State of Colorado

Department of Health Care Policy and Financing

Colorado Medicaid
Community Mental Health Services Program

FY 06–07 Site Review Report

for

Access Behavioral Care

April 2007

HSAG Health Services Advisory Group

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This is the third year that Health Services Advisory Group, Inc. (HSAG) has performed site reviews of the Colorado behavioral health organizations (BHOs). Compliance with federal regulations and contract requirements was evaluated in 10 areas (i.e., delegation; provider issues; practice guidelines; member rights and responsibilities; access and availability; utilization management; continuity-of-care system; quality assessment and performance improvement program; grievances, appeals, and fair hearings; and credentialing). Individual records were reviewed in the areas of grievances, denials, coordination of care for children transitioning from inpatient to outpatient services, and documentation of services to evaluate implementation of select requirements related to the standards. Details of the site review methodology are contained in Appendix D of this report.

This report documents results of the fiscal year (FY) 06–07 site review for **Access Behavioral Care** (**ABC**) related to compliance with requirements in the 10 standard areas and the elements of the record reviews evaluated as part of the site review.

2. Summary of Follow-Up on Prior Year Review for Access Behavioral Care

As a follow-up to the FY 05–06 site review report, **ABC** was required to submit a corrective action plan (CAP) to the Colorado Department of Health Care Policy & Financing (the Department) addressing all elements for which **ABC** received a score of *Partially Met* or *Not Met*. The plan included interventions to achieve compliance and the timeline. The Department reviewed the CAP and associated documentation, requesting revisions where necessary. **ABC** completed all corrective actions for FY 05–06.

3. Summary of the FY 06–07 Site Review for Access Behavioral Care

The findings for the FY 06–07 site review were determined from a desk review of the documents submitted by **ABC** to HSAG prior to the on-site portion of the review, interviews with key **ABC** staff members, and a review of records conducted during the site review.

For the review of the 10 standards, the individual elements (i.e., contract requirements) reviewed for each standard were assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable (N/A)*. A summary score was then determined by calculating the percentage of applicable elements found compliant (i.e., *Met*).

Table 3–1 presents the number of elements for each of the 10 standards, the number of applicable elements for each standard, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *N/A*), the overall compliance score for each standard, and the overall compliance score for the review of standards. Details of the review of the 10 standards can be found in Appendix A.

Table 3–1—Summary of Scores for the Standards

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I	Delegation	13	12	6	6	0	1	50%
II	Provider Issues	26	25	23	1	1	1	92%
III	Practice Guidelines	5	5	5	0	0	0	100%
IV	Member Rights and Responsibilities	18	18	17	1	0	0	94%
V	Access and Accessibility	20	20	19	1	0	0	95%
VI	Utilization Management	8	8	7	1	0	0	88%
VII	Continuity-of-Care System	15	15	15	0	0	0	100%
VIII	Quality Assessment and Performance Improvement Program	12	12	11	1	0	0	92%
IX	Grievances, Appeals, and Fair Hearings	11	11	6	5	0	0	55%
X	Credentialing	32	32	30	2	0	0	94%
	Totals	160	158	139	18	1	2	88%

For the review of records for documentation of services, denials, and grievances, elements in each record reviewed were assigned a score of Yes (compliant), No (not compliant), or Not Applicable (N/A). For each of the scored record reviews, a summary score was then determined by calculating the percentage of applicable elements found compliant.

Table 3–2 presents the number of records reviewed, the number of applicable elements, and the number of compliant elements. It also provides an overall compliance score for each record review as well as a combined record review compliance score. Details of each record review can be found in Appendix B. The coordination-of-care record review was not scored. A narrative summary of each record review can be found in Section 4.

Table 3–2—Summary of Scores for the Review of Records

Associated Standard #	Description of Record Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
II	Documentation of Services	**10**	**21**	**19**	**90%**
VI	Denials	**10**	**30**	**28**	**93%**
VII	Coordination of Care—Children Transitioning From Inpatient to Outpatient Services	**10**	**Not Scored**	**Not Scored**	**Not Scored**
IX	Grievances	**10**	**40**	**0**	**0%**
	Totals	**40**	**91**	**47**	**52%**

Table 3–3 presents the overall scores (percentage of compliance) for the review of the standards, for the review of records, and for the review of the standards and records combined.

Table 3–3—Overall Compliance Scores

Review of the Standards—Percentage Compliant	**88%**
Review of Records—Percentage Compliant	**52%**
Overall Percentage Compliant	**75%**

This section of the report describes **ABC**'s strengths and required actions related to each of the standards and types of records reviewed. Details of the scores related to the review of the standards can be found in Appendix A and details of the scores related to the review of records can be found in Appendix B.

Standard I—Delegation

Strengths

ABC had delegation agreements with each of its delegates for credentialing and an effective system for monitoring delegation activities, requiring corrective action when necessary, and following up on required corrective action. The two delegation agreements for the delegation of credentialing contained all of the required language.

Required Actions

During HSAG's site review process, it was determined that the Mental Health Center of Denver (MHCD) had processed Medicaid consumer grievances. **ABC** did not have an agreement with MHCD that delegated the processing of grievances to MHCD. **ABC** must either process all Medicaid consumer grievances through **ABC**'s grievance processing mechanism, or enter into a delegation agreement with MHCD for the processing of grievances. If **ABC** chooses to enter into a delegation agreement with MHCD, **ABC** must ensure that the agreement includes all of the requirements and monitor MHCD for performance of delegated activities.

Standard II—Provider Issues

Strengths

ABC had an effective tracking mechanism to ensure that it had an agreement with each provider. **ABC** had policies and procedures for monitoring providers and several mechanisms for monitoring and ensuring corporate compliance.

Review of Documentation of Services

A sample of 10 consumer service records was reviewed to assess **ABC**'s compliance with contract requirements related to documentation of services for encounters submitted. Sample record Nos. 2 and 6 were unavailable at the time of the site review. **ABC** staff reported that **ABC** was unable to obtain the records from the providers. Two records from the oversample were reviewed to obtain a sample of 10 records. **ABC** was compliant with 19 of 21 of the total applicable elements reviewed for a record review score of 90 percent. Nine of 10 records contained documentation of the service for the day the encounter was submitted. The 10th record contained documentation dated the day following the date for which the encounter was submitted. Nine of 10 records contained documentation that described the service for which the encounter was submitted. For one record, the provider used an incorrect encounter code.

Required Actions

ABC must ensure that providers submit accurate encounter codes that represent the services provided. **ABC** must also ensure that it has effective processes in place for obtaining medical records from providers in a timely manner and for addressing any failure to comply.

ABC's monitoring methods were aggregate in nature. **ABC** did not have processes to monitor specific providers for requirements, particularly for the requirements related to the content of medical records. **ABC** must monitor for medical record requirements.

ABC's policy regarding termination of providers described notification to the Department and included all of the requirements except the correct time frame. The time frame indicated was 60 days prior to the termination of the contract and should be 90 days prior to the termination of the contract. **ABC** must revise its policy and implement the correct time frame for notification.

Standard III—Practice Guidelines

Strengths

ABC had practice guidelines in place for the treatment of major depression, attention deficit/hyperactivity disorder, and bipolar disorder. The BHO demonstrated that it had policies, procedures, and practices in place to ensure that practice guidelines were based on valid and reliable clinical evidence, considered the needs of members, were adopted in consultation with contracting health care professionals, and were reviewed periodically as appropriate. **ABC** posted practice guidelines adopted by the BHO on the Colorado Access Web site. Practice guidelines were also available to contracted providers in the provider manual and were available to consumers and family members upon request.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard IV—Member Rights and Responsibilities

Strengths

ABC had policies, procedures, and practices in place to provide consumer rights information to consumers and their representatives, staff, and providers, fostering a structure and philosophy that promoted recovery and took rights into account when providing services.

The BHO had an active, functioning Office of Consumer and Family Affairs, and demonstrated consumer involvement and empowerment in many of its programs and initiatives. Consumers were represented on committees and councils of the BHO, and **ABC** sponsored and supported a Consumer and Family Advisory Board.

Required Actions

While the BHO had an advance directive policy and procedure that met content requirements, information provided during the interview was inconsistent with the policy. No evidence of training or education of staff or providers was available for the review period. The BHO must ensure that it follows its policy, which stated that the BHO would provide annual training to providers on advance directives requirements, and that it would educate its staff.

Standard V—Access and Availability

Strengths

ABC had processes in place to evaluate and report on timeliness of access to services. Data were collected and analyzed by the BHO to evaluate the sufficiency of the network in meeting the needs of consumers. The BHO demonstrated that consumers had a choice among providers, as evidenced by the presence of single-case agreements and its process to inform consumers of the array of providers in the network.

Required Actions

Because the BHO's procedure for evaluating the provision of alternative services included only summary financial data, the BHO did not have a process for evaluating the degree to which it had sufficient capacity in number and location of services to meet contract requirements. **ABC** relied primarily on event reporting (e.g., appeals, grievances, advocates' complaints) as indicators of whether or not the capacity for alternative services was sufficient. **ABC** must develop and implement a mechanism to monitor the provision of alternative services that ensures sufficient capacity is available as described in the contract with the Department.

Standard VI—Utilization Management

Strengths

ABC had numerous policies and procedures, program descriptions, and other written documents that described the BHO's Utilization Management (UM) Program. The BHO used several utilization measures, including daily census trending graphs, penetration rates, inpatient days/1000, and average length-of-stay data to detect both underutilization and overutilization of services. The BHO also actively reviewed UM-related data through its quality improvement committee structure and reported key findings to providers, as appropriate.

Review of Denial Records

A sample of 10 denial records were reviewed to assess **ABC**'s compliance with contract requirements related to the presence and content of required documentation, and the timeliness of resolution and documentation. **ABC** was compliant with 28 of 30 of the total applicable elements reviewed for an overall score of 93 percent. **ABC** was fully compliant in the following areas: 1) the notice included the reason for the denial, and 2) the decision was made by a qualified clinician. Notices of action for two cases reviewed were not sent in a timely manner to the consumer and provider following a utilization review (UR) denial as required in Exhibit G of the BHO's contract with the Department. In one case in the sample, a consumer with a diagnosis of mental retardation was denied a request for outpatient services. The denial reason was that the consumer did not have a covered diagnosis.

Required Actions

ABC must ensure that a notice of action is sent in a timely manner to the consumer and provider following a UR denial decision.

The BHO must revise its policy regarding UR determinations to be consistent with the BBA and with contract requirements because differing time frames were in use.

Standard VII—Continuity-of-Care System

Strengths

ABC had a comprehensive set of policies and procedures related to continuity of care and demonstrated that it collaborated closely with providers, state agencies, public schools, and community programs to ensure continuity of care for enrolled members. **ABC** staff participated in several community initiatives to improve communication and continuity of care for consumers, including a collaboration to improve access to mental health services for incarcerated adults. The BHO also participated in several projects that involved the colocation of mental health services within primary medical care settings.

Review of Coordination of Care—Children Transitioning from Inpatient to Outpatient Services

Ten records were reviewed for evidence of care coordination and outpatient follow-up for children following discharge from an inpatient facility. In one case, **ABC** management staff indicated that **ABC** had no record of a request for authorization for hospitalization, no record of a paid or denied claim that **ABC** submitted to the Department, and no record of authorization or payment for outpatient services for this patient. In the other nine records, there were notes in the **ABC** service authorization database describing communication with the inpatient facility or describing **ABC**'s understanding of the discharge plan. One of these nine records indicated that the inpatient stay was not paid for by **ABC**. The patient in this case had a noncovered diagnosis. Five records indicated that the children were discharged to placement arranged and paid for by the Division of Human Services (DHS) with no outpatient services requested or provided by **ABC**. Three records indicated that a follow-up appointment for services provided by **ABC** or a subcontractor for **ABC** was scheduled. In two of these three records, there was a progress summary documenting that the patient attended the scheduled appointment.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard VIII—Quality Assessment and Performance Improvement (QAPI) Program

Strengths

ABC provided policies and procedures, an annual evaluation, and various other documents that defined the scope and purpose of the QAPI program and described the quality improvement activities used by the BHO to improve clinical and service delivery systems. Information provided through staff interviews demonstrated that program practice matched policy and that the BHO had an appropriate health information system in place to collect, analyze, and report quality data. **ABC** also demonstrated that it integrated information from multiple data sources as part of the quality improvement process and implemented corrective action plans to address identified problems in performance as appropriate.

Required Actions

The BHO must include MHCD grievance information in its trending, analysis, and any necessary interventions aimed at improving consumer satisfaction.

Standard IX—Grievances, Appeals, and Fair Hearings

Strengths

ABC had policies, procedures, and dedicated staff resources in place for processing requests for grievances, appeals, and fair hearings according to State and federal requirements. Documentation (paper) and tracking systems (electronic database) in use by the BHO were noteworthy in their orderliness and completeness, and allowed the BHO to examine case-specific as well as systemwide data for trends. **ABC**'s information for providers about the grievance system had been approved by the Department, and the BHO had a planned mechanism for distribution of the new information.

Review of Grievance Records

A sample of grievance records was requested from **ABC**; however, because **ABC** did not report any clinical or quality-of-care grievances in the time frame requested, **ABC** provided documentation from its partner/provider MHCD, which also processed Medicaid consumer grievances. Upon review, there was no evidence of required acknowledgment letters or written resolution letters being sent to consumers, qualifications of the person deciding the grievance, or whether consumers had been provided reasonable assistance in the filing process. Because of this lack of documented evidence and the brevity of the notes in the database, it was not possible to evaluate these requirements or whether the resolution was responsive to the grievance issue.

Required Actions

ABC must ensure that all Medicaid consumer grievances are processed according to State requirements and Medicaid regulations, whether processed by the BHO or by a delegate. This process must include thorough documentation and record-keeping, timely written notice of acknowledgment and resolution to the consumer, decision-making by qualified and noninvolved staff, and reasonable assistance to the consumer.

Because **ABC** handles formal grievances and complaints differently, the BHO must ensure that all expressions of dissatisfaction are handled in accordance with Medicaid and State regulations, and that data from each are included in tracking and trending so that opportunities to improve care and services can be identified.

Standard X—Credentialing

Strengths

ABC had policies and procedures and sophisticated database mechanisms to document the credentialing and recredentialing of practitioners and the assessment of organizational providers. The credentialing and recredentialing policies included the majority of the requirements. There was evidence that **ABC** followed the credentialing and recredentialing policies and procedures.

Required Actions

The credentialing and recredentialing policies were inconsistent with information from the interview regarding how applicants were notified of their appeal rights under the credentialing and recredentialing processes. **ABC** must revise policies to include a description of how applicants are notified of their rights under the credentialing process, including the right to an appeal process. Additionally, when the BHO chooses to alter the conditions of a practitioner's participation based on issues of quality of care, the appeal process was only offered to physician practitioners. **ABC** must expand the policies regarding an appeal process for practitioners to include all practitioners as defined by the *NCQA Standards and Guidelines for the Accreditation of MBHOs*.

ABC is required to submit to the Department a CAP for all elements within the standards scored as Partially Met or Not Met and for all elements within the record reviews scored as No. The CAP must be submitted within 30 days of receipt of the final version of this report. For each element that requires corrective action, the BHO must identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. After the Department has approved the CAP, **ABC** will be required to submit documents identified as evidence of compliance.

Table 5-1 describes activities required for the CAP process.

Table 5-1—Corrective Action Plan Process	
Step 1:	**Corrective action plans are submitted.**
	Each BHO will submit a CAP to the Department within 30 calendar days of receipt of the final external quality review site review report. CAPs will be submitted via HSAG's file transfer protocol (FTP) site and the BHO will e-mail notification to the Department and HSAG. For each of the elements within the standards receiving a score of *Partially Met* or *Not Met*, and for each element within the record reviews receiving a *No*, the CAP must address the planned intervention(s) to achieve compliance and the timeline(s) for the intervention(s).
Step 2:	**Plans are reviewed and approved.**
	HSAG and the Department will review the CAPs. The Department will notify each BHO as to the adequacy of its plan. If the Department determines that a CAP is adequate to bring the BHO into full compliance with the applicable contract requirements, the Department will notify the BHO in writing that the plan is approved. If the Department determines that a CAP is not adequate to bring the BHO into full compliance with one or more contract requirements, the Department will require the BHO to submit a revised CAP. Following the review of the revised plan, the Department will notify the BHO in writing of its decision to approve the plan or to require further revisions.
Step 3:	**Progress reports may be required.**
	Based on the nature and seriousness of the noncompliance, the Department may require the BHO to submit regular reports to the Department detailing progress made on one or more elements in the CAP.
Step 4:	**Corrective actions are implemented.**
	Each BHO is expected to implement all corrective actions and achieve full compliance with the applicable contract requirements within 60 calendar days of the Department's written notification of having approved the BHO's CAP. The Department may extend the time frame for implementation of one or more of the corrective actions if requested by a BHO in writing and with cause.

