Colorado Medicaid
Community Mental Health Services Program

FY 07–08 Site Review Report

for

Access Behavioral Care

June 2008

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

HSAG Health Services Advisory Group

1600 East Northern Avenue, Suite 100 • Phoenix, AZ 85020
Phone 602.264.6382 • Fax 602.241.0757

CONTENTS

Overview of FY 07–08 Compliance Monitoring Activities

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

This is the fourth year that HSAG has performed compliance monitoring reviews of the BHOs. For the fiscal year (FY) 07–08 site review process the Department requested a focused review of five areas of performance. HSAG developed a review strategy consisting of five components for review, which corresponded with the five areas identified by the Department. These are: Access to Care (Component 1), Coordination of Care (Component 2), Oversight and Monitoring of Providers (Component 3), Member Information (Component 4), and Review of Corrective Action Plans and Supporting Documentation (Component 5). Compliance with federal regulations and contract requirements was evaluated through review of the five components. This report documents results of the FY 07–08 site review activities. Details of the site review methodology and summaries of the findings, strengths, opportunities for improvement, and required actions for each component are contained within the section of the report that addresses each component. Template data collection tools for Components 1, 3, and 4, as well as completed documents for Components 2 and 5, are found in the appendices.

In developing the data collection tools and in reviewing the five components, HSAG used the BHOs' contract requirements and regulations specified by the BBA with revisions that were issued on June 14, 2002, and effective on August 13, 2002. The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services final protocol *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)* (see Appendix H).

Objective of the Site Review

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

- The BHO's compliance with federal regulations and contract requirements in the five areas of review.
- The quality, timeliness, and access to mental health care furnished by the BHO, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of the area reviewed.
- Activities to sustain and enhance performance processes.

To accomplish these tasks, HSAG:

- Collaborated with the Department to determine the review and scoring methodologies for each component of the review, data collection methods, the schedule, the agenda, and other issues as needed.
- Collected and reviewed documents before and during the on-site portion of the review.
- Analyzed the data and information collected.
- Prepared a report of findings (2007–2008 Site Review Report) for each BHO.

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

Summary of Results

Each component of the review was assigned an overall score of *In Compliance*, *In Partial Compliance*, or *Not In Compliance* based on conclusions drawn from the review activities. Required actions were assigned to any component receiving a score of *In Partial Compliance* or *Not In Compliance.* As appropriate, opportunities for improvement were also identified for some components regardless of the score. While recommendations for enhancement of BHO processes were provided based on these identified opportunities for improvement, these recommendations (as differentiated from required actions) do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **Access Behavioral Care** (**ABC**) for each of the components. Details of the findings for each component follow in subsequent sections of this report.

Table 1-1—Results

Component	Overall Score
Component 1—Access to Care	☐ *In Compliance* ☐ *In Partial Compliance* ☒ *Not In Compliance*
Component 2—Coordination of Care	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 3—Oversight and Monitoring of Providers	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*
Component 4—Member Information	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 5—Review of FY 06–07 CAPs	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*

Methodology

HSAG conducted member interviews and telephone assessments of **ABC**'s access processes and compared the results with the BHO's policies and published practices and with information obtained from interviews with key BHO staff members.

HSAG reviewed for compliance with the following contract requirements:

- *Exhibit C.1:* "The Contractor shall assess the need for services."
- *II.F.1.a.5*: "The Contractor shall meet the standards for timeliness of service for routine, urgent, and emergency care."
- *II.F.1.f:* "The Contractor shall allow, to the extent possible and appropriate, each Member to choose his or her health professional."

Member Interviews

The Department provided HSAG with a sample of 10 Medicaid members (with an oversample of 25 Medicaid members) who received or attempted to receive services between the dates of January 1, 2007 and December 31, 2007. The intended sample mix for each BHO was as follows: three Medicaid members who received only an intake visit during the review period, three Medicaid members who received an intake and subsequent services during the review period, and four Medicaid members who were identified by various stakeholder groups.[2-1] HSAG interviewed two adult members, one of whom received services following the intake appointment and four individuals whose children were Medicaid members who had received an intake appointment, with two receiving subsequent services. There were no Medicaid members identified by the stakeholder groups who met the selection criteria for the sample (members who experienced an issue accessing services between July 1, 2006, and December 31, 2007, and had not had the matter investigated by either the Medicaid ombudsman or the Department). HSAG developed a short questionnaire that was conducted via telephone. Members were asked to describe their experience of obtaining an individual, confidential assessment for entry into services. Interview questions were designed to obtain members' perceptions related to the ease of gaining access to services provided by the BHO and information provided to them during initial and subsequent contact with the BHO.

[2-1] Stakeholder groups are the Mental Health Planning and Advisory Council, the Mental Health Advisory Committee, and the Office of the Ombudsman for Medicaid Managed Care.

Telephone Assessment of BHO Access Processes

HSAG conducted five calls per BHO to assess the processes and practices at each BHO for providing access or intake services to Medicaid members in the BHO's service area. The HSAG caller identified him/herself as an HSAG representative calling on behalf of the Department. The caller then asked a series of situational and standard questions about policies and processes for providing access to services. Answers were recorded by each caller and are summarized in the findings section below. The caller worksheets (see Appendix B) included scripts with a set of situations to present to the BHO intake worker. The situations presented to the BHO intake worker were different for each of the four calls. The caller worksheets also included a set of policy or process questions, which were standard questions to be asked during each call. Each scripted call was made to each BHO simultaneously. That is, Call Script 1 was made to each BHO on Tuesday, January 8, 2008, at 2 p.m.; Call Script 2 was made to each BHO on Saturday, January 12, 2008, at 3 p.m. and repeated on Monday, January 28, 2008, at 12:30 p.m.; Call Script 3 was made to each BHO on Wednesday, January 23, 2008, at 9:30 a.m.; and Call Script 4 to each BHO on Tuesday, January 29, 2008 at 4 p.m.

Summary of Findings

ABC's Care Coordination policy stated that care coordination goals are to, among other goals, establish individualized care plans based on a needs assessment. The Summary of Provider Responsibilities section in the provider manual addressed providers' responsibilities regarding assessing members' need for services. Appendix A to the provider manual included the standards for assessments. **ABC**'s 2008 Access to Care Plan did not specifically address **ABC**'s processes or requirements for assessing members' need for services.

During the telephone assessment calls, the HSAG caller was told by the Mental Health Center of Denver (MHCD) that Medicaid members requesting new services were denied appointments unless the call was placed to MHCD at 8 a.m. on a Monday morning. The staff member stated that if Medicaid members called for initial access to services on days other than Monday, or on a Monday after the allotted number of Medicaid appointments for the week were taken, the member would be instructed to call the following Monday at 8 am. When asked about access to urgent care services, the MHCD staff member reported that MHCD does not provide urgent care. She offered no suggestion where Medicaid members would obtain care for urgent needs. A staff member from the Denver Health and Hospital Authority (DHHA) Outpatient Behavioral Health Services (another organizational provider for **ABC**) told the HSAG caller that Medicaid members requesting admission to services were not provided appointments over the phone. The staff member stated that Medicaid members were told to arrive at 7 a.m. on Tuesdays or Thursdays to wait to see if they would be offered one of approximately three appointments available to Medicaid members for that day.

ABC's member handbook included a thorough discussion about choosing a provider, a list of member rights, and standards for timely access to services. **ABC**'s provider manual, as well as provider bulletins, informed providers of the standards for timely access to services. **ABC**'s FY 07–08 Quarter 2 Access to Care Report indicated that the most recent data showed **ABC** to be 96 percent compliant with the timeliness standards for access to emergency services, 100 percent

compliant with the timeliness standards for access to urgent care services, and 98.6 percent compliant with access to routine appointments.

Summary of Strengths and Opportunities for Improvement

ABC's communication with providers regarding requirements for assessment of members and standards for timely access to services included information in the provider manual and provider newsletters. There was no evidence of further interaction or training with providers or monitoring for compliance with access-to-care requirements.

During the telephone assessment calls to **ABC**'s organizational providers, MHCD and DHHA staff members stated that Medicaid members would be denied appointments for access to services unless the members either called or presented for services at specific times and specific days. In addition, they stated that no urgent care was available and offered no alternative resource for urgent care.

ABC's organizational providers' methods for responding to Medicaid members' request for services presented significant barriers to obtaining timely access to assessments of need and subsequent care. **ABC**'s measurement of compliance with access standards did not include members who called or presented for services outside of the organizational providers' time frames for allowing members to obtain appointments. In addition to noncompliance with standards for timely access to services, practices described by **ABC**'s providers constituted noncompliance with the Code of Federal Regulations (CFR) Medicaid managed care requirement that the BHO ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees (42 CFR 438.206[c][1][ii]). Also of concern is the possible lack of access to services for Medicaid members with urgent care needs.

Although the provider directory included independent practitioners, during one telephone assessment call, the **ABC** staff member told the HSAG caller that the network consisted of only three organizational providers (MHCD, DHHA, and the University Hospital Outpatient Clinic). The HSAG caller was not informed that independent practitioners were also part of the provider network. **ABC** may want to clarify who is included in the **ABC** provider network with the intake/customer service staff members.

Summary of Required Actions

ABC must immediately submit a plan of correction to the Department that describes **ABC**'s plan to train its organizational providers and the content of that training.[2-2] The plan of correction must also include **ABC**'s performance expectations for providers and how **ABC** will monitor its providers for compliance with access standards. The plan of correction must ensure that Medicaid members are offered hours of operation equal to enrollees of commercial health care plans who seek services from **ABC**'s providers. Further, **ABC** must work directly with the Department regarding completion of this required action and respond to the Department's feedback and requirements as appropriate.

[2-2] In response to the Department's request for an immediate corrective action plan (CAP) based on findings in the Access to Care component, **ABC** submitted a CAP directly to the Department that was approved by the Department on April 25, 2008.

ABC must ensure that measurement of compliance with access standards captures data based on Medicaid members' initial request for services.

ABC must also describe what facilities are part of its urgent care network, how Medicaid members in **ABC**'s service area are informed of the procedures for accessing urgent care services, and how **ABC** will ensure that its members receive urgent care services, if needed.

Methodology

Care coordination (as defined in the FY 07–08 BHO contract) means the process of identifying, screening, and assessing members' needs; identification of and referral to appropriate services; and coordinating and monitoring an individualized treatment plan. This treatment plan should also include a strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment. The focus of the FY 07–08 Coordination of Care record review was to use the clinical record to identify and assess the BHO's and providers' practices related to care coordination with primary care physicians and parents or guardians of children receiving services, specifically with respect to medication management. The Department provided HSAG with a sample of 10 Medicaid members (with an oversample of 5) who were children (0–17 years of age) and who received a medication management visit between January 2007 and September 2007. A reference period of 45 days prior to, and 45 days following, the medication management encounter date was used for review of each record. The purpose of the record review was to identify instances of care coordination between mental health provider(s) and the family (parent or guardian) and between mental health provider(s) and the primary care physician (PCP) related to medication management. Mental health providers may include the prescriber or the therapist.

