues are then referred to the Local Credentialing Committee for review and on to ValueOptions’ National Credentialing Committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
NCQA CR9—Element A		
Findings: The VO Ongoing Monitoring of Provider Sanctions policy stated that required Web sites are searched 30 days after the regular release of sanction information on that Web site. On-site, NBHP/VO staff members provided examples of monthly database searches for sanctions to compare to the Colorado provider list. Staff members confirmed a monthly search of the federal database (OIG), National Practitioner Data Bank (NPDB), and DORA.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
2.R. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR10—Element A1	Documents Submitted/Location Within Documents: 1. N701_Practitioner_and_Provider_Compliance – Pages 2-4, Section V 2. N703_Involuntary_Suspension_Quality_of_Care – Pages 3-4, Section V, E and G 3. N705_Practitioner_Disenrollments – Entire Policy Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policies detail the actions available to manage network providers who do not meet minimum standards of quality. Policy N701 details the written warning, monitoring, and consultation process. Policies N703 and N705 detail the process for involuntary suspension and disenrollment from the provider network.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner and Provider Compliance policy described a wide range of possible actions against a practitioner for noncompliance or quality reasons, based on the type of compliance issue identified. Actions to be taken (as described in the Involuntary Suspension policy and the Practitioner Disenrollments policy) included training, increased monitoring, suspension, or disenrollment, as appropriate. On-site, staff members provided examples of actions taken for selected providers. Staff members reported that in the past, one Colorado provider was removed from the network due to loss of license.		
Required Actions: None.		
2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR10—Element A2 and B	Documents Submitted/Location Within Documents: 1. N703_Involuntary_Suspension_Quality_of_Care – Entire Policy 2. N705_Practitioner_Disenrollments – Page 4, Section V, B8 Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policies detail the actions available to manage network providers who do not meet minimum standards of quality. Included are policies that address procedures for taking action against providers and reporting those actions to the appropriate authorities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: VO's policies addressed reporting to NPDB and, as required, to State regulatory agencies. Staff members confirmed that decisions to report sanctions or terminations are made by the NCC, the agencies reported to are determined on a case-by-case basis, and DORA may be notified as appropriate.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
2.T. A well-defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner’s participation based on issues of quality of care or service which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner’s choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR10—Element A3and C	Documents Submitted/Location Within Documents: 1. N606_Provider_Appeal_Process – Entire policy 2. N607_Fair_Hearing_Process – Entire policy Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policies detail the process available to practitioners if they choose to formally appeal decisions of the ValueOptions®’ National Credentialing Committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
Findings: VO's policies described the appeal process for providers for whom VO has taken action, or changed the conditions of the provider participation based on issues of quality. Appeal processes included all the required processes.		
Required Actions: None.		
2.U. Making the appeal process known to practitioners. NCQA CR10—Element A4	Documents Submitted/Location Within Documents: 1. EQRO ProviderManual_2012Sept_PR –Folder; Page 37 & 38 *MISC 2. Disenrollment_Letter Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions process for informing practitioners of the appeal process is detailed in the Colorado Medicaid and National Provider Handbooks and in the Practitioner Agreement.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: VO's credentialing and recredentialing policies stated that applicants are notified of the appeal process in writing when notified of the adverse decision. NBHP provided an example of a disenrollment letter sent by VO, which informed the provider of how to appeal the decision. Providers were also informed via the provider manual of their right to appeal and to a fair hearing in cases of sanctions or disenrollment from the provider network. The provider manual was incorporated into the provider agreement by reference.		
Required Actions: None.		
3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A	Documents Submitted/Location Within Documents: 1. N601_Role_of_National_Credentialing_Committee – Entire Policy 2. N604_Role_of_Local_Credentialing_Committee – Entire Policy 3. NCC_Minutes_082112, Page 1 4. Minutes_CLCC_2012Aug10, Page 1 Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions uses a peer-review process via the Local Credentialing Committee and a National Credentialing Committee to make credentialing/recredentialing decisions. The committee's membership includes a range of participating providers from specific disciplines indicating a peer review process is used.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
Findings: VO policies described the roles of the LCC, which is the NBHP-level committee, and the NCC. The LCC roster and minutes demonstrated adequate local professional representation and use of the peer review process to make recommendations to the NCC.		
Required Actions: None.		
4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds. ◆ Medical director or equally qualified individual review and approval of clean files.	Documents Submitted/Location Within Documents: 1. NCC_Minutes_082112, Page 4 2. Minutes_CLCC_2012Aug10, Page 2 Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. Minutes from the National and Local Credentialing Committees reflect the review of provider credentials who do not meet minimum thresholds and that the medical director (or equally qualified designee) review/approve practitioner files.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
NCQA CR2—Element B		
Findings: LCC and NCC meeting minutes demonstrated review of credentials for selected practitioners and review and approval of practitioners recommended (by report) by the national medical director to the NCC for inclusion in the network. On-site, staff members clarified that the local credentialing committee is a single committee for the VO Colorado network, which includes three BHOs. Each BHO is represented on the committee by each BHO's medical director and selected providers and/or quality improvement staff.		
Required Actions: None.		
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes:	Documents Submitted/Location Within Documents: 1. N401_Primary_Source_Verification_Policy – Entire policy 2. N401A_Sample_Primary_Source_Verification_Report -Entire Report Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. The attached policies and checklist detail the verification process and elements reviewed during the credentialing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification [board certification time limit = 180 calendar days]). ◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days).		
NCQA CR3—Elements A and B		

Findings:

