Colorado Medicaid
Community Mental Health Services Program

FY 2008–2009 Site Review Report

for

Access Behavioral Care

June 2009

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

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Overview of FY 2008–2009 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 fifth year that HSAG has performed compliance monitoring reviews of the BHOs. For the fiscal year (FY) 2008–2009 site review process, the Department requested a focused review of four areas of performance.[1-1] HSAG developed a review strategy consisting of four components for review, which corresponded with the four performance areas identified by the Department. These were: Member Information (Component 1), Notices of Action (Component 2), Appeals (Component 3), and Underutilization (Component 4). Compliance with federal regulations and contract requirements was evaluated through review of the four components. This report documents results of the FY 2008–2009 site review activities for the review period of July 1, 2007, through June 30 2008. 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. Completed data collection tools for each component are found in the appendices. In addition, HSAG has included an overview of **Access Behavioral Care** (**ABC**) follow-up activities and status regarding the corrective actions that were required as a result of the FY 2007–2008 compliance site review.

In developing the data collection tools and in reviewing the four 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 F).

[1-1] The Department developed these performance areas through surveys of participants from the Medicaid Mental Health Advisory Committee (MHAC) and the Medicaid Mental Health Planning and Advisory Council (MHPAC). The Department developed the MHAC to exchange information and identify, evaluate, and communicate issues related to the Colorado Medicaid Community Mental Health Services Program. MHPAC was created as a result of federal laws passed in 1986 and 1992, which require states and territories to perform mental health planning in order to receive federal Mental Health Block Grant funds (Sections 1911–1920 of the Public Health Service [PHS] Act [42 USC 300x-1 through 300x-9] and Sections 1941–1956 of the PHS Act [42 USC 300x-51 through 300x-66]).

Objective of the Site Review

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

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

Summary of Results

HSAG assigned each element within the components in the Compliance Monitoring Tool a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Scored*. *Not Scored* was used when materials had been previously reviewed and approved by the Department as meeting requirements, but minor revisions would enhance the clarity or compliance of the materials. HSAG assigned each element within the record review tools a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* Based on the results from the Compliance Monitoring Tool, the record review scores, and conclusions drawn from the review activities, HSAG assigned each component of the review an overall score of *In Compliance*, *In Partial Compliance*, or *Not In Compliance.* HSAG assigned required actions to any individual element within the Compliance Monitoring Tool or the record reviews receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for enhancement for some components, regardless of the score. While HSAG provided recommendations for enhancement of BHO processes based on these identified opportunities for improvement, they do not represent noncompliance with contract or BBA regulations at this time.

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

Table 1-1—Summary of Scores for the Components

Component #	Description of Component	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable or Not Scored*	Score (% of *Met* Elements)
1	Member Information	25	22	22	0	0	3	100%
2	Notices of Action	9	9	6	3	0	0	67%
	Notices of Action Record Review	50	40	38	0	2	10	95%
3	Appeals	23	22	20	2	0	1	91%
	Appeals Record Review	42	42	38	0	4	0	90%
4	Underutilization	4	4	4	0	0	0	100%
	Totals	**153**	**139**	**128**	**5**	**6**	**14**	**92%**

Table 1-2 presents the overall score for **ABC** for each of the components.

Table 1-2—Results	
Component	**Overall Score**
Component 1—Member Information	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 2—Notices of Action	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*
Component 3—Appeals	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*
Component 4—Underutilization	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and all member informational materials and templates used by the BHO during the review period. While on-site, HSAG reviewed additional documentation and interviewed key BHO personnel. Details of the findings for Component 1 follow in Appendix A—Component 1.

Summary of Findings and Opportunities for Improvement

Overall Score: In Compliance

ABC had an effective mechanism for ensuring that the required information was mailed within one month of **ABC**'s notification of enrollment. Mailings occurred monthly after receiving the notification of enrollment. **ABC**'s materials were available in Spanish, large print, and audio format. In addition, staff members reportedly offered to read materials when needed. For oral interpretation services, **ABC** used contracted interpreters, the language line, or bilingual staff members in the customer service department at **ABC**. While the consumer handbook included all of the requirements, there were some areas that represented opportunities for improvement for **ABC**. The consumer handbook informed members that they may choose their provider. **ABC** may also consider specifically informing members of the process for changing providers upon members' request. The information in the member handbook informing members about the process for requesting continued benefits during the appeal or State fair hearing processes was vague and did not include all of the requirements or specify the time frame for filing. **ABC** may consider enhancing this information in the member handbook.