HSAG reviewed for compliance with the following contract requirements:

- *II.F.1.g.3:* "The Contractor shall coordinate with the Member's medical health providers to facilitate the delivery of health services, as appropriate."
- *II.G.1.c:* "The Member has the right to participate in decisions regarding his or her health care."
- *II.G.5:* "The Contractor shall encourage involvement of the Member, family members, and advocates in service planning."

Summary of Findings

ABC's Care Coordination policy addressed coordinating with medical health providers for members with Early and Preventive Screening, Diagnosis, and Treatment (EPSDT) needs or members with special health care needs. The Provider Responsibilities section of the provider manual indicated that providers were required to coordinate care for members who have coexisting conditions or are involved with other providers or agencies. The Clinical Record Documentation Standards Section of the provider manual indicated that the individual service plan should include all care coordination and case management activities with other involved care providers or agencies, including school, human service, and/or legal systems. **ABC** contracted with a vendor to perform a record audit for the presence of selected medical record requirements in the medical records. The audit indicated that the contractor reviewed to determine whether a treatment plan was present; however, the contractor did not review for the content of the treatment plan. **ABC** provider bulletins included articles that addressed the importance of care coordination and/or documentation standards

and requirements, including a reminder for providers that members can participate in their care. Member newsletters included articles that encouraged members to see a PCP or addressed physical health and wellness topics.

ABC had two performance improvement projects (PIPs) in process that addressed coordination-of-care topics. These were the Care Coordination Between Behavioral Health and Primary Care PIP and the Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment PIP. The PIP that addressed coordination between emergency services (for psychiatric care) and outpatient treatment included an intervention to refer members to the care coordination department following the second psychiatric emergency room visit. The PIP that addressed communication between primary care and behavioral health was new and **ABC** had not yet determined interventions.

Providers were informed of member rights in the provider manual and members were informed of their rights in the member handbook. The Provider Responsibilities section of the provider manual required providers to be aware of member rights, which included the member's right to participate in treatment decisions.

The coordination-of-care record review included 10 records of children who received a medication management visit within the review period. No records from the oversample were reviewed. Five of the 10 records contained documentation of discussions with the family that occurred separate from the medication management visit and pertained to medications. In 5 records, documentation indicated that the prescribing psychiatrist also provided primary therapy to the members. In 2 records, documentation indicated that the primary therapist attended medication management sessions with the member. Three records contained documentation of coordination with other agencies. There were no records that contained documentation of coordination efforts with the PCP.

Summary of Strengths and Opportunities for Improvement

The record review demonstrated that primary therapists coordinated with prescribers and family members regularly. In several instances, the primary therapist also provided the member's behavioral health therapy and included family members in treatment sessions and treatment planning. **ABC**'s PIP designed to improve coordination of care between emergency service providers and outpatient therapy providers described the use of care coordinators in addition to primary therapists to enhance the services provided to members. While **ABC**'s provider manual included direction to providers regarding coordination of care with PCPs, **ABC** may want to consider developing additional criteria or guidelines to ensure that coordination and communication with the PCP occurs at all appropriate times during the member's treatment.

Summary of Required Actions

There are no corrective actions required at this time, as **ABC** was found to be in compliance with this component.

Methodology

HSAG conducted a desk review of policies and an on-site review of documentation with an interview of key BHO personnel. This component of the compliance monitoring review was designed to examine the BHO's processes for directly monitoring independently contracted providers, and to examine the BHOs' processes for monitoring the community mental health centers' (CMHCs) supervision and training of their providers. Specific attention was paid to the BHO's practices related to identifying and responding to issues during its monitoring of the CMHCs. The review period for this component of the review was January 1 through December 31, 2007.

HSAG reviewed for compliance with the following contract requirements:

- *II.F:* "The Contractor shall ensure that required and alternative services are provided through a well-organized service delivery system. The service delivery system shall include mechanisms for ensuring access to quality, specialized care from a comprehensive provider network."
- *II.G.4.h.3:* "Additional Member rights include the right to have an independent advocate, request that a provider be considered for inclusion in the network, and receive culturally appropriate and competent services from participating providers."
- *II.H.10.a.1:* "The Contractor shall be responsible for all work performed under this Contract, but may enter into Provider agreements for the performance of work required under this Contract. No provider agreements, which the Contractor enters into with respect to performance under the Contract, shall in any way relieve the Contractor of any responsibility for the performance of duties required under this Contract."
- *II.H.10.a.3:* "The Contractor shall monitor Covered Services rendered by provider agreements for quality, appropriateness, and patient outcomes. In addition, the Contractor shall monitor for compliance with requirements for Medical Records, data reporting and other applicable provisions of this Contract."

Summary of Findings

ABC's FY 06–07 Network Adequacy report demonstrated that **ABC** monitored the services and the service delivery system by monitoring the geographic locations of providers and members. The Quality Assessment and Performance Improvement (QAPI) Impact Analysis and Annual Report demonstrated that **ABC** monitored the service delivery system by monitoring penetration rates and utilization management measures, including hospital recidivism and over- and underutilization. The QAPI Impact Analysis and Annual Report also included an analysis of the MHSIP and YSS-F results and grievance and appeal data. **ABC**'s provider directory included an extensive list of providers with a wide variety of professional licenses and in a variety of locations in the Denver metropolitan area.

The provider manual listed member rights, which included the member's right to request that specific providers be added to the network. Members were informed of this right through the member handbook. The member handbook was available in alternative formats and languages. The QAPI Impact Analysis and Annual Report indicated that during FY 06–07 **ABC** offered cultural competency training to more than 200 providers, and that the rate of satisfaction with the cultural sensitivity of services was 70 percent, based on MHSIP results. **ABC**'s review of a statistically valid sample of encounter records indicated that **ABC** reviewed records for the completeness and accuracy of encounter data and for the presence of selected medical record requirements.

Summary of Strengths and Opportunities for Improvement

While **ABC** had mechanisms to monitor services and the service delivery system, it used only aggregate measures to do so. There was minimal evidence that **ABC** monitored performance of individual and organizational providers regarding requirements for the provision of services and documentation of services provided. **ABC** may want to consider peer or record review processes, for example, designed to assess the appropriateness, quality, and outcomes of services provided by a sample of practitioners.

During the 2007 audit of a statistically valid sample of encounter records, the **ABC** contractor who performed the audit reviewed for some, but not all, of **ABC**'s medical record requirements. In particular, the contractor did not review Medicaid member records for the presence of an assessment. **ABC** management staff members reported that there were no review activities or other mechanisms used to ensure that members received an assessment (as required in section 2 of this report).

Summary of Required Actions

ABC must develop provider-specific monitoring mechanisms to assess performance of providers related to service provision.

ABC must develop a mechanism for monitoring providers that ensures that members receive an assessment.

Methodology

HSAG compared results of the member interviews and the telephone assessments to BHO policies and to documentation provided to members in writing. This component assessed the accuracy of information provided verbally during the intake process at the BHO and at facilities designated by the BHO to perform the intake function on behalf of the BHO.

HSAG reviewed for compliance with the following contract requirements:

- *II.G.4.b:* "The Contractor shall have in place a mechanism to help Members and potential Members understand the requirements and benefits of the plan."
- *II.G.1.d:* "The Contractor shall establish and maintain written policies and procedures for treating all Members in a manner that is consistent with the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand."

Summary of Findings

ABC's member handbook included a complete description of services available through **ABC**. A welcome letter was used as an enclosure to the member handbook mailing. The letter was an easy-to-read outline of the information that could be found in the handbook. The handbook also described other benefits available under the Medicaid State plan as well as member rights. **ABC**'s Effective Communication with Limited English Proficient Persons and Sensory-Impaired/Speech-Impaired Persons policy described the availability of member materials in alternative formats and the availability of assistance with interpretation and assistive devices. The Member Rights and Responsibilities policy described the process for treating all members in a manner consistent with the rights.

Provider bulletins as well as the provider manual included information about member rights, including the member's right to receive information about available treatment options. The August 2007 provider bulletin included the Medicaid managed care regulations regarding provider-enrollee communications.

ABC management staff reported that **ABC**'s customer service department consisted of 12 staff members available to assist members with understanding the benefits of the Medicaid State plan and a referral to a contracted provider. Member newsletters included descriptions of Medicaid State plan benefits and services available through **ABC**'s contracted providers.

During the member interviews conducted by HSAG, one of six members interviewed remembered being told about a complaint process. Three members remembered receiving written information about **ABC**; however, none of those members remembered anything about the content of the information they received.

Summary of Strengths and Opportunities for Improvement

ABC's written materials for members were well-developed and contained easily understood information about benefits and services. The customer service department appeared to have adequate staff to assist members when phone calls were placed to **ABC**. During HSAG's assessment calls to **ABC**, the customer service staff members were professional and helpful. **ABC**'s written mechanisms (the member handbook and the member newsletters), as well as the customer service staff's ability to respond to calls and requests, provided ways to help members understand the benefits and requirements of the plan. **ABC**, however, may want to consider helping members by developing additional mechanisms based on different learning styles and by using more active outreach methods.

Summary of Required Actions

There are no corrective actions required at this time, as **ABC** was found to be in compliance with this component.

6. Component 5—Corrective Action Plan and Document Review *for* Access Behavioral Care

Methodology

As a follow-up to the FY 06–07 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all elements for which it received a score of *Partially Met* or *Not Met*. The plan was to include interventions to achieve compliance and the timeline. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with the BHO until HSAG and the Department determined that the BHO completed each of the required actions from the FY 06–07 compliance monitoring site review, or until the time of the on-site portion of the BHO's review.

Summary of Findings

ABC completed all corrective actions in Standard I—Delegation, Standard IV—Member Rights and Responsibilities, Standard V—Access and Availability, Standard VI—Utilization Management, Standard VIII—Quality Assessment and Performance Improvement, and Standard X—Credentialing.

Summary of Strengths and Opportunities for Improvement

There was evidence that **ABC** completed two of three required actions in Standard II—Provider Issues. **ABC** did not complete the required action for Standard II, Element 6D—Monitoring of Providers—Requirements for Medical Records. In addition, **ABC** completed three of six required actions in Standard IX—Grievances, Appeals, and Fair Hearings. **ABC** did not complete the required actions for Standard IX, Element 3—Reasonable Assistance Provided to Members Filing a Grievance; Standard IX, Element 4A—Individuals Who Make Grievance Decisions are Not Involved in Any Previous Level of Review; and Standard IX, Element 7—Record Review (grievance processing by the delegate).