The VO Primary Source Verification policy described the processes to conduct timely primary source verification. NBHP provided a sample verification report used to track the process for individual practitioners and ensure that the information is verified within the required time frames. On-site review of credentialing records demonstrated that all primary source verification was completed within the required time frames.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil). ◆ The correctness and completeness of the application. NCQA CR4—Element A NCQA CR7—Element C C.R.S.—13-64-301-302	Documents Submitted/Location Within Documents: 1. N201_Practitioner_Credentialing _Process –Page 3, Section V E 2. N501_Practitioner_Recredentialing_Process – Page 3, Section V E 3. CO_Standard_Cred_Application Page 17, Section X, Page 19, Section A, Page 20 Section C, F and G, Page 21 Section 1, Page 25 Section 3, 4, Page 26 Section 1, 2, Page 40 pp1, Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. It is ValueOptions policy that any practitioner who applies for inclusion into the Colorado Medicaid provider network must complete an application that includes a current attestation that addresses the following issues: reasons for inability to perform essential functions, lack of illegal drug use, any loss of license, any felony convictions, any loss or limitation of privileges, proof of malpractice insurance, and to the correctness/completeness of their application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of credentialing and recredentialing records demonstrated that VO requires the Colorado standard credentials application. Each record contained the completed application. The application included the required content and required the applicant to attest to the accuracy and completeness of the information provided. VO used a VO supplement to the application that informed providers the amount required for malpractice/liability insurance. On-site review of credentialing and recredentialing records demonstrated that providers met or exceeded the requirements for malpractice insurance amounts.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. NCQA CR5—Element A NCQA CR7—Element D	Documents Submitted/Location Within Documents: 1. N401_Primary_Source_Verification_Policy – Entire Policy Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. Per ValueOptions policy N401 on the credentialing process, the credentialing committees receive information on provider sanctions prior to making a credentialing decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Primary Source Verification policy included the processes used to query for sanction activity using NCQA-compliant sources. Each of the credentialing and recredentialing records reviewed on-site contained evidence of query for sanction activities using the OIG, DORA, and/or the NPDB as applicable.		
Required Actions: None.		
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR6—Element A	Documents Submitted/Location Within Documents: 1. N406A_Practitioner_Site_Visit – Entire policy 2. Practitioner_Site_Visit_Tool-Entire Document 3. N406B_Facility_Organization_Site_Visit – Entire policy 4. Facility_Organization_Site_Visit_Tool - Entire Document 5. Site_Visit_Example1 Entire Document 6. Site_Visit_Example2 Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions has policies that detail minimum standards for office space and medical record documentation criteria. In addition, ValueOptions® has policies that explain how these standards are monitored via the site review process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
Findings: The VO Practitioner Site Visit policy stated that VO’s criterion for complaints that trigger a site visit (for individual practitioners) is two complaints within a six-month period. The Practitioner Site Visit Tool was thorough. During the on-site interview, staff members reported that there had been no individual practitioners in Colorado that met the criteria for requiring a site visit. Staff also reported that VO uses a national vendor for site visits, but if deemed appropriate, Colorado provider support staff could do a site visit when responding to complaints.		
Required Actions: None.		
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Monitoring member complaints for all practitioner sites at least every six months. ◆ Documenting follow-up visits for offices that had subsequent deficiencies.	Documents Submitted/Location Within Documents: 1. N406A_Practitioner_Site_Visit – Entire policy 2. Practitioner_Site_Visit_Complaint_Reports 3. NCC_Minutes_012412 – Sample Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policies state that required follow-up activities are triggered by the site review process or member complaints. These policies include corrective actions and the continued monitoring of member complaints. Complaints reports are run every six months and presented to the NCC. To date, there have been no practitioner sites that meet the criteria to require a Site Visit be conducted.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
NCQA CR6—Element B		
Findings: These required steps were adequately described in the VO policy. During the on-site interview, staff members stated that if noncompliance with standards (such as medical record requirements) are discovered through clinical quality audits, corrective actions are required, the first step usually being individualized training. Documentation of all training and subsequent interactions are maintained in the provider’s file and reviewed during the recredentialing process.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid DEA or CDS certificate (effective at the time of recredentialing). ◆ Board certification (verification time limit = 180 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR7—Elements A and B NCQA CR8— Element A	Documents Submitted/Location Within Documents: 1. N501_Practitioner_Recredentialing_Process – Entire Policy 2. N502_Facility_Program_Clinic_Recredentialing_Process – Entire Policy Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions formally recredentials its providers every 36 months. This process utilizes information verified from primary sources and is specifically detailed in policies N501 and N502.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The VO Practitioner Recredentialing Process policy described recredentialing independent practitioners at least every 36 months, using primary source verification and all required processes. On-site review of recredentialing records demonstrated that NCQA-approved primary sources were used. One provider in the record review was recredentialed at 39 months and one at 37 months instead of 36 months. The providers were non-responsive to initial requests for recredentialing information. The files included documentation of numerous attempts by VO to contact the provider, both in writing and verbally; and evidence of VO having worked with the provider until the required documentation was obtained. No required actions or recommendations are necessary related to this finding.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with State and federal regulatory bodies. NCQA CR11—Element A1	Documents Submitted/Location Within Documents: - N203_Facility_Provider_Credentialing_Process – Page 3, Section V. I - N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Page 1, Section III, Page 2, Section IV.A.1 Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. During the credentialing process, ValueOptions staff confirms that organizational providers are in good standing with state and federal regulatory bodies.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Facility Provider Credentialing Process policy described VO’s NCQA-compliant procedures for assessing organizational providers. On-site review of organizational provider records demonstrated that VO verified licensure and queried the OIG database to verify eligibility to participate in federal health care programs.		
Required Actions: None.		
11.B. The Contractor confirms that the provider has been reviewed and approved by an accrediting body. NCQA CR11—Element A2	Documents Submitted/Location Within Documents: N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Page 2 Section V. A 4 Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions credentialing criteria, as stated in policy N206, for organizational providers confirms whether the provider has been reviewed and approved by an accrediting body.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy described verification of whether the organizational provider has been reviewed and approved by an accrediting body. On-site review of records demonstrated that VO obtained verification of accreditation for accredited organizations. One of the organizational providers reviewed on-site was accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status. NCQA CR11—Element A3	Documents Submitted/Location Within Documents: 1. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Page 2, Section IV.4 2. N406B_Facility_Organization_Site_Visit – Entire policy 3. Site_Visit_Example1 - Entire Document 4. Site_Visit_Example2 – Entire Document Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. If during the credentialing criteria for organizational providers ValueOptions is unable to confirm whether the provider has been reviewed and approved by an accrediting body, then ValueOptions conducts an on-site assessment of the organization.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The policy described the procedure for on-site quality assessment for non-accredited organizational providers. NBHP provided two examples of completed site review forms. NBHP performed annual contract compliance site reviews for network CMHCs and included review of credentialing requirements in the annual site visits, therefore exceeding the requirement to perform site visits at the time of recredentialing. All non-accredited organizational provider records reviewed included a site visit.

Required Actions:

None.

11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status. NCQA CR11—Element A	Documents Submitted/Location Within Documents: 1. N502 Facility Program_Clinic Recredentialing Process – Entire Policy Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions credentialing criteria for organizational providers confirms whether the provider has been reviewed and approved by an accrediting body and confirms that the organization continues to be in good standing with state and federal regulatory bodies at minimum every 3 years. If ValueOptions is unable to confirm whether the provider has been reviewed and approved by an accrediting body, then ValueOptions conducts an on-site assessment of the organization.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
Findings: The VO Facility/Program//Clinic Recredentialing Process policy required reassessment of organizational providers at least every 3 years. One organizational provider reviewed on-site was re-assessed one month late. The record contained adequate documentation of numerous contacts by VO/NBHP with the facility beginning six months prior to the 36-month due date. The provider was non-responsive to initial requests for information. No required actions or recommendations are necessary related to this finding.		
Required Actions: None.		
11.E. The Contractor’s policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.)	Documents Submitted/Location Within Documents: 1. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Page 2, Section V A 4 Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions accepts accreditation as per the ValueOptions policy. If ValueOptions is unable to confirm whether the provider has been reviewed and approved by an accrediting body, then ValueOptions conducts an on-site assessment of the organization.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
NCQA CR11—Element A		
Findings: The VO Credentialing Criteria for Facility/Organizational Providers policy listed acceptable accrediting organizations as NCQA, The Joint Commission (TJC), CARF, Council on Accreditation (COA), American Osteopathic Association (AOA), Healthcare Facilities Accreditation Program (HFAP), Accreditation Association for Ambulatory Health Care (AAAHC), Det Norske Veritas (DNV), or Community Health Accreditation Program (CHAP). One of the organizational providers reviewed on-site was accredited by CARF.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts. NCQA CR11—Element A	Documents Submitted/Location Within Documents: - N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Pages 3-14, Section V. C. - N406B_Facility_Organization_Site_Visit – Page 2, Section V B Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions credentialing criteria for organizational providers confirms whether the provider has been reviewed and approved by an accrediting body and confirms that the organization continues to be in good standing with state and federal regulatory bodies. If ValueOptions is unable to confirm whether the provider has been reviewed and approved by an accrediting body, then ValueOptions® conducts an on-site assessment of the organization.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing Criteria for Facility/Organizational Providers policy described the criteria for each type of organization to be included in the network.		
Required Actions: None.		
13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners. NCQA CR11—Element A	Documents Submitted/Location Within Documents: - N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Entire policy - Facility_Organization_Site_Visit_Tool – Page 2 Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. The ValueOptions organizational site review process includes a review of provider credentials for its practitioners. This information is detailed in policy N206 and in ValueOptions Facility Environmental Site Review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: VO's policy and site visit tool included processes to ensure that organizational providers credential their individual practitioners. Completed site review tools were reviewed in organizational provider files.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization’s standard.	Documents Submitted/Location Within Documents: 1. N406B_Facility_Organization_Site_Visit – Page 2, Section V A and Page 4, Section V M 2. Site_Visit_Example1 – Entire Document 3. Site_Visit_Example2 – Entire Document Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. If a provider indicates a state level or CMS review is completed, ValueOptions reviews the site visit to ensure criteria is met and the organization passed inspection.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
NCQA CR11—Element A		
Findings: The VO Credentialing Criteria for Facility/Organizational Providers policy indicated that a CMS or State certification could substitute for a site visit for non-accredited organizations. While VO obtained and reviewed Department of Behavioral Health (DBH) site reviews conducted at the CMHCs, and addressed any issues therein, VO also performed its own annual site reviews for network CMHCs.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
15. The Contractor’s organizational provider assessment policies and process includes assessment of at least: ◆ Inpatient facilities. ◆ Residential facilities. ◆ Ambulatory facilities. NCQA CR11—Element B	Documents Submitted/Location Within Documents: 1. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Entire policy Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions. The ValueOptions organizational site review policies and process include a review of the following facilities: inpatient, residential, and ambulatory. This information is detailed in policy N206.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Credentialing Criteria for Facility/Organization Providers policy included criteria and processes for inpatient, outpatient/ambulatory, and residential facilities. Review of records on-site demonstrated that VO/NBHP contracted with each of these types of facilities.		
Required Actions: None.		
16. The Contractor has documentation that it has assessed contracted behavioral health care (organizational) providers. NCQA CR11—Element C	Documents Submitted/Location Within Documents: 1. N206_Credentialing_Criteria_for_Facility_Organizational_Providers-Entire Policy Description of Process: ValueOptions assesses all providers initially and again within 36 months of the prior credentialing date. All information obtained from these assessments, including application information, verifications, credentialing decisions and correspondence, is entered into our proprietary credentialing software application and electronic file cabinet, NetworkConnect.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of organizational provider records demonstrated adequate record keeping of organizational provider assessments.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
17. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR12	Documents Submitted/Location Within Documents: 1. DelegationAgree2011_NBHP-pages 2,4, 14 *Misc 2. CAP_DelegationCAP_BHO_2011Oct03_COM-Entire Document 3. 3BHOCAPforCODeskAuditToolforVODElegationAgtFinalReport 100212. -Entire Document 4. ProvideForum_Presentation_BHO_2012APR_PR Policies_NBHP-Entire Document *Misc Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions refer to ProviderPolicies_NBHP-Entire Document In addition, the BHO has a delegation agreement and Delegation Oversight policy and procedures that outlines the requirements of the NCQA CR 12 standards as follows: • Retains the right to approve, suspend, and terminate individual practitioners, providers, and sites. Refer to DelegationAgree2011_NBHP-page 2 • Audits credentialing files annually against NCQA standards. Refer to DelegationAgree2011_NBHP-page 14 • Performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. Refer to Delegation Oversight (page 2, Section 3.01) • Evaluates regular reports. Refer to Delegation Oversight (page 2, Section 3.01)and Delegation Agreement (pages 14 and 15, Provider Credentialing and Recredentialing Section) • The organization identifies and follows up on opportunities for improvement, if applicable. Refer to DelegationAgree2011_NBHP-page 4.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