Member rights, as printed in the member handbook, included the right to "get services from a provider who speaks your language or get interpretation services in any language needed." The member handbook, however, did not inform members of how to obtain interpreter services. Also, the member handbook specifically informed members that interpretation services were available for members who are deaf or hard of hearing, but did not inform members of how to obtain these services. **ABC** may consider notifying members of how to access interpreter services.

Summary of Strengths

ABC employed a variety of methods to help members and potential members understand the requirements and benefits of the plan. The member handbook had a complete list and explanation of benefits offered. The quarterly member newsletters rotated subject matter that covered information about specific illnesses as well as services available to assist. Member newsletters were sent to the entire Medicaid member population of the City and County of Denver quarterly.

ABC held Consumer and Family Board meetings quarterly that were open to all Medicaid members enrolled for services at **ABC**. **ABC** used $15 gift certificates for groceries as an incentive to attend. The meeting agenda was published each quarter in the newsletter with the advertisement of the incentive offering. Content of both the member newsletters and the Consumer and Family Board meetings was driven by those in attendance at the previous Board meeting.

In addition to the use of the AT&T language line and contracted interpreters, approximately half of **ABC**'s customer service department consisted of employees who were bilingual in Spanish, Korean, Russian, Italian, or Cambodian. **ABC** used a contracted vendor to certify bilingual staff members prior to allowing them to translate or conduct business in an alternative language.

Summary of Required Actions

There were no corrective actions required for this component.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation, interviewed key BHO personnel, and conducted a record review of documentation associated with completed notices of action.

For the record review, a sample of 10 actions with an oversample of 5 actions was selected from all Medicaid member actions sent by **ABC** during the review period. The oversample was used if 1 or more action records was deemed not applicable or was not available during the on-site review. A total of 10 records were reviewed for the timeliness and content of the documentation related to notices of action. (The entire sample was reviewed if the BHO had fewer than 10 notices of action sent during the review period.) Details of the findings for Component 2 follow in Appendix A—Component 2.

Summary of Findings and Opportunities for Improvement

Overall score: In Partial Compliance

ABC had a mechanism for appropriate utilization control, ensuring that medically necessary services were provided in an amount, duration, and scope needed to achieve the purpose for which they were provided. **ABC**'s utilization management (UM) program included a process for sending notices of action when services were denied, terminated, reduced, or authorized in an amount, duration, or scope that was less than requested. The UM policies and procedures included most of the required provisions.

ABC's notice-of-action letters were impersonal, indirectly addressing members in third-person language. **ABC** may consider addressing members directly in notices of action by writing them in first person.

Notice-of-Action Record Review Summary

HSAG reviewed 10 notice-of-action records at **ABC**. All 10 records met the requirement to mail the notice of action within the required time frame. Two notices were confusing as to what action was being taken by **ABC**. All records reviewed included documentation that the individual who made the decision was qualified to do so. All 10 notices contained the content required by the BBA.

Summary of Strengths

ABC's notices of action sent to members included all of the required information and quite a bit of nontemplate language describing the reason for the decision. In addition, the notice-of-action letters were sent with an attachment consisting of an overview of the appeal and State fair hearing processes. **ABC** had an effective mechanism to track the timeliness of notices sent, that qualified clinicians made decisions, and that the electronic UM system included complete documentation of the individuals involved and discussions that had occurred regarding the authorization decision.

Summary of Required Actions

ABC's definition of an action was not consistent with the BBA definition. In addition, **ABC**'s various documents (two policies, the member handbook, and the provider manual) had slightly different versions of the definition, none of which was consistent with the BBA. Since **ABC**'s documents did not accurately define an action such as a denial of payment, the policies also did not address the time frame for sending this type of notice of action to members. **ABC** must revise all applicable policies and related documents to include a definition of an action that is consistent with the BBA definition and is consistent across types of actions.

Two records reviewed on-site contained notices of action that did not clearly express the reason for the decision in the letter that was sent to the member. **ABC** must ensure that notices of action are easily understood from a member perspective.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation, interviewed key BHO personnel, and conducted a record review of documentation associated with Medicaid member appeals.

For the record review, a sample of 10 appeals with an oversample of 5 appeals was requested. **ABC** submitted 6 records. (The entire sample of 6 records was reviewed since the BHO had fewer than 10 appeals during the review period.) The appeal records were reviewed for the timeliness and content of the documentation related to appeals. Details of the findings for Component 3 follow in Appendix A—Component 3.

Summary of Findings and Opportunities for Improvement

Overall Score: In Partial Compliance

ABC had an established process that allowed members access to the **ABC** appeal process and the State fair hearing process. **ABC** had evidence that it informed members about the appeal and State fair hearing processes via the member handbook and member newsletters. **ABC**'s policies, member materials, and provider materials indicated that members and authorized representatives may file orally or in writing. Not all of the materials, however, clarified that an oral request must be followed by a written request. **ABC** should await the Department's clarification regarding this requirement and ensure that materials reflect the appropriate information. **ABC**'s policies included most of the required information.