ABC had contracted with a vendor to perform an audit of medical records to determine compliance with **ABC**'s requirements for the content of medical records. Only a portion of **ABC**'s requirements was included in the audit. During the on-site portion of the FY 07–08 site review, **ABC** management staff members reported that they had determined that their process (developed and implemented as a result of the FY 06–07 corrective action plan) had not been successful and that they were currently discussing options to accomplish a complete review for medical record requirements.

ABC had monitored MHCD, its delegate for grievance processing, for the quality and completeness of MHCD's delegated activities. Through its monitoring process, **ABC** determined that changes were required regarding which portions of grievance processing **ABC** would delegate and **ABC**'s method of monitoring the delegate. **ABC** had developed a revised process and revised tools, which were to become effective in April 2008. Given the transitional status of **ABC**'s processes for monitoring the performance of MHCD regarding grievance processing, there were specific

requirements not monitored during the review period (January 1, 2007, through December 31, 2007) or by the time of the FY 07–08 site review.

Summary of Required Actions

While revising **ABC**'s process for monitoring providers for medical record requirements, **ABC** must ensure that each of its medical record requirements is monitored.

While revising its process and procedures for monitoring MHCD for compliance with requirements related to grievance processing, **ABC** must ensure that there are mechanisms to ensure that members are provided reasonable assistance with filing grievances. In addition, **ABC** must ensure that individuals who make grievance decisions are individuals who were not involved in any previous level of review, and that grievances are processed according to all Medicaid managed care requirements.

ABC must submit evidence of having implemented its new monitoring and audit procedures.

Appendix A. Member Interview Worksheet for Access Behavioral Care

The member interview worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Member Interview Worksheet

Interviewer Name: Barbara McConnell Hector Cariello (Spanish-Speaking)	BHO Name: Access Behavioral Care
Member ID: _____ *(not to appear in the report)*	Member Name: _____ *(not to appear in the report)*

Introduce Yourself and Describe (Briefly) HSAG

The State of Colorado has asked us to interview a few Medicaid members to ask about their recent experiences at _____ (name the provider or make a general reference to services if the provider agency is unknown). Do you have a few minutes to talk about your experiences?

Members: (If child, parent was interviewed)

Member #1: Child
Member #2: Child
Member #3: Child
Member #4: Adult
Member #5: Adult
Member #6: Child

Where services were received:

Member #1: Dickerson office
Member #2: Assessment was done in the home
Member #3: Denver Health
Member #4: Wouldn't say where he received services
Member #5: Centro de la Familia
Member #6: Aurora Mental Health

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Member Interview Worksheet

1. *How did you feel about your first appointment at _____? Were you satisfied with your experience during your first appointment at _____?*

How did you feel?

Member #1: "I felt good. It was very informative."
Member #2: "I felt violated."
Member #3: "I felt good about the first appointment, then I was transferred to the east side clinic, I wasn't happy about that."
Member #4: "It depends on where you go. It's hard to get people who are qualified. Master's level is pretty good."
Member #5: "Fine."
Member #6: The parent said the appointment consisted of only 10 minutes of questions, then they were told they couldn't be helped that day. The parent said the family was in crisis and she felt the appointment was impersonal. They left without answers.

Were you satisfied?

Member #1: Yes
Member #2: No
Member #3: Yes
Member #4: The member declined to answer this question
Member #5: Yes
Member #6: No

2. *Can you tell me why you felt that way? Describe why you were/were not satisfied.*

Member #1: "(The therapist) was great. She let me cry and bawl whenever."
Member #2: The member stated that the appointment was the result of an accusation made by the child's father during a custody battle and that the assessment found no evidence to substantiate the accusation.
Member #3: "I felt like we got nowhere with the treatment. He's (the child) just the same."
Member #4: "Overall, the problem is finding people with credentials. People are unable to properly diagnose."
Member #5: "The staff treated me well."
Member #6: "We needed immediate help and didn't get it. She ran away that night."

3. *Was there anything that bothered you about the appointment or the person you talked to?*

Member #1: "No."
Member #2: "The situation."
Member #3: "I liked the person, just felt like the whole thing didn't help."
Member #4: "DVR is the worst system. They made a bizarre diagnosis. It was just a psychologist."
Member #5: "No."
Member #6: The parent explained that the child was running away a lot at this time. She had had a good therapist in the past and was on medication, but lost that due to loss of Medicaid eligibility. When she became eligible again, she attempted to return to treatment. The parent said that the child needed medications and was told it would take two to three weeks before someone would call with an appointment.

4. *If so, did you ever talk to anyone about it, or do anything about it?*

Member #1: N/A
Member #2: The parent reported that the only person she spoke to was the person who came to the house to do the assessment and that person treated her "terribly."
Member #3: "No"
Member #4: "No." The member then asked if there was a complaint logged about him.
Member #5: N/A
Member #6: "No." The parent stated that she tried to get social services to help, but social services said she needed to go through Medicaid first.

5. *If yes, did you receive anything in the mail about your complaint?*

Member #1: N/A
Member #2: N/A
Member #3: N/A
Member #4: N/A
Member #5: N/A
Member #6: N/A

6. *Were you ever told what you can do if you are unhappy about the help you are getting from your counselor? Did you ever get something about this in the mail?*

Member #1: Didn't remember
Member #2: "No."
Member #3: "No one ever told me that."
Member #4: "No. They don't want to listen. They just say I'm crazy."
Member #5: "Yes."
Member #6: "No."

7. Did you ever get any written information about the BHO (either when you went there or in the mail)?

Member #1: "Yes. Through the mail."
Member #2: "No. The person who did the assessment did not bring anything. The person who came out to do the assessment threatened me with a court order if I did not cooperate."
Member #3: Didn't remember
Member #4: "Yes."
Member #5: "Yes."
Member #6: "No."

8. (If yes): What do you remember about the information?

Member #1: "Nothing. I didn't read it, but I still have it."
Member #2: N/A
Member #3: N/A
Member #4: Could not remember anything
Member #5: Could not remember anything
Member #6: N/A

9. Where were you told you could get counseling? Were you given more than one place to go?

Member #1: "No. As a matter of fact, I came across someone named Jo Beth. She put me in touch with the Dickerson office. That's where I requested."
Member #2: N/A
Member #3: "No. They just transferred me."
Member #4: "I could have gone to several places."
Member #5: Member could not recall
Member #6: "No. I was going to call Medicaid to ask."

10. Did you go back for counseling after your first appointment?

Member #1: "Yes—once a week."
Member #2: "No."
Member #3: "Yes."
Member #4: "Yes."
Member #5: "No."
Member #6: "No."

11. (If no): Do you mind telling me why?

Member #1: N/A
Member #2: The member stated that the assessment was the result of an accusation made by the child's father during a custody battle and that the requirement was for an assessment only.
Member #3: N/A
Member #4: N/A
Member #5: "The pills that were prescribed made me sick."
Member #6: "The counselor said she could not force my daughter to therapy."

If the Member Was Denied Services (or Told He or She Didn't Qualify)

12. Did you get a letter explaining why they couldn't help you?

Member #1: N/A
Member #2: N/A
Member #3: N/A
Member #4: N/A
Member #5: N/A
Member #6: "No."

13. (If yes): Did it explain anything else you could do to get help if you didn't agree with the letter?

Member #1: N/A
Member #2: N/A
Member #3: N/A
Member #4: N/A
Member #5: N/A
Member #6: N/A

14. Is there anything else you would like to tell me about the Medicaid mental health services you have received?

Member #1: "It's been really, really helpful. They have been really good. I was having a hard time at first getting him to appointments, but now I'm laid off, so it's not a problem. It's a good partnership."
Member #2: "I'm glad it's over."
Member #3: The person the HSAG employee spoke to is the guardian of her nephew (who is the member). The guardian explained that they were going for treatment every week, but appeared to be getting nowhere. She explained that because she works full time, the frequency of the appointments was becoming a burden. "They didn't want anyone else to bring him, so I just stopped going. He's just the same—still has the same problems."

Member #4: The member complained that he was given the wrong diagnosis, but said he feels that he can't complain. He felt that the therapist who diagnosed him did not have appropriate credentials. The member made a point of telling the HSAG caller that he has two professional degrees. The member commented that PhDs are taken too seriously.

Member #5: "No."

Member #6: The parent explained that she arrived to the intake appointment early and her daughter would not get out of the car. The mother explained this to the therapist and the therapist refused to go to the car to talk to the child. The therapist told the mother to drop the child off at the teen shelter. The mother has asked for residential services.

"They said I should let her go."

Appendix B. Telephone Assessment Worksheet for Access Behavioral Care

The telephone assessment worksheet follows this cover page.

Telephone Assessment Worksheet 1

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Access Behavioral Care Telephone number called: 303-751-9030

Date of call: Tuesday, January 8, 2008 Time of call: 2 p.m.

Caller: Jennifer Goodman

Name of person answering the phone: A

Offered name: X Had to ask name: _____

Notes:

Person assigned to help or transferred to: _____

Offered name: _____ Had to ask name: _____

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

Urban

Specific questions for the first call:

1. *How would someone (perhaps a parent) obtain services for a child with Asperger's syndrome who has additional symptoms (i.e., if the parent describes symptoms of psychosis or depression)?*

   A responded that the first step would be to check the member's eligibility with Medicaid and ABC. Second, A would ask who the PCP was to make sure the PCP remained involved. Then, she would refer the caller to the provider network directory so that the person could pick a provider. If the caller said that he or she could not get an appointment to see a provider, ABC would get a service coordinator involved to assist in linking a member with a provider.

2. *How would you (the BHO) respond to a nursing home calling to obtain services for a resident (for depression)?*

   (If the BHO indicates that the resident would have to travel to a CMHC or provider office, ask how transportation could be arranged or services could be provided at the nursing home.)

   The first step would be to check eligibility. If the member is in a nursing facility, A would discuss linking a provider in the provider network with the member in the nursing facility. The caller could use the provider directory to choose a provider located close to the nursing facility. Depending on the circumstances, a service coordinator would be assigned to assist the nursing facility. If transportation is needed, then members are referred to LogistiCare of Colorado. Their phone number is 1-800-285-5150. If the member has trouble getting transportation, ABC will assist.

General questions asked during each call:

3. *What is your next availability for a routine appointment?*

   Call 1 (call placed at 2 p.m. on Tuesday, January 8, 2008): A stated that availability of providers for routine care is up to the individual provider. If the member cannot get an appointment with the provider of his or her choice, then the ABC call line can use its care coordination department to assist.

   Call 2 (Saturday): N/A (see Telephone Assessment Worksheet 2 for details)

   Call 2 (repeated—call placed at 12:30 p.m. on Monday, January 28): V said that the member services center would give the member the names of several providers who could see the member. Assistance making appointments is also provided.

   Call 3 (call placed at 9:30 a.m. on Wednesday, January 23): A said that she would refer the caller to the provider directory to obtain services. If the caller had done this already and was unable to obtain assistance, then A would assist the caller with making an appointment in a timely fashion.