Although VO is a partner in NBHP, NBHP had a delegation agreement between the partnership and VO to document the relationship and activities performed by VO on behalf of the partnership, and to formalize the oversight structure. Oversight was accomplished by regular reporting and an annual delegation audit performed by an external contractor. Staff reported that monthly and quarterly reports were regularly reviewed by the NBHP CEO and that annual audit results were reviewed by the NBHP board of directors. Review of board meeting minutes on-site confirmed board review of annual audit results.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
18. The Contractor has a written delegation document with the delegate that: ♦ Is mutually agreed upon. ♦ Describes the responsibilities of the Contractor and the delegated entity. ♦ Describes the delegated activities. ♦ Requires at least semiannual reporting by the delegated entity to the Contractor. ♦ Describes the process by which the Contractor evaluates the delegated entity's performance. ♦ Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill its obligations.	Documents Submitted/Location Within Documents: 1. DelegationAgree2011_NBHP-Entire Document *Misc Description of Process: Attached are the delegation agreements for NBHP with an Amendment which describes the elements listed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
NCQA CR12—Element A		
Findings: The delegation agreement described delegated activities and responsibilities for both parties, reporting requirements, and specified how NBHP will monitor VO's performance of the credentialing program. The agreement also provided for remedies if VO's performance is not adequate. The fully executed agreement signed by both parties was reviewed on-site.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
19. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR12—Element B	Documents Submitted/Location Within Documents: 1. Final NBHP Management Services Agreement_NBHP_2011September01_COM 2. ProviderPolicies_NBHP-Entire Document Description of Process: The BHO delegates credentialing and recredentialing to ValueOptions refer to NBHPPProviderPolicies. In addition, the BHO has a Management Services Agreement that outlines the requirements of the NCQA CR 12, element B.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The Business Associate Agreement, Exhibit C to the Management Services Agreement between NBHP and VO, was HIPAA-compliant and included the requirements for safeguarding PHI. During the on-site interview, staff members confirmed that VO's credentialing process did not use member-level data (complaint information used for recredentialing is in aggregate). Staff described HIPAA-compliant security processes to ensure the confidentiality of all materials obtained during credentialing and recredentialing processes.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
20. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement.	Documents Submitted/Location Within Documents: 1. DelegationAgree2011_NBHP *Misc Description of Process: Attached are the BHO Delegation Agreements that the contractor retains the right to approve suspend or terminate individual practitioners, providers and sites where it has delegation decision making.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
NCQA CR12—Element C		

Findings:

Although the partnership (NBHP) included VO as a member of the partnership, there was a delegation agreement between the partnership and VO (as required by the Department). The delegation agreement did not include a provision that NBHP retains the right to approve, suspend, and terminate individual practitioners and providers. This provision was present in the delegation agreement submitted for the 2010 EQRO site visit, but it had been removed from the most recently signed agreement. In practice NBHP's mechanism to exercise the right to approve, suspend, and terminate individual practitioners and providers is accomplished through the VO local credentialing committee (LCC), which included the NBHP medical director and local practitioners. The LCC may make recommendations to the VO NCC regarding credentialing, recredentialing, or actions related to quality of care.

Required Actions:

NBHP must either revise the delegation agreement or use an addendum to include the required provision that NBHP retains the right to approve, suspend, and terminate individual practitioners and providers.

21. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed.	N/A	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
NCQA CR12—Element D		

Findings:

Not Applicable.

Required Actions:

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
22. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR12—Element E	Documents Submitted/Location Within Documents: 1. DelegationAgree2011_NBHP-Entire Policy *Misc 2. CAP-DelegationCAP_BHO_2011OCT03.COM- Entire Document -page 15 3. 3BHOCAPforCODeskAuditToolforVODElegationAgtFinalReport 100212. - Entire Document Description of Process: The BHO conducted a delegation audit in 2011 and 2012. Tools and CAPs are attached for review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: NBHP provided annual audit reports (2011 and 2012) completed by an independent contractor on behalf of NBHP and two other Colorado BHOs in partnership with VO. The audit evaluated all activities delegated to VO, including credentialing and recredentialing. The audit process included a file audit for compliance with NCQA standards.		
Required Actions: None.		
23. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR12—Element F	Documents Submitted/Location Within Documents: 1. DelegationAgree2011_NBHP-Entire Policy *Misc 2. CO DeskaudittoolforVO Delegation Agt Final FY2012-Entire Document 3. DELEGATION REVIEW SUMMARY-Entire Document 4. CAP_DelegationCAP_BHO_2011OCT03_COM-Entire Document Description of Process: Delegation Audit was conducted in 2011 With audit results in the Delegation Review Summary and the required CAP in the CAP_DelegationCAP_BHO_2011OCT03_COM documents. The revised 2012 Desk top audit tool is attached called CO Deskaudittoolfor VO Delegaiton Agt. Final FY2012	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: NBHP provided annual audit reports (2011 and 2012) completed by an independent contractor on behalf of NBHP and two other Colorado BHOs in partnership with VO. The audit evaluated all activities delegated to VO, including credentialing and recredentialing. The audit process included a review of policies and procedures and review for compliance with NCQA standards.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
24. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR12—Element G	Documents Submitted/Location Within Documents: 1. COPR_ActivityLog_BHO Report_2012_PR-Entire Document 2. CO QRTLY CRED REPORT_VOCO_2012July03_PR-Entire Document 3. CO QRTLY CRED REPORT_VOCO_2012APR06_PR-Entire Document Description of Process: All reports are submitted as specified in the deliverables to each BHO as evidenced by emails to the BHO.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: NBHP provided examples of quarterly credentialing reports received from VO. On-site, staff reported that the local director of provider network relations and the NBHP board of directors reviewed reports, as needed.		
Required Actions: None.		
25. The Contractor identifies and follows up on opportunities for improvement, if applicable. NCQA CR12—Element H	Documents Submitted/Location Within Documents: 1. DelegationAgree2011_NBHP-Entire Policy *Misc 2. CAP-DelegationCAP_BHO_2011OCT03.COM-Entire Document 3. 3BHOCAPforCODeskAuditToolforVODElegationAgtFinalReport 100212. -Entire Document Description of Process: The organization identifies and follows up on opportunities for improvement. Refer to Delegation Agreement (page3, Article V – Corrective Action). Also refer to Delegation CAP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Both the Management Services Agreement and the Delegation Agreement between NBHP and VO included the provision to require corrective action for inadequate performance of the delegated activities. NBHP provided evidence of having required corrective actions and following up until corrected.		
Required Actions: None.		