Table 5-1—Corrective Action Plan Process	
Step 5:	**Substantiating documentation is submitted.**
	When all Department-approved corrective actions have been implemented, the BHO will submit documentation to the Department substantiating the completion of all required corrective actions and compliance with the related contract requirements.
Step 6:	**Documentation substantiating implementation of the plans is reviewed and approved.**
	Following a review of the documentation, the Department will inform the BHO as to whether: (1) the documentation is adequate to demonstrate completion of all required actions and compliance with the related contract requirements, or (2) the BHO must take additional actions and/or submit additional documentation. The Department 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 contract requirements.

Table 5-2 can be used by the BHO to document its planned interventions for any required actions that are listed.

Table 5-2—FY 06–07 Corrective Action Plan *for* ABC				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard I: Delegation				
2. Written Agreements The Contractor has a written agreement with each subcontractor.	ABC must either process all Medicaid consumer grievances through ABC's grievance processing mechanisms or enter into a delegation agreement with MHCD for the processing of Medicaid consumer grievances.			
3. Content of Agreement The written agreement: A. Specifies the activities delegated to the subcontractor.	If ABC chooses to delegate Medicaid consumer grievance processing to MHCD, the written agreement must specify the activities delegated to MHCD with regard to grievance processing.			
B. Specifies the reporting responsibilities delegated to the subcontractor.	If ABC chooses to delegate Medicaid consumer grievance processing to MHCD, the written agreement must specify the reporting responsibilities of MHCD related to the delegated activity of grievance processing.			
D. Specifies that the subcontractor shall comply with the standards specified in the contract between the BHO and the Department for any responsibilities delegated to the subcontractor.	If ABC chooses to enter into a delegation agreement with MHCD, the agreement must specify that the subcontractor shall comply with the standards specified in the contract between the BHO and the Department for any delegated activities, or specify the specific standards required by the BHO contract with the Department related to the delegated activities.			

Table 5-2—FY 06–07 Corrective Action Plan *for* ABC				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
5. Monitoring of Delegates The Contractor monitors services provided through subcontracts for: A. Quality	ABC must monitor the services provided by each of its delegates for quality of performance by the delegate.			
B. Data Reporting	ABC must monitor the data reporting required by each of its delegates.			
Standard II: Provider Issues				
6. Monitoring of Providers D. Requirements for medical records	ABC must monitor for medical record requirements.			
8. Termination of Provider Agreements The Contractor notifies the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area and provides the notice at least ninety (90) days prior to termination of the services unless the termination is based on quality or performance issues.	ABC must have a process in place to notify the Department in writing of its decision to terminate any existing provider agreement, where such termination causes the delivery of covered services to be inadequate in a given area, and provide the notice at least 90 days prior to termination of the services unless the termination is based on quality or performance issues.			

Table 5-2—FY 06–07 Corrective Action Plan *for* ABC				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
13. Record Review: Documentation of Services	ABC must ensure that providers submit accurate encounter codes that represent the services provided. ABC must ensure that it has effective processes in place for obtaining medical records from providers in a timely manner and for addressing any failure to comply.			
Standard IV: Member Rights and Responsibilities				
5. Advance Directives A. The Contractor has written policies and procedures for Advance Directives.	ABC must ensure that training/education of providers and staff is conducted to ensure providers are aware of their responsibilities under the BHO's advance directives policy.			
Standard V: Access and Availability				
10. Alternative Services The BHO has sufficient capacity to provide alternative services as described in Exhibit K of the Contract with the Department (effective 3/31/06). These services are available to serve the specified number of Members, and at the specified locations.	ABC must develop and implement a mechanism to monitor alternative service provision that ensures sufficient capacity is available as described in its contract with the Department.			

Table 5-2—FY 06–07 Corrective Action Plan *for* ABC				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard VI: Utilization Management				
1. Utilization Management Program B. The UM program includes written policies and procedures.	The BHO must revise its policy regarding utilization review determinations to be consistent with the BBA and with contract requirements.			
7. Record Reviews: Denials	ABC must ensure that a notice of action is sent in a timely manner to the consumer and provider following a UR denial decision.			
Standard VIII: Quality Assessment and Performance Improvement Program				
3. Member Satisfaction B. The Contractor's tools to monitor member satisfaction include: 3. Grievance and appeal data	The BHO must include MHCD grievances in its trending, analysis, and interventions to address consumer satisfaction issues.			
Standard IX: Grievances, Appeals, and Fair Hearings				
1. Grievance and Appeal Records The Contractor maintains a record of grievances and appeals.	The BHO must ensure that whether complaints are processed by ABC or a delegate, all complaints and expressions of dissatisfaction are considered as grievances; are processed to ensure written acknowledgment, timely resolution, and reasonable assistance to the consumer; and that complaint data are included in the analysis and reporting of grievances.			

Table 5-2—FY 06–07 Corrective Action Plan *for* ABC				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
3. Reasonable Assistance The Contractor provides members with assistance in completing any forms required by the Contractor, putting oral requests for a state fair hearing into writing, and taking other procedural steps including providing interpretive services and toll-free numbers that have adequate TTY/TTD interpreter capability.	ABC must ensure that all consumers are given reasonable assistance with the grievance process, whether the process occurs through the BHO or is conducted by a delegate.			
4. Individuals who Make Decisions The Contractor ensures that the individuals who make decisions on grievances and appeals are: A. Individuals who were not involved with any previous level of review or decision-making.	ABC must ensure that all Medicaid grievance decisions are made by individuals not previously involved, whether grievances are processed by ABC or by a delegate.			
B. Individuals who have the appropriate clinical expertise in treating the member's condition or disease if deciding an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an	ABC must ensure that all grievance decisions are made by staff with appropriate qualifications to do so, whether processed by ABC or by a delegate.			

Table 5-2—FY 06–07 Corrective Action Plan *for* ABC				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
appeal, a grievance that involves clinical issues, or an appeal that involves clinical issues.				
5. Accepts Grievances and Appeals The Contractor accepts grievances and appeals orally or in writing.	ABC must ensure that grievances and appeals are accepted orally and in writing, whether processed by ABC or by a delegate.			
7. Record Reviews: Grievance	ABC must ensure that all Medicaid consumer grievances are processed according to State requirements and Medicaid regulations, whether processed by the BHO or by a delegate. This process must include thorough documentation and record-keeping, timely written notice of acknowledgment and resolution to the consumer, decision-making by qualified and noninvolved staff, and reasonable assistance to the consumer.			
Standard X: Credentialing				
3. Content of Policies and Procedures The written policies and procedures specify: P. How the applicant is notified of these rights and of the appeal process.	ABC must revise policies to include a description of how applicants are notified of their rights under the credentialing process, including the right to an appeal process.			

Table 5-2—FY 06–07 Corrective Action Plan *for* ABC				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
T. An appeal process for instances in which the BHO chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service.	ABC must have policies and processes that provide an appeal process for instances in which the BHO chooses to alter the conditions of practitioners' participation based on issues of quality of care or service. The policy must apply to practitioners as they are defined by the NCQA Standards and Guidelines for the Accreditation of MBHOs.			

The review of the standards follows this cover page.

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
1. Pre-delegation Assessment	Prior to entering into subcontracts, the Contractor evaluates the proposed subcontractor's ability to perform the activities to be delegated.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings Access Behavioral Care (ABC) reported that no new delegation contracts were entered into during the review period.	
II.C.1	**Required Actions** None	
2. Written Agreements	The Contractor has a written agreement with each subcontractor.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There were agreements for delegation of credentialing with University Physicians, Inc. (UPI) and Denver Health and Hospital Authority (DHHA). During HSAG's site review process, it was determined that the Mental Health Center of Denver (MHCD) had processed Medicaid consumer grievances. ABC did not have an agreement with MHCD that delegated the processing of grievances to MHCD.	
II.C.2	**Required Actions** ABC must either process all Medicaid consumer grievances through ABC's grievance processing mechanisms or enter into a delegation agreement with MHCD for the processing of Medicaid consumer grievances.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement	The written agreement: A. Specifies the activities delegated to the subcontractor.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The UPI and DHHA agreements specified the activities that were delegated. The contract between ABC and MHCD did not specify activities performed by MHCD related to grievance processing.	
	Required Actions If ABC chooses to delegate Medicaid consumer grievance processing to MHCD, the written agreement must specify the activities delegated to MHCD with regard to grievance processing.	
	B. Specifies the reporting responsibilities delegated to the subcontractor.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The UPI and DHHA agreements described the reporting responsibilities of the delegates. The MHCD contract specified the reporting responsibilities of MHCD related to service provision, but not related to grievance processing.	
	Required Actions If ABC chooses to delegate Medicaid consumer grievance processing to MHCD, the written agreement must specify the reporting responsibilities of MHCD related to the delegated activity of grievance processing.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement	C. Includes provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article 3 in the UPI and the DHHA agreements described remedies, including possible termination of the agreement, for inadequate performance. Section 40.1 through 40.4 of the MHCD agreement indicated that immediate termination of the agreement would occur in the event of failure to comply with specified contractual requirements.	
	Required Actions None	
	D. Specifies that the subcontractor shall comply with the standards specified in the contract between the BHO and the Department for any responsibilities delegated to the subcontractor.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The UPI and DHHA agreements specified that the subcontractor comply with the credentialing standards set forth by the National Committee for Quality Assurance (NCQA). This contract provision satisfied the credentialing requirements specified in the contract between the BHO and the Department. ABC did not have an agreement that addressed delegated activities or specified compliance with the BHO standards with regard to any activity delegated to MHCD.	
	Required Actions If ABC chooses to enter into a delegation agreement with MHCD, the agreement must specify that the subcontractor shall comply with the standards specified in the contract between the BHO and the Department for any delegated activities, or specify the specific standards required by the BHO contract with the Department related to the delegated activities.	
II.C.2		

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
4. Policies and Procedures II.C.4	The Contractor has written procedures for monitoring the performance of subcontracts: A. On an ongoing basis	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy QM203 included written procedures for monitoring delegates on an ongoing basis.	
	Required Actions None	
	B. Through formal review	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy QM203 included procedures for formal review of delegates.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
5. Monitoring of Delegates	The Contractor monitors services provided through subcontracts for: A. Quality	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A review of the reports submitted by UPI and DHHA and the annual audit results performed by ABC for UPI and DHHA included a review of quality. There was no evidence of monitoring MHCD for the quality of MHCD's processing of grievances.	
	Required Actions ABC must monitor the services provided by each of its delegates for quality of performance by the delegate.	
	B. Data reporting	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A review of the periodic reports submitted by UPI and DHHA and ABC's review of those reports demonstrated that ABC monitored UPI and DHHA for data reporting requirements. There was no evidence of monitoring MHCD for data reporting related to MHCD's processing of grievances.	
II.C.3	**Required Actions** ABC must monitor the data reporting required by each of its delegates.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
6. Corrective Action II.C.5	If the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor take corrective action.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Audit documents reviewed for DHHA provided evidence that corrective action plans were required when areas for improvement were identified.	
	Required Actions None	
7. Termination of Subcontracts II.C.9	The Contractor notifies the Department in writing of its decision to terminate any existing subcontract applicable to the performance of services under the Contract.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy QM203 described the process for notifying the Department of the decision to terminate a delegation agreement 60 days prior to the proposed termination date. ABC management staff reported that no delegation subcontracts had been terminated within the review period.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
8. Access to Records II.C.8	All subcontracts provide for access to all records by the Secretary of the U.S. Department of Health and Human Services, for 3 years following disposition of property or equipment. **Findings** Section C.3 of the UPI and DHHA agreements and Sections 46 through 48 of the MHCD agreement contained language that guaranteed access to records by the U.S. Department of Health and Human Services. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Results for Standard I					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
6	6	0	1	12	50%

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
1. Provider Discrimination	A. The Contractor does not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR301 included the required nondiscrimination language. ABC management staff reported that providers were informed of ABC's nondiscrimination policy via the provider manual, and that ABC ensured nondiscrimination by applying credentialing requirements equally regardless of license type or population served.	
	Required Actions None	
	B. If the Contractor declines to include individual or groups of providers in its network, it gives the affected providers written notice of the reason for its decision.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR301 described the process for notifying practitioners in writing of the reason for declining participation in the network. Two types of template letters were reviewed and included the reason for declining participation in the network.	
	Required Actions None	
II.H.4.a		