   Call 4 (call placed at 4 p.m. on Tuesday, January 29): J said that the member services department would refer the caller to the provider directory to make an appointment.

Additional calls were placed to a selection of ABC's organizational providers to ask appointment availability questions since the ABC access line could not provide appointment availability.

Call 5 (initiated by Rachel Henrichs to the Mental Health Center of Denver on Thursday, March 13, 2008, at 4:05 p.m.): L said that Medicaid members are directed to call the center at 8 a.m. on Mondays. She stated that this is when intake appointments are scheduled. L explained that if all of the appointments are gone by the time the member gets through, the member will be instructed to call again the following Monday. She stated that there are a limited number of appointments available to Medicaid members and those appointments are only scheduled on Monday. The HSAG caller called the center again on Monday, March 17, 2008, at 8:10 a.m. and spoke to J. J confirmed the intake process for Medicaid members as described by L. J stated that there are about 7 appointments available for intake for Medicaid members during a typical week, but that during the week of March 17, 2008, there were 12 Medicaid intake appointments available.

Call 6 (initiated by Rachel Henrichs to University Of Colorado Outpatient Clinic on Friday, March 14 at 8:20 a.m.): The HSAG caller got a recording that asked the caller to leave a name, date of birth, phone number, and insurance information, including the name of the insurance, the customer service number of the insurance company, and the policy number. The recording said someone would call back in two to three business days to review this information.

Call 7 (initiated by Rachel Henrichs to Denver Health Outpatient Behavioral Health Services on Friday, March 14, 2008, at 1:30 p.m.): B explained that intake appointments for Medicaid members are walk-in only. Members must come to the center at 7 a.m. on Tuesday or Thursday. Appointments are given on a first-come-first-served basis. The HSAG caller asked approximately how many members are seen each day. B answered, "about three."

3.a. Are callers always directed to a CMHC for services or are they given the choice between a CMHC or a contractor before the appointment is set?

Call 1: A explained that members can see any provider in the provider directory. The network providers are Mental Health Center of Denver, University Hospital, and Denver Health.

Call 2 (Saturday): N/A (see Telephone Assessment Worksheet 2 for details)

Call 2 (repeated): V said that members are provided a choice.

Call 3: A said that members are given a choice of any provider in the provider directory, be it a clinic or individual provider.

Call 4: J said that members can choose from a CMHC or a private provider.

3.b. If a member asks if he or she can see someone other than a CMHC provider, what do you tell the member?

Call 1: Members can see any provider in the provider directory. The network providers are Mental Health Center of Denver, University Hospital, and Denver Health.

Call 2 (Saturday): N/A (see Telephone Assessment Worksheet 2 for details)

Call 2 (repeated): Members can see anyone in the provider network.

Call 3: A said that members are given a choice of any provider in the provider directory, be it a clinic or individual provider.

Call 4: J said that members can choose from a CMHC or a private provider.

3.c. If a member calls with a request to see a specific private therapist who is not in your network, what do you tell the member?

Call 1: A said that if the provider is not in the network, then the member has to go through the Prior Authorization department as prior authorization is required to access services from an out-of-network provider.

Call 2 (Saturday): N/A (see Telephone Assessment Worksheet 2 for details)

Call 2 (repeated): V said that members could switch to anyone in the provider directory or the member could try to get prior authorization or a referral to see the member's current therapist.

Call 3: A said that prior authorization is required for out-of-network providers. The member could ask that the provider call ABC for prior authorization.

Call 4: J said the member would be advised to choose a provider in the network. If the member wanted to see a provider outside of the network, he or she would need to obtain prior authorization.

4. What is your next availability for an urgent appointment?

Call 1: A repeated that scheduling is up to the provider of the member's choice. However, if the member cannot get an appointment with that provider, then the ABC call line will assist the member and use ABC's clinical care manager to obtain services for that member's urgent needs.

Call 2 (Saturday): N/A (see Telephone Assessment Worksheet 2 for details)

Call 2 (repeated): V would most likely refer the caller to a service coordinator to make sure the member got the needed assistance quickly.

Call 3: A would transfer the caller to a service coordinator so that the member could be seen immediately.

Call 4: J said that the member services department would refer this member to a hospital.

Call 5: L told the HSAG caller that this center does not make urgent appointments. L did not indicate if she would provide the member with further direction regarding where to receive urgent services.

5. *If I was a Medicaid member calling with an emergency what directions would you give me and how long would it take for me to be seen?*

   Call 1: A repeated that scheduling is up to the provider of the member's choice. However, if the member cannot get an appointment with that provider, then the ABC call line will assist the member and use ABC's clinical care manager to obtain services for that member's emergency needs.

   Call 2 (Saturday): N/A (see Telephone Assessment Worksheet 2 for details)

   Call 2 (repeated): V would most likely refer the caller to a service coordinator to make sure the member got the needed assistance quickly.

   Call 3: A would transfer the caller to a service coordinator so that the member could be seen immediately.

   Call 4: J said that the member services department would refer this member to a hospital.

   Call 5: L stated that this center does not treat new members on an emergent basis—only established patients. L did not indicate if she would provide the member with further direction regarding where to receive emergency services.

6. *What is the procedure if a member indicates that he or she has moved from another BHO's catchment area, but the eligibility file does not reflect the change?*

   Call 1: A said that ABC gets eligibility information from the State. If the member moved into ABC's catchment area but ABC had no record of it, the member would be referred to the Medicaid eligibility office. If the member had trouble calling Medicaid or needed assistance, the ABC call center would be willing to either do a conference call or call the State for them and then call the member back.

   Call 2 (Saturday): N/A (see Telephone Assessment Worksheet 2 for details)

   Call 2 (repeated): V said that she would look on the Web portal to see if the caller was eligible. V would ask the caller for his or her address so she could tell whether the caller was a member of ABC's service area. V could then assist with making an appointment.

   Call 3: ABC checks its internal source files as well as a portal site to find out if the caller is within its service area. If the caller is not, he or she would be directed to the Medicaid agency call center to rectify the situation. ABC would assist in this process if need be.

   Call 4: J said that the member services department would attempt to verify eligibility. If eligibility could not be verified, the member would be referred to ABC's eligibility department to work with the Medicaid agency to correct the files.

Telephone Assessment Worksheet 2

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Access Behavioral Care Telephone number called: first 303-751-9030, then 800-984-9133

Date of call: Saturday, January 12, 2008 (repeated on Monday, January 28, 2008)
Time of call: 3 p.m. (Saturday), 12:30 p.m. (repeated)

Caller: Jennifer Goodman

Name of person answering the phone: Recording (Saturday), V (repeated call)

Offered name: X (repeated call) Had to ask name: _____

Notes:
Saturday: The HSAG caller dialed both numbers and received a recording asking that the caller leave a message and saying that messages would be returned the next business day. The recording also provided the option to press 1 in the case of an emergency. The HSAG caller did not choose to press 1 to use emergency resources, and ended the call.

On Monday, January 28 the HSAG caller repeated the call and was able to obtain answers to the questions.

Person assigned to help or transferred to: _____

Offered name: _____ Had to ask name: _____

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

Urban

Specific questions for the second call:

1. *What would you tell an elderly man if he called to request outpatient counseling (for depression) and indicated that he has both Medicare and Medicaid, but cannot find a Medicare provider? (This man is not in a facility. He either lives independently or with family.)*

   V said that the member services line would assist him with choosing a provider from the provider directory near his location. V said she would assist with setting up an appointment if needed.

2. *Would the answer given above change if this man was in a wheelchair?*

   If the gentleman was in a wheelchair, V would ask if he needed assistance or if a family member could help. If he needed assistance, she would connect him with LogistiCare, ABC's transportation provider.

3. *What would a host home provider need to do to obtain services for an adult with Down's syndrome who is a resident of a host home and who has had behavioral changes recently that staff members of the community-centered board are interpreting as signs of depression?*

   V said she would assist the caller in making an appointment with a provider or, depending on how the conversation went, she might link the caller with a service coordinator.

Telephone Assessment Worksheet 3

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Access Behavioral Care Telephone number called: 800-984-9133, then 303-751-9030

Date of call: Wednesday, January 23, 2008 Time of call: 9:30 a.m.

Caller: Jennifer Goodman

Name of person answering the phone: A, then A

Offered name: X Had to ask name: _____

Notes:
The HSAG caller dialed the toll-free number and A answered the phone. When the HSAG caller introduced herself and explained the reason for the call, A immediately transferred the HSAG caller to her supervisor, who did not answer the phone.

Next, the HSAG caller dialed the 303-751-9030 number and spoke to a different A, who was the same person that the HSAG caller spoke to during the first telephone assessment call.

The HSAG caller noted that A's answers to the questions during this assessment were consistent with the answers given during the first assessment. The HSAG caller felt that this was a good sign that A was knowledgeable of ABC's policies. The HSAG caller also noted that A was very positive and pleasant to work with.

Person assigned to help or transferred to: _____

Offered name: _____ Had to ask name: _____

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

Urban

Specific questions for the third call:

1. *What is the procedure for alternative care facilities (ACFs) to obtain services for their residents?*

   A said that the person calling would be referred to the Mental Health Center of Denver, University Hospital, or Denver Health to obtain services for residents. A service coordinator would be able to assist the caller with obtaining services from any of these entities.

2. *How would you (the BHO) respond if a Medicaid member called and said his or her family member (e.g., son, daughter, spouse, etc.) was having the following symptoms:*
   - *Spending more time alone*
   - *Exhibiting agitation and anxiety when he or she is around people*
   - *Crying frequently*
   - *Making statements of feeling worthless*
   - *Making statements that he or she should be punished (either for something specific or nonspecific)*
   - *Not eating or sleeping*
   - *Not doing the things he or she used to do*

   (Note to caller: The above is a list of classic warning signs that a person may be at risk for suicide. The purpose of this question is to determine if the BHO would assess for suicide risk if these symptoms are reported, even if the caller does not specifically mention suicide.)

   A did not verbally acknowledge that these symptoms are warning signs that a person may be at risk for suicide. A did say that she would immediately transfer the caller to a service coordinator. A spoke very highly of the skills and capacity of the service coordinators. A said she would stay on the line with the caller until a service coordinator answered the call (to ensure that the caller would not be put into voicemail).

Telephone Assessment Worksheet 4

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Access Behavioral Care Telephone number called: 303-751-9030

Date of call: Tuesday, January 29, 2008 Time of call: 4 p.m.

Caller: Jennifer Goodman

Name of person answering the phone: J

Offered name: X Had to ask name: _____

Notes:

Person assigned to help or transferred to: _____

Offered name: _____ Had to ask name: _____

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

Urban

Specific questions for the fourth call:

1. *What is the procedure if a Medicaid member calls and urgently requests medication? The member may have been on medication from a private provider or might be from another state, but is new to Medicaid eligibility and has not yet received services from the BHO.*

   J said that member services would have to verify the caller's eligibility. If the caller was eligible, then a service coordinator could assist the member with finding a provider who would prescribe medications. The caller would use his or her Medicaid card and a Medicaid pharmacy to obtain the medications.