Appendix A. **Colorado Department of Health Care Policy and Financing**
FY 2012–2013 Compliance Monitoring Tool
for **Northeast Behavioral Health Partnership, LLC**

Results for Standard VIII—Credentialing and Recredentialing									
Total	Met	=	<u>46</u>	X	1.00	=	<u>46</u>		
	Partially Met	=	<u>1</u>	X	.00	=	<u>0</u>		
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Applicable	=	<u>2</u>	X	NA	=	<u>NA</u>		
Total Applicable		=	<u>47</u>	Total Score	=	<u>46</u>			

Total Score ÷ Total Applicable				=	<u>98%</u>				
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Standard X—Quality Assessment and Performance Improvement		
Requirement	Evidence as Submitted by the BHO	Score
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. 42CFR438.240(a) Contract: II.H.1	Documents Submitted/Location Within Documents 1. DelegationPolicyandProcedures_NBHP – Pages 16-17 2. ProgramDescriptionFY13_NBHP – Entire Document Description of Process: NBHP delegates all quality management functions to ValueOptions (refer to DelegationPolicyandProcedures_NBHP – Pages 16-17). ValueOptions, along with the NBHP Quality Improvement Utilization Management Committee (QIUMC) develops an annual program description/plan that details the planned quality improvement activities for the fiscal year. The annual plan is reviewed by the QIUM committee and approved by the NBHP Board of Managers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: NBHP staff stated that quality management (QM) activities are delegated to its partner organization, VO. The QM Delegation policy outlined NBHP’s responsibilities for oversight of the delegated QM processes including verification that the QM program incorporated practice guidelines, performance improvement projects, performance measurement, member satisfaction, monitoring of over- and underutilization, and resolution of identified quality of care concerns. The 2012–2013 Quality Improvement and Utilization Management Program Description and Annual Plan (program description) outlined a comprehensive program for monitoring and evaluating quality. The program description stated that structure, processes, and outcomes are evaluated continuously, opportunities for improvement are identified, and interventions and/or performance improvement projects are implemented. The program description outlined the various components of the program in detail.		
Required Actions: None.		
2. The Contractor’s QAPI Program includes mechanisms to detect both underutilization and overutilization of services. 42CFR438.240(b)(3) Contract: II.H.2.n	Documents Submitted/Location Within Documents. 1. UnderutilizationComparisonReportFY11Q4 to FY12Q2_NBHP-Entire Document 2. ECMReportFY11_NBHP– Entire Report 3. WorkPlanFY13_NBHP-Page 2 4. PerformanceMeasuresFY12Q3_NBHP-Entire Document 5. Top20UtilizersFY12Q3_NBHP-Entire Document 6. ProgramDescriptionFY13_NBHP-Pages 8, 13, 15, 31-33 Description of Process: NBHP ensures mechanisms are in place to detect and evaluate both over and underutilization. These mechanisms include the NBHP underutilization measure reviewed quarterly, the enhanced clinical management (ECM) report, the top 20 utilizers report and a quarterly review of performance measures including information on ER usage, average length of stay, and discharges	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	per 1000. The attached NBHP work plan includes the review of utilization measures and over and underutilization efforts are described in the NBHP QI Program Description attached. Pages 8, 13, 15, and 31-33 contain specific references to utilization measures.	
Findings: The quality improvement (QI) program description stated that the NBHP Quality Improvement/Utilization Management (QI/UM) Committee reviews UM issues and indicators, including under- and overutilization. The scope of the program included clinical utilization management and review of provider clinical records for over- and underutilization. The program description stated that data are analyzed to identify utilization patterns and contributing factors, and appropriate intervention is implemented. Several examples of utilization tracking reports were provided. The annual QI/UM Work Plan defined review and reporting requirements for the UM reports described above.		
Required Actions: None.		
3. The Contractor’s QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to all members. 42CFR438.240(b)(4) Contract: II.H.2.m.6	Documents Submitted/Location Within Documents. 1. ProgramDescriptionFY13_NBHP – Entire Document 2. AnnualEvaluationFY13_NBHP – Entire Document 3. 403PractitionerMedRecordReviewAnalysisandReportingPolicy_VOCO – Pages 1-2, Section III.A 4. 309QualityofCareIssuesOutlierPracticePatternsPolicy_VOCO – Entire Policy 5. 308CriticalAdverseIncidents_Policy_VOCO – Entire Policy Description of Process: NBHP uses several mechanisms to assess the quality and appropriateness of care provided to all members. These mechanisms include clinical treatment record audits, adverse incident and quality of care evaluation and investigations, as well as the clinical care management review processes used to authorize care for members. The NBHP QM/UM Program Description, along with the policies listed above; provide information regarding the mechanisms used to assess quality and appropriateness of care for members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The QM/UM Program Description stated that the purpose of the QM/UM program, which includes the NBHP Work Plans and meetings of the QI/UM Committee, is to evaluate quality and appropriateness of care, pursue opportunities to improve patient care, and resolve problems. The program description also stated that the care management program monitors members who are identified as having care patterns that require monitoring of appropriate use of services, levels of care, and community supports. Care management staff provides comprehensive reviews of care and refers cases that appear to be outside best practice guidelines for specialized review. The program description described the processes for monitoring quality and appropriateness of care including		