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity	A. The Contractor has a mandatory compliance plan and administrative and management arrangements or procedures that are designed to guard against fraud and abuse, and that include: 1. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state requirements.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Colorado Access Corporate Compliance Plan Description, the Standards of Business Conduct, and related policies adequately articulated ABC's commitment to compliance with applicable State and federal regulations and guard against fraud and abuse. The provider manual defined fraud and abuse and informed providers of how to report instances of fraud and abuse.	
	Required Actions None	
	2. Designation of a compliance officer and compliance committee that is accountable to senior management.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The corporate compliance plan described the designation of a corporate compliance officer (the staff attorney) and an executive compliance committee. Corporate Compliance Committee meeting minutes were reviewed on-site.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity	3. Training and education for the compliance officer and the Contractor's employees.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CMP204 described initial compliance training and annual Internet refresher training regarding compliance and the compliance plan. The content of the training was reviewed. ABC's corporate compliance officer indicated that initial training and annual refresher training was required for ABC employees.	
	Required Actions None	
	4. Provisions for internal monitoring and auditing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policies CMP201 and CMP202 described processes for reporting and investigation of reported fraud and abuse. Policy CMP211 described ongoing auditing and monitoring to ensure compliance and fraud prevention. ABC management staff described the use of utilization data to identify provider trends and look for suspected fraud or abuse. ABC management staff provided a letter that had been sent to a provider that discussed potential concerns about his utilization patterns.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity II.G.5.c.1-7 II.H.5.d	5. Provisions for prompt response to detected offenses and for development of corrective action initiatives.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CMP211 described ABC's planned response to suspected instances of fraud and abuse and the roles of the compliance committee and the corporate compliance officer.	
	Required Actions None	
	B. The Contractor reports possible instances of Medicaid fraud to the Department within ten (10) business days of receipt of information. The Referrals include specific background information, the name of the Provider and a description of how the Contractor became knowledgeable about the occurrence.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CMP211 described reporting of possible instances of fraud to the Department within 10 business days. ABC management staff stated that there had been no cases of suspected fraud or abuse reported to ABC during the review period.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
3. Provider Agreements II.H.10.a.2	The Contractor has a written agreement with each provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Agreement templates reviewed included the Behavioral Health Professional Provider Agreement and the Facility Agreement. Examples of signed contracts were reviewed on-site in the credentialing files and were consistent with the templates provided. The signed agreement for MHCD was also reviewed on-site, as was a printout of the database used to ensure that ABC had a written agreement with each provider.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
4. Content of Agreement	The written agreement: A. Specifies the activities of the provider	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section B of the Behavioral Health Professional Provider Agreement and the Facility Agreement specified the activities to be performed by the provider. Sections 21-24 of the MHCD contract specified the activities to be performed by MHCD.	
	Required Actions None	
	B. Specifies the reporting responsibilities of the provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Sections B and C of the Behavioral Health Professional Provider Agreement and the Facility Agreement included the reporting responsibilities of the provider. Sections 22-24 and 31 of the MHCD agreement specified the reporting responsibilities of the provider.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
4. Content of Agreement	C. Includes provisions for revoking the agreement or imposing other sanctions if the provider's performance is inadequate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Sections D2 and D3 of the Facility Agreement and the Behavioral Health Professional Provider Agreement included provisions for revoking the agreement in the case of inadequate performance. Section 40 of the MHCD agreement included provisions for revoking the agreement in the case of inadequate performance.	
II.H.10.a.2	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
5. Liability for Payment	The Contractor provides that its Medicaid members are not held liable for: A. The Contractor's debts in the event of the Contractor's insolvency.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section C6 of the Behavioral Health Professional Provider Agreement and the Facility Agreement, and Section 35 of the MHCD agreement included the required clause prohibiting Medicaid member liability in the event of ABC's insolvency.	
	Required Actions None	
	B. Covered services provided to the member for whom the Department does not pay the Contractor, or the Department or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section C6 of the Behavioral Health Professional Provider Agreement and the Facility Agreement, and Section 35 of the MHCD agreement included the required clause prohibiting Medicaid member liability in the event of ABC's nonpayment.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
5. Liability for Payment II.H.11.a	C. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section C6 of the Behavioral Health Professional Provider Agreement and the Facility Agreement, and Section 35 of the MHCD agreement included the required clause prohibiting Medicaid member liability for any payment or co-pay.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	The Contractor monitors covered services provided under provider agreements for: A. Quality	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A review of BHO Quality Improvement and Program Evaluation (BQIPE) Committee meeting minutes demonstrated that the committee reviewed quality indicators for services provided.	
	Required Actions None	
	B. Appropriateness	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A review of a UM data system screen print, data gathered in the database for care management programs, and clarification during the interview demonstrated that ABC monitored services provided for appropriateness.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	C. Member outcomes	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Mental Health Statistics Improvement Program (MHSIP) survey results were summarized in the QAPI Program Impact Analysis and Annual Report. A review of BQIPE Committee meeting minutes indicated that grievance and appeals data and performance improvement project data were reviewed and demonstrated monitoring of member outcomes.	
	Required Actions None	
	D. Requirements for medical records	☐ **Met** ☐ **Partially Met** ☑ **Not Met** ☐ **N/A**
	Findings There was no evidence of monitoring that addressed specific requirements for content of medical records.	
	Required Actions ABC must monitor for medical record requirements.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	E. Requirements for data reporting	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The provider manual described the process for ABC's review of CCAR and encounter data that were submitted. A review of 411 encounter records performed by ABC confirmed monitoring for encounter data reporting. ABC provided an Excel spreadsheet it used to monitor CCAR submissions.	
II.H.10.a.3	**Required Actions** None	
7. Policies and Procedures	The Contractor has written procedures for monitoring the performance of providers on an ongoing basis.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC Fiscal Year 2006-2007 Quality Assessment and Performance Improvement (QAPI) Work Plan included procedures for monitoring the performance of providers on an ongoing basis.	
II.H.10.a.4	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
8. Termination of Provider Agreements II.H.10.d	The Contractor notifies the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area and provides the notice at least ninety (90) days prior to termination of the services unless the termination is based on quality or performance issues.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy PNS203 included the process for reporting decisions to terminate provider agreements to the Department; however, the policy stated a 60-day advance notice to the Department was required. The requirement to notify the Department is 90 days prior to termination of the agreement (unless the termination is based on quality or performance issues). ABC management staff reported that there were no terminations of provider agreements during the review period that caused the delivery of covered services to be inadequate in a given area.	
	Required Actions ABC must have a process in place to notify the Department in writing of its decision to terminate any existing provider agreement, where such termination causes the delivery of covered services to be inadequate in a given area, and provide the notice at least 90 days prior to termination of the services unless the termination is based on quality or performance issues.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
9. Prohibited Affiliations II.H.6.a	The Contractor does not knowingly have a relationship of the type described below with the following: An individual or an affiliate of an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CMP206 described ABC's policy prohibiting relationships with individuals who have been disbarred, suspended, or excluded from activities as described in Executive Order 12549. Policy PNS202 described the process for checking for sanctions during the credentialing process. A review of credentialing files confirmed that the processes described had been implemented.	
	Required Actions None	
10. Marketing II.H.8	The Contractor adheres to all contract requirements related to marketing.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings ABC management staff reported that during the review period, ABC did not engage in marketing activities as marketing is defined in the BHO contract with the Department.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
11. Department Approved Member Handbook II.H.8.a	The BHO's Member Handbook was submitted to and approved by the Department prior to distribution.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC management staff reported that a 2006 version of the member handbook had been submitted to the Department and has not yet been approved. Therefore, ABC is currently using the member handbook that was reviewed and approved by the Department in 2005. ABC staff indicated that the new handbook would be distributed following Department approval.	
	Required Actions None	
12. Statistically Valid Sampling II.J.6.c.3.c	The BHO reviews compliance with criteria for submission of encounter claims data each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC reviewed a statistically valid sample of encounter records (411) for compliance with contract criteria. The report ABC submitted indicated that ABC reviewed for the accuracy and completeness of the data and the presence of documentation in the medical record. The data submitted with the report indicated that ABC submitted both paid and denied claims. The report also indicated that the sample included data from the Mental Health Center of Denver as well as other subcontracted providers, and represented the array of services provided by ABC.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
13. Record Review: Documentation of Services	Presence, timeliness, and accuracy of documentation to support encounter claims.	
	Findings A sample of 10 consumer service records was reviewed to assess ABC's compliance with contract requirements related to documentation of services for encounters submitted. Sample Records 2 and 6 were unavailable at the time of the site review. ABC staff reported that ABC was unable to obtain the records from the providers. Two records from the oversample were reviewed to obtain a sample of 10 records. ABC was compliant with 19 of 21 of the total applicable elements reviewed for a record review score of 90 percent. Nine of 10 records contained documentation of the service on the day the encounter was submitted. The 10th record contained documentation dated the day following the date for which the encounter was submitted. Nine of 10 records contained documentation that described the service for which the encounter was submitted. For one record, the provider used an incorrect encounter code.	
	Required Actions ABC must ensure that providers submit accurate encounter codes that represent the services provided. ABC must ensure that it has effective processes in place for obtaining medical records from providers in a timely manner and for addressing any failure to comply.	

Results for Standard II					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
23	1	1	1	25	92%

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	Any practice guidelines adopted by the Contractor will: A. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the field.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure CCS311, Clinical Practice Guidelines, stated that all practice guidelines adopted by Access Behavioral Care (ABC) were based on valid and reliable clinical evidence and/or the consensus of health care professionals in the particular field addressed by the guidelines. During the interview, ABC staff reported that clinical practice guidelines for the treatment of bipolar disorder had been adopted by the BHO this review period. BHO Quality Improvement and Program Evalution (BQIPE) Committee meeting minutes throughout the review period documented that numerous bipolar practice guidelines were identified through a literature search, that available consumer and family resource materials were reviewed, and that committee members consulted with local experts in the treatment of bipolar disorder prior to adoption of the guidelines. The BQIPE Committee meetings were chaired by the ABC associate medical director and were attended by a consumer representative, family representative, provider representatives, and key clinical and leadership staff from the BHO.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	B. Consider the needs of the members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06/07 Desk Review Form stated that practice guidelines may be proposed by Colorado Access staff, providers, consumer advocates, or other community stakeholders. Policy and Procedure CCS311, Clinical Practice Guidelines, also included a requirement that clinical practice guidelines consider the needs of Colorado Access' members. BQIPE Committee meetings consistently included a consumer representative, and minutes from the May 16, 2006, BQIPE Committee meeting documented seeking consumer input regarding the bipolar disorder practice guidelines at a Consumer-Provider Partnership Council meeting. ABC staff also reported that consumer and family feedback regarding the bipolar disorder practice guidelines was solicited at Consumer Advisory Board (CAB) and Family Advisory Board (FAB) meetings.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	C. Be adopted in consultation with contracting health care professionals.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure CCS311, Clinical Practice Guidelines, stated that clinical practice guidelines adopted by the BHO were adopted in consultation with contracted health care professionals. Minutes of BQIPE Committee meetings throughout the review period demonstrated that provider representatives from the Mental Health Center of Denver (MHCD) and University of Colorado Hospital (UCH) were consistently in attendance during discussions regarding clinical practice guidelines. Minutes from the BQIPE Committee meeting held on May 16, 2006, documented a discusion regarding the plan to involve a local subject matter expert in the treatment of bipolar disorders in future BHO discussions regarding bipolar disorder practice guidelines.	
	Required Actions None	
	D. Be reviewed and updated periodically as appropriate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure CCS311, Clinical Practice Guidelines, stated that physical health practice guidelines were to be reviewed and updated annually and that behavioral health practice guidelines were to be reviewed and updated periodically as appropriate. During the interview, ABC staff stated that the BHO had adopted practice guidelines in previous years for the treatment of major depression and ADHD. ABC staff reported that a review of the guidelines for major depression was completed at a BQIPE Committee meeting in December 2006.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
II.I.2.a.1		
2. Dissemination	The Contractor disseminates practice guidelines to all affected providers and, upon request, to members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure CCS311, Clinical Practice Guidelines, stated that the BHO disseminated clinical practice guidelines to all affected providers through the Colorado Access Web site, as referenced in the provider manual, and upon request to members and potential members. The ABC Provider Manual contained information regarding clinical practice guidelines, including how to access guidelines on the Colorado Access Web site, and a telephone number to call to request hard copies of guidelines adopted by the BHO. ABC also provided an April 2006 Provider Update used by the BHO to notify providers about the posting of guidelines for ADHD and major depression in adults on the health plan Web site. ABC staff stated that in addition to learning about the availability of practice guidelines on the Web site, consumers received information about the guidelines through consumer bulletins.	
II.I.2.a.2	**Required Actions** None	

Results for Standard III					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
5	0	0	0	5	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	The Contractor has written policies and procedures for treating members in a manner that is consistent with the member's right to: A. Receive information about his/her rights.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had policies and procedures that addressed the consumer's right to receive information about consumer rights and included the procedures for the BHO and provider staff to communicate that information to the consumer. Policy CS212, Member Rights and Responsibilities, also described the BHO's requirements for staff and providers to annually review consumer rights and to sign an attestation statement that they had reviewed and would deliver services in accordance with those rights. Communication of rights was accomplished, in part, through the Consumer and Family Member Handbook (sent to all new Medicaid members and given to new consumers), the Office of Consumer and Family Affairs (OCFA) fact sheet, and the ABC Provider Manual. Minutes of the Consumer and Family Advisory Board meetings demonstrated the BHO's commitment to the effective communication of rights information to consumers and their families.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	B. Be treated with respect and with due consideration for his/her dignity and privacy.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had policies and procedures that addressed the consumer's right to be treated with respect and with consideration for dignity and privacy. Policy CS212, Member Rights and Responsibilities, also described the BHO's requirements for staff and providers to annually review all consumer rights and to sign an attestation statement that they had reviewed and would deliver services in accordance with those rights. The consumer rights information was included in the consumer handbook, a fact sheet, and the provider manual. The BHO had additional policies that addressed nondiscrimination, cultural sensitivity, and privacy/confidentiality.	
	Required Actions None	
	C. Participate in decisions regarding his/her health care, including the right to refuse treatment except as provided by law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had policies and procedures that addressed the consumer's right to participate in decisions about health care, including the right to refuse treatment. Policy CS212, Member Rights and Responsibilities, also described the BHO's requirements for staff and providers to annually review all consumer rights and to sign an attestation statement that they had reviewed and would deliver services in accordance with those rights. The rights information was included in the consumer handbook, a fact sheet, and the provider manual.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	D. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had policies and procedures that addressed the consumer's right to receive information on treatment options in a way that they could understand. Policy CS212, Member Rights and Responsibilities, also described the BHO's requirements for staff and providers to annually review all consumer rights and to sign an attestation statement that they had reviewed and would deliver services in accordance with those rights. The rights information was included in the consumer handbook, a fact sheet, and the provider manual.	
	Required Actions None	
	E. 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.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had policies and procedures that addressed the consumer's right to be free from seclusion or restraint as a means of coercion, discipline, convenience, or retaliation. Policy CS212, Member Rights and Responsibilities, also described the BHO's requirements for staff and providers to annually review all consumer rights and to sign an attestation statement that they had reviewed and would deliver services in accordance with those rights. The rights information was included in the consumer handbook, a fact sheet, and the provider manual.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	F. Request and receive a copy of his/her medical records and to request that they be amended or corrected.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had policies and procedures that addressed the consumer's right to request and receive a copy of his or her medical records and to request that they be amended or corrected. Policy CS212, Member Rights and Responsibilities, also described the BHO's requirements for staff and providers to annually review all consumer rights and to sign an attestation statement that they had reviewed and would deliver services in accordance with those rights. The rights information was included in the consumer handbook, a fact sheet, and the provider manual.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	G. Be furnished health care services in accordance with 42 C.F.R. Sections 438.206 through 438.210.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had policies and procedures that addressed the consumer's right to be furnished health care services in accordance with 42 Code of Federal Regulations (CFR) Sections 438.206 through 438.210. These regulatory sections were addressed in several BHO policies on service delivery and included requirements for the availability of services, assurance of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services. Policy CS212, Member Rights and Responsibilities, described the BHO's requirements for staff and providers to annually review all consumer rights and to sign an attestation statement that they had reviewed and would deliver services in accordance with consumer rights. The rights information was included in the consumer handbook, a fact sheet, and the provider manual.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights II.G.3	H. Be free to exercise his/her rights without it affecting the way the Contractor and its providers treat the member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had policies and procedures that addressed the consumer's right to be free to exercise his or her rights without it affecting the way the consumer is treated. Policy CS212, Member Rights and Responsibilities, also described the BHO's requirements for staff and providers to annually review all consumer rights and to sign an attestation statement that they had reviewed and would deliver services in accordance with consumer rights. The rights information was included in the consumer handbook, a separate fact sheet, and the provider manual. The BHO staff members articulated the process that would be followed in the event of an allegation of retaliation against a consumer for filing a complaint, although they stated that there had not been such an occurrence.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	A. The Contractor ensures that its staff and affiliated providers take these rights into account when furnishing services to members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC policy, CS212 Member Rights and Responsibilities, and the provider manual required that staff and providers comply with all consumer rights and that those rights be taken into account when providing services. The BHO had a process for rights information to be distributed to consumers, family members, and legal representatives to ensure there was awareness of consumer rights. ABC staff also furnished all providers with copies of provider bulletins and had documentation of the new provider orientation that was conducted. Staff described that periodic training and focused chart audits of providers have occurred to ensure that rights were taken into account. The BHO also stated that issues regarding respecting consumer rights would be identified through the grievance and complaint process and through consumer/family advisory board meetings.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	B. The BHO has a process to ensure the member's right to an independent advocate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC policy, Member Rights and Responsibilities, the consumer and provider handbooks, and the OCFA fact sheet gave consumers and providers information about the consumers' right to an independent advocate. BHO staff stated that most consumers choose or are accompanied by their own advocate rather than request assistance from the BHO to obtain an independent advocate. BHO staff members were able to describe several organizations that they have and would use if an independent advocate was requested by a consumer: Colorado Cross-Disability Coalition, the Mental Health Association, and the National Alliance for the Mentally Ill.	
	Required Actions None	
	C. The BHO has processes to follow-up on all member complaints about a staff person or provider and to ensure that the staff/providers do not retaliate against the member for expressing a concern.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC Policy ADM203, Member Grievances and Appeal Process, contained procedures for following up on consumer complaints. The ABC Provider Manual contained language for providers to ensure that there would be no retaliation against a consumer for expressing a complaint. BHO staff members stated that there had been no allegations of retaliation by consumers and were able to describe the process for follow-up and investigation, should such an allegation occur. ABC used a protected peer review process and its quality committee for investigation of allegations against providers. This information was used in the credentialing and contracting processes.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	D. The BHO furnishes to each of its Members information about the assistance available through the Medicaid Managed Care Ombudsman Program and how to access Ombudsman Program Services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had documented evidence of distribution of an explanatory letter to providers about the requirement to inform consumers about the availability of the ombudsman program. The letter was accompanied by the official flyer (in English and Spanish), and instructed providers to post the flyer in their service locations or to distribute the information to consumers receiving services in other locations.	
II.G.3-4	**Required Actions** None	
3. Member Responsibilities	The Contractor has written requirements for member participation and responsibilities in receiving covered services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC OCFA flyer and the consumer handbook contained a listing of consumer responsibilities and requirements for participation when receiving covered services. ABC also addressed these responsibilities in the policy on consumer rights and responsibilities, and in the handbook. The BHO staff described the processes used for routine and occasional distribution of these materials to consumers and their representatives.	
II.G.2	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
4. Consumer and Family Affairs II.G.5	The Contractor has an Office of Consumer and Family Affairs to work with members and families.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The roles and responsibilities of the ABC OCFA were described in the consumer handbook, provider manual, and the OCFA flyer. Information was provided to consumers as to how to access the OCFA staff and what assistance (advocacy, answering questions, etc.) would be provided by the office. The organizational chart and QAPI program description listed the advocacy manager as responsible for the processing of member grievances.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
5. Advance Directives	A. The Contractor has written policies and procedures for Advance Directives.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC policy CCS303, Advance Directives, contained the BHO's policy statements and procedures for providing advance directives information to members. The policy included all of the required aspects at 42 CFR 422. The policy required annual training of providers and education of staff on advance directives requirements; however, the BHO had not conducted a training.	
	Required Actions ABC must ensure that training/education of providers and staff is conducted to ensure providers are aware of their responsibilities under the BHO's advance directives policy.	
	B. The Contractor provides all adult members with written information on Advance Directives policies, which includes: 1. A description of the applicable state law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC policy on advance directives stated that the BHO provided all adult members written information about advance directives at the time of their enrollment, and subsequently upon request. The consumer handbook contained information about the types of advance directives allowable under State law and described them in layman's terms. This same information was available to consumers on the ABC Web site.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
5. Advance Directives	2. The member's rights under the law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The consumer handbook contained information about the consumer's advance directives rights under the law. This same information was available to consumers on the ABC Web site.	
	Required Actions None	
	3. The fact that complaints concerning non-compliance with the Advance Directive requirements may be filed with the State Department of Public Health and Environment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The consumer handbook and the ABC Web site contained information about the consumer's right to file a complaint with the appropriate State department and gave the contact information (telephone number and address) for filing a complaint.	
	Required Actions None	
II.H.7		