2. *How would a member who was recently released from a psychiatric hospital (and who has not previously received psychiatric services from this BHO) obtain outpatient services?*

   The member will need medication within seven days.

   Can outpatient therapy services and provision of the medication/prescription be handled with the same initial appointment?

   J said that a service coordinator would arrange for the member to find a provider to get outpatient services. That provider would provide both therapy and the prescription. The service coordinator would link the member with a provider with an appointment available within 7 days.

Appendix C. Record Review Worksheet for Access Behavioral Care

The completed record review worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Record Review Worksheet

The goal of this record review is to identify and describe specific documentation that provides evidence of ongoing communication between the psychiatrist or nurse prescriber and the parents, therapist/care coordinator/case manager, and/or the primary care physician (PCP) regarding a child who has received services through the BHO.

Documentation to be reviewed: Therapist and physician/prescriber progress notes, specific forms used for documentation of service planning meetings, or other pertinent documentation regularly used by the BHO to document ongoing communication with family members or the PCP.

Member ID: Sample 1	Encounter Reference Date: April 24, 2007
Reviewer Name: Barbara McConnell	Review Date: March 17, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/10/07	Progress Note	CNS (Clinical Nurse Specialist)	Grandmother	N/A	Case Management Session	Yes

Content of Documentation (Brief Description):

This note documented a discussion about symptoms of attention deficit hyperactivity disorder, events at home, coping strategies, medications, and school.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/20/07	Progress Note	CNS	Grandmother	N/A	Case Management Session	Yes

Content of Documentation (Brief Description):

This note described a discussion about symptoms, school, coping strategies, medications, response to medications, and goals.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/24/07	Clinical Progress Note	MD	Grandmother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced in the sample. The documentation included a discussion about symptoms, response to medications, school, therapy strategies, and goals.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Record Review Worksheet

Member ID: Sample 2	Encounter Reference Date: February 8, 2007
Reviewer Name: Barbara McConnell	Review Date: March 17, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
2/8/07	Progress Note	MD	Father	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced in the sample. The documentation included a discussion about symptoms, school, medications, and therapy.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
1/9/07	Progress Note	MD	Father	MD	Telephone Call	No

Content of Documentation (Brief Description):

This note indicated that the MD called the father to discuss concerns about the second consecutive no-show.

HSAG HEALTH SERVICES ADVISORY GROUP

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Record Review Worksheet

Member ID: Sample 3	Encounter Reference Date: March 16, 2007
Reviewer Name: Barbara McConnell	Review Date: March 17, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/16/07	Clinical Progress Note	MD	Grandmother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced in the sample. The note also documented a discussion about symptoms, behavior, response to medications, the treatment plan, and interventions recommended. The note indicated that the child was doing well at home and at school with the current medications.

Member ID: Sample 4	Encounter Reference Date: May 31, 2007
Reviewer Name: Barbara McConnell	Review Date: March 17, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/10/07	Clinical Progress Note	MD	Group Home Staff Member	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced in the sample. The documentation indicated that symptoms, placement, and the treatment plan were all discussed.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/22/07	Progress Note	MD	Caseworker	MD	Telephone Call	Yes

Content of Documentation (Brief Description):

This note indicated that the MD spoke to the caseworker about symptoms and medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/31/07	Clinical Progress Note	MD	Group Home Staff Member	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced in the sample. The documentation indicated that the child's symptoms, behaviors, treatment plan, and response to medications were discussed.

Member ID: Sample 5	Encounter Reference Date: May 14, 2007
Reviewer Name: Barbara McConnell	Review Date: March 20, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/30/07	Progress Note	MD	Mother	Therapist	Medication Management	Yes

Content of Documentation (Brief Description):

The note indicated that the MD made an outreach call to the mother.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/14/07	Clinical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced in the sample. This note documented a discussion about symptoms, response to medication, and mental status. The note indicated that mood was assessed. Discussions also included the treatment plan.

Member ID: Sample 6	Encounter Reference Date: June 5, 2007
Reviewer Name: Barbara McConnell	Review Date: March 17, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/21/07	Case Management Progress Note	PsyD	In-home Therapist	In-home Therapist	Telephone Call	No

Content of Documentation (Brief Description):

The note documented that the therapist called and discussed therapy and behavior management strategies.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/7/07	Case Management Progress Note	PsyD	In-home Therapist	In-home Therapist	Telephone Call	Yes

Content of Documentation (Brief Description):

The note documented that the in-home therapist called to discuss symptom management, treatment strategies, and medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/27/07	Progress Note	PsyD	Father	N/A	Therapy Visit	Yes

Content of Documentation (Brief Description):

The note documented a discussion about symptoms, lack of progress, goals, the treatment plan, and medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/20/07	Progress Note	PsyD	Father	N/A	Therapy	Yes

Content of Documentation (Brief Description):

The note documented a discussion about symptoms, behaviors, and medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/6/07	Clinical Progress Note	MD	Father	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

The note documented a discussion regarding medications, symptoms, therapy benefits, response to medications, the treatment plan, and school. The note also indicated that the child's therapist was present.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/5/07	Clinical Progress Note	MD	Father	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced in the sample. The documentation described a discussion about medications, symptoms, and the treatment plan.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/11/07	Clinical Progress Note	MD	Father	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a discussion about therapy results and progress, symptoms, medication side effects, and the treatment plan.

HSAG HEALTH SERVICES ADVISORY GROUP

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Record Review Worksheet

Member ID: Sample 7	Encounter Reference Date: May 8, 2007
Reviewer Name: Barbara McConnell	Review Date: March 17, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/8/07	Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced in the sample. The note also indicated that the child was doing well at home and at school. Symptoms, response to medications, and the treatment plan were discussed.

Member ID: Sample 8	Encounter Reference Date: May 29, 2007
Reviewer Name: Barbara McConnell	Review Date: March 17, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/10/07	Clinical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a discussion about symptoms, response to medication, the treatment plan, and strategies for response to the changing family situation.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/19/07	Clinical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented discussions regarding the family's planned move out of state, symptoms, response to medications, the treatment plan, coping skills, and the direction to find a PCP.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/29/07	Clinical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced in the sample. The note documented discussions regarding therapy, school, response to medications, the treatment plan, and progress. The note also indicated that there was discussion regarding the family's plan to move out of state and strategies for coping with it. The mother was encouraged to find a PCP for her child.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/17/08	Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented discussions about the child's progress and symptoms. The note indicated that the child was doing well at home and that they discussed how the day treatment was going.

Member ID: Sample 9	Encounter Reference Date: May 1, 2007
Reviewer Name: Barbara McConnell	Review Date: March 17, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/20/07	Authorization to Release Information	N/A	N/A	N/A	N/A	N/A

Content of Documentation (Brief Description):

The file included an authorization—signed by the mother on March 20, 2007—to release information regarding assessments and effects of medication to Denver Public Schools.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/1/07	Medication Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced in the sample. The note documented a discussion about symptoms, medications, school, and the treatment plan. At the time of this note, the case was a medication management-only case.

Member ID: Sample 10	Encounter Reference Date: May 21, 2007
Reviewer Name: Barbara McConnell	Review Date: March 17, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/2/07	Clinical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

The note documented a discussion regarding the child's progress, symptoms, school, the treatment plan, and response to medications. The note indicated that the therapist was present.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/21/07	Clinical Progress Note	MD	Mother and Father	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced in the sample. The note indicated that the in-home therapist was present and that the discussion included symptoms, progress with therapy, response to medication, and the treatment plan.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/23/07	Clinical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a discussion about symptoms, behaviors, school, the treatment plan, and response to medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/9/07	Clinical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a discussion about symptoms, behavior, response to medication, and the treatment plan. The note also included the statement, "Consider referral back to in-home services."

Appendix D. Oversight and Monitoring of Providers Worksheet for Access Behavioral Care

The oversight and monitoring of providers worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Oversight and Monitoring of Providers Worksheet

The following questions were used to prompt discussion during the on-site portion of the review:

Does the BHO use member satisfaction data to improve the quality of services provided by community mental health centers (CMHCs) and the independent provider network (IPN)? If so, how?

Is member satisfaction information used by the BHO's CMHCs to identify staff training needs?

How does the BHO know whether mental health center staff receives appropriate: (a) supervision, (b) training, and (c) professional development/continuing education?

How does the BHO know that its CMHC providers have a culturally appropriate work force?

How does the BHO know that its provider network (CMHC and IPN) is adequately prepared (in training, skills, and competence) to work with the BHO's members (in terms of member diagnosis, age, etc.)?

Review of the CMHC's policies/procedures for training content to determine if CMHC policies are compliant with BHO policies (intake, grievance system provider-member communication, advance directives, second opinion, etc.)?

Review of agendas or orientation curriculum and attendance records of the CMHC for compliance with BHO policies?

Review/audit of credentialing records to determine compliance with BHO policies?

Review of policies/procedures for clinical supervision?

Review of forms/tools used for provider supervision?

Provider profiling (reports or data)?

Review of data provided by the CMHC?

Data kept regarding cultural or linguistic competencies?

Review of percentage of Spanish-speaking members at each CMHC?

Utilization data per individual provider?

Trending grievance data?

Other?

How does the BHO ensure that CMHC providers are aware of, and in compliance with, the BHO's practice guidelines and grievance system and of any relevant policies and contract requirements (training completed, skills/certifications, completion of supervisory practices [performance reviews etc.])?

How does the BHO ensure that the IPN is aware of, and in compliance with, the BHO's practice guidelines, grievance system, policies, and contract requirements?

How has the BHO evaluated the services provided by the CMHC for quality, appropriateness, and patient outcomes (including member satisfaction)?

Quality initiatives?

Chart reviews?

Other?

How has the BHO evaluated the services provided by independent contractors for quality, appropriateness, and patient outcomes (including member satisfaction)?

Has the BHO used complaint/grievance data in the category of professional conduct and competence to improve services provided? (If yes, how? If no, why?)

The FY 06–07 corrective action plan with FY 07–08 findings and results follows this cover page.