ABC's policies as well as member and provider materials were not accurate regarding the time frames for filing appeals when requesting continued benefits. The provider manual mixed two types of appeals to define timely filing (appeals related to the denial or limited authorization of requested services and appeals related to the termination, suspension, or reduction of previously authorized services). **ABC** may consider clarifying provider information regarding the two time frames for filing appeals based on the type of appeal.

Appeals Record Review Summary

Six appeal records were reviewed. Each of the records contained evidence of assistance provided to members during the appeal process. For all six cases, **ABC** met the required time frames for acknowledging the appeal and for sending the notice of resolution. Appeal resolution letters contained nontemplate language clearly explaining the reasons for the decision; however, much of the nontemplate language was technical and not easy to understand. In addition, the letters

indirectly addressed members using third-person language. All records contained evidence that the individuals who made decisions on the appeals had not been involved in any previous level of review and had the required clinical expertise.

Summary of Strengths

The UM system included documentation of the assistance provided to members during the appeal process. As an example, one of six records reviewed included documentation of the member requesting (and being sent) a copy of the InterQual utilization guidelines used for the determination in her particular case.

Records reviewed on-site contained evidence that **ABC** met all time frames for acknowledgment and resolution of appeals. In addition, **ABC** had an effective mechanism to ensure that reviewers who made decisions on appeals were not involved in any previous level of review and had the appropriate clinical expertise to decide the appeal.

The on-site record review also demonstrated that **ABC** used the extension process when it was in the member's interest to do so, and met all requirements regarding notice to the member of the extension.

Summary of Required Actions

The language used in the appeal resolution letters was very technical and appeared to be for a professional audience rather than for the member. For example, although the letter addressed the member, it was written in third person and included words such as "symptomatology," "psychopathology," and "disparity." These words, as well as the writing style, were well above the average reading level of a Medicaid member. **ABC** must ensure that members can easily understand the appeal resolution letters.

The Member Appeal Process policy included the provision that members may request continuation of benefits during the appeal and State fair hearing processes; however, the policy stated that filing must occur within 20 days (rather than 10 days or before the date of the proposed action). **ABC** must revise its applicable policies and related documents to accurately reflect the requirements and time frames for continuation of benefits during the appeal and State fair hearing processes.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation and interviewed key BHO personnel. Details of the findings for Component 4 follow in Appendix A—Component 4.

Summary of Findings and Opportunities for Improvement

Overall Score: In Compliance

ABC had a variety of routine reports that analyzed and trended utilization data and were designed to identify over- and underutilization. Reports included data on average daily census for all programs (including acute, inpatient, day treatment, routine, and home-based services) and the capability to sort data by week, quarter, or year to compare the period chosen to the previous period. **ABC** also reported the capability to run reports by organizational provider to identify high- and low-volume outliers.

Summary of Strengths

Staff reported that the ER Heavy Hitter Report was cross-checked with reports of outpatient service use and used to determine if outreach to members by the customer service department was warranted. **ABC** provided documentation of follow-up calls made by the **ABC** customer service department following member discharge from inpatient hospitalization. The medical record audit tool included a section for the reviewer to document whether the treatment record contained evidence of appropriate coordination of care during member transition between levels of care.

Summary of Required Actions

There were no corrective actions required for this component.

6. Follow-up on FY 2007–2008 Corrective Action Plan for Access Behavioral Care

Methodology

As a follow-up to the FY 2007–2008 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all components for which it received a score of *In Partial Compliance* or *Not In Compliance*. The plan was to include interventions to achieve compliance and the timeline associated with those activities. 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 2007–2008 compliance monitoring site review, or until the time of the on-site portion of the BHO's FY 2008–2009 site review.

Summary of FY 2007–2008 Required Actions

ABC was required to 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. In its plan of correction, **ABC** was required to include performance expectations for providers and how **ABC** planned to monitor its providers for compliance with access standards. **ABC** was also required to indicate in the plan of correction how it planned to ensure that Medicaid members were offered hours of operation equal to those offered to enrollees of commercial health care plans who sought services from **ABC**'s providers. Further, **ABC** was required to work directly with the Department regarding completion of this required action and respond to the Department's feedback and requirements, as appropriate.

In addition, **ABC** was required to ensure that measurement of compliance with access standards captured data based on Medicaid members' initial request for services.

ABC was required to describe what facilities were part of its urgent care network, how Medicaid members in **ABC**'s service area were informed of the procedures for accessing urgent care services, and how **ABC** planned to ensure that its members received urgent care services, if needed.