Results for Standard IV					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
17	1	0	0	18	94%

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
1. On-site Nursing Facilities II.F.2-3	The Contractor: - Provides medically necessary mental health services on-site in nursing facilities for members who are residents of nursing facilities and who cannot reasonably travel to a service delivery site for their services. - Considers the ability of the resident to travel when determining the service delivery site (i.e., BHO site or nursing facility).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC Policy CCS413, Access and Availabillty for Consumers Residing in Nursing Facilities, contained the procedures used by the BHO to identify providers to serve consumers in their nursing facility residence when they are unable to travel to a service delivery location. ABC's procedures included providing assistance with travel arrangements for consumers needing transportation between the nursing facility and a service site. During the interview, staff described that MHCD had a team and a nursing facility coordinator position with primary responsibility for the coordination of services for nursing facility residents. In addition, the BHO had contracted with a nurse practitioner with behavioral/geriatric certifications to provide services and perform outreach as needed to nursing facility residents.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
2. Dual Medicare/Medicaid Eligible	A. The Contractor makes an effort to identify and include providers in the Contractor's network that are capable of billing Medicare for dual Medicare and Medicaid eligible members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC Policy ABC307, Access and Availabiltiy for Dual Eligible Members, contained procedures for identifying dual-eligible members needing assistance and for either identifying an available Medicare provider or providing the service in or out of its Medicaid managed care network. The BHO staff identified Medicare providers when referring consumers for services through the provider directory. The UM database (CareStepp) also had an indicator for Medicare providers.	
	Required Actions None	
	B. If qualified Medicare providers cannot be identified, the Contractor provides the medically necessary mental health services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC Policy ABC307, Access and Availabiltiy for Dual Eligible Members, contained procedures for providing the service in or out of its Medicaid managed care network if an available Medicare provider could not be identified. The BHO's claims payment system was set up to assist with identifying and coordinating Medicare and Medicaid benefits. The BHO stated that because Medicare providers were geographically sparse in the area, the Medicaid network provided many services for the dual-eligibles.	
	Required Actions None	
II.F.4		

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	A. The Contractor monitors providers to determine compliance with standards for timely access.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO provided evidence of quarterly reporting to the Department during the review period for access-to-service measures. There was evidence that results were monitored, analyzed, and discussed in various quality improvement committees.	
	Required Actions None	
	B. The Contractor meets standards for timeliness of service including the following: 1. Emergency services are available - By phone within 15 minutes of the initial contact. - In person within one hour of contact in urban and suburban areas. - In person within two hours of contact in rural and frontier areas.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The provision of emergency services for ABC consumers occurred primarily in the hospital emergency rooms (ERs), although mobile crisis teams were also occasionally deployed, according to ABC staff. The ER clinician reported to ABC on the ER check-in time for the consumer and the time that the consumer was seen for a mental health intake/assessment. These data were used by ABC to analyze, trend, and report quarterly to the Department on the emergency service timeliness standard.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	2. Urgent care is available within 24 hours.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The provision of timely urgent care services was tracked by ABC through its C&T form (contact and triage), when services for consumers were assessed and reported as urgent by providers, for both independent practitioners and the mental health center. Data were monitored, trended, and reported through the quality improvement committee.	
	Required Actions None	
	3. Routine services are available within seven calendar days.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Timely provision of routine services was tracked and reported through the use of data elements recorded on an authorization form used by the BHO, and was reported for both MHCD and independent providers. The date and time of the service request and the date and time of the appointment being offered were captured in order for the BHO to calculate whether the providers were able to provide an appointment within seven days. The BHO reported that providers who could not meet the timeliness standard were to assist the consumer with a referral to the ABC service coordinators in order to find another provider. This was consistent with the provider manual. A secret shopper methodology was also used periodically to monitor appointment availability, and the BHO followed up with specific providers who were not able to meet the standard. Access data were monitored, trended, and reported in quality committees.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	C. The Contractor takes corrective action if there is a failure to comply with standards for timely access.	
	Findings This element was not reviewed or scored.	
	Required Actions	
	D. The authorization process takes into consideration other factors, such as the need for services and supports to assist a Member to gain new skills or regain lost skills that support or maintain functioning and promote recovery.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC provided documentation of its provider training module, which emphasized the recovery model and services and supports to assist individuals to achieve or regain functioning. Discussion during the interview included a description of the BHO's philosophy of recovery and of several initiatives that the BHO has supported, including care management, clubhouse, drop-in centers, and assertive community treatment. Additionally, staff in the care management area had been trained to assist consumers in developing WRAP plans.	
	Required Actions None	
II.F.1.a.7 II.F.1.a.4.a-e II.F.1.a.8 Exhibit C.III.C		

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	In establishing and maintaining the provider network, the Contractor considers: A. Including both Essential Community Providers and other providers.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC Policy PNS202, Selection and Retention of Providers, addressed the requirement to include essential community providers (ECPs) and other providers in the network. There was evidence in the provider network listing that the BHO had contracts with both types of providers. The Quarterly Network Adequacy Report documented the contracted FQHCs (two) and other ECPs, as well as all other types of providers with whom the BHO held contracts. During the interview, BHO staff members described the network as "mostly open" and stated that each request to join the network was evaluated against the needs, for example language and expertise.	
	Required Actions None	
	B. The anticipated Medicaid enrollment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC Policy PNS202, Selection and Retention of Providers, in the Provider Selection section addressed the requirement to consider the anticipated Medicaid enrollment. The Quarterly Network Adequacy Report established the ratio of providers to Medicaid members by county.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	C. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the enrolled population.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC Policy PNS202, Selection and Retention of Providers, in the Provider Selection section addressed the requirement to consider the expected utilization of services. The QAPI Program Impact Analysis and Annual Report discussed trends in utilization by service setting, type, length of stay, and inpatient days per 1,000 as part of the organization's assessment of availability of services.	
	Required Actions None	
	D. The numbers and types (training/experience) of providers required to furnish the contracted Medicaid services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC Policy PNS202, Selection and Retention of Providers, in the Provider Selection section addressed the requirement to consider the number and types of providers required to furnish services when establishing the network. The Quarterly Network Adequacy Report listed providers by type (license or category) and by location.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	E. The numbers of network providers who are not accepting new Medicaid patients.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC Policy PNS202, Selection and Retention of Providers, in the Provider Selection section addressed the requirement to consider the number of providers not accepting new Medicaid patients. The Quarterly Network Adequacy Reports documented the number (which was small) of providers who were not accepting new members.	
II.F.1.c	**Required Actions** None	
5. Out-of-Network Providers	If the Contractor is unable to provide covered services to a particular member, the Contractor provides the covered services out of network at no cost to the member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Quarterly Network Adequacy Report documented evidence that the BHO obtained providers out of region and out of network as needed to provide covered services to members. This practice was supported in the policy on selection of providers.	
II.F.1.d	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
6. Geographic Access II.F.1.e II.1.a.5	A. The Contractor has arrangements to ensure proximity of participating providers to the residences of members so as not to result in unreasonable barriers to access and to promote continuity of care taking into account the usual means of transportation ordinarily used by members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC Policy PNS202, Selection and Retention of Providers, addressed the requirements to ensure proximity of providers to consumers. Numerous examples of network adequacy reports documented the BHO's analysis of geographic access of consumers to participating providers.	
	Required Actions None	
	B. The Contractor ensures that providers are located throughout the Contractor's service area, within 30 miles or 30 minutes travel time, to the extent such services are available.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC Policy PNS202, Selection and Retention of Providers, addressed the requirements to ensure providers were located within 30 miles or 30 minutes of consumers. Numerous examples of network adequacy reports documented the BHO's analysis of geographic access (miles and minutes) of consumers to participating providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
7. Selection of Providers	The Contractor allows each member to choose, to the extent possible and appropriate, his or her health professional.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy ABC304, Consumer Choice in Behavioral Health Providers, addressed the requirement to give members choice of providers by telling them they have a choice and providing them a directory of participating providers. During the interview, BHO staff members stated that at consumers' requests, some additional providers have been added to the network.	
II.F.1.f	**Required Actions** None	
8. Recovery Model	The Contractor will demonstrate commitment to the recovery model.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC provider manual and member handbook described the roles of the Office of Consumer and Family Affairs. The BHO had an active Consumer Advisory Board (CAB) and Family Advisory Board (FAB), and meeting minutes provided evidence of consumer/family involvement in some levels of BHO policy and decision-making, including review and discussion of BHO information and reports and participation on the Quality Improvement Committee. Numerous recovery and empowerment initiatives and services were described by ABC, including clubhouse, Wellness Recovery Action Plan development, and drop-in centers.	
Exhibit C.II	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
9. Medication Management Exhibit C.IV.I	The BHO provides or arranges for the monitoring of medications prescribed, and consultation provided to Members by a physician as necessary.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO provided a listing of current prescribers in its provider network. During the interview, ABC staff discussed the model for the majority of consumers receiving medication and monitoring services through its contracted mental health center. For consumers in the independent practitioner network, therapists have typically referred consumers needing medication services to physicians with whom the therapist had a professional relationship. The BHO provides a separate authorization for the physician service. The BHO also described physician consultation services available to PCPs who prescribe psychotropic medications, and the use of hospital-based psychiatrists as a way of augmenting the prescribing network. The BHO recognized, similar to the national trend, that the children's psychiatry network at ABC had fewer prescribers than were needed.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
10. Alternative Services Exhibit K.III.A-I	The BHO has sufficient capacity to provide alternative services as described in Exhibit K of the Contract with the Department (effective 3/31/06). These services are available to serve the specified number of Members, and at the specified locations. **Findings** The BHO provided quarterly Alternative Services Reports as evidence of expenditures toward the required alternative services. During the interview, BHO staff members stated that the BHO could perform a closer analysis of the number of services provided, the number of service sites, and whether all requests for these services could be accommodated. The BHO had not performed this analysis; however, BHO staff members had confidence that if there were capacity issues, they would hear about them through the grievance and appeal process, through reports from the active advocacy community, or their through the BHO's consumer and family advisory boards. While these sources may indicate capacity issues, the BHO's approach did not meet the Department's expectation for more active monitoring to ensure sufficient capacity. **Required Actions** ABC must develop and implement a mechanism to monitor alternative service provision that ensures sufficient capacity is available as described in its contract with the Department.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**

Results for Standard V					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
19	1	0	0	20	95%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program	A. The Contractor has a Utilization Management (UM) Program to monitor the access to and appropriate utilization of covered services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Utilization Management Program Description described the Colorado Access Utilization Management (UM) Program, including the program's governance structure, goals and objectives, and a description of UM program activities. The FY 06-07 Quality Assessment and Performance Improvement (QAPI) Work Plan included both utilization monitors (penetration rate, inpatient days/1,000) as well as various quality indicators regarding access to care. The BHO also had numerous policies and procedures that described UM program activities, goals and objectives, and program requirements. .	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program	B. The UM program includes written policies and procedures.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC provided the following UM-related policies and procedures for review. Policy and Procedure CCS307, Colorado Access Utilization Review Determinations, described the utilization review (UR) process, including making timely and appropriate determinations, the handling of UR denials, and member noticing requirements. Policy and Procedure CCS302, Medical Criteria for Utilization Review, addressed the development and dissemination of UR criteria and guidelines. Policy and Procedure CCS301, Qualifications for Staff Engaged in Utilization Management Activities, defined qualifications for staff involved in making UR determinations. Upon review, it was determined that Colorado Access Policy and Procedure CCS307, Utilization Review Determinations, contained information regarding noticing requirements that was inconsistent with requirements included in the BBA and the BHO's contract with the Department. Section II.A.4. of the policy incorrectly allowed up to 15 calendar days for standard service authorization decisions that deny or limit services to ABC consumers. This was inconsistent with timelines prescribed in Exhibit G of the BHO's contract with the Department. Additionally, in order to be consistent with the BBA, Section II.A.5a. of the policy needed to clarify that extensions may not exceed an additional 14 calendar days.	
	Required Actions The BHO must revise its policy regarding utilization review determinations to be consistent with the BBA and with contract requirements.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program II.J.1	C. The Contractor has a mechanism in effect to ensure consistent application of the review criteria for authorization decisions and, as applicable, consultation with the requesting provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure CCS307, Utilization Review Determinations, stated that reviewer staff members were to use established UR criteria or guidelines to help ensure consistency in UR decisions across reviewers. The policy also allowed for peer-to-peer provider consultation in cases where a prospective review resulted in an adverse service determination. During the interview, staff reported that the BHO used standardized level-of-care (LOC) criteria based on InterQual guidelines and that ABC conducted periodic interrater reliability studies to help ensure the consistency of medical necessity decisions made by reviewers. BHO staff indicated that all UR decisions were made by service coordinators employed by ABC. Staff stated that routine outpatient services provided by independent providers and nonemergency admissions to hospitals, residential treatment facilities, and intensive outpatient levels of care, including day hospitals and assertive community treatment teams for consumers served by MHCD and independent providers, were prior-authorized by the BHO. Staff also indicated that service coordinators conducted periodic continued-stay reviews on these intensive levels of care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
2. Over-/Under-Utilization II.I.2.e	The Contractor has in effect mechanisms to detect both under-utilization and over-utilization of services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 QAPI Work Plan described use of the following utilization monitors to detect over- and underutilization: penetration rates, inpatient days/1,000, average length of stay (ALOS) for Level 2 facilities, and the number of members affected by inpatient and outpatient benefit limits. Examples of several reports used by the BHO to help detect under- and overutilization were also provided for review. Reports provided included emergency room high utilizers, paid claims in excess of $10,000, the Expenditures for Alternative Services Report, and daily census trending graphs. ABC staff stated that information from reports used to detect under- and overutilization of services were used by the BHO to monitor changes in service mix and that the information was frequently shared with providers at BQIPE Committee meetings.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
3. Evaluation of UM Program II.J.I.e	The Contractor has mechanisms to evaluate the effects of the UM program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings UM data were reviewed throughout the year at both BQIPE Committee meetings and Quality Improvement Committee (QIC) meetings. Minutes for a QIC meeting on November 21, 2006, documented a discussion regarding utilization reports, including ALOS data and hospital costs per day and per admission. The QAPI Program Impact Analysis and Annual Report Fiscal Year 2005-2006 included an evaluation of the BHO's UM program, including a summary of results for utilization monitors required by the Department and a summary of service utilization by level of care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
4. Clinical Expertise II.J.1.g	The Contractor ensures that any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope, that is less than requested, is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure CCS301, Qualifications for Staff Engaged in Utilization Management Activities, required that staff conducting utilization reviews have the appropriate training, knowledge, skills, and clinical experience. The policy mandated that reviewers who were not licensed must work under the supervision of an appropriately licensed and experienced health care professional and that utilization review denials must be signed by a licensed physician familiar with standards of care in the State of Colorado. During the interview, ABC staff confirmed that all clinical denials were reviewed by a licensed physician. Findings from the denial record review indicated that the BHO's practice was consistent with policy and that 100 percent of the UR denials included in the sample had been reviewed and signed by a licensed physician.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
5. Co-occurring MI/DD	The Contractor has written criteria for determining whether the need for mental health services for a member with co-occurring mental illness and developmental disabilities is a result of the individual's mental illness, or a result of the individual's developmental disability, or developmental delay (if the member is under age 5).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings During the interview, ABC staff members stated that they continued to participate with the Department and other BHOs in the refinement of the BHO Practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in Children, Youth, and Adults with Developmental Disability (DD). The BHO also provided a copy of the practice standards, last revised on August 29, 2005.	
II.E.1	**Required Actions** None	
6. Compensation for Conducting UM Activities	The Contractor does not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure CCS301, Qualifications for Staff Engaged in Utilization Management Activities, stated that Colorado Access does not provide financial or other incentives to staff making UR determinations that may result in inappropriate utilization. ABC also had staff involved in making UR determinations sign an Employee Affirmation Statement of Unencumbered Utilization Review Determinations. The attestation stated that: 1) reviewer decisions are based on coverage, eligibility, medical necessity, and appropriateness of care; 2) the BHO does not give rewards for issuing authorization denials; and 3) the BHO does not offer any financial or other incentives to encourage determinations that result in underutilization.	
II.F.1.g	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
7. Record Review—Denials	Presence and timeliness of required documentation and decisions by qualified clinician.	
	Findings A sample of 10 denial records were reviewed to assess ABC's compliance with contract requirements related to the presence and content of required documentation and the timeliness of resolution and documentation. ABC was compliant with 28 of 30 of the total applicable elements reviewed for an overall score of 93 percent. ABC was fully compliant in the following areas: 1) the notice included the reason for the denial, and 2) the decision was made by a qualified clinician. Notices of action for two cases reviewed were not sent in a timely manner to the consumer and provider following a UR denial as required in Exhibit G of the BHO's contract with the Department. In one case in the sample, a consumer with a diagnosis of mental retardation was denied a request for outpatient services. The denial reason was that the consumer did not have a covered diagnosis.	
	Required Actions ABC must ensure that a notice of action is sent in a timely manner to the consumer and provider following a UR denial decision.	