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# 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.	Colorado Access (ABC) has agreed with HCPF (the Department) and HSAG that it is in the best interests of the BHO, MHCD, and the State that a delegation agreement be executed for the processing of Medicaid grievances. This delegation agreement between Colorado Access and MHCD has been initiated with a target implementation date of July 1, 2007. **September 2007 HCPF/HSAG comments:** Plan accepted.	Delegation Agreement April 2007.pdf
Standard I: Delegation—FY 07–08 Document Review			
2. Written Agreements Documents reviewed: ◆ Delegation agreement between MHCD and Colorado Access ABC management staff reported that the delegation agreement between MHCD and Colorado Access was signed in May 2007 and was effective July 2007. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	The delegation agreement between Colorado Access and MHCD will include the processing and resolution of the grievances from Medicaid members. This includes receiving the grievances via telephone, in person, or by mail; the mailing of acknowledgment letters in the time frames required by Volume 8; following up with research during the processing of the grievance; the mailing of resolution letters to members and designated client representatives; documenting the grievance and follow-up actions in a database designed by Colorado Access to capture all data required; and reporting data to Colorado Access. In addition, the agreement will include activity exclusions, specifically for the processing of quality-of-care concerns and clinical appeals. These two activities will be handled exclusively by Colorado Access for Medicaid consumers. **September 2007 HCPF/HSAG comments:** Plan accepted.	Delegation Agreement April 2007.pdf
Standard I: Delegation—FY 07–08 Document Review			
3. A. Content of Agreements—Specifies the activities Documents reviewed: ◆ Delegation agreement between MHCD and Colorado Access The delegation agreement specified the processing of grievances by MHCD. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	The delegation agreement will include the requirement to report grievance data no less than quarterly to Colorado Access, including which specific data must be included in that reporting. **September 2007 HCPF/HSAG comments:** The information reported by MHCD should not be limited to the numbers of grievances. These reports should include information about the nature of the grievance, how it was resolved, and other details for quality analysis, trending, and, where necessary, corrective action.	Delegation Agreement April 2007.pdf WeeklyRawDataFY08.xls
Standard I: Delegation—FY 07–08 Document Review			
3.B. Content of Agreements—Specifies the reporting responsibilities Documents reviewed: ◆ Delegation agreement between MHCD and Colorado Access Article One, Section A6, of the delegation agreement specified the reporting responsibilities of MHCD. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	The delegation agreement between Colorado Access and MHCD will specify the requirements for processing grievances by including the applicable section from Volume 8 that is attached as Exhibit G to the contract between Colorado Access and the State of Colorado. **September 2007 HCPF/HSAG comments:** Plan accepted.	Delegation Agreement April 2007.pdf
Standard I: Delegation—FY 07–08 Document Review			
3.D. Content of Agreements—Specifies that the subcontractor shall comply with the standards specified in the contract between the BHO and the Department Documents reviewed: ◆ Delegation agreement between MHCD and Colorado Access Page one of the agreement states, "Delegate agrees that performance under this agreement must be compliant with Colorado Access' own contractual obligations with HCPF." The required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# 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.	Colorado Access regularly monitors each of its delegates, including a review of quality. The new delegation agreement between MHCD and Colorado Access for management of grievances will have comprehensive oversight, including specific review for quality. **September 2007 HCPF/HSAG comments:** This intervention is not adequate. In addition to adding monitoring-related language to the delegation agreement, ABC must describe how it will monitor this delegate's performance of the specific activity (grievance processing). Also, the evidence of compliance must include more than the delegation agreement. For example, documents might include templates of the reports the delegate is expected to submit to ABC, a schedule of document submission requirements, a schedule of audits (if applicable), audit forms or other tools to be used to periodically and formally review how the delegate is performing, a template for a summary report of monitoring activities, etc.	Delegation Agreement April 2007.pdf WeeklyRawDataFY08.xls MHCD Grievance Audit File Tool.xls
Standard I: Delegation—FY 07–08 Document Review			
5.A. Monitoring of Delegates—Quality Documents reviewed: ◆ Delegation agreement between MHCD and Colorado Access ◆ Draft delegation agreement between MHCD and Colorado Access (with additional changes) ◆ Template for auditing grievance files ◆ Template for MHCD reporting of grievance information to Colorado Access ◆ Completed grievance record review tool ◆ Grievance log On-site, during the FY 07–08 site review, ABC management staff reported that based on monitoring of MHCD grievance processing, which consisted of reviewing MHCD policies and performing an on-site (at MHCD) audit of grievance records, ABC determined that a change in the process for MHCD grievance processing was needed. ABC staff reported that they were developing revised procedures with a planned effective date of April 1, 2008. Despite ABC's self-identified need to refine its monitoring processes and procedures, HSAG found evidence that ABC was monitoring its delegates for quality. Therefore, this required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
B. Data Reporting	ABC must monitor the data reporting required by each of its delegates.	The delegation agreement between Colorado Access and MHCD will include requirements for monitoring processes, including those for accuracy and completeness of data reporting and record-keeping. This monitoring, while required on a quarterly basis, will be monitored initially on a monthly basis. **September 2007 HCPF/HSAG comments:** This intervention is not adequate. The monitoring method must include both ongoing monitoring as well as formal review of the quality of the performance of the delegated activity and of the adequacy of reporting by the delegate to ABC (or, if applicable, to the Department on behalf of ABC). Please provide more details on how ABC will monitor MHCD and include any forms or tools to be used in the monitoring process.	Delegation Agreement April 2007.pdf WeeklyRawDataFY08.xls MHCD Grievance Audit File Tool.xls
Standard I: Delegation—FY 07–08 Document Review			
5.B. Monitoring of Delegates—Data reporting Documents reviewed: ◆ The Delegation agreement between MHCD and Colorado Access ◆ Data template ◆ Audit template ABC provided templates used for ongoing monitoring of data reporting. In addition, ABC performed an audit of a statistically valid sample of encounter data. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
Standard II: Provider Issues			
6. Monitoring of Providers D. Requirements for medical records	ABC must monitor for medical record requirements.	Colorado Access is committed to ensuring that medical records for its members contain appropriate and required information. Colorado Access is proposing an annual review of a statistically valid sample to monitor for the presence of the following content in the medical records sample: 1. Admission Colorado Client Assessment Record (CCAR), at a minimum (if applicable) 2. Completed ABC Contact & Triage Form 3. Treatment plan 4. Presence of advance directives or evidence that the provider gave appropriate information on advance directives 5. Presence of treatment consent 6. Presence of releases of information, as applicable 7. Presence of documentation of clinical services **September 2007 HCPF/HSAG comments:** In addition to checking for the presence of an admission CCAR, this intervention should be expanded to check for the presence of all CCARs required for that member, including admission, update, and discharge CCARs.	QM302 Review of Provider Medical Records 11-16-07.pdf MSR Services Agreement II v1.0.3 (CA) (PDF)_final 020306.pdf MA CA Claim Audit Study number 3 Ltr 10.3.07 v1.0.1.pdf ABC Provider_Newsletter.October 2006.pdf ABC Provider_Newsletter_May 2007.pdf ABC Provider_Newsletter_October 2007.pdf Colorado Access Claim Validation 2007 Training Materials v1.0.3.pdf CCA Test Results _Colorado Access_ v 2 0 0.pdf MBQIC Minutes 10.07.doc

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
Standard II: Provider Issues—FY 07–08 Document Review			
6.D. Monitoring of Providers—Requirements for medical records Documents reviewed: ◆ Policy QM302, Review of Provider Medical Records, November 16, 2007 ◆ Medical Site Reviewers (MSR) services agreement ◆ Claim Audit Study 3 ◆ ABC Provider Newsletter, October 2006 ◆ ABC Provider Newsletter, May 2007 ◆ ABC Provider Newsletter, October 2007 ◆ Colorado Access claim validation 2007 training materials ◆ CCA test results ◆ MBQIC minutes, October 2007 This required action is continued. Policy QM302 (Attachment A) described medical record requirements. The provider manual listed requirements for medical records; however, the requirements in the provider manual differed from, and were less detailed than, the requirements listed in the policy. During the site review of FY 07–08, ABC management staff reported that ABC policies were internal documents and not distributed to providers. Medical Site Reviewers, on behalf of ABC, completed an audit of some of the medical record requirements. Provider compliance with the remaining medical record requirements was not monitored. During the FY 07–08 site review, ABC management staff members reported that they were currently developing processes for monitoring providers for medical record requirements.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	Colorado Access will revise its Policy and Procedure PNS203 to clarify the requirement to notify the Department 90 days prior to termination of the agreement (unless the termination is based on quality-of-performance issues). **September 2007 HCPF/HSAG comments:** Plan accepted.	PNS203 Communication of Changes to the Provider Network 8-7-07.pdf
Standard II: Provider Issues—FY 07–08 Document Review			
8. Termination of Provider Agreements Documents reviewed: ◆ Policy PNS203 The policy has been changed to reflect the requirement to notify the Department 90 days prior to termination of an agreement unless the termination is based on quality-of-performance issues. This required action has been completed			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# 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.	Colorado Access is committed to ensuring that procedure coding is as accurate as possible, representing the services provided. As part of the statistically valid encounter sample process, provider records will be reviewed for coding accuracy. In addition, Colorado Access will work closely with providers who are required to submit records for review to ensure that these records are received in a timely manner, implementing corrective actions for any failure to comply. Providers will be reminded, through blast faxes and provider bulletins, of their responsibility to submit records for review when requested. If providers do not comply with requests, provider representatives will meet the providers to conduct retraining on contractual issues and requirements. **September 2007 HCPF/HSAG comments:** ABC should provide evidence that the BHO has established a process for reviewing provider records for coding accuracy. Examples of this evidence may include monitoring tools to be used, directions for reviewers, etc. Also, this corrective action needs to address actions taken with the specific providers who did not comply with the record review request in FY 06–07, instead of just planning for future record requests.	QM302 Review of Provider Medical Records 11-16-07.pdf MSR Services Agreement II v1.0.3 (CA) (PDF)_final 020306.pdf MA CA Claim Audit Study number 3 Ltr 10.3.07 v1.0.1.pdf HCPF ABC Claim Encounters Flat File.doc ABC Provider_Newsletter.October 2006.pdf ABC Provider_Newsletter_May 2007.pdf Colorado Access Claim Validation 2007 Training Materials v1.0.3.pdf CCA Test Results _Colorado Access_ v2 0 0.pdf MBQIC Minutes 10.07.doc FAM CTR CAP LETTER_1.doc MHCD RECORD REQ CAP LETTER.doc