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Requirement	Evidence as Submitted by the BHO	Score
clinical utilization management, quality indicators and QI projects, provider credentialing, satisfaction surveys, treatment record review, assessment of access to care and grievances, and clinical guidelines. Several policies outlined the processes by which quality and appropriateness are monitored and addressed, and included review of adverse events, practitioner medical records, and quality of care concerns. The QM/UM annual evaluation report provided an analysis of the monitoring results within each of these focus areas.		
Required Actions: None.		
4. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual quality report describes: ◆ The Contractor’s performance on the standard measures on which it is required to report. ◆ The results of each performance improvement project. ◆ The techniques used by the Contractor to improve its performance, effectiveness, and quality outcomes. ◆ Qualitative and quantitative impact the techniques had on quality. ◆ The overall impact and effectiveness of the quality assessment and improvement program. ◆ How past quality assessment and performance improvement activities will be used to target improvement for the next year. ◆ A description and organizational chart for each quality committee. <i>42CFR438.240(e)(2)</i> Contract: II.H.2.s.1 Exhibit R3	Documents Submitted/Location Within Documents: 1) AnnualEvaluationFY13_NBHP – In annual evaluation bullet points 1-7 are located on the following pages: Bullet Point 1: Entire Document; <u>an example can be found on pages 5-12</u> Bullet Point 2: Pages 21-23 Bullet Point 3: Pages 6-7, 10-11, 14 Bullet Point 4: Entire Document; <u>an example can be found on page 7</u> Bullet Point 5: Pages 34-37 Bullet Point 6: Pages 11, 14, 15, 22 Bullet Point 7: Pages 38-41 2) ProgramDescriptionFY13_NBHP-Pages 8, 37 3) ManagersMinutes2012Sept7_NBHP – Page 3, Section Quality Improvement Report 4) QMUMCommitteeMinutes2011Oct11_NBHP – Page 2, New Business, QIUM Program Evaluation Description of Process: NBHP conducts an annual evaluation of the Quality Management Program that includes evaluating the effectiveness and impact of the program. Results of the evaluation are documented in the annual report and reviewed by the QIUM committee and the NBHP Board of Managers. The 2012 NBHP Annual QIUM Evaluation (AnnualEvaluationFY13_NBHP) displays highlights and comments that correspond to each bulleted item.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Findings: The QM/UM annual evaluation report included a committee structure organizational chart and description of each quality committee as well as a discussion of the results of various performance improvement initiatives. This annual report addressed all of the required elements; however, HSAG recommended that the documentation of continued quality of care concerns and recommendations for the subsequent year's QI Work Plan be more clearly identified in the annual QI Evaluation report to clarify ongoing areas for improvement from one year to another. The overall effectiveness of the QM/UM programs was summarized and performance on individual work plan goals were addressed, including recommendations for continuing or adding goals for the succeeding year. The program description stated that the QI/UM Committee and the NBHP Board of Managers annually reviews and approves the QI/UM Program Description and annual evaluation report. During on-site interviews, staff stated that the Members Committee (subcommittee of QI/UM Committee) and the CMHCs routinely review the ongoing measures of performance and contribute feedback to the QI/UM Committee. QI/UM Committee minutes confirmed that the annual evaluation report and the annual QI Work Plan were presented to the committee for approval. QI minutes included evidence of quarterly review of the dashboard reports, presentation and discussion of ongoing performance measures, access and availability measures, and performance improvement project updates; however, the minutes did not include any discussion of the findings or any conclusions or recommendations. HSAG recommends that NBHP enhance documentation in the QI/UM Committee minutes to include more substantive discussion of conclusions and recommendations based on the reports and data submitted for review.		
Required Actions: None.		
5. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting health care professionals. ◆ Are reviewed and updated periodically as appropriate. <i>42CFR438.236(b)</i> Contract: II.H.2.h	Documents Submitted/Location Within Documents: 1. 105LDevelopingandUpdatingTreatmentGuidelinesPolicy_VOCO—Entire policy Description of Process: As described in the attached policy, Clinical guidelines are based on valid and reliable clinical evidence and consider the needs of members. They are adopted after review by the NBHP QIUM committee consisting of behavioral and physical healthcare professionals. VO Colorado Partnerships reviews and updates treatment guidelines every two years, or as necessary to reflect current knowledge about best treatment practices.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Findings: The VO-CO Developing and Updating Treatment Guidelines policy described the role of the Clinical Advisory/Utilization Management Committee (CAUMC) in the development of treatment, diagnosis, and program-based guidelines using information gathered from existing standards, scientific literature, or current principles and processes. The policy stated that locally developed guidelines are developed and adopted with the involvement of appropriate medical and clinical specialists who have expertise in the area they are reviewing. The committee edits and updates existing guidelines at least every two years. The VO Developing and Updating Treatment Guidelines policy stated that VO determines which guidelines to establish or adopt based on analyses of characteristics of the covered population. During the on-site review, HSAG noted that some components of the requirements were found in the corporate policy. When supplemented with the VO-CO policy, all required elements were present; however, neither policy contained all of the requirements. HSAG suggested that the VO-CO Developing and Updating Treatment Guidelines policy incorporate all of the required elements from the VO corporate policy (of the same name) to ensure that the local policy includes all required elements.		
Required Actions: None.		
6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost. <i>42CFR438.236(c)</i> Contract: II.H.2.h.2	Documents Submitted/Location Within Documents: 307LMemberInfoReq_Policy_VOCO - Page 2, *MISC - Section III.E and Page 6, Section V.F.3 *MISC http://www.nbhpartnership.com/providers/prv_information.htm - ClinicalGuidelinesEmailBlast2012_3BHO-Entire Document 236LDistributionofClinicalLevelofCareGuidelinesPolicy_VOCO- - Entire Document - EQROProviderManual_2012Sept_PR – Page 28, Clinical Guidelines *MISC - PracticeGuidelinesPolicy_NBHP-Page 2, Last Paragraph - MemberHandbook_NBHP-page 9 *MISC - ProviderForum_Presentation_BHO_2012APR_PR-Pages 24-36 *MISC Description of Process: Distribution of practice guidelines occurs via the provider manual and other publications (email blasts) as well as through trainings and provider forums as referenced in the attached Distribution of Clinical Level of Care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	Guidelines Policy. Additionally, NBHP has a Practice Guidelines Policy that specifically references disseminating information to providers and members. The distribution of these materials such as member information, handbooks, enrollment notices, provider listings etc. is outlined in the attached Member Information Requirements Policy. Guidelines are available at no cost on the NBHP website referenced in item 2 above.	
Findings: The VO-CO Developing and Updating Treatment Guidelines policy stated that new and revised treatment guidelines are routinely distributed to NBHP providers via the provider manual, at provider forums, at individual training sessions, and are available in hard copy or on the BHO Web site. The Distribution of Clinical Level of Care Guidelines policy detailed VO's responsibilities and procedures for distribution of clinical guidelines. NBHP presented evidence of distribution of guidelines through the Web site, provider manual, provider forums, and e-mail blasts to providers. Staff stated that members and the public have access to guidelines at no cost through the BHO Web site.		
Required Actions: None.		
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. 42CFR438.236(d) Contract: II.H.2.h.3	Documents Submitted/Location Within Documents: - C107 Developing and Updating Treatment Guidelines-page 3, number 3 - DelegationPolicyandProcedures_NBHP – Pages 16-17 Description of Process: “C107 Developing and Updating Treatment Guidelines” notes that relevant utilization management criteria, member education materials, benefit interpretations and practitioner communications are considered by VO when guidelines are developed to help foster consistency to these areas affected by the guidelines. DelegationPolicyandProcedures_NBHP delegates all quality management functions to ValueOptions®. Guidelines are reviewed across the three Colorado BHOs that ValueOptions® contracts with to assure consistency and gain consensus across the guidelines. Guidelines are reviewed across the three Colorado BHO's that ValueOptions® contracts with to assure consistency and gain consensus across the guidelines; this includes ensuring the areas to which the guidelines apply (utilization management	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	decisions, member education, coverage of services, etc.) are consistent with the guidelines, as specified in Policy C107, and in the NBHP Delegation Policy delineating that ValueOptions must comply with Medicaid contract requirements.	
Findings: The VO Developing and Updating Treatment Guidelines policy stated that the Executive Medical Management Committee reviews relevant UM criteria, member education materials, benefit interpretations, and practitioner communications to ensure consistency with clinical guidelines. During the on-site review, staff stated that the NBHP Clinical Guidelines Committee (subcommittee of the QI/UM Committee) reviews all practice guidelines, that any changes to guidelines are communicated to both members and providers, and that CMHC clinical directors inform providers of any changes in clinical guidelines. Staff stated that consistency of operational processes and decisions with practice guidelines is achieved through this informal process rather than a formally defined mechanism.		
Required Actions: None.		
8. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. Contract: II.H.2.q.2	Documents Submitted/Location Within Documents: 1) ITDelegationPolicy_NBHP-Entire Document 2) HealthInfoSystemFlow_3BHO-Entire Document Description of Process: NBHP delegates the information technology and health information systems processing to ValueOptions® (please refer ITDelegationPolicy_NBHP). ValueOptions® health information systems captures data including, but not limited to: authorizations, claims, eligibility, provider networks, and encounters. This information is synchronized with a Data Warehouse, a machine optimized for reporting and analysis. This information is also used to generate data extracts and create reports to support the BHO's operations.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The overview of the VO-CO Health Information System stated that the health information system collects and integrates eligibility, encounter, claims, care management, and Colorado Client Assessment Record (CCAR) data for users to analyze, evaluate, and produce reports. The NBHP Health Information System Delegation policy stated that NBHP delegates responsibility for the health information system operations to VO, which must have the ability to collect, analyze, integrate, and report data.		
Required Actions: None.		

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9. The Contractor’s health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. <i>42CFR438.242(a)</i> Contract: IL.H.2.q.2	Documents Submitted/Location Within Documents: - UtilizationPaidClaimsAnalysis201112_NBHP-Entrie Document - GrievanceAndAppeals_3BHO-Entrie Document - GrievanceSummaryReport_3BHO-Entrie Document - CombinedDataReportCardJune2012_3BHO-Entrie Document Description of Process: The ValueOptions® health information system is structured to provide data for reporting utilization (see UtilizationPaidClaimsAnalysis201112_NBHP.), grievance, and appeal data (see GrievanceandAppeals_3BHO and GrievanceSummaryReport_3BHO). The ValueOptions® information system has the ability to check the place of service for encounters submitted – for certain locations such as jails or correctional facilities for adults, ValueOptions® is able to identify temporary loss of Medicaid eligibility and prevent those encounters from being submitted to the State (see the following errors in the CombinedDataReportCardJune2012_3BHO, Error Summary Tab): 50: Adult in correctional facility is NOT eligible for Medicaid services. 57: Place of service not consistent with USCM procedure specification. Information on dis-enrollments for other than loss of Medicaid eligibility is provided by HCPF, such as the date of death report. Please note that the “Date of Death” reports are large in size and contain PHI – they are available upon request, but not submitted as evidence.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The NBHP Health Information System Delegation policy stated that the health information system (HIS) collects member–specific demographic data and produces information on utilization and member grievances and appeals. The QA/UM Program Description stated that NBHP uses the CareConnect system for care management and claims data and described numerous data sources used for quality improvement measurement, including claims/encounter data, authorization data, clinical treatment records, member demographic information, satisfaction surveys, and complaints and grievances. Staff stated that grievance information is maintained in a separate MS Access database and submitted examples of the online entry forms for recording and tracking grievances. NBHP also submitted automated reports of dollars used within various levels of service, and encounters held for resolution of member eligibility determination. Staff stated that data regarding disenrollments for any reason other than eligibility (e.g., deaths) are received from the Department.		