Results for Standard VI					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
7	1	0	0	8	88%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
1. Written Policies and Procedures II.F.1.h.1	The Contractor has written policies and procedures that ensure coordination of the provision of covered services to its members, and that address expectations for timely coordination of care.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure CCS305, Care Coordination, and Policy and Procedure CCS306, Providing Continuity of Care and Transition of Care for Members, were provided for review. The policies described the process for ensuring coordination of the provision of covered services without interruption and provided general guidance to staff regarding timeliness expectations for completing coordination activities.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	The written policies and procedures address: A. Service accessibility	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The following Colorado Access coordination-of-care policies included information regarding service accessibility: CCS305, Care Coordination; CCS309, Emergency and Post-Stabilization Care; and PNS306, Availability of After Hours Coverage.	
	Required Actions None	
	B. Attention to individual needs	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access provided the following coordination-of-care policies that addressed attention to individual needs: CCS305, Care Coordination, and ABC303, Consumer Access to Wraparound Services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	C. Continuity of care	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy CCS306, Providing Continuity of Care and Transition of Care for Members, addressed ensuring continuity of care for consumers under various circumstances. Section II of the policy included procedures to ensure continuity of care for newly enrolled ABC consumers. Section III of the policy addressed ensuring continuity of care for consumers following changes in the provider network.	
	Required Actions None	
	D. Maintenance of health	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy CCS305, Care Coordination, stated that a goal of care coordination was to improve consumer access to mental health care, community resources, and social supports. Colorado Access Policy CCS306, Providing Continuity of Care and Transition of Care for Members, included a procedure regarding assisting new ABC consumers in transitioning care from out-of-network mental health providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	E. Independent living	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access provided the following coordination-of-care policies that addressed independent living: CCS305, Care Coordination, and ABC303, Consumer Access to Wraparound Services. During the interview, ABC staff members stated that they used InterQual guidelines in making placement setting recommendatons and that efforts were made to support consumers so that they could live in the least restrictive setting possible.	
	Required Actions None	
	F. Coordination with other medical and behavioral health plans	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy CCS305, Coordination of Care, stated that a goal of care coordination included identifying opportunities to assist consumers in accessing medical care, mental health care, and other community resources and social supports.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	G. Confidentiality and privacy consistent with 45 CFR parts 160 and 164 (HIPAA)	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access provided the following coordination-of-care policies that addressed confidentiality and the release of records: HIP201, Confidentiality, Privacy and Security of Corporate and Member Information, and HIP202, Notice of Privacy Practices for Colorado Access Members. The Confidentiality, Privacy and Security of Corporate and Member Information policy included guidance regarding the use and disclosure of consumer information consistent with 45 CFR, Parts 160 and 164 (HIPAA). The Notice of Privacy Practices for Colorado Access Members policy described the BHO's process of consumer notification regarding the use and disclosure of protected information by the BHO.	
II.F.1.h.1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
3. Care Coordination	A. The Contractor provides for care coordination, which addresses the member's need for integration of mental health and other services. This includes identifying, providing, arranging for and/or coordinating with other agencies to ensure that the member receives the health care and supportive services that allow the member to remain in her/his community.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access provided several documents to demonstrate that the BHO provided care coordination to address the consumer's need for integration of mental health and other community services. The following Colorado Access policies and procedures addressed identifying, providing, arranging for, and coordinating mental health services with other community services: ABC303, Consumer Access to Wraparound Services, and CCS305, Care Coordination. Section V of the ABC Provider Manual addressed provider requirements related to coordination of care. Information included in a Care Management Overview document indicated that Colorado Access operated at least two care management programs that specifically target consumers with mental health diagnoses (Bipolar Care Management and AFFIRM). The BHO also provided a youth transitional brochure called "You're an Adult (Or Close Enough) So What's New." The brochure contained community resource information relevant to youth transitioning to the adult treatment system. Additionally, the BHO provided a memorandum of understanding (MOU) between Colorado Access, the Division of Youth Corrections, Denver Public Schools, the courts, and other community agencies. The MOU described the process for providing services to youth at risk of incarceration or out-of-home placement. In the interview, ABC staff reported collaborating closely with numerous community agencies, including schools, home-based providers, the Denver Police Department, Denver Options, the Mental Health Center of Denver (MHCD), and juvenile and adult corrections.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
3. Care Coordination II.F.1.h Exhibit C.III.B	B. The BHO, in consultation with the service provider, Member, family, and/or person with legal custody, shall determine the medical and/or clinical necessity of the covered service.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO provided numerous policies and procedures and other written documents that directed internal ABC staff to actively involve members, parents/guardians, and providers in determining the medical necessity of services. Colorado Access Policy CCS305, Care Coordination, stated that the member, family members, and/or legal representative(s), as appropriate, will, to the degree possible, be involved in developing a health care treatment plan in conjunction with the health plan and its provider(s). Policy and Procedure CCS307, Utilization Review Determinations, included a provision that providers, consumers, and/or consumers' parents/guardians receive written notification of any adverse service determination and be afforded an opportunity to appeal utilization review decisions. The BHO also provided a memorandum of understanding (MOU) developed by the Denver Collaborative Partnership that described interagency involvement (including child welfare) in making integrated service recommendations to the court for youth being recommended for commitment. During the interview, ABC staff stated that BHO service coordinators conducting utilization reviews routinely asked parents or guardians of youth whether they were in agreement with the level of care recommended by the treatment team. In addition, ABC required that its providers obtain the signature of the consumer and parent/guardian on treatment plans as evidence of their active involvement in the treatment planning process.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
4. Coordination with Medical Care Services	A. The Contractor assists members in obtaining necessary medical treatment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure CCS305, Care Coordination, included procedures regarding assessing consumer health care needs and assisting ABC members in receiving needed medical treatment. Section V of the ABC Provider Manual described provider requirements related to medical service coordination, including referring youth for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and coordinating with medical providers regarding any significant physical or behavioral health care need. The BHO also provided CareSTEPP print screens that documented having assisted consumers in securing medical services.	
	Required Actions None	
	B. If a member is unable to arrange for supportive services to obtain medical care due to his/her mental illness, these supportive services will be arranged for by the Contractor or another person who has an existing relationship with the member whenever possible.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure CCS305, Care Coordination, addressed the need to provide supportive services that are based on an individual service plan to ensure appropriate consumer access to medical care. The BHO also provided CareSTEPP print screens that documented having provided supportive service to consumers in securing medical services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
4. Coordination with Medical Care Services II.F.1.h	C. The Contractor coordinates with the member's medical health providers to facilitate the delivery of health care services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure CCS305, Care Coordination, identified improvements in the physical and mental health status of members as a goal of care coordination. The policy also included procedures that addressed the identification and prioritization of heath care needs and described steps to coordinate with medical and community service providers. During the interview, ABC staff stated that the BHO was participating in several initiatives aimed at improving communication and coordination with primary medical providers. These projects included the Depression in Primary Care Initiative and the Medical Home Project. The FY 06-07 Desk Review Form used for the site review stated that consumers who participated in the Depression in Primary Care Initiative showed a statistically significant reduction in PHQ-9 scores. The BHO also provided a flyer regarding the Medical Home Project, an initiative that allowed for easy access to mental health services and made continuing medical education on child psychiatric disorders and psychiatric consultation services available to participating pediatricians.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
5. School-Based Services Exhibit C.IV.I	Mental health services are provided to school-aged children and adolescents on site in their schools, with the cooperation of the schools.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC provided an example of an Alternative Services Report. The report was used to track BHO quarterly expenditures for alternative services, school-based services, and residential care. Both the ABC Consumer and Family Member Handbook and the ABC Provider Manual listed school-based services as a covered benefit. The provider manual also included information regarding how to access crisis mobile services in community settings, including schools. At the interview, ABC staff reported that the BHO had a long-standing relationship with the Denver Public Schools and that MHCD and other providers offered school-based services at a signficant number of schools throughout the district. BHO staff indicated that services in the schools were provided based on written agreements between the school district and providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
6. EPSDT	The Contractor provides services identified under the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section III.C.3. of Policy and Procedure CCS305, Care Coordination, included a provision that EPSDT identified services be included in the consumer's individualized care plan as appropriate. In addition, the BHO provided the following documents to demonstrate that information regarding the EPSDT program was shared with providers: provider manual, Section V, Care Coordination and Care Management, which stated that services identified through an EPSDT screening were to be provided even if the service was not included in the State's Medicaid plan; examples of EPSDT information available on the health plan Web site; and a copy of a Behavioral Health Provider Orientation, which identified coordinating care with physical health providers, including EPSDT referrals, as a provider requirement. ABC also provided an example of an Outpatient Benefit Limitation Monitoring Report and Inpatient Benefit Limitation Report. These reports demonstrated that services were provided to children in excess of the benefit limits and were tracked under the EPSDT category.	
II.E.1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
7. Record Review—Coordination of Care: Inpatient to Outpatient Transition (children). Exhibit C.I	There is evidence of coordination of care provided for children transitioning from an inpatient facility to outpatient services.	
	Findings Ten records were reviewed for evidence of care coordination and outpatient follow-up for children following discharge from an inpatient facility. In one case, ABC management staff indicated that ABC had no record of a request for authorization for hospitalization, no record of a paid or denied claim that ABC submitted to the Department, and no record of authorization or payment for outpatient services for this patient. In the other nine records, there were notes in the ABC service authorization database describing communication with the inpatient facility or describing ABC's understanding of the discharge plan. One of these nine records indicated that the inpatient stay was not paid for by ABC. The patient in this case had a noncovered diagnosis. Five records indicated that the children were discharged to placement arranged and paid for by DHS with no outpatient services requested or provided by ABC. Three records indicated that a follow-up appointment for services provided by ABC or a subcontractor for ABC was scheduled. In two of these three records, there was a progress summary documenting that the patient attended the scheduled appointment.	
	Required Actions None	