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
			ROCKY MTN COUNS RECORD REQ CAP LETTER.doc Provider letters for noncompliance .enclosures.doc
Standard II: Provider Issues—FY 07–08 Document Review			
13. Record Review: Documentation of services Documents reviewed: ◆ Report of the 411 Audit Results ◆ Letters to providers requiring additional information for corrective action ◆ Corrective action plans ABC's report of results for the audit of the statistically valid sample of encounter records (411 audit) documented ABC's review for accuracy and completeness of encounter data. Letters written to various providers demonstrated that ABC communicated with providers regarding the results of the 411 audit and requested further information or corrective action, as appropriate. In addition, corrective action plans reviewed during the FY 07–08 site visit demonstrated that ABC required corrective action regarding the timeliness of providing files for monitoring purposes. All required records were available for the FY 07–08 coordination-of-care record review. These required actions have been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	Colorado Access is developing updated training and education materials for providers and staff regarding advance directives. This updated training will be conducted with internal clinical staff on an annual basis. Contracted providers will be offered annual training conducted by an experienced trainer. All providers will receive educational materials on advance directives via our provider bulletins and blast-faxes. **September 2007 HCPF/HSAG comments:** This intervention is not adequate. Offering training to subcontracted providers will not ensure that these providers will take the training or will obtain the information. The intervention must be more specific to ensure that providers have received and have understood these requirements.	QM302 Review of Provider Medical Records 11-16-07.pdf What is an Advance Directive.pdf ABC_DenverHandbook.pdf ABC Provider_Newsletter_October 2007.pdf ABC_Denver_ProviderManual .pdf CCS303 Advance Directives 11-13-06.pdf MA CA Claim Audit Study number 3 Ltr 10.3.07 v1.0.1.pdf ADVANCE DIRECTIVE TRAINING SCHEDULE 2008.doc

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
			Member materials for Web site: http://www.nlm.nih.gov/medlineplus/advancedirectives.html#cat42 http://www.dora.state.co.us/insurance/senior/stern12.pdf http://www.caringinfo.org/UserFiles/File/PDFs/States/Colorado.PDF
Standard IV: Member Rights and Responsibilities—FY 07–08 Document Review			
5.A. Advance Directives—The contractor has written policies and procedures for advance directives Documents reviewed: ◆ Advance directive training schedule, 2008 ◆ Provider Newsletter, October 2007 ◆ Advance directives training manual on the Web site ◆ Provider Newsletter, May 2007 ◆ Policy CCS303 The May 2007 Provider Newsletter informed providers how the advance directives training manual would be distributed. Advance directive requirements were provided in the October 2007 Provider Newsletter. During the FY 07–08 site review, ABC management staff reported that ABC had revised the training plan. ABC had not provided in-person training in January, but had relied on the provider newsletter and the online training to provide advance directives training. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	Colorado Access will develop and implement a plan to monitor capacity for alternative services based on the unique number of members served (the definition of capacity included in Exhibit K to the contract with the State of Colorado). The number of consumers listed in Exhibit K for capacity in each of the described alternative services will be compared to data that is used to compile the B3 services report. This will be done on a quarterly basis. **September 2007 HCPF/HSAG comments:** This intervention must provide not just a plan, but also the development of templates of the actual documents, reports, etc., that will be used to ensure the BHO has the capacity to provide alternative services as described in Exhibit K of the contract. These templates must be provided as evidence of compliance.	Alternative Services Response 11-9-07.doc Exhibit K Worksheet.xls QTR Minutes.Partnership.11.13.07 .doc
Standard V: Access and Availability—FY 07–08 Document Review			
10. Alternative Services Documents reviewed: ◆ Alternative services response, November 9, 2007 ◆ Exhibit K worksheet ◆ Quarterly partnership committee minutes, November 13, 2007 The completed alternative services worksheet for the second quarter of FY 08 demonstrated that ABC monitored the provision of alternative services by contracted providers. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# 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.	Colorado Access will revise its policy (CCS307) regarding utilization review determinations so that it is consistent with the BBA and the requirements of its contract with the State of Colorado. Colorado Access will send notifications regarding utilization review determinations within 10 days. In addition, Colorado Access will clarify its policy to confirm that extensions may not exceed an additional 14 calendar days. **September 2007 HCPF/HSAG comments:** Plan accepted.	CCS307 Utilization Review Determinations 11-16-07.pdf
Standard VI: Utilization Management—FY 07–08 Document Review			
1.B. Utilization Management Program—Includes written policies and procedures Documents reviewed: ◆ Utilization Review Determinations policy The policy has been revised to include each of the BBA managed care requirements, including the requirement that extensions to utilization review decisions may not exceed 14 calendar days. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	Colorado Access will ensure that notices of action are sent in a timely manner to consumers and providers following a UR denial decision by continuing to monitor utilization management turnaround times on a quarterly basis, maximizing the number of notices sent to members in a timely manner. Colorado Access will initiate refresher training for staff involved in these decisions, and when Colorado Access identifies problem areas in timeliness, staff will receive additional training to correct the problem. **September 2007 HCPF/HSAG comments:** This intervention must also explain the actions that were taken to address the failure to meet timeliness standards with the two notices of action issued in FY 06–07 that were reviewed during the site visit.	Standard VI.7 Response.doc
Standard VI: Utilization Management—FY 07–08 Document Review			
7. Record Review—Denials Documents reviewed: ◆ Turnaround-time audit of denials ◆ Turnaround-time training roster ABC's audit of denial records for timeliness of notices of action completed for denials that occurred from July 2006 to February 2008 demonstrated that ABC had a mechanism to ensure the timeliness of notices of action. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	MHCD grievance information will be included not only in grievance data reporting, but also in trending and analysis. As part of the analysis process, interventions will be identified, as appropriate, to address specific issues and trends that are seen. Inclusion of MHCD data in grievance analysis will be evident through internal reporting at the Medical and Behavioral Quality Improvement Committee. In addition, any intervention required as a result of analysis will be documented and sent to MHCD and included in the MBQIC minutes. **September 2007 HCPF/HSAG comments:** This intervention must also specify the type of data to be submitted by MHCD that ABC will use for trending and analysis. Evidence of compliance must include MHCD's reporting requirements and any report templates.	Delegation Agreement April 2007.pdf WeeklyRawDataFY08.xls MHCD Grievance Audit File Tool.xls
Standard VIII: Quality Assessment and Performance Improvement Program —FY 07–08 Document Review			
3.B.3. Member Satisfaction—Contractor's tools to monitor member satisfaction include grievance and appeal data Documents reviewed: ◆ Delegation agreement, April 2007 ◆ Weekly raw data, FY 08 ◆ MHCD Grievance Audit File Tool ◆ MBQIC meeting minutes, December 4, 2007, and January 8, 2008 The MBQIC meeting minutes demonstrated that the grievances processed at MHCD were included in trending and analysis of data reviewed by ABC's quality improvement program staff. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	The delegation agreement between Colorado Access and MHCD will include requirements for processing grievances according to the requirements of Volume 8, which is included as Exhibit G to the contract between Colorado Access and the State of Colorado. Additionally, Colorado Access is participating in a work group with the Department and the other BHOs to reexamine and redefine member concerns, complaints, expressions of dissatisfaction, and grievances. It is the understanding of Colorado Access that the outcomes of this work group will be included in the next BHO contract; therefore, these new requirements will be implemented in the Colorado Access grievance process and included in the delegation agreement with MHCD. **September 2007 HCPF/HSAG comments:** Regardless of whether changes are made to the BHO contract, the requirement to consider all complaints and expressions of dissatisfaction as grievances is based on federal managed care regulations. This intervention should include a monitoring plan to ensure that both ABC and MHCD staff members who process grievances adhere to revised guidelines in the delegation agreement.	Delegation Agreement April 2007.pdf WeeklyRawDataFY08.xls MHCD Grievance Audit File Tool.xls
Standard IX: Grievances, Appeals, and Fair Hearings —FY 07–08 Document Review			
1. Grievance and Appeal Records Documents reviewed: ◆ Grievance record review completed August 6, 2007 The completed grievance record review audit conducted by ABC for grievances processed by MHCD demonstrated that ABC monitored MHCD for the content and completion of grievance processing. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# 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.	Colorado Access provides reasonable assistance to members who express grievances. This requirement will be included in the delegation agreement between Colorado Access and MHCD and will be monitored as a part of the delegation oversight process. **September 2007 HCPF/HSAG comments:** ABC must also provide monitoring tools, plans, schedules, and/or other applicable documents that demonstrate evidence of compliance with this requirement.	Delegation Agreement April 2007.pdf WeeklyRawDataFY08.xls MHCD Grievance Audit File Tool.xls

Standard IX: Grievances, Appeals, and Fair Hearings —FY 07–08 Document Review

3. Reasonable Assistance

Documents reviewed:

- Summary of audit completed by ABC at MHCD, August 6, 2007
- Completed audit tool, August 6, 2007
- Revised audit tool, March 2008
- Revised agreement between MHCD and ABC
- Revised MHCD Grievance Form

This required action continues. The summary demonstrated that ABC reviewed grievance records on-site at MHCD in August 2007, as well as reviewed MHCD's polices and procedures for grievances. The audit tool used in 2007 did not include a review for whether members were provided reasonable assistance with filing grievances. During the FY 07–08 site review, ABC management staff provided a revised audit tool template and an MHCD agreement, with proposed revisions, and reported that ABC was planning to change the contract related to MHCD's responsibilities for processing grievances, effective April 2008. ABC staff indicated that the next audit using the revised tool would be conducted in summer 2008, as the audit is an annual event. The revised audit tool included a section for review of whether the member was provided reasonable assistance with filing grievances. While ABC was in the process of developing a revised monitoring process and audit tool that included the required elements, the revisions were not yet implemented at the time of the FY 07–08 site review.

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	Colorado Access has consistently ensured that all Medicaid grievance decisions are made by individuals not previously involved in the grievance situation. This requirement will be included in the delegation agreement to be executed between Colorado Access and MHCD, and will be monitored as a part of the delegation oversight process. **September 2007 HCPF/HSAG comments:** ABC must also provide monitoring tools, plans, schedules, and/or other applicable documents that demonstrate evidence of compliance with this requirement.	Delegation Agreement April 2007.pdf WeeklyRawDataFY08.xls MHCD Grievance Audit File Tool.xls

Standard IX: Grievances, Appeals, and Fair Hearings —FY 07–08 Document Review

4.A. Individuals Who Make Decisions—Are individuals who were not involved with any previous level of review

Documents reviewed:

- Summary of audit completed by ABC at MHCD, August 6, 2007
- Completed audit tool, August 6, 2007
- Revised audit tool, March 2008
- Revised agreement between MHCD and ABC
- Revised MHCD Grievance Form

This required action continues. The summary demonstrated that ABC reviewed grievance records on-site at MHCD in August 2007, as well as reviewed MHCD's policies and procedures for grievances. The audit tool used in 2007 did not include a review for whether or not individuals who made decisions about grievances were involved with any previous level of review or decision-making. During the FY 07–08 site review, ABC management staff provided a revised audit tool template and an MHCD agreement, with proposed revisions, and reported that ABC was planning to change the contract related to MHCD's responsibilities for processing grievances, effective April 2008. ABC staff indicated that the next audit would be conducted in summer 2008, as the audit is an annual event. The revised audit tool included a section for reporting whether or not individuals who made decisions about grievances were involved with any previous level of review or decision making. While ABC was in the process of developing a revised monitoring process and audit tool that included the required elements, the revisions were not yet implemented at the time of the FY 07–08 site review.