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During the on-site review, staff described some uses of HIS reports for QI/UM purposes as follows: (1) a “summit” of NBHP clinical and finance personnel was organized to review the various types of data available through the HIS and stimulated discussion of the use of the data for QI/UM purposes; and (2) VO staff meet separately with each CMHC monthly to perform in-depth analysis of specific reports, such as the member high-utilizer report, to determine any follow-up actions to intervene in preventing hospitalizations. Staff stated that NBHP uses the “best practices” approach to solve problems and shares successful intervention methods with other CMHCs.		
Required Actions: None.		
10. The Contractor collects data on member and provider characteristics and on services furnished to members. <i>42CFR438.242(b)(1)</i> Contract: None.	Documents Submitted/Location Within Documents: 1. AuthorizationsDataDictionary_3BHO-Entrie Document 2. ClaimsDataDictionary_3BHO-Entrie Document 3. MembersDataDictionary_3BHO-Entrie Document 4. ProvidersDataDictionary_3BHO-Entrie Document 5. VendorsDataDictionary_3BHO-Entrie Document 6. VOFlatFileLayout20120823_3BHO-Entrie Document 7. PHPGuideForManagedCarePlans_3BHO -Entire Policy 8. UniformServiceCodingManual20120501_3BHO -Entire Policy 9. FY2012CoreSystemTableRecordCounts_NBHP-Entrie Document Description of Process: ValueOptions maintains an extensive collection of data which includes member and provider characteristics and services rendered to members. The following ValueOptions® data dictionaries give insight into the extent of the characteristics stored/capable of being stored in our systems: • Data Dictionary to Authorizations (found in evidence file called AuthorizationsDataDictionary_3BHO.) • Data Dictionary to Claims (found in evidence file called ClaimsDataDictionary_3BHO). • Data Dictionary to Members (found in evidence file called MembersDataDictionary_3BHO). • Data Dictionary to Providers (found in evidence file called ProvidersDataDictionary_3BHO). • Data Dictionary to Vendors (found in evidence file called	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	VendorsDataDictionary_3BHO). • Data Dictionary to VO Flat File Specification (found in evidence file called VOFlatFileLayout20120823_3BHO). • State of Colorado’s PHP Interface File Layout (found in evidence file called PHPGuideForManagedCarePlans_3BHO -Entire Policy). • Uniform Service Coding Manual (USCM) Document (found in evidence file called UniformServiceCodingManual20120501_3BHO -Entire Policy). To demonstrate the robustness of the data currently being stored, the FY2012CoreSystemTableRecordCounts_NBHP document is provided, which shows the number of records loaded, by table, for the FY2012 time period. The SQL logic used to produce the record counts is provided within the same document, under a different tab.	
Findings: The QA/UM Program Description stated that NBHP uses the CareConnect system for care management and claims data. The health information system data sources used to support quality management included claims, encounter data, authorization data, clinical treatment records, member demographic information, adverse incidents, satisfaction surveys, complaints and grievances, provider data, and Colorado Client Assessment Record (CCAR) data. The Providers Data Dictionary provided evidence of information collected on provider characteristics (e.g., age, gender, specialty, hospital affiliation) and the Member Data Dictionary provided evidence of information collected on member characteristics (e.g., age, gender, marital status, address, insurance information). The Authorization Data Dictionary and Claims Data Dictionary included information on member services, including diagnoses, dates of service, service codes, and authorization information.		
Required Actions: None.		

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Requirement	Evidence as Submitted by the BHO	Score
11. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member surveys. ◆ Anecdotal information. ◆ Grievance and appeals data. Contract: IL.H.2.m.1	Documents Submitted/Location Within Documents: 1. MHSIP.YSSFReport2011_2BHO – Slides 7, 9, 11, 20, 24, 26 2. FactFindersCY2011_NBHP – Graphs 1, 2, 5, 6, 8, 10, 12, 13, 15 3. GrievanceAndAppealsAnalysisQ1FY12_NBHP – Entire Document 4. GrievanceAndAppealsAnalysisQ2FY12_NBHP – Entire Document 5. GrievanceAndAppealsAnalysisQ3FY12_NBHP – Entire Document 6. GrievanceAndAppealsAnalysisQ4FY12_NBHP – Entire Document 7. ComplaintsAndGrievanceReportFY12_NBHP – Entire Document 8. ComplimentComplaintandAppealSummary_NBHP – Entire Document 9. MembersMeetingAgenda2012May8_NBHP – Page 1, New Business, Grievance Report Description of Process: NBHP monitors member perceptions of accessibility and adequacy of services provided through the MHSIP, YSSF, and Fact Finders Survey tools. Results from these surveys are monitored bi-annually by the NBHP QIUM committee and the NBHP Board of Managers. Additionally NBHP monitors grievances and appeals by type and days to resolution in the Complaints and Grievance Report FY12 and the Compliment, Complaint, and Appeal Summary presented quarterly at QIUM committee meetings. Anecdotal evidence is demonstrated in the Grievance and Appeals Analysis Reports.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The QI program description stated that quality indicators include routine, urgent, and emergent access times and that the Quality of Care Committee (QOCC) (subcommittee of the QI/UM Committee) reviews provider access issues. The quarterly Grievance and Appeals Analysis summarized reasons for member grievances related to access and appointment availability, including how the grievances were resolved. The quarterly Complaints and Grievance Report and annual summary tracked the statistics related to each category of grievances, including access and availability. NBHP submitted evidence of member survey results regarding access and availability of care. The QA/UM annual evaluation reported the results of assessments related to access to care standards and results of member satisfaction surveys, which included access to care measures. During the on-site interview, staff stated that the Member’s Committee, the Access and Continuity of Care Committee, and the QI/UM Committee review access performance indicators quarterly. In addition, member grievances are reviewed individually to identify any common contributing factors. Required Actions: None.		

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Requirement	Evidence as Submitted by the BHO	Score
12. The Contractor monitors member perceptions of well-being and functional status as well as accessibility and adequacy of services provided by the Contractor by reviewing the results of the statewide Mental Health Statistics Improvement Program (MHSIP), the Youth Services Surveys (YSS), and the Youth Services Surveys for Families (YSS-F). Contract: II.H.2.m.2	Documents Submitted/Location Within Documents: All of the below referenced documents are located in the Evidence folder for Standard X, unless otherwise noted: 1) MHSIP.YSSFReport2011_2BHO – Entire Document 2) QIUMCommitteeMinutes2012June12_NBHP – Page 2, New Business, Item 2 Description of Process: NBHP monitors perceptions of well-being and functional status as well as accessibility and adequacy of services through bi-annual review of the MHSIP and the YSS-F by the NBHP QIUM committee. These reports are reviewed for trends within the BHO as well as comparisons across BHO's.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Mental Health Statistics Improvement Program (MHSIP) and the Youth Services Survey for Families (YSS-F) PowerPoint presented the results of the 2011 surveys for each CMHC population and compared trends in responses over three years. The QI/UM annual evaluation report, presented to the QI/UM Committee and NBHP Board of Managers included the summary analysis of results of member satisfaction surveys (MHSIP, YSS, and FactFinders). Staff stated that the results of these surveys were reviewed bi-annually. The minutes of the QI/UM Committee meeting documented that the results were presented to the committee for review, but they did not document any discussion or conclusions. During the on-site interview, staff stated that the CMHCs review survey results within their internal QI Committees. NBHP has been trending the survey results over three years in order to establish benchmarks for performance, which have not yet been determined by the QI/UM Committee.		
Required Actions: None.		

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Requirement	Evidence as Submitted by the BHO	Score
13. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported. Contract: IL.H.2.m.5	Documents Submitted/Location Within Documents: 1. 309QualityofCareIssuesOutlierPracticePatternsPolicy_VOCO – a. Pages 8-10, Section V.G.4.b.v and 6.d, I, J.3-4 2. 305MemberSatisfactionSurvey_Policy_VOCO_QM – a. Page 3, Section V.F-G 3. 303LGrievance_Policy_VOCO_OMFA – Page 13, Section V.D. 4. QOCCAPLetter_NBHP – Entire Document Description of Process: The attached Quality of Care Issues Outlier Practice Patterns Policy outlines the identification, notification, documentation, investigation, resolution, monitoring and reporting of potential quality of care (QOC) issues and trends. Additionally, the Member Satisfaction Survey Policy reverences the CAP response to low satisfaction rates. Patterns detected in Grievances are addressed in the attached Grievance Policy. Highlights and notations in the policies listed above identify the corrective action plan processes. See attached QOCCAP Letter for an example.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: NBHP submitted several policies related to grievances, adverse events, member satisfaction surveys, and outlier practice patterns that documented clinical grievances or serious adverse events are forwarded to the medical director for investigation and intervention as required, and that patterns of grievances and adverse events are tracked by provider and type of incident, and reviewed. NBHP staff reported that provider incidents are reviewed by the QOCC and administrative incidents are reviewed by the QI/UM Committee. Staff also reported that corrective actions are imposed by the reviewing committee as appropriate. The Member Satisfaction Survey policy stated that the NBHP quality committees analyzed survey results to identify opportunities for improvement and develop corrective actions as indicated. NBHP provided, as an example, a letter that was sent to a provider requesting a corrective action plan, following a sentinel event. Required Actions: None.		