Results for Standard VII					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
15	0	0	0	15	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
1. Internal Quality Assessment and Performance Improvement Program II.I.1	The Contractor has an internal Quality Assessment and Performance Improvement (QAPI) Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A review of documents provided by the BHO demonstrated that ABC had a Quality Assessment and Performance Improvement (QAPI) Program in place that targeted continuous quality improvement of both its clinical and service delivery systems. Documents reviewed included the Quality Assessment and Performance Improvement (QAPI) Program Impact Analysis and Annual Report Fiscal Year 2005-2006. ABC also provided meeting minutes for both the BHO Quality Improvement and Program Evaluation (BQIPE) Committee and the medical Quality Improvement Committee (QIC). The above documents included comprehensive information regarding the BHO's governance structure, a description of goals related to the QAPI Program, and a detailed description of the quality measures, studies, and other activities used by the BHO as part of its quality improvement process.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program	The scope of the QAPI program includes, but is not limited to: A. A quality assessment and performance improvement plan that: 1. Delineates current and future quality assessment and performance improvement activities.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Quality Assessment and Performance Improvement (QAPI) Program Description and FY 06-07 Quality Assessment and Performance Improvement (QAPI) Work Plan described the BHO's current and future performance improvement activities. The QAPI Work Plan included a brief descriptor of each quality initiative, information regarding the objective/rationale, the intervention/activities, the metric/method, the goal/benchmark, frequency, the target date and the project lead for each quality measure and utilization monitor. Minutes from a BQIPE Committee meeting on January 24, 2006, included a discussion of the need to update the QAPI Work Plan to clarify metrics, identify performance improvement projects and reassign responsibility to be consistent with current structures and processes, priorities, and contractual requirements. QIC meeting minutes also indicated that the FY 06-07 QAPI Work Plan was reviewed and approved by the committee at a May 16, 2006, meeting.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program	2. Integrates findings and opportunities for improvement identified in studies, performance outcome measurements, member satisfaction surveys, and other monitoring and quality activities.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 QAPI Program Description and FY 06-07 QAPI Work Plan described the BHO's use of data from a variety of sources to monitor consumer outcomes and the effectiveness of clinical and service quality initiatives. The QAPI Program Impact Analysis and Annual Report Fiscal Year 2005-2006 presented key quality management findings, synthesized information from multiple data sources, and identifed strategies to improve future performance at the BHO. The report contained information from multiple data sources that demonstrated improved outcomes for adult consumers, including an increase in the percentage of members living independently, and statistically significant improvement in problem severity, level of functioning, and strengths and resources based on Colorado Client Assessment Record (CCAR) scores.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program II.I.2	B. Processes for addressing quality of care concerns.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure QM201, Investigation of Potential Clinical Quality of Care Grievances and Concerns, provided guidance to BHO staff in the handling of potential quality-of-care concerns, including information about noticing requirements and the monitoring and trending of aggregate data. The QAPI Program Impact Analysis and Annual Report Fiscal Year 2005-2006 included summary data regarding the number of reported quality-of-care concerns (QOCC) per member month. The ABC Provider Manual included information regarding provider reporting requirements, instructions for reporting, and a copy of the ABC Potential Quality of Care Incident Notification Form. The ABC Consumer and Family Member Handbook contained information regarding QOCCs, including examples of the types of events to be reported and reporting instructions.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	A. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The following ABC documents demonstrated that the BHO actively monitored consumer perception of accessibility and adequacy of services. The QAPI Program Impact Analysis and Annual Report Fiscal Year 2005-2006 contained results of the Mental Health Statistics Improvement Program (MHSIP) survey. The member survey included several indicators related to accessibility and adequacy of services, including whether service locations were convenient for the consumer and whether the consumer would recommend the agency to a friend or family member. During the interview, ABC staff stated that grievance and appeal data are also used by the BHO to evaluate member satifaction with the service delivery system.	
	Required Actions None	
	B. The Contractor's tools to monitor member satisfaction include: 1. Member Surveys	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Use of the MHSIP member survey and the Youth Services Survey for Families (YSSF) were included as planned quality initiatives in ABC's Fiscal Year 2005-2006 and FY 06-07 QAPI Work Plans. The FY 2007 MHSIP Consumer Survey document provided information regarding the survey's purpose and methodology, included a summary of survey findings, and identified planned actions for improvement to address survey domain scores that fell below the statewide average.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	2. Anecdotal Information	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC provided Consumer Advisory Board (CAB) and Family Advisory Board (FAB) meeting minutes to demonstrate that consumer and family member feedback was considered by the BHO as part of its QAPI Program. CAB meeting minutes dated June 1, 2006, and October 7, 2006, documented that quality improvement data were shared at the meetings and that consumers were provided with an opportunity to provide feedback regarding the mental health service delivery system. Minutes from the FAB meeting held on April 26, 2006, documented feedback provided by a family member related to problems with care and a communication breakdown.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	3. Grievance and Appeal data	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The QAPI Impact Analysis and Annual Report Fiscal Year 2005-2006 included grievance data trended by reason and a list of planned interventions to address identified trends and patterns. The BHO was required to submit a Grievance and Appeal Report Analysis to the Department each quarter that included an analysis of identified trends and corrective actions to be taken, if any. QIC and BQIPE Committee meeting minutes throughout the review period documented that the committee reviewed summary grievances and appeals data and took follow-up action as appropriate. Information provided in the grievance interview was that grievance information obtained during processing by MHCD was not included in the analysis of this data source by the BHO.	
	Required Actions The BHO must include MHCD grievances in its trending, analysis, and interventions to address consumer satisfaction issues.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction II.I.2.d	C. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaints is detected, or when a serious complaint is reported.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Access Policy and Procedure QM201, Investigation of Potential Clinical Quality of Care Grievances and Referrals, described the process for reviewing and taking appropriate corrective action to address any substantiated clinical quality-of-care grievances or concerns. The QAPI Impact Analysis and Annual Report Fiscal Year 2005-2006 and FY 2007 MHSIP Consumer Survey demonstrated that the BHO analyzed grievance data related to access to care and information from the MHSIP and YSSF surveys to identify patterns of consumer dissatisfaction. Analysis of grievance data included a comparison of the number of reported grievances by fiscal year and trending of member complaints by type of grievance. Analysis of member survey data included a comparison of performance by survey domain by fiscal year, a comparison of BHO performance to statewide data, and a discussion of the statistical significance of key survey items. The QAPI Impact Analysis and Annual Report Fiscal Year 2005-2006 and FY 2007 MHSIP Consumer Survey identified actions for improvement and other planned strategies to address significant findings.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
4. Health Information System II.I.h.2	The Contractor has a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to: A. Utilization	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC provided a written overview of the Colorado Access health information system that described the BHO's systems, basic data integrity and security processes, and the applications used in the collection, analysis, integration, and reporting of utilization data. The BHO also provided a PowerPoint presentation regarding PowerSTEPP, the software application used to capture authorization and clinical information as part of the utilization review process. During the interview, staff reported using PowerSTEPP and the Thomson Medstat Market Analysis Tool to assist in the collection, analysis, and reporting of utilzation data.	
	Required Actions None	
	B. Grievances and Appeals	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Print screens from the Colorado Access reporting package used to document and track grievance and appeal information were provided by the BHO. The application tracked the timely resolution of consumer grievances and appeals and contained information including the type of complaint, responsible staff, narrative notes regarding actions planned and/or taken in response to the grievance or appeal, and information regarding the status of the complaint.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
5. Program Impact Analysis II.I.2.j.1	The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program. **Findings** The FY 06-07 QAPI Program Description stated that the BHO's program was evaluated at least annually and that the evaluation report was submitted for review and approval to the BQIPE Committee, QIC, and Board of Directors. The QAPI Program Impact Analysis and Annual Report Fiscal Year 2005-2006 included a comprehensive review of the BHO's quality management structures, processes, and resources; reviewed the status of achieving goals and objectives from the prior fiscal year; and assessed the effectiveness of clinical and service quality initiatives and consumer outcomes. BQIPE Committee meeting minutes dated October 10, 2006, and QIC meeting minutes dated October 17, 2006, documented that the annual evaluation was reviewed and approved. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Results for Standard VIII					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
11	1	0	0	12	92%

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
1. Grievance and Appeal Records Exhibit G: 8.209.3.C	The Contractor maintains a record of grievances and appeals.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC demonstrated both its electronic database and the paper copy files that it maintained for purposes of documenting, tracking, and reporting Medicaid grievances and appeals. There was evidence that the BHO used experienced staff to document and maintain records of grievances and appeals and their resolutions, and submitted reports to the Department on a quarterly basis. Some of the data reported in the Department-required grievance reports included grievances processed by the BHO's contracted partner/provider Mental Health Center of Denver (MHCD). However, the BHO did not have the specific information about the nature and resolution of the Medicaid consumers' grievances that were processed by MHCD, copies of any correspondence sent to the consumers, or whether the grievance was resolved by a qualified and uninvolved staff member. These grievance data were also not included in the ABC database. The BHO also described its complaint processing procedures for consumers who did not want to file a formal grievance. The ABC call center staff documented the consumer's complaint reason, received assistance from the consumer service representatives as needed, and resolved the complaint by phone. These complaints were not included in the overall collection, analysis, and reporting of grievance data, and were not processed according to the Medicaid grievance standards.	
	Required Actions The BHO must ensure that whether complaints are processed by ABC or a delegate, all complaints and expressions of dissatisfaction are considered as grievances; are processed to ensure written acknowledgment, timely resolution, and reasonable assistance to the consumer; and that complaint data are included in the analysis and reporting of grievances.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
2. Provider Information Exhibit G: 8.209.3.B	The Contractor provides a Department approved description of the grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the Contractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO received the Department's approval of its provider grievance information contained in the provider manual. The process for disseminating provider information included giving each new provider a copy of the manual, making it available on the ABC Web site, and sending any revisions for page replacement as needed for updates or changes that are made to the content. In addition, ABC staff stated that they send provider bulletins on a regular basis with updates and reminders.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
3. Reasonable Assistance Exhibit G: 8.209.4.C	The Contractor provides members with assistance in completing any forms required by the Contractor, putting oral requests for a state fair hearing into writing, and taking other procedural steps including providing interpretive services and toll-free numbers that have adequate TTY/TTD interpreter capability.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC policy on grievances and appeals addressed the requirements to provide reasonable assistance to consumers, including help with forms, putting oral requests into writing, and providing interpretive services as needed. The consumer handbook communicated the availability of this assistance the consumers. During the interview, ABC staff described the customer service and grievance area staff and the capability for Spanish language interpreters for callers, as well as the availability of a language line. ABC's experience has been that most grievances have been filed over the phone as oral grievances. While the process for assistance to consumers filing grievances with ABC is clearly in place, the BHO did not have evidence that its partner/provider, MHCD, processed Medicaid grievances in a manner that provided reasonable assistance to consumers. These grievances were reported to the Department in the BHO's quarterly data.	
	Required Actions ABC must ensure that all consumers are given reasonable assistance with the grievance process, whether the process occurs through the BHO or is conducted by a delegate.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
4. Individuals Who Make Decisions	The Contractor ensures that the individuals who make decisions on grievances and appeals are: A. Individuals who were not involved with any previous level of review or decision-making.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The consumer handbook communicated to consumers that individuals who review and make decisions about their complaints or appeals would be qualified to do so and would not have been involved previously. The ABC policy on grievances and appeals also addressed this requirement. The processing of grievances and appeals through the centralized customer service department at ABC ensured that complaints and appeals were processed by uninvolved individuals. The review of grievance records provided and processed by MHCD on behalf of ABC did not provide documentation of the process used to ensure that the decision-maker was uninvolved.	
	Required Actions ABC must ensure that all Medicaid grievance decisions are made by individuals not previously involved, whether grievances are processed by ABC or by a delegate.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
4. Individuals Who Make Decisions Exhibit G: 8.209.4	B. Individuals who have the appropriate clinical expertise in treating the member's condition or disease if deciding an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance that involves clinical issues, or an appeal that involves clinical issues.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The consumer handbook communicated to consumers that individuals who review and make decisions about their complaints or appeals would be qualified to do so. The ABC policy on grievances and appeals also addressed this requirement. Evidence was provided that ABC staff processing grievances and appeals had qualifications to do so; however, there was no evidence of the qualifications of the MHCD staff member that provided grievance decisions for the clinical care grievances processed on behalf of ABC.	
	Required Actions ABC must ensure that all grievance decisions are made by staff with appropriate qualifications to do so, whether processed by ABC or by a delegate.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
5. Accepts Grievances and Appeals Exhibit G: 8.209.4	The Contractor accepts grievances and appeals orally or in writing.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC member handbook and the policy on grievances and appeals stated that consumers could access these processes either orally or in writing. Customer services staff provided an overview and demonstration of the database used to log and track all grievances and appeals, and evidence was available that ABC accepted grievances and appeals orally and in writing. However, the review of MHCD's available grievance documentation did not provide evidence of whether grievances were accepted both orally and in writing.	
	Required Actions ABC must ensure that grievances and appeals are accepted orally and in writing, whether processed by ABC or by a delegate.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process	A. The Contractor provides the member an opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and informs the member of the limited time available in the case of expedited resolution.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC policy on grievances and appeals, in the section describing procedures for appeals processing, addressed the requirements to allow an opportunity for the consumer to present evidence and to inform the consumer of the limited time involved in the case of an expedited resolution. The ABC consumer handbook and the Notice of Action letter attachment also communicated these requirements to consumers.	
	Required Actions None	
	B. The Contractor provides the member and the designated client representative opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents and records considered during the appeal process.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC policy on grievances and appeals, in the section describing procedures for appeals processing, addressed the requirement to provide the consumer the opportunity to review records before and during the appeal process. The ABC consumer handbook and the Notice of Action letter attachment also communicated these requirements to consumers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process	C. The Contractor includes as parties to the appeal, the member and, as applicable, the designated client representative or legal representative.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC policy on grievances and appeals, in the section describing procedures for appeals processing, addressed the requirement to include the consumer and the consumer's representative as parties to the appeal. The ABC consumer handbook and the Notice of Action letter attachment also communicated this requirement to consumers.	
	Required Actions None	
	D. The Contractor has an expedited review process for appeals when the contractor determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC policy on grievances and appeals, in the section describing procedures for appeals processing, addressed the requirements for an expedited appeal resolution. The ABC consumer handbook and the Notice of Action letter attachment also communicated these requirements to consumers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process Exhibit G: 8.209.4	E. The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The ABC policy on grievances and appeals, in the section describing procedures for appeals processing, addressed the requirement to ensure that no punitive action is taken against a provider for requesting or supporting a consumer's appeal. The ABC consumer handbook and the Notice of Action letter attachment also communicated this requirement to consumers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
7. Record Review—Grievance	Presence and timeliness of required documentation, decisions by qualified clinician, and responsiveness of resolution.	
	Findings A sample of grievance records was requested from ABC. Because ABC did not report any clinical or quality-of-care grievances in the time frame requested, ABC provided documentation from its partner/provider, MHCD, which also processed Medicaid consumer grievances. The documentation provided was an electronic database printout with brief notes about the nature and date of the complaint, the date it was resolved, brief notes about the resolution/decision, information about whether the consumer was satisfied with the resolution, and the last name of the staff person. There was no evidence that MHCD sent the required acknowledgment letters or written resolution letters to the consumers, that the person deciding the grievance had the qualifications to do so, or of whether the consumers had been provided reasonable assistance in the filing process. ABC staff reported that, upon requesting the grievance records, they had become aware that MHCD did not have any additional grievance documentation and that MHCD had not sent any written correspondence to the consumers during the process.	
	Required Actions ABC must ensure that all Medicaid consumer grievances are processed according to State requirements and Medicaid regulations, whether processed by the BHO or by a delegate. This process must include thorough documentation and record-keeping, timely written notice of acknowledgment and resolution to the consumer, decision-making by qualified and noninvolved staff, and reasonable assistance to the consumer.	

Results for Standard IX					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
6	5	0	0	11	55%