ABC was required to develop provider-specific monitoring mechanisms to assess performance of providers related to service provision. **ABC** was also required to develop a mechanism for monitoring providers that ensured that members received an assessment. As **ABC** was in the process of revising its process for monitoring providers for medical record requirements, **ABC** was required to include in the new monitoring process a mechanism to ensure that each of its medical record requirements was monitored.

ABC was required to monitor the Mental Health Center of Denver (MHCD) for compliance with requirements related to grievance processing and to ensure that members were provided reasonable assistance with filing grievances. **ABC** was also required to ensure that individuals who made grievance decisions were individuals who were not involved in any previous level of review, and that grievances were processed according to all Medicaid managed care requirements.

Summary of Findings

ABC submitted its Access to Care Corrective Action Plan (CAP), dated March 21, 2008, within the time frame required by the Department. Monthly reports describing the progress of **ABC**'s Access to Care CAP demonstrated **ABC**'s commitment to work directly with the Department to resolve its access-to-care compliance issues. The Access to Care CAP described **ABC**'s plan to train organizational providers regarding performance expectations, including the required time frames for provision of routine, urgent, and emergent services. Sign-in rosters provided evidence that training at each of **ABC**'s three largest organizational providers occurred as planned. The plan also described **ABC**'s secret shopper program designed to monitor compliance with performance expectations. Results of the secret shopper calls provided evidence that the CAP was implemented as written. During initial meetings with each of **ABC**'s three largest organizational providers, the organizations' management members clarified to **ABC** that intake processes, while noncompliant with timeliness standards, were not unique to Medicaid members and did not represent lack of compliance in offering hours of operation and opportunity for access equivalent to clients served via other insurance plans.

Documentation of secret shopper calls and outlines for trainings provided at **ABC**'s organizational providers (University of Colorado Hospital Clinic [UCH], Denver Health and Hospital Authority [DHHA], and MHCD) demonstrated that **ABC**'s performance expectation was that timely access to services be measured from the member's first contact with the organization. Documentation provided demonstrated that **ABC** required CAPs, as needed, related to tracking access-to-care statistics. **ABC**'s access-to-care training also included the expectation that providers refer members back to **ABC** for assignment to another provider if the provider is unable to meet timeliness expectations. Secret shopper callers noted whether this referral was made, if applicable.

ABC described its urgent care network as including walk-in hours at MHCD clinics, the practice of directing members to **ABC** for referral to a provider with availability for service provision within 24 hours, and the use of Denver Health Mobile Crisis Services. The Mobile Crisis Services team had the capability to provide urgently needed services to all **ABC** members via in-home assessment, triage, and referral to additional services as needed. The provider manual included information about mobile crisis services. **ABC** staff indicated that members were informed about mobile crisis services as needed by providers.

The Partnership Newsletter—4th Quarter 2008 included a discussion about emergency room services, how to receive services when a crisis begins to build, and how to prevent a mental health emergency, including how to access services from the mobile crisis unit. The member handbook defined urgent services and informed members that urgent services should be available within 24 hours. **ABC** staff reported that **ABC**'s urgent care services are not provided by a separate network and that providers are expected to either provide urgent care within 24 hours or direct members to the emergency room, if appropriate. During the initial phase of the secret shopper program, **ABC** reiterated to its organizational providers the responsibility and required time frames for providing urgent care, or to direct members to the emergency room (as evidenced by the Access to Care Training agenda and handout—April 2008).

The 2008 Access Behavioral Care Provider Medical Record Documentation Study described the methodology and the results of the medical record audit completed by **ABC**. Both organizational and individual providers were included in the study.

The 2008 Access Behavioral Care Provider Medical Record Documentation Study described the methodology and the results of the medical record audit completed by **ABC**. Completed medical record review tools included a review for the presence of an assessment and whether the assessment was updated as necessary. The tools also included a review for the medical record requirements described in the provider manual and in the Review of Medical Records policy.

The completed MHCD Grievance File Audit tool and the executive summary of the Grievance File Audit Report demonstrated that the grievance file audit of MHCD grievance files, completed in August 2008, confirmed that members filing grievances (for cases reviewed by **ABC**) were provided assistance as needed.

The tool and executive summary also demonstrated that during the grievance file audit, **ABC** confirmed that (for the cases reviewed by **ABC**) individuals who make grievance decisions were individuals who were not involved in any previous level of review, and that grievances were processed according to all Medicaid managed care requirements. **ABC**'s revised audit procedures had been implemented, as well, and the grievance file audit of MHCD completed in August 2008 included a review for whether grievances were processed according to all Medicaid managed care requirements.

Summary of Required Actions

ABC successfully completed the FY 2007–2008 required actions. There were no required actions continued from FY 2007–2008.

The completed compliance monitoring tool follows this cover page.

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(3) Contract: II.G.d.g & II.G.d.h	1. The Contractor provides all members the required information (see below) within a reasonable time after the BHO receives notice of enrollment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The Colorado Access Policy OMFA201, Printed Member Marketing/Informational Materials, stated that ABC would mail new member packets upon notification by the Department of the member's enrollment into ABC. New member packets included a welcome letter, member handbook, provider directory, and ABC's Notice of Privacy Practice and contained all of the required information. ABC staff described the process of receiving enrollment data from the Department and sending the packets monthly.	
	Required Actions: None	
Contract: II.G.d.b	2. The Contractor has a mechanism to help members and potential members understand the requirements and benefits of the plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: ABC employed a variety of methods to help members and potential members understand the requirements and benefits of the plan. The member handbook provided a detailed explanation of benefits and limits and suggested that members call with questions or for additional information. ABC mailed quarterly newsletters to its members. Information covered in the newsletters included benefit information, health tips, signs and symptoms of common mental health ailments, and grievance process information. All newsletters included an agenda for, and an invitation to, the next Consumer and Family Advisory Board (CFAB) meeting. Members were offered a $15 grocery gift card as an incentive to attend these meetings. CFAB meeting minutes indicated that attendance at each meeting was 50 to 60 members. ABC staff reported that the content of both the member newsletter and the CFAB meetings was driven by the members in attendance each quarter. CFAB meetings included presentations on ABC's quality improvement program, alternative services offered by ABC, side effects to common medications, and upcoming events such as free medical and dental clinics, National Alliance on Mental Illness (NAMI) conferences, picnics, dances, and drop-in center events. ABC staff reported that board membership consisted of whoever attended each quarter and that one member served as co-chair of the committee and consistently attended.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(b)(1)&(3) 42CFR438.10(d) Contract: II.G.d.a; II.G.d.c; & II.G.d.d	3. The Contractor provides all enrollment notices, informational materials (handbooks, newsletters, directories), and instructional materials (health education, grievance system notices) in a manner and format that may be easily understood: ◆ In the prevalent non-English language. ◆ In alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: Policy ADM207—Effective Communication with Limited English Proficiency (LEP) and Sensory-Impaired/Speech Impaired (SI-SI) Persons stated that all member materials would be provided in a manner and format that may be easily understood. This policy also stated that information would be made available in alternative formats. All written member materials included a statement written in Spanish telling members how to obtain Spanish versions. Materials also included a statement instructing members how to obtain information in large print, on tape, or in another language. Local, toll-free, and teletype/telecommunications device for the deaf (TTY/TTD) telephone numbers were included on all materials reviewed. ABC used the Microsoft Word literacy level function to review reading level for member materials. Additionally, Colorado Access (ABC's parent company) was a member of the America's Health Insurance Plans Health Literacy Taskforce. ABC staff reported monthly meetings (via teleconference), which consisted of discussion and best-practice sharing regarding the development of member materials. The purpose of the task force was to establish best practices for communicating with members, including those with low health literacy. ABC staff members also reported that ABC followed guidelines of the Harvard School of Public Health Literacy Studies Program when developing member materials.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(c)(4)&(5) Contract: II.G.d.c; II.G.d.e; & II.G.d.f	4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: Policy ADM207—Effective Communication with LEP and SI-SI Persons stated that interpretation services would be paid for by ABC or the provider. ABC used the provider manual to notify providers that interpreters and auxiliary aids would be provided to members free of charge. Providers were also given information on how to access translation services. ABC staff members reported that approximately half of the Colorado Access customer service staff were bilingual (Spanish/English) and that the customer service department also included a staff member who spoke Korean, one who spoke Russian, one who spoke Italian, and one who spoke Cambodian. ABC staff described the process of certifying these staff members in the applicable language via the use of language fluency testing administered by a contractor, Escalante International. ABC staff reported that customer service staff responded to calls received in other languages, and that requests for interpretation on-site were handled by contracted interpreters or the AT&T language line. Member rights, as printed in the member handbook, included the right to "get services from a provider who speaks your language or get interpretation services in any language needed." The member handbook, however, did not inform members of how to obtain interpreter services. The member handbook also specifically informed members that interpretation services were available for members who are deaf or hard of hearing, but the policy did not inform members of how to obtain these services. ABC may consider notifying members of how to access interpreter services.	
	Required Actions: None	
42CFR438.10(c)(5) Contract: II.G.d.f	5. The Contractor notifies members that written information is available for prevalent non-English languages and how to access the materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: All member materials reviewed included instructions, written in Spanish, on how to obtain copies in Spanish. ABC provided examples of Spanish materials, including member newsletters and the member handbook.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(d)(2) Contract: II.G.d.f	6. The Contractor notifies members that written information is available in alternative formats and how to access the materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: Policy ADM207—Effective Communication with LEP and SI-SI Persons stated that all member materials would be made available in alternative formats. Member materials reviewed (e.g., member newsletters, notice-of-action and resolution letters, the welcome letter, the member handbook, and the provider directory) included instructions on how to obtain materials in Spanish, other languages, large print, or audio formats.	
	Required Actions: None	
42CFR438.10(f)(2) Contract: II.G.d.k	7. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information (42CFR438.10), upon request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: ABC used the member newsletters to remind members annually that they may receive a hard copy of the member handbook upon request and via the ABC Web site. The January 2008 newsletter also included an explanation as to why members have Access Behavioral Care.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(4) Contract: II.G.d.i	8. The Contractor gives written notice of any significant change in information to members at least 30 days before the intended effective date of the change.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The ABC member handbook stated that members would be given written notice 30 days before any change to benefits or services. ABC staff reported that there were no significant changes in information provided to members during the review period; therefore, there were no examples of notice provided to members.	
	Required Actions: None	
42CFR438.10(f)(5) Contract: II.G.d.j	9. The Contractor makes a good-faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who is receiving or has received in the last six months his or her primary mental health care from, or was seen on a regular basis by, the terminated provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: Policy CCS306—Delivering Continuity of Care and Transition of Care for Members stated that Colorado Access would make a good-faith effort to give members written notice of a network transition (provider group termination or vendor contract termination) within 15 days. The member handbook stated that members would be given written notice within 15 days of ABC learning that a provider is leaving. ABC staff stated that when notice is received that a provider is leaving, the ABC decision support team would run a query to determine what members, if any, were currently assigned to that provider. The customer service team would then contact the member. ABC staff stated that there were no examples of provider termination during the review period.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f) Contract: II.G.d.g.	10. Member information materials include: ◆ Names, locations, and telephone numbers of, and non-English languages spoken by, current contracted providers, including identification of providers who are not accepting new patients. ◆ Any restrictions on freedom of choice among network providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: ABC's member handbook informed members that they have a choice of providers. The hard copy provider directory included the names, locations, and telephone numbers of contracted providers. ABC's Web site included a provider search tool, which allowed members to search for providers by name, location, specialty, languages spoken, and whether or not a provider was accepting new patients.	
	Required Actions: None	
42CFR438.10(f) Contract: II.G.d.g	11. Member information materials include: ◆ Member rights as specified in 42CFR438.100. ◆ Additional member rights that include the right to: ▪ Have an independent advocate. ▪ Request that a specific provider be considered for inclusion in the network. ▪ Receive a second opinion. ▪ Receive culturally appropriate and competent services from participating providers. ▪ Receive interpreter services for members with communication difficulties or for non-English-speaking members. ▪ Prompt notification of termination or changes in services or providers. ▪ Express an opinion about the Contractor's services to regulatory agencies, legislative bodies, or the media without the Contractor causing any adverse effects upon the provision of covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The ABC member handbook included all of the required member rights.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(g) Contract: II.G.d.g	12. Member information regarding the grievance, appeal, and fair hearing procedures have been approved by the Department and include: ◆ The right to file grievances. ◆ The right to file appeals. ◆ The right to a State fair hearing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook included the member's right to file a grievance and an appeal, and the member's right to request a State fair hearing. The notice-of-action template letter also informed members of their right to appeal and/or request a State fair hearing. ABC provided e-mail documentation of the Department's approval of ABC's member materials.	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	13. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The requirements and time frames for filing grievances and appeals. ◆ The method for obtaining a State fair hearing. ◆ The rules that govern representation at a State fair hearing.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The member handbook included the requirements and time frames for filing a grievance, an appeal, and requesting a State fair hearing. The member handbook also reviewed the method for obtaining a State fair hearing and the rules that govern representation at the hearing. Time frames for filing an appeal and a request for a State fair hearing were also included in the notice-of-action template letter. The time frames for filing appeals included in these documents included the time frame for filing appeals related to a denial or limited authorization of a requested service (20 days), but not the time frame for filing an appeal related to the termination, suspension, or reduction of a previously authorized service (10 days or before the date of the proposed action). ABC may consider including information in member materials about both time frames for filing appeals.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(g) Contract: II.G.d.g	14. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook clearly stated that assistance is available for filing grievances, appeals, and for requesting a State fair hearing. The member handbook offered both local and toll-free telephone numbers that members can call for help, and also offered local, toll-free, and TTY/TTD telephone numbers for the Medicaid ombudsman. This information was also included in the notice-of-action template letters.	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	15. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State fair hearing is filed within the timeframes specified for filing ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The member handbook and the notice-of-action template letter both stated that members may be able to continue services during the process and that "if you lose…you may have to pay." The information provided in these documents did not specify that the member must request continued services, did not explain the circumstances under which a member may request continued services, and did not include the time frames for requesting continued services. ABC may consider revising member materials to provide additional information to members regarding the process for requesting continued services during the appeal or State fair hearing processes.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(g) Contract: II.G.d.g	16. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook stated that providers, as designated client representatives (DCRs), can file an appeal for a member or help the member with an appeal.	
	Required Actions: None	
42CFR438.10(f)(6) Contract: II.G.d.g	17. Information provided to members includes: ◆ The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. ◆ Procedures for obtaining benefits, including authorization requirements. ◆ The extent to which and how members may obtain benefits from out-of-network providers. ◆ How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract, including any cost-sharing and how transportation is provided.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: ABC's member handbook described services available from ABC and included a table that listed the type of service, the benefit limit, and whether authorization was necessary. The handbook informed members that it was the provider's responsibility to obtain authorization. The handbook also explained procedures for obtaining services and how members could get services from out-of-network providers. The handbook gave information about who to call for services offered through Medicaid, but not provided by ABC, including how to arrange transportation.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(6) Contract: II.G.d.g	18. Information provided to members includes: ◆ The extent to which and how after-hours and emergency coverage are provided, including: ▪ What constitutes an emergency medical condition, emergency services, and poststabilization services with reference to the definitions in 42 CFR 438.114(a). ▪ The fact that prior authorization is not required for emergency services. ▪ The process and procedures for obtaining emergency and poststabilization services, including the use of the 911 telephone system or its local equivalent. ▪ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services. ▪ The fact that the member has the right to use any hospital or other setting for emergency care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook included definitions and discussions of an emergency medical condition, emergency services, and poststabilization services that were consistent with the BBA. The handbook clearly stated that emergency services do not require prior approval and offered members the option of going to the nearest emergency room and calling 911. Members were given the names and addresses of the three emergency rooms in the network, and they were told that they could go to any emergency room.	
	Required Actions: None	
42CFR438.10 Contract: II.G.d.g	19. Information provided to members includes policies on referral for specialty care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook stated that members have the right to ask for referrals to specialty programs and that they could call ABC for assistance in finding a specialist.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10 42CFR438.6(I)(2) 42CFR422.128 Contract: II.G.d.g	20. Member information regarding advance directives for adult members includes: ◆ The member's right to formulate advance directives. ◆ The member's rights under the State law to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment. ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State agency. ◆ The Contractor's policies regarding implementation of advance directives, which must include: ▪ A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. ▪ The difference between institution-wide conscientious objections and those raised by individual physicians. ▪ Identification of the State legal authority permitting such objection. ▪ Description of the range of medical conditions or procedures affected by the conscientious objection. ▪ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. ▪ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. ▪ Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. ▪ The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive. ▪ Provisions for ensuring compliance with State laws regarding advance directives. ▪ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. ▪ Provisions for the education of staff concerning its policies and procedures on advance directives. ▪ Provisions for community education regarding advance directives that includes:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	• What constitutes an advance directive. • Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. • A description of applicable state law concerning advance directives.	
	Findings: ABC's member handbook informed members of their right to have advance directives, described the types of advance directives recognized in Colorado, and informed members of how to file complaints regarding noncompliance with advance directives. ABC's Advance Directives policy included ABC's process for facilitating a transfer from a provider in the event of a provider's refusal to carry out an advance directive on moral or religious grounds. The policy also included the process for documenting whether a member has an advance directive, provisions for informing members of any changes in State laws regarding advance directives, and the fact that care is not conditioned on whether or not members have an advance directive. ABC monitored providers' compliance with ABC's Advance Directives policy via an annual medical record review. Additional advance directive information and links to additional Web sites containing advance directive information was available on ABC's Web site.	
	Required Actions: None	
Contract: II.G.d.h	21. Information provided to members includes: ◆ The fact that no fees may be assessed for covered mental health services provided to enrolled members. ◆ Notice that the member has been enrolled in the Community Mental Health Services Program operated by the Contractor, and that enrollment is mandatory. ◆ The Contractor's hours of operation. ◆ That assistance is available through the Medicaid Managed Care Ombudsman Program and how to access ombudsman services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The first page of the member handbook stated that members have been automatically enrolled in ABC based on the county they live in, that ABC's services are free to members, and ABC's hours of operation. The availability of assistance through the Ombudsman Program was mentioned several times throughout the handbook. Local, toll-free, and TTY/TTD telephone numbers were also listed in several sections of the handbook.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
Contract: II.G.d.h	22. Information provided to members includes: ◆ Appointment standards for routine, urgent, and emergency situations. ◆ Procedures for requesting a second opinion. ◆ Procedures for requesting accommodations for special needs, including written materials in alternative formats. ◆ Procedures for arranging transportation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook included appointment standards for routine, urgent, and emergency situations. The handbook instructed members on how to request second opinions and where to call to request accommodations for special needs. Procedures for arranging transportation were also included in the handbook.	
	Required Actions: None	
42CFR438.10 Contract: II.G.d.h	23. Information provided to members includes: ◆ Information on how members will be notified of any changes in services or service delivery sites. ◆ Procedures for requesting information about the Contractor's Quality Improvement Program. ◆ Information on any member and/or family advisory boards the Contractor may have in place.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: ABC used its member handbook to inform members that they would be given written notice of any changes in service. The member handbook invited members to call for information about ABC's quality improvement program and for information about joining the Consumer and Family Advisory Board. ABC's quarterly newsletters advertised quarterly Consumer and Family Advisory Board meetings. Along with location, date, and time, ABC included the agenda for each meeting in the newsletter and offered a $15 grocery gift card as an incentive for members and family members to attend. ABC staff stated that ABC used the newsletters and meetings to announce changes in services or delivery sites.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10 Contract: II.G.d.g	24. Additional information that is available upon request: ◆ Physician incentive plans	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: Policy ADM 221 described ABC's physician incentive program and stated that information regarding the physician incentive program is provided to members upon request. Staff confirmed that members could request and receive physician incentive information at any time.	
	Required Actions: None	
42CFR438.10 Contract: II.G.d.g	25. Information that must be made available annually and upon request: ◆ Information on the structure and operation of the Contractor ◆ The Contractor's service area ◆ The benefits covered under the contract ◆ The fact that no fees may be assessed for covered mental health services provided to enrolled members ◆ To the extent available, quality and performance indicators, including enrollee satisfaction	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: Members were informed in the member handbook that the required information is available upon request. ABC informed members annually via member newsletters that member handbooks are available on ABC's Web site or hard copy upon request. In addition, the second quarter 2009 member newsletter included a reminder of services available from ABC, showed ABC's service area, described how to obtain a copy of the annual quality report, explained that all mental health services are free, and stated that member handbooks are available on ABC's Web site and via hard copy upon request.	
	Required Actions: None	

Results for Member Information							
Total	Met	=	22	X	1.00	=	22
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	3	X	N/A	=	
Total Applicable		=	22	**Total Score**		=	22

Total Score ÷ Total Applicable	=	100%

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.400(b) Contract: Exhibit G—8.209.2	1. The Contractor defines action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determination policy, the Member Appeal Process policy, the member handbook, and the provider manual were reviewed for compliance with the BBA definition of action. The documents reviewed were not complete and were not consistent with each other. One bullet in the definition of action contained in the Utilization Review Determination policy simply stated: "failure to act within the timeframes below," as it was stated in Exhibit G to the contract; however, the time frames for resolution of grievances and appeals were not addressed in this particular policy. The Member Appeal Process policy did not include the failure to act within the time frames for grievances and appeals. The Member Appeal Process policy also included exceptions to the denial-of-payment bullet. The bullet stated, "The denial, in whole or part, of payment for a service (except payment denials issued by a mental health prepaid inpatient health plan) which makes the member liable for payment." This language was inconsistent with the BBA definition of an action. The definition of action in the member handbook did not include the denial-of-payment bullet, and the definition of an action in the provider manual was vague.	
	Required Actions: ABC must revise all applicable policies and related documents to include a definition of an action that is consistent with the BBA definition and is consistent across policies and related documents.	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.404(a) Contract: Exhibit G—8.209.4.A.1	2. Notices of action must meet the language and format requirements of 42CFR438.10 and ensure ease of understanding.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The notice-of-action template letters were easy to understand. ABC staff inserted specific language into the letters to describe the reason for the action. ABC included a two-page handout of important information about the appeal and State fair hearing processes with each notice of action sent. ABC staff stated that each letter was initially sent in English and contained prominent language that informed the member in Spanish that a Spanish version of the letter is available by contacting ABC. While most of the added language in the letters describing the reason for the decision was easy to understand, there were two notices of action in the record review that were not easily understood. In these two records, the reason for the action was unclear. In addition, while the notices of action sent to the members were addressed to the member, the letter referred to the member in the third person and was written as if the reader was the provider rather than the member. The result was a letter that was impersonal and not member friendly. ABC may consider presenting information in