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Requirement	Evidence as Submitted by the BHO	Score
14. The Contractor investigates, analyzes, tracks, and trends quality of care (QOC) concerns. (Client complaints about care are not quality of care concerns under this section and should be processed as grievances, unless the Department instructs otherwise.) Contract: IL.H.2.o	Documents Submitted/Location Within Documents: 309QualityofCareIssuesOutlierPracticePatternsPolicy_VOCO – Page 7, Section V.G.2-3, Pages 10-11, Sections K-L - SummaryofQOCIssues_NBHP – Entire Document - QOCDatabaseInvestigation_NBHP – Entire Document - QOCTrendReportJuly2010toPresent_NBHP – Entire Document - AdverseIncidentReportQ4FY12_NBHP – Entire Document Description of Process: ValueOptions has a process for investigating, analyzing, tracking and trending quality of care concerns. This is noted in the Quality of Care Issues Policy listed above. Investigations are completed on reported adverse incidents that are classified as major or sentinel events; if a potential quality of care issue is identified during the investigation of an adverse incident, it is documented as a quality of care issue as well. Reported quality of care concerns are investigated and reviewed by the Quality of Care Committee (QOCC) for disposition. The document titled SummaryofQOCIssues_NBHP provides a summary of an NBHP QOC issue and subsequent investigation. An example of a quality of care investigation (QOCDatabaseInvestigatin_NBHP) and a quality of care trend report (QOCTrendRpt_Jul2010toPresent_NBHP2012) are also included for review, as noted above.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Quality of Care (QOC) Issues and Outlier Practice Patterns policy stated that QOC concerns are investigated and monitored through resolution by the QOCC. Member grievances concerning clinical care and adverse clinical events were processed and reviewed by appropriate committee(s) using the quality management process. The policy outlined the procedures for managing an individual urgent care issue and for monitoring and trending patterns of issues for corrective action by the NBHP quality committees. The policy specified that member grievances concerning QOC would also be processed as member grievances. The policy also specified that QOC concerns are reviewed during the provider recredentialing process. NBHP submitted sample trending reports of adverse incidents and individual QOC concerns. During the on-site interview, staff discussed follow-up on the pattern of QOC concerns related to coordination of discharge plans noted on the QOC Trend Report. Staff stated that initiatives to emphasize discharge coordination were being addressed by the NBHP medical director, working with individual providers at the CMHCs. Staff stated that practitioners sometimes fail to notify other providers of intent to discharge. The infrequency and isolated incidence of QOC concerns makes the identification of any significant trends by the QI/UM Committee difficult; however, NBHP staff reported analyzing two years of data to increase the possibility of identifying trends. Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	Evidence as Submitted by the BHO	Score
15. When a quality of care concern is raised, the Contractor : ◆ Sends an acknowledgement letter to the originator of the concern. ◆ Investigates the QOC issue(s). ◆ Conducts follow-up with the member to determine if the immediate health care needs are being met. ◆ Sends a resolution letter to the originator of the QOC concern, which contains: • Sufficient detail to foster an understanding of the resolution. • Description of how the member’s health care needs have been met. • A contact name and telephone number to call for assistance or to express any unresolved concerns. Contract: II.H.2.o	Documents Submitted/Location Within Documents: 1. 308CriticalAdverseIncidents_Policy_VOCO – Page 7.V.D. 2. 309QualityofCareIssuesOutlierPracticePatternsPolicy_VOCO-Pages 5-6, Sections V.C-D.1 and V.D.5, and Pages 10-11, Section V.G.1-3 and V.G.4.a.i-iii 3. SummaryofQOCIssues_NBHP – Entire Document 4. QOCDatabaseInvestigation_NBHP – Entire Document 5. QOCResolutionLetter_NBHP – Entire Document 6. QOCAcknowledgementLetter_NBHP – Entire Document Description of Process: As indicated in the Quality of Care (QOC) Issues Policy, an acknowledgement letter is sent, and an investigation completed. Upon receipt, each QOC issue is evaluated to determine the urgency of the issue and assess immediate follow-up actions to assure well-being of the member. Since adverse incidents may also be quality of care issues, all adverse incidents are evaluated upon receipt to determine whether there are any urgent safety issues to be addressed – noted in the Critical/Adverse Incident Policy listed above. The QOCC reviews the results of the investigation and makes a determination as to whether the investigation has identified a quality of care issue, and provides direction as to the appropriate follow-up, which may include obtaining more information, developing and monitoring a corrective action, etc. The document titled Summary of QOCIssues_NBHP provides an example of an NBHP QOC issue and subsequent investigation. Resolution letters are sent following the completion of a QOC investigation; because some of the QOC issues are reported retrospectively, the health care needs of the member have clearly already been met. However, VOCO does have a procedure included in the Quality of Care and Adverse Incident policies, for responding to the immediate needs of a member; however no QOC issues occurred during the review period that required this type of response.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Quality of Care Issues and Outlier Practice Patterns policy and Critical Adverse Incidents policy outlined the process for responding to QOC concerns and included each of the required steps. Samples of the acknowledgement letter and resolution letter substantiated that NBHP incorporated the information outlined in the requirements. The sample database investigation file indicated that a thorough investigation of the QOC concern was performed and documented. QOCC documentation outlined the summary of individual QOC issues, investigation, and resolution.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	Evidence as Submitted by the BHO	Score
During on-site review, staff explained that QOC concerns are often identified retrospectively, when the timing for follow-up directly with the member would be inappropriate. Staff also reported, however, that NBHP conducts medical record review during investigation of the incident to substantiate that the member did not have an adverse outcome. Required Actions: None.		
16. The Contractor’s health information system includes a mechanism to ensure that data received from providers are accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. <i>42CFR438.242(b)(2)</i> Contract: II.H.2.q.1	Documents Submitted/Location Within Documents: 1. ListOfEditsPerformedAgainstClaimsAndEncounters_3BHO-Entire Document 2. xx201206_LOG_3BHO-Entire Document 3. xx201206_ERR_3BHO-Entire Document 4. xx201206_DUP_3BHO-Entire Document 5. xx201206_MOD_3BHO-Entire Document 6. xx_duplicates_hold_inventory_3BHO-Entire Document 7. xx_eligibility_hold_inventory_3BHO-Entire Document 8. UniformServiceCodingManual20120501_3BHO-Entire Document 9. VOFlatFileLayout20120823_3BHO-Entire Document 10. CombinedDataReportCardJune2012_3BHO-Entire Document Description of Process: The accuracy and completeness of data is assessed at reception/load time and feedback is sent to the submitter (for each submission) in the form of multiple log files: LOG : A detailed accounting of each record that had an error (or warning). The end of the LOG file includes a summary, by error type and frequency. ERR: A file containing only key elements of failed records; this allows submitters the ability to focus on errors and identify if a trend exists which could be resolved at a procedural level, rather than on a line-by-line basis. DUP: A file containing records from the submission that appear to be duplicates. This file shows which previous records were accepted (and in what file) as well as the duplicate record that is being withheld from the current submission. A summary of duplicates detected appears at the end of the report. MOD: The selection of procedure modifiers is an important method of conveying to the State the special circumstances under which the service was provided. To help the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Appendix A. **Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for Northeast Behavioral Health Partnership, LLC**

Standard X—Quality Assessment and Performance Improvement		
Requirement	Evidence as Submitted by the BHO	Score
	submitter verify that the procedure modifier selected was the correct one, this file offers a line-by-line accounting of key properties of the record and the selected modifier. Duplicates_Hold_Inventory: A complete account of ALL records that have been held from the submitter for being a duplicate. The first part of the report shows which records are held, and the previously-submitted records which rendered it a duplicate. The second part of the report shows a summary of duplicate records, total units and total charges, by submission. The last part of the report show the complete total by count, total units and total charges. Eligibility_Hold_Inventory: A complete list of all records that have been held for eligibility reasons. Eligibility is based on the date of service being between the effective and expiration dates of at least one(1) eligibility record received from the State. Records which fail this test are reported back to the submitter here. As this is a historical file, the first part is every record in order of Medicaid ID and Service Date. The second part is an aggregate by member, in descending order by total charges (the ones at the top of the list are worth more if resolved, as they tie up more funds). The last part of the report shows the total number of records, units and charges that are held for failing eligibility. Standardizing the collection of encounter data is addressed by employing the State of Colorado’s Uniform Service Coding Manual (USCM), which not only describes the standard layout for submitting encounters (pages 238-249), but also clearly specifies the necessary and required attributed of all encounters submitted to the State, by procedure code (pages 10-180 and 212-215). ValueOptions uses the USCM (entire document) to augment existing edits for claims and encounters, resulting in early detection/reporting and holding of unacceptable records. A list of edits performed on claims and encounters is included as ListOfEditsPerformedAgainstClaimsAndEncounters_3BHO. The accuracy and timeliness of submitted data is best viewed through the use of the monthly Data Report Cards. The tabs in this document show overall error trends in both a chart and a spreadsheet. A reconciliation tab allows for in-depth exploration of the data submitted, its disposition/status and aggregate values. A timeliness tab	

Standard X—Quality Assessment and Performance Improvement		
Requirement	Evidence as Submitted by the BHO	Score
	shows when the submissions were sent to VO-CO, when they were processed, and when data from that file was sent to the State. A color-coding scheme is used to convey early, on-time or late submission. All submitters are using standardized formats; for submitters of encounters, the VO-CO Flat File format is being used. For claim, both UB-04 and CMS-1500 forms are used. These standardized formats allow submitters and VO-CO staff to leverage their knowledge across multiple MHCs and enhancements that are implemented for one can be shared by all.	
Findings: NBHP employs various methods of ensuring that data submitted by providers are complete and accurate. NBHP submitted evidence of automated edits, which are applied to claims/encounters at the time the information is loaded into the system and include screening for eligibility, duplicate submissions, and coding accuracy, and completeness of the required fields of data. Staff stated that detection of errors is reported back to the providers for correction, and claims/encounters are held for correction prior to submission to the State. Staff stated that NBHP uses the Uniform Service Coding Standards Manual (USCM) as the guide for requirements for accurate and complete submission of claims/encounter data and that all providers are using standardized formats for data submission. NBHP submitted evidence of detailed and summary reports of errors provided to submitters to allow for detection and correction of patterns of submission errors. A sample Combined Data Report Card documented the monthly analysis of timeliness and data quality of encounters submitted by each CMHC, including a summary of error reasons, encounter error trends, dollars held due to ineligibility or duplication, and overall timeliness of submission of NBHP encounter data to the State.		
Required Actions: None.		