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
1. Excluded Providers	The Contractor does not employ or contract with providers excluded from participation in federal health care programs under Title XI of the Social Security Act, Sections 1128 and 1128A.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR318, Ongoing Monitoring of Sanctions, described the process for ensuring that ABC did not employ or contract with providers excluded from federal health care programs. Credentialing files demonstrated that ABC checked the federal database to ensure that providers were eligible for federal health care participation.	
II.H.3.e	**Required Actions** None	
2. Written Policies and Procedures	The Contractor documents the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs, and who render services or authorize services to members, and who fall within the Contractor's scope of authority and action.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR301, Practitioner Credentialing and Recredentialing, described the mechanisms and processes for credentialing and recredentialing licensed independent practitioners. A review of credentialing files and printouts of credentialing checklists demonstrated documentation of the mechanism for the credentialing and recredentialing of practitioners.	
NCQA CR1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	The written policies and procedures specify: A. The types of practitioners to credential and recredential. At a minimum, this includes all physicians and other licensed and/or certified practitioners who have an independent relationship with the BHO and who see enrollees outside the inpatient hospital setting or outside the facility-based settings.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section I of Policy CR301, Practitioner Credentialing and Recredentialing, specified the types of providers ABC credentialed and recredentialed.	
	Required Actions None	
	B. The verification sources used.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section XIV of Policy CR301, Practitioner Credentialing and Recredentialing, described the verification sources used in the credentialing and recredentialing processes.	
	Required Actions None	
	C. The criteria for credentialing and recredentialing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section VIII of Policy CR301, Practitioner Credentialing and Recredentialing, described the criteria for credentialing and recredentialing.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	D. The process for making credentialing and recredentialing decisions.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Sections XIV and XV of Policy CR301, Practitioner Credentialing and Recredentialing, described the process for making credentialing and recredentialing decisions.	
	Required Actions None	
	E. The process for managing credentialing files that meet the organization's established criteria.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Sections VII and XIV of Policy CR301, Practitioner Credentialing and Recredentialing, described the process for managing credentialing files.	
	Required Actions None	
	F. The process to delegate credentialing or recredentialing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy QM203, Delegation, addressed the delegation processes at ABC.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	G. The process to ensure that credentialing and recredentialing are conducted in a non-discriminatory manner, i.e., the Contractor 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.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR301, Practitioner Credentialing and Recredentialing, described ABC's nondiscrimination policy and application of criteria to all applicants.	
	Required Actions None	
	H. The process for notifying a practitioner about any information obtained during the Contractor's credentialing process that varies substantially from the information provided to the organization by the practitioner.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR312, Practitioner Rights, described the process for notifying practitioners about information obtained during the credentialing process that varied substantially from information provided by the applicant.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	I. The process to ensure that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision. Note: The organization (BHO) is not required to notify providers of recredentialing approvals.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section XVI of Policy CR301, Practitioner Credentialing and Recredentialing, described the process for notifying practitioners of the credentialing decision within 60 days of the committee's decision.	
	Required Actions None	
	J. The Medical Director or other designated physician's direct responsibility and participation in the credentialing program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR301, Practitioner Credentialing and Recredentialing, described the medical director's responsibility and participation in the credentialing program.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	K. The process to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR301, Practitioner Credentialing and Recredentialing, described the process for ensuring the confidentiality of credentialing files that contained information obtained during the credentialing process.	
	Required Actions None	
	L. The process for ensuring that listings in provider directories and other materials for enrollees are consistent with credentialing data, including education, training, certification, and specialty.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR301, Practitioner Credentialing and Recredentialing, described the process for ensuring that listings in provider directories and other materials for enrollees are consistent with credentialing data.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	M. The right of practitioners to review information submitted to support their credentialing application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR301, Practitioner Credentialing and Recredentialing, described the right of practitioners to review information submitted to support their credentialing application.	
	Required Actions None	
	N. The right of practitioners to correct erroneous information.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR301, Practitioner Credentialing and Recredentialing, described the right of practitioners to correct any erroneous information.	
	Required Actions None	
	O. The right of practitioners, upon request, to be informed of the status of their credentialing or recredentialing application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR301, Practitioner Credentialing and Recredentialing, described the right of practitioners, upon request, to be informed of the status of their credentialing or recredentialing application.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	P. How the applicant is notified of these rights and of the appeal process.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR312, Practitioner Rights, stated that applicants were notified of their rights under the credentialing process through the provider manual and through Schedule A of the Colorado Health Care Professionals Credentials Application; however, neither the provider manual nor Schedule A addressed the right to an appeal process. Both documents included all applicant rights under the credentialing process, except the right to an appeal process. Further, ABC management staff indicated that practitioners were given the provider manual (or given the Web site address) once accepted for participation in the network, not during the application process. Therefore the provider manual was not a mechanism to inform new applicants of rights under the credentialing process. Policy numbers CR204 and CR213 were also reviewed for evidence of compliance. Neither policy fully addressed the requirement. These policies addressed the hearing and appeal processes when the BHO chooses to alter the conditions of providers' agreements. Neither policy addressed how new applicants were informed of the right to an appeal process under the credentialing program. In addition, both documents addressed an appeal process only offered to physicians and not offered to other independent licensed practitioners.	
	Required Actions ABC must revise policies to include a description of how applicants are notified of their rights under the credentialing process, including the right to an appeal process.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	Q. The procedure for ongoing monitoring of sanctions, complaints and adverse events (for high-volume providers).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR318, Ongoing Monitoring of Sanctions, described the process for ongoing monitoring of sanctions, complaints and adverse events.	
	Required Actions None	
	R. The range of actions available to the Contractor if the provider does not meet the Contractor's standards of quality.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR204, Corporate Compliance Program Education and Training, described the range of actions available to ABC if providers did not meet ABC's standards of quality.	
	Required Actions None	
	S. Procedures for detection and reporting of incidents of questionable practice, in compliance with Colorado statutes and regulations, the Health Care Quality Improvement Act of 1986, and NCQA standards.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR317, Reporting Adverse Actions, and Policy CR204, Altering the Conditions for Provider Participation, addressed procedures for detection and reporting of incidents of questionable practice.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures CR1-Element A and B NCQA CR9 CR10-Element A and C II.H.3.g	T. An appeal process for instances in which the BHO chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR 213, Hearing and Appeal Process for Providers, described the appeal process for instances in which the BHO chooses to alter the conditions of practitioners' participation based on issues of quality of care. However, the policy addressed only physician practitioners. ABC management staff confirmed that the appeal process was only offered to physicians.	
	Required Actions ABC must have policies and processes that provide an appeal process for instances in which the BHO chooses to alter the conditions of practitioners' participation based on issues of quality of care or service. The policy must apply to practitioners as they are defined by the NCQA Standards and Guidelines for the Accreditation of MBHOs.	
4. Credentialing Committee NCQA CR2	The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing decisions.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR301, Practitioner Credentialing and Recredentialing, described the role of the credentialing committee in the credentialing process. A review of Credentialing Committee meeting minutes confirmed the use of the peer-review process for making credentialing decisions.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
5. Provider Application NCQA CR4-Element A	Providers are required to complete an application for inclusion in the Contractor's provider network that addresses: - The provider's health status, and reasons for any 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 activity - Current malpractice insurance coverage - The correctness and completeness of the application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC used the Colorado Health Care Professionals Credentials Application. Supplementals A and B of the application addressed all of the above requirements. A review of credentialing files confirmed that ABC required the use of the Colorado Health Care Professionals Credentials Application, including supplementals A and B.	
	Required Actions None	
6. High Volume Practitioners NCQA CR6-Element B	The Contractor specifies the method to identify high-volume providers.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ABC specified high-volume practitioners as licensed professional counselors who practice within specific zip codes. ABC staff reported that encounter data were used to determine ABC's definition of high-volume practitioners.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
7. Evaluation of High Volume Practitioners NCQA CR6-Element B	For high-volume providers, the Contractor conducts: A. An initial site visit	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR302, Office Site Visit for Initial Practitioner, described the process for conducting the initial site visit. A review of credentialing files confirmed that initial site visits were conducted for high-volume practitioners.	
	Required Actions None	
	B. An initial evaluation of treatment record-keeping practices at each site.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Medical record-keeping practices were assessed through the use of a site visit form. Completed forms were reviewed in credentialing files on-site.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
8. Requirements for Credentialing Policies for Organizational Providers NCQA CR11	The Contractor has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR305, Organizational Provider Assessment, described the procedures for the initial and ongoing (every three years) assessment of organizational providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
9. Policy Content—Organizational Provider Credentialing	The Contractor's written policies and procedures include: A. The Contractor confirms that the organization is in good standing with state and federal regulatory bodies.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section III of Policy CR305, Organizational Provider Assessment, described the process for confirming that the organizational provider was in good standing with State and federal regulatory bodies.	
	Required Actions None	
	B. The Contractor determines whether the provider has been reviewed and approved by an accrediting body.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section III of Policy CR305, Organizational Provider Assessment, described the process to confirm whether the provider had been reviewed and approved by an accrediting body.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
9. Policy Content—Organizational Provider Credentialing	C. If there is no accreditation status, the Contractor conducts an on-site quality assessment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section III of policy CR305, Organizational Provider Assessment, described the process for conducting an on-site quality assessment if the organizational provider was not approved by an accrediting body. Section VI.E of Policy CR305 described the criteria for the on-site quality assessment and addressed assessment of whether the organizational provider credentials its practitioners through review of the organizational provider's credentialing policies. A sample assessment form reviewed on-site included an assessment of the organizational provider's credentialing policies. A review of organizational provider credentialing files confirmed that ABC performed on-site quality assessments.	
	Required Actions None	
	D. At least every three years, the Contractor confirms that the organizational provider remains in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Policy CR305, Organizational Provider Assessment, included the provision that ABC conducted the assessment of organizational providers (confirming that the provider remains in good standing with State and federal regulatory agencies, determining accreditation status, and conducting an on-site quality review for nonaccredited organizational providers) every three years. A review of organizational provider files confirmed that organizational providers were assessed initially and reassessed in three years as applicable.	
NCQA CR11-Element A	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		

Results for Standard X					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
30	2	0	0	32	94%

The review of the records follows this cover page.

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Access Behavioral Care

Type of Record Reviewed	**Documentation of Services**		
Review Period	**January 1, 2006 - June 30, 2006**	**Reviewer**	**Barbara McConnell**
Review Date	**January 9, 2007**	**Participating BHO Staff Member**	**Rich Duncan**

Table B-1—Documentation of Services

#	Member ID	Provider ID	Date of Encounter	Doc Date Matches Encounter Date	Service Documentation Within 7 Days of Encounter Date	Procedure Code Submitted	Description of Procedure Code	Documentation Describes Procedure Code Submitted
1	*******	FHL	12/13/2005	Y	NA	90806	Psytx, Off, 45-50 Min	Y
3	*******	CRC	12/28/2005	Y	NA	90847	Family Psytx w Patient	Y
4	*******	DFPHD	6/1/2005	Y	NA	90806	Psytx, Off, 45-50 Min	Y
5	*******	MHCD	12/31/2005	Y	NA	H0043	Supported Housing, Per Diem	Y
7	*******	MP	12/15/2005	Y	NA	90847	Family Psytx w Patient	Y
8	*******	SdlR	1/17/2005	N	Y	90862	Medication Management	Y
9	*******	ECCCOS	11/17/2005	Y	NA	90806	Psytx, Off, 45-50 Min	Y
The progress summary was written in Spanish. The BHO staff member translated the documentation of the session.								
10	*******	NRBH	4/5/2005	Y	NA	90882	Environmental Manipulation	Y
The progress summary described a case management telephone contact with the grandmother.								
11	*******	KAI	3/14/2005	Y	NA	H2022	Com Wrap-Around Sv, Per Diem	N
There were two progress summaries dated March 14, 2005. One described daily activities the consumer performed while in a residential treatment center (RTC). The other described a social skills group the consumer attended while at the RTC. ABC management staff reported that RTC services should have been submitted using a different per diem encounter code, rather than the encounter code for wrap-around services.								
12	*******	JCMH	10/12/2005	Y	NA	90806	Psytx, Off, 45-50 Min	Y
			# Applicable Elements	**10**	**1**			**10**
			# Compliant Elements	**9**	**1**			**9**
			% Compliant Elements	**90%**	**100%**			**90%**

TOTALS	
Total # Applicable Elements	**21**
Total # Compliant Elements	**19**
Total % Compliant Elements	**90%**

Table Legend: DOS = Date of Service, Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Access Behavioral Care

Type of Record Reviewed	**Coordination of Care Inpatient to Outpatient Transition (Children)**		
Review Period	**October 1, 2005 - June 30, 2006**	**Reviewer**	**Barbara McConnell**
Review Date	**January 9, 2007**	**Participating BHO Staff Member**	**Rich Duncan**

Table B-2—Coordination of Care Inpatient to Outpatient Transition (Children)

#	Member ID	DOB	Primary Dx	D/C Date From Inpatient Facility	Date of First Follow-up	Documentation of Coordination and follow-up following an inpatient stay	In-Pt. Provider	Out-Pt. Provider
1	*******	*********	PSYCHOSIS NOS	2/1/2006		N	CHILDRENS HOSPITAL ASSOCIATION	N/A
ABC management staff reported that ABC had no record of a request for authorization for the hospitalization and no record of a paid or denied claim that ABC submitted to the Department for the hospitalization. There was also no record of authorization or payment of outpatient services by ABC.								
2	*******	*********	CANNABIS ABUSE-CONTIN	5/25/2006		Y	DENVER HEALTH MEDICAL CENTER	N/A
ABC management staff reported that this diagnosis was not a covered diagnosis and that there was no request for authorization or payment for inpatient or outpatient services through ABC. ABC had requested records from the Denver Health and Hospital Authority (DHHA) and there was a copy of discharge instructions that directed the patient to go to a step-down group at Denver Health.								
3	*******	**********	UNSPECIFIED EPISODIC MOOD DISORDER	1/11/2006		Y	CMHI FORT LOGAN	N/A
ABC service coordinator notes show a discharge date of January 11, 2006. There were service coordinator notes in the database that the discharge was to an RTC paid by the Division of Human Services (DHS). There were no outpatient services provided by ABC.								
4	*******	*********	ADJUST DISORD MIXED DISTURB EMOT CONDUCT	2/7/2006		Y	CMHI FORT LOGAN	N/A
ABC service coordinator notes show a discharge date of February 7, 2006. There were service coordinator notes in the database that the discharge plan was for a DHS placement. There were no outpatient services provided by ABC.								
5	*******	*********	BIPOLAR I DISORD MOST RECENT EP UNSPEC	10/20/2005		Y	PSI CEDAR SPRINGS HOSPITAL INC	N/A
There were service coordinator notes in the database that the discharge plan was for a DHS placement. There were no outpatient services provided by ABC.								
6	*******	********	BIPOL AFF, MIXED-UNSPEC	10/19/2005	10/20/2005	Y	CHILDRENS HOSPITAL ASSOCIATION	Children's Hospit
There were service coordinator notes that indicated that the discharge plan was for the patient to attend the day treatment program at Children's Hospital. The discharge summary from the day treatment program showed an admit date to the day treatment program of October 20, 2005, and a discharge date from the day treatment program of October 24, 2005.								
7	*******	*********	DRUG-INDUCED MOOD DISORDER	1/2/2006	1/5/2006	Y	CHILDRENS HOSPITAL ASSOCIATION	MHCD
There were service coordinator notes that indicated that this hospitalization was initially denied due to a diagnosis that was not a covered diagnosis. The hospital appealed the decision and ABC subsequently paid the claim based on evidence of a psychiatric diagnosis during the hospitalization. There was a progress summary from MHCD describing a therapy visit at MHCD on January 5, 2006.								
8	*******	*********	BIPOL MANIC-SEV W PSYCH	3/16/2006		Y	CMHI FORT LOGAN	
ABC service coordinator notes show a discharge date of March 16, 2006. There were service coordinator notes in the database that the discharge plan was to go to an RTC paid by DHS. There were no outpatient services provided by ABC.								
9	*******	*********	RECURR DEPR PSYCHOS-UNSP	2/23/2006		Y	CMHI FORT LOGAN	
There were service coordinator notes in the database that the discharge plan was to go to an RTC paid by DHS. There were no outpatient services provided by ABC.								

Table Legend: Y=Yes, N=No

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Access Behavioral Care

Table B-2—Coordination of Care Inpatient to Outpatient Transition (Children)								
#	Member ID	DOB	Primary Dx	D/C Date From Inpatient Facility	Date of First Follow-up	Documentation of Coordination and follow-up following an inpatient stay	In-Pt. Provider	Out-Pt. Provider
10	*******	********	SCHIZOPHRENIA NOS-UNSPEC	2/23/2006		Y	CMHI FORT LOGAN	Denver Health M
There were service coordinator notes indicating that an appointment was scheduled for March 2, 2006. There was no documentation to indicate whether the appointment was kept.								

Table Legend: Y=Yes, N=No

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Access Behavioral Care

Type of Record Reviewed	**Grievances**		
Review Period	**January 1, 2006 - September 30, 2006**	**Reviewer**	**Bonnie Marsh**
Review Date	**January 9, 2007**	**Participating BHO Staff Member**	**Reyna Garcia**

Table B-3—Grievances Record Review

#	Case ID #	Date Grievance Received	Date of Acknowledgement Letter	Acknowledgement Sent Within 2 Working Days	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Resolved and Notice Sent per Requirement	Appropriate Level of Expertise	Resolution Responsive to Member Grievance?
1	******	7/27/2006		N		0	NA	N	N	N
Consumer was referred to the residential program manager to make complaint on meals not occuring three times a day. The outcome indicated was "satisfactory."										
2	******	9/15/2006		N		0	NA	N	N	N
Consumer unsatisfied with the resolution. Notes are unclear about getting B-12 shots at a particular location.										
3	******	3/2/2006		N		0	NA	N	N	N
Consumer was worried about proper placement after hospitalization. A living arrangement was found for the member, but it was unclear if it was timely.										
4	******	6/13/2006		N		0	NA	N	N	N
Consumer was having difficulty at ALF placement. Case Manager was "looking into it".										
5	******	9/7/2006		N		0	NA	N	N	N
Consumer stated she shouldn't be on monitored medications. Consumer was told she had the right to not take her medications. The resolution indicated was "satisfactory."										
6	******	3/21/2006		N		0	NA	N	N	N
Consumer complained about not being allowed to go to her room until 7:30 p.m. Staff indicated it was not true that the consumer couldn't go to her room. Staff didn't want her to sleep all day. Report stated the consumer was "satisfied" with the resolution.										
7	******	5/12/2006		N		0	NA	N	N	N
Consumer was being discharged from the hospital on a Friday without money for food. A list of where free meals and food were available was provided.										
8	******	1/4/2006		N		0	NA	N	N	N
Consumer was to be evicted and complained that the case manager was not helping her. Consumer lost Section 8 housing but was not aware. Case manager was "trying to help resolve." Consumer was said to be "satisfied."										
9	******	2/17/2006		N		0	NA	N	N	N
Consumer needed to know when rent assistance check would come. Outcome listed as "satisfactory." The check was already on the case manager's desk.										
10	******	6/6/2006		N		0	NA	N	N	N
Consumer couldn't get medications when he needed them. The nurse said that he was out of medications at the time, but they would be in shortly. A "satisfactory" resolution was indicated.										