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	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.	Colorado Access ensures that all grievance decisions are made by staff with appropriate qualifications to do so. This requirement will be included in the delegation agreement to be executed between Colorado Access and MHCD, and will be monitored as a part of the delegation oversight process. **September 2007 HCPF/HSAG comments:** ABC also must provide monitoring tools, plans, schedules, and/or other applicable documents that demonstrate evidence of compliance.	Delegation Agreement April 2007.pdf WeeklyRawDataFY08.xls MHCD Grievance Audit File Tool.xls

Standard IX: Grievances, Appeals, and Fair Hearings —FY 07–08 Document Review

4.B. Individuals Who Make Decisions—Are individuals who have appropriate clinical expertise

Documents reviewed:

- Completed audit tool, August 6, 2007

The completed grievance record audit included review for whether the individual making the grievance decision had the appropriate level of expertise. This required action has been completed.

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	Colorado Access accepts grievances both orally and in writing. This requirement will be included in the delegation agreement to be executed between Colorado Access and MHCD, and will be monitored as a part of the delegation oversight process. **September 2007 HCPF/HSAG comments:** ABC must also provide monitoring tools, plans, schedules, and/or other applicable documents that demonstrate evidence of compliance.	Delegation Agreement April 2007.pdf WeeklyRawDataFY08.xls MHCD Grievance Audit File Tool.xls
Standard IX: Grievances, Appeals, and Fair Hearings —FY 07–08 Document Review			
5. Accepts Grievances and Appeals Documents reviewed: ◆ The MHCD grievance log The ABC grievance log, which included grievances submitted by MHCD, included grievances that had been received in writing and by telephone. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	Colorado Access maintains comprehensive and complete records regarding Medicaid consumer grievances, as demonstrated during the on-site visit by the EQRO. As part of the delegation agreement between Colorado Access and MHCD, the CMHC will be required to maintain records, including records of written acknowledgments and resolutions to consumers, as well as documentation of research, follow-up, and other actions related to grievance processing. In addition, the agreement will require that decisions regarding grievances be made by qualified and noninvolved staff, and that reasonable assistance be provided to consumers. **September 2007 HCPF/HSAG comments:** ABC also must provide monitoring tools, plans, schedules, and/or other applicable documents that demonstrate evidence of compliance.	Delegation Agreement April 2007.pdf WeeklyRawDataFY08.xls MHCD Grievance Audit File Tool.xls

Standard IX: Grievances, Appeals, and Fair Hearings —FY 07–08 Document Review

7. Record Reviews: Grievance

Documents reviewed:

- Completed audit tool
- Template of the revised delegation agreement between ABC and MHCD

This required action continues. The audit ABC conducted at MHCD in August 2007 did not include a review for all requirements. The revised audit tool (March 2008) included the requirements missed in August 2007, and removed other requirements that ABC planned to perform itself, effective April 2008. During the FY 07–08 site review, ABC management staff explained that ABC had revised the delegation agreement between MHCD and ABC to delegate only a portion of the grievance process to MHCD. The revised delegation agreement included all of the requirements; however, it had not yet been implemented. ABC staff reported that the revised agreement would become effective in April 2008.

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
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.	Colorado Access provides notification to applicants of their rights under the credentialing process, including the appeal process. In order to ensure that this process is understood clearly, Colorado Access will revise its applicable policies and associated documentation to provide clarification. This clarification will include a description of how applicants are notified of their rights under the credentialing process, including the right to an appeal process. **September 2007 HCPF/HSAG comments:** Plan accepted.	Standard X.3 Response.doc
Standard X: Credentialing—FY 07–08 Document Review			
3.P. Content of Policies and Procedures—Specify how applicant is notified of rights and appeal process Documents reviewed: ◆ Policy CR301—Practitioner Credentialing and Recredentialing ◆ Policy 312—Practitioner Rights The Practitioner Rights policy included a description of how applicants are informed of their rights under the credentialing process, including how applicants are informed of their appeal rights. This required action has been completed.			

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# 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.	As a licensed health maintenance organization, Colorado Access conducts credentialing activities within the regulatory and statutory requirements for a peer review body. Current Colorado regulation and statute grants immunity to individual members of a proper peer review body, and grants a privilege to peer review documentation, for peer review and credentialing of physicians only. There is no legal protection in Colorado for peer review committee activities for nonphysician practitioners. As a result, Colorado Access cannot guarantee committee participants immunity from suit where the committee makes a credentialing decision about a nonphysician that is based on a quality-of-care finding. Rather, Colorado Access meets National Committee for Quality Assurance (NCQA) standards with regard to credentialing, but refers all quality-of-care issues to the appropriate licensing/certification board for a decision as to whether the practitioner should continue to be licensed/certified. **September 2007 HCPF/HSAG comments:** This corrective action required does not involve peer review or professional "immunity" and is not specific to or limited to physicians. Rather, the requirement is that ABC comply with the NCQA standard that states, "An organization that has taken action against a practitioner for quality reasons reports the action to the appropriate authorities and offers the practitioner a formal appeal process." ABC must provide all practitioners (not just physicians) a process to appeal any decision the BHO may make to alter the conditions of a practitioner's participation based on issues of quality of care or service.	Standard X.T Response.doc

Table E-1—FY 06–07 Corrective Action Plan *for* ABC			
Evaluation Elements	**Required Actions**	**Planned Intervention**	**# of Attachment With Evidence of Compliance**
Standard X: Credentialing—FY 07–08 Document Review			
3.T. Content of Policies and Procedures—Specify 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 Documents reviewed: ◆ Policy CR213—Hearing and Appeal Process The Hearing and Appeal Process policy described the appeal process available to practitioners as defined in the NCQA Standards and Guidelines for the Accreditation of MBHOs. This required action has been completed.			

Appendix F. Site Review Participants for Access Behavioral Care

Table F–1 lists the participants in the FY 07–08 site review of **ABC**.

Table F–1—HSAG Reviewers and BHO Participants		
HSAG Review Team		**Title**
	Barbara McConnell, MBA, OTR	Project Director
	Jennifer Goodman, JD	Executive Director (telephone assessment calls)
	Rachel Henrichs	Project Coordinator (telephone assessment calls)
	Hector Cariello, MPH-HCAHPS	Project Coordinator (conducted member interviews in Spanish)
ABC Participants		**Title**
Carrie Bandell		Director of Quality Management
Robert Bremer		Behavioral Health Quality Manager/Deputy Director of Access Behavioral Care
Rich Duncan		Manager of Behavioral Health Services
Reyna Garcia		Executive Director for CHP+, Director of Customer Service
Christine Gillaspie		Utilization Manager
Tina Mack		Customer Service Supervisor
Gary Marx		Human Resources/Facilities Director
Claudine McDonald		Director of Office of Consumer and Family Affairs
Gretchen McGinnis		Director of Strategic Planning and Business Development
Mike McKitterick		Vice President of Clinical Services
Travis Perez		Quality Program Manager
LeNore Ralston		Executive Director of Access Behavioral Care
Phil Reed		Chief Financial Officer
Marie Steckbeck		Vice President of Operations
Sharon Steadman		Executive Director of Access Advantage
Marshall Thomas		Chief Executive Officer
Department Observers		**Title**
Katie Brookler		Manager of Quality Improvement
Sue Carrizales		Behavioral Health Specialist
Jerry Smallwood		Managed Care Benefits Section Manager

Appendix G. Corrective Action Plan Process for FY 07–08 for Access Behavioral Care

ABC is required to submit to the Department a corrective action plan for all components scored as *In Partial Compliance* or *Not In Compliance*. The corrective action plan with supporting documents must be submitted within 30 days of receipt of the final report. For each element that requires correction, the plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion.

Table G-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each BHO will submit a corrective action plan to the Department within 30 calendar days of receipt of the final EQR site review report via the file transfer protocol (FTP) site with an accompanying e-mail notification regarding the posting. For each of the components receiving a score of *In Partial Compliance* or *Not In Compliance*, the corrective action plan must address the planned intervention(s) to complete the required actions and the timeline(s) for the intervention(s).
Step 2	**Documents submitted with the corrective action plan**
	The BHOs should complete the required actions and submit documentation substantiating the completion of all required corrective actions.
Step 3	**Prior approval for timelines exceeding 30 days**
	If the BHO plans to complete the required action later than 30 days following the receipt of the final report, it must obtain prior approval from the Department in writing.
Step 4	**Progress reports may be required**
	For any planned interventions receiving an extended due date beyond 30 days following receipt of the final report, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements in the corrective action plan.
Step 5	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the corrective action plan and supporting documentation, the Department will inform the BHO as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements, or (2) the BHO must submit additional documentation. The Department 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.

The template for the corrective action plan follows.

Table G-2—FY 07–08 Corrective Action Plan *for* ABC				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
1. Access to Care				
2. Coordination of Care				
3. Oversight and Monitoring of Providers				
4. Member Information				
5. Review of Corrective Action Plans and Supporting Documentation				

Appendix H. Compliance Monitoring Review Activities for Access Behavioral Care

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

Table H–1—Compliance Monitoring Review Activities Performed

For this step,	HSAG…
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff provided an orientation at the B-QuIC meeting on November 27, 2007, for the BHO and the Department to preview the FY 07–08 compliance monitoring review process and to allow the BHOs to ask questions about the process. HSAG reviewed the processes related to the request for information, CMS' protocol for monitoring compliance, the components of the review, and the schedule of review activities. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives responded to questions from the BHO related to the process and federal managed care regulations to ensure that the BHO was prepared for the compliance monitoring review. HSAG maintained contact with the BHO as needed throughout the process and provided information to key management staff members about review activities. Through this telephone and/or e-mail contact, HSAG responded to the BHO's questions about the request for documentation for the desk audit and about the on-site review process.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the FY 07–08 BHO contract to develop HSAG's monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the desk audit request and sent a documentation request form and an on-site agenda. The BHO had 30 days to provide all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the five components. ◆ Documents requested included applicable policies and procedures, minutes of key BHO committee or other group meetings, reports, logs, and other documentation. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

Table H–1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
Activity 4:	**Conducted Interviews**
	Prior to the on-site portion of the review: ◆ HSAG conducted interviews of Medicaid members who had received or requested to receive services from the BHO. ◆ HSAG conducted telephone assessments of the BHO's access processes. During the on-site portion of the review: ◆ HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	During the on-site portion of the review: ◆ HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document, i.e., the original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents that HSAG needed during its desk audit. ◆ HSAG requested and reviewed additional documents that HSAG needed to review during the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	Following the on-site portion of the review: ◆ HSAG met with BHO staff to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 07–08 Site Review Report to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions to be required of the BHO to achieve full compliance with managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 07–08 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG coordinated with the Department to incorporate the Department's comments. ◆ HSAG distributed a second draft report to the BHO for review and comment. ◆ HSAG coordinated with the Department to incorporate the BHO's comments and finalize the report. ◆ HSAG distributed the final report to the BHO and the Department.