Results for Standard X—Quality Assessment and Performance Improvement									
Total	Met	=	<u>16</u>	X	1.00	=	<u>16</u>		
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>		
Total Applicable		=	<u>16</u>	Total Score	=	<u>16</u>			

Total Score ÷ Total Applicable		=	<u>100%</u>
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Appendix B. **Record Review Tools**
for **Northeast Behavioral Health Partnership, LLC**

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
Credentialing Record Review Tool
for Northeast Behavioral Health Partnership, LLC

Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Michelle Denman and Cathleen Gilbert

Review Period:	October 2009 through October 2012
Date of Review:	November 27, 2012

SAMPLE	1		2		3		4		5		6		7		8		9		10	
Provider ID#	137672		622704		652795		655664		663114		664010		664057		671010					
Provider Type (MD, PhD, NP, PA, MSW)	LCSW		LPC		LPC		LCSW		LCSW		LCSW		LPC		LPC					
Application Date	11/22/11		11/28/11		5/3/10		3/26/10		7/6/10		6/2/10		8/6/10		11/11/10					
Specialty	Social Worker		Counselor		Counselor		Social Worker		Social Worker		Social Worker		Counselor		Counselor					
Credentialing Date (Committee/Medical Director Approval Date)	4/17/12		12/13/11		1/25/11		8/31/10		10/19/10		8/24/10		11/16/10		1/25/11					
Item	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Initial Credentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X					
♦ A valid DEA or CDS certificate (if applicable)	NA		NA		NA		NA		NA		NA		NA		NA					
♦ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is board certified)	NA		NA		NA		NA		NA		NA		NA		NA					
♦ Work history	X		X		X		X		X		X		X		X					
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X					
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X					
♦ Signed application and attestation	X		X		X		X		X		X		X		X					
♦ The provider's credentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X					
Applicable Elements	6		6		6		6		6		6		6		6					
Point Score	6		6		6		6		6		6		6		6					
Percentage Score	100%		100%		100%		100%		100%		100%		100%		100%					

Total Record Review Score											Total Applicable: 48	Total Point Score: 48	Total Percentage: 100%
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Notes:	
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Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Northeast Behavioral Health Partnership, LLC

Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Michelle Denman and Cathleen Gilbert

Review Period:	October 2009 through October 2012
Date of Review:	November 27, 2012

SAMPLE	1		2		3		4		5		6		7		8		9		10	
Provider ID#	057780		065875		140767		284764		492580		505066		621941		535851		528557		636877	
Provider Type (MD, PhD, NP, PA, MSW)	LPC		LCSW		PhD		LCSW		LMFT		LMFT		LPC		PhD		LPC		LPC	
Application/Attestation Date	11/8/10		3/23/12		4/24/12		3/27/12		2/23/11		1/20/12		4/23/12		12/20/11		7/17/12		3/23/12	
Specialty					Psychology										Psychology					
Last Credentialing/Recredentialing Date	3/31/08		8/18/09		8/18/09		8/18/09		7/29/08		11/25/08		8/31/09		5/29/09		6/16/09		8/18/09	
Recredentialing Date (Committee/Medical Director Approval Date)	2/22/11		7/17/12		8/14/12		7/17/12		5/17/12		2/14/12		9/18/12		4/17/12		7/17/12		6/12/12	
Item	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Recredentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	NA		NA		NA		NA		NA		NA		NA		NA		NA		NA	
♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	NA		NA		NA		NA		NA		NA		NA		NA		NA		NA	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date	X		X		X		X		X			X	X		X			X	X	
Applicable Elements	6		6		6		6		6		6		6		6		6		6	
Point Score	6		6		6		6		6		5		6		6		5		6	
Percentage Score	100%		100%		100%		100%		100%		83%		100%		100%		83%		100%	
Total Record Review Score									Total Applicable: 60				Total Point Score: 58				Total Percentage: 97%			

Notes: For records 6 and 9, ValueOptions began the recredentialing process 6 months before the recredentialing due date and made numerous attempts to contact the provider and collect necessary paperwork. The two instances when ValueOptions did not complete the recredentialing application within 36 months (record 6 and 9; 39 and 37 months, respectively) were due to the providers' non-responsiveness.

Appendix C. Site Review Participants for Northeast Behavioral Health Partnership, LLC

Table C-1 lists the participants in the FY 2012–2013 site review of **NBHP**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	Title
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
NBHP Participants	Title
Patrice Marqui	Director, Office of Member and Family Affairs
Jennifer Woodard	Quality Management Specialist
Stacey Thompson	Quality Improvement Director
Myna Camarenu	Administrative Assistant, Office of Member and Family Affairs
LaRue Leffingwell	Executive Assistant
Steve Coen	Clinical Peer Advisor
Amie Adams	Clinical Director
Cathleen Gilbert	Vice President of Provider Relations
Michelle Denman	Director of Provider Relations
Leslie Moldauer	Medical Director
Department Observers	Title
Russell Kennedy	Quality/Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2012–2013 for Northeast Behavioral Health Partnership, LLC

If applicable, the BHO is required to submit a CAP to the Department for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each required action, the BHO should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the BHO must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process	
Step 1	Corrective action plans are submitted
	If applicable, the BHO will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting to HSAG and the Department. The BHO will submit the CAP using the template provided. For each of the elements receiving a score of <i>Partially Met</i> or <i>Not Met</i>, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	Prior approval for timelines exceeding 30 days
	If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	Department approval
	Following review of the CAP, the Department or HSAG will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	Documentation substantiating implementation
	Once the BHO has received Department approval of the CAP, the BHO should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	Progress reports may be required
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	Documentation substantiating implementation of the plans is reviewed and approved
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the BHO as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the BHO must submit additional documentation. The Department or HSAG will inform each BHO in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the BHO into full compliance with all the applicable federal Medicaid managed care regulations and contract requirements.

The template for the CAP follows.

Table D-2—FY 2012–2013 Corrective Action Plan *for* NBHP

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
Standard VIII—Credentialing and Recredentialing ♦ The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement.	Although the partnership (NBHP) included VO as a member of the partnership, there was a delegation agreement between the partnership and VO (as required by the Department). The delegation agreement did not include a provision that NBHP retains the right to approve, suspend, and terminate individual practitioners and providers. NBHP must either revise the delegation agreement or use an addendum to include the required provision that NBHP retains the right to approve, suspend, and terminate individual practitioners and providers.				

Appendix E. Compliance Monitoring Review Activities for Northeast Behavioral Health Partnership, LLC

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, February 11, 2003.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	HSAG completed the following activities:
Activity 1:	Planned for Monitoring Activities
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the dates of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff attended Behavioral Health Quality Improvement Committee (BQUIC) meetings to discuss the FY 2012–2013 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the BHOs were prepared for the compliance monitoring review.
Activity 2:	Obtained Background Information From the Department
	◆ HSAG used the BBA Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, on-site agenda, record review tools, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific Managed Care regulations or contract requirements. ◆ HSAG considered the Department responses when determining compliance and analyzing findings.
Activity 3:	Reviewed Documents
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the desk review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	Conducted Interviews
	◆ During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	Collected Accessory Information
	◆ During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.)
Activity 6:	Analyzed and Compiled Findings
	◆ Following the on-site portion of the review, HSAG met with BHO staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2012–2013 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions required of the BHO to achieve full compliance with Medicaid managed care regulations and associated contract requirements.
Activity 7:	Reported Results to the Department
	◆ HSAG completed the FY 2012–2013 Site Review Report. ◆ HSAG submitted the site review report to the BHO and the Department for review and comment. ◆ HSAG incorporated the BHO's and Department's comments, as applicable, and finalized the report. ◆ HSAG distributed the final report to the BHO and the Department.