Table Legend: Y=Yes, N=No, NA=Not Applicable

Table B-3—Grievances Record Review										
#	Case ID #	Date Grievance Received	Date of Acknowledgement Letter	Acknowledgement Sent Within 2 Working Days	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Resolved and Notice Sent per Requirement	Appropriate Level of Expertise	Resolution Responsive to Member Grievance?
			# Applicable Elements	10				10	10	10
			# Compliant Elements	0				0	0	0
			% Compliant Elements	0%				0%	0%	0%
TOTALS										
			Total # Applicable Elements	40						
			Total # Compliant Elements	0						
			Total % Compliant Elements	0%						

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Access Behavioral Care

Type of Record Reviewed	**Denials**		
Review Period	**January 1, 2006 - September 30, 2006**	**Reviewer**	**Tom Cummins**
Review Date	**January 9, 2007**	**Participating BHO Staff Member**	**Chris Gillespie**

Table B-4—Denials Record Review

#	Member ID	Date of Initial Request	Standard/Expedited Authorization Decision			Termination, Suspension, or Reduction of Previously Authorized Services		Notice Includes Reasons	Decision Made by Qualified Clinician
			Date Notice Sent	# of Days For Decision	Notice Sent per Requirement	Date Notice Sent	Notice Sent per Requirement		
1	*********	7/5/2006	7/12/2006	7	Y			Y	Y
The denial was due to a diagnosis not covered (799.9). The consumer reportedly has had other covered diagnoses in the past and the request could be resubmitted.									
2	*********	8/17/2006	9/5/2006	19	Y			Y	Y
The denied request was for outpatient services provided from July 3, 2006-August 16, 2006. A request for additional information was sent on August 17, 2006, with a notice that if no further information was received within 14 days, a denial would occur. The BHO received nothing further from the provider. Denial notice sent September 5, 2006.									
3	*********	9/12/2006	9/14/2006	2	Y			Y	Y
The request was for home-based services for youth living in foster care. Physician reviewer assessed need for outpatient services only and another provider had already been authorized to provide outpatient care. Purpose of request was to preserve placement, not treat mental illness.									
5	*********	3/7/2006	3/22/2006	15	N	3/22/2006	NA	Y	Y
Hospitalization was approved at admission for three days (March 7, 2006-March 10, 2006). After services were provided beyond the dates authorized, the BHO sent a letter on March 22, 2006, denying dates of service for the entire hospitalization. There was no evidence of an extension of time frame request. Denied - not a covered diagnosis (mood disorder with hallucinations in conditions classified elsewhere.) Decision was by a physician.									
6	*********	6/20/2006	6/27/2006	7	Y			Y	Y
Request was for outpatient care. Denied due to a noncovered diagnosis (dementia in conditions classified elsewhere with behavioral disturbance). Physician made denial decision.									
8	*********	7/10/2006	8/2/2006	22	Y			Y	Y
Request was received for additional outpatient services (authorized services had been delivered). An extension letter was sent on July 11, 2006, requesting additional information. No further information was submitted by the provider. Denial letter was sent on August 2, 2006.									
9	*********	4/5/2006	4/7/2006	2	Y			Y	Y
Request was for outpatient services. Denied as not a covered diagnosis (V code--physical abuse of child). Entry stated provider could resubmit with different diagnosis (post-traumatic stress disorder), if appropriate. Physican made the decision.									
10	*********	6/15/2006	6/27/2006	12	N			Y	Y
Request was for outpatient services. Denial was based on a noncovered diagnosis (gender identity disorder in adolescents or adults). No evidence of a request for a time frame extension.									
11	*********	1/17/2006	1/20/2006	3	Y			Y	Y
Request was for outpatient services. Denial was due to a noncovered diagnosis (mental retardation). Physician denied the service.									
12	*********	3/20/2006	3/22/2006	2	Y			Y	Y
Request was for outpatient services. Denial was due to a noncovered diagnosis (substance abuse). Physician made the decision.									

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Access Behavioral Care

Table B-4—Denials Record Review

#	Member ID	Date of Initial Request	Standard/Expedited Authorization Decision			Termination, Suspension, or Reduction of Previously Authorized Services		Notice Includes Reasons	Decision Made by Qualified Clinician
			Date Notice Sent	# of Days For Decision	Notice Sent per Requirement	Date Notice Sent	Notice Sent per Requirement		
				# Applicable Elements	10			10	10
				# Compliant Elements	8			10	10
				% Compliant Elements	80%			100%	100%
TOTALS									
				Total # Applicable Elements	30				
				Total # Compliant Elements	28				
				Total % Compliant Elements	93%				

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix C. Site Review Participants for Access Behavioral Care

Review Dates

Dates for HSAG's site review for **ABC**, the period under review, and the contract term are shown in Table C–1 below.

Table C–1—Review Dates	
Dates of On-Site Review	January 9–10, 2007
Period Under Review	January 1, 2006–December 31, 2006
Contract Term	FY 06–07

Participants

Participants in the FY 06–07 site review of **ABC** are listed in Table C–2 below.

Table C–2—HSAG Reviewers and BHO Participants		
HSAG Review Team		**Title**
Team Leader	Bonnie Marsh, BSN, MA	Executive Director, EQR Services
Reviewer	Barbara McConnell, MBA, OTR	Colorado Project Director
Reviewer	Tom Cummins, LCSW	Consultant
ABC Participants		**Title**
Rob Bremer		Behavioral Health Quality Manager
Rich Duncan, MS, LPC		Manager, Behavioral Health
Reyna Garcia		Director, Claims and Customer Service
Christine Gillespie, RN, BSN, CCM		Manager of Utilization Management
Heather Hernandez		Service Coordinator
Bethany Himes		Supervisor, Intake Coordination
John Kiekhaefer		Service Coordinator
Molly McCoy		Staff Attorney
Mike McKitterick, RN		Vice President of Clinical Services
Travis Perez		Credentialing and Service Quality Coordinator
LeNore Ralston		Executive Director, Access Behavioral Health and CHP+
Gary Snider		Director, Provider Network Services
Marie Steckbeck		Vice President of Operations
Marshall Thomas, MD		President and Chief Executive Officer
David Proper		Project Coordinator
Debra Saviers		Customer Service Representative

Table C–2—HSAG Reviewers and BHO Participants	
Department Observers	**Title**
Sue Carrizales	Behavioral Health Specialist
Nancy Jacobs	Behavioral Health Benefits Supervisor
Connie Young	Quality Improvement/Behavioral Health Specialist
CMS Observers	**Title**
Cindy Smith	CMS Region 8

Overview

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine the MCOs' and PIHPs' compliance with contract requirements and federal regulations. The Department has elected to complete this requirement by contracting with an external quality review organization (EQRO). HSAG is the EQRO for the Department. The U.S. Department of Health and Human Services' (DHHS') Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQR.

The site review addressed the BHO's compliance with federal regulations and contract requirements in 10 areas: delegation; provider issues; practice guidelines; member rights and responsibilities; access and availability; utilization management; continuity-of-care system; quality assessment and performance improvement program; grievances, appeals, and fair hearings; and credentialing.

Individual records were reviewed to evaluate implementation of contract requirements for grievances, denials, coordination of care for children transitioning from inpatient to outpatient services, and documentation of services provided.

In developing the monitoring tool, HSAG used the BHO's contract requirements and the regulations specified by the BBA, including revisions that were issued June 14, 2002, and effective August 13, 2002. The site review adhered to the February 11, 2003, CMS final protocol: *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Regulations.*

Methodology and Process

Objective of the Site Review

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

- The BHO's compliance with federal regulations and contract requirements.
- The quality and timeliness of, and access to, mental health care furnished by the BHO.
- Interventions to improve quality.
- Activities to sustain and enhance performance processes.

To accomplish these tasks, HSAG assembled a team to:

- Collaborate with the Department to determine the review and scoring methodology, data collection methods, schedule and agenda, and other issues as requested.
- Collect and review data and documents before and during the on-site portion of the review.
- Analyze the data and information collected.
- Prepare a report of findings and required actions for each BHO.

Site Review Activities

Throughout this process, HSAG worked closely with the Department and the BHO to ensure a coordinated and supportive approach to completing the site review activities.

The following table describes the activities that were performed throughout the site review process.

Table D–1—Site Review Activities Performed

For this step,	HSAG…
Step 1:	**Established the review schedule.**
	Before the site review, HSAG coordinated with the Department and the BHO to set the site review schedule and assign staff to the site review teams.
Step 2:	**Prepared the data collection tools and submitted them to the Department for approval.**
	To ensure that all information was collected, HSAG developed monitoring tools consistent with BBA protocols. To create the monitoring tool standards, HSAG used the requirements as set forth in the contract between the Department and the BHO. HSAG also followed the guidelines specified by the BBA, including revisions that were issued June 14, 2002, and effective August 13, 2002. Additional criteria used in developing the monitoring tools included the NCQA 2006 Standards for the Accreditation of Behavioral Health Organizations and applicable Colorado and federal requirements.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 3:	**Prepared and submitted the Desk Review Form to the Department and the BHO.**
	After review and approval of the monitoring tools by the Department, HSAG forwarded a Desk Review Form to the BHO and requested that the BHO submit specific information and documents to HSAG within 30 days of the request. The Desk Review Form included instructions on how to organize and prepare the documents related to the review of the standards and records.
Step 4:	**Forwarded a BHO Document Request Form to the BHO.**
	HSAG forwarded a BHO Document Request Form to the BHO as an attachment to the Desk Review Form. The BHO Document Request Form contained the same standards and contract requirements as those in the tool used by HSAG to assess the BHO's compliance with contract requirements for each of the 10 standards. The Desk Review Form included instructions for completing the "BHO Information and Associated Documentation" section of this form. This step provided the opportunity for the BHO to identify, for each requirement, the specific BHO documents or other information that provided evidence of compliance, and streamlined the ability of the reviewers to identify all applicable documentation for review.
Step 5:	**Developed a site review agenda and submitted it to the BHO.**
	HSAG developed an agenda to assist BHO staff in planning for participation in the site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective site review, as well as minimizing disruption to the BHO's day-to-day operations. An agenda sets the tone and expectations for the site review so that all participants understand the process and time frames for the review.
Step 6:	**Provided orientation.**
	HSAG staff provided an orientation for the BHO and the Department to preview the site review process and respond to the BHO's and Department's questions. The orientation included identifying the similarities and differences between the FY 05–06 and the FY 06–07 review processes related to the request for information and documentation prior to the on-site portion of the site review, the schedule of review activities, and the process for the review of records.
Step 7:	**Participated in telephone conference calls with the BHO to answer questions and provide any other needed information before the site review.**
	Prior to the site review, HSAG representatives conducted a pre-site review teleconference with the BHO to exchange information, confirm the dates for the site review, and complete other planning activities to ensure that the site review was completed methodically and accurately. HSAG maintained contact with the BHO as needed to answer questions and provide information to key BHO management staff members. This teleconference and subsequent contact gave BHO representatives the opportunity to request clarification and present any questions about the request for documentation for the desk review and the site review processes.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 8:	**Received desk review documents and evaluated information before the on-site review.**
	Reviewers used the documentation received from the BHO to gain insight into the BHO's structure, enrolled population, providers, services, operations, resources, and delegated functions, if applicable, and to begin compiling the information and findings before the on-site portion of the review. During the desk review process, the reviewers: ◆ Documented findings from the review of the materials submitted by the BHO as evidence of compliance with the requirements. ◆ Identified areas and issues requiring further clarification or follow-up during the interviews. ◆ Identified information not found in the desk review documentation to be requested during the on-site portion of the review.
Step 9:	**Received record review listings and posted samples to HSAG's FTP site prepared for each BHO.**
	The Desk Review Form provided the BHO with the purpose, timelines, and instructions for submitting record review lists and for pulling sample records for HSAG's review. HSAG generated four unique record review samples based on data files supplied by the BHO or the Department. These files included the following databases: consumer grievances, consumer denials, consumers who are children and had been discharged from an inpatient facility, and encounters that had been reviewed by the BHO as part of a statically valid sample of encounters. From each of these databases, a random sample of unduplicated records was selected. For each of the record reviews, HSAG selected 10 records for the sample and five additional records for the oversample.
Step 10:	**Conducted the on-site portion of the review.**
	During the site review, BHO staff members were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. Activities completed during the site review included the following: ◆ Conducted interviews with BHO staff. Interviews were used to obtain a complete picture of the BHO's compliance with contract requirements, to explore any issues not fully addressed in the documents, and to increase overall understanding of the BHO's performance. ◆ Reviewed information and documentation. Throughout the desk review and site review processes, reviewers used a standardized monitoring tool to guide the identification of relevant information sources and to document the findings regarding compliance with the 10 standards. This activity included a review of applicable policies and procedures, meeting minutes, quality studies, reports, records, and other documentation. ◆ Received and reviewed records. Reviewers used standardized monitoring tools to review records and to document findings regarding compliance with contract requirements and the BHO's policies and procedures. ◆ Summarized findings at the completion of the site review. As a final step, HSAG reviewers met with BHO staff to provide a high-level summary of the preliminary findings from the site review.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 11:	**Calculated the individual scores and determined the overall compliance score for performance.**
	All of the 10 standards in the monitoring tool were reviewed and the information analyzed to determine the BHO's performance on the individual elements within each standard. For the review of records, each element was reviewed and the BHO's documentation analyzed to determine compliance.
Step 12:	**Prepared a report of findings and required actions.**
	After completing the documentation of findings and scoring for each of the 10 standards and for the reviews of records, HSAG prepared a draft report of the site review findings, scores, and required actions for the BHO. The report was forwarded to the Department and the BHO for their review and comment. After the Department's approval of the draft, a final, individual BHO report was issued to the Department and the BHO.

Evaluation and Scoring Methodology

Standards

The BHO's performance in complying with the elements (i.e., contract requirements) related to each of the 10 standards was evaluated against evidence obtained through a review of the BHO's documents and information provided during interviews with BHO staff. A score was assigned and the review findings and related substantiating evidence were documented in the "Findings" sections of the monitoring tool. The score (*Met, Partially Met*, or *Not Met*) indicated the degree to which the BHO's performance was in compliance with the individual elements in each standard. A score of *Not Applicable* (*N/A*) was used if an individual element did not apply to the BHO. Corrective actions required by the BHO to achieve compliance with the requirements were documented in the "Required Actions" section of the monitoring tool.

Scoring Methodology (Definitions)

The BHO received a score of *Met*, *Partially Met*, *Not Met*, or *N/A* for each element of each standard. This methodology follows the CMS final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*: *A protocol for determining compliance with Medicaid Managed Care Regulations*, February 11, 2003, and is defined below.

Met indicates full compliance, defined as either of the following:

- All documentation listed under a regulatory provision, or component thereof, must be present, or
- BHO staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews, or
- Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

- No documentation is present and staff have little or no knowledge of processes or issues addressed by the regulatory provisions, or
- For provisions with multiple components, key components of a provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for remaining components.

Not Applicable (***N/A***) signifies that the requirement does not apply, because:

- The standard or element was not applicable to the BHO.

To arrive at an overall percentage of compliance score for each standard, the total number of elements receiving a score of *Met* was divided by the total number of applicable elements.

Record Reviews

The evaluation of records to determine compliance with contract requirements was accomplished through the use of a record review tool developed for each of the applicable reviews (grievances, denials, coordination of care, and documentation of services).

Similar to the methodology followed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for determining the sample size required for confidence when evaluating compliance with elements of performance, a sample of 10 records with an oversample of five records was used for record reviews (unless there were 10 or fewer available records, in which case all available records were reviewed). The samples were selected from all applicable BHO records from January 1, 2006, through September 30, 2006 for the review of grievances and denials. For the review of documentation of services, HSAG used a random sample of 10 records with an oversample of five records selected from the 411 records submitted by each BHO for the validation of the BHO's review of a statistically valid sample of encounter data. For the coordination-of-care record review, HSAG used a sample of 10 records with an oversample of five records selected from the Department's encounter data list of children with inpatient stays and discharge dates between October 1, 2005, and June 30, 2006. Each record was reviewed for evidence of BHO compliance with the applicable elements.

For each type of record review except coordination of care, the BHO received a score of *Yes* (compliant), *No* (not compliant) or *N/A* for each of the elements evaluated. Except for the coordination-of-care record review, the BHO received an overall percentage-of-compliance score for each type of record review and for all the scored record reviews combined. The overall record review score was calculated by dividing the total number of elements scored *Yes* by the total number of applicable elements.

Determination of Overall Compliance Percentage Score

The overall compliance percentage score for each BHO was calculated by dividing the total number of elements that were compliant for the standards and the record reviews by the total number of applicable elements.

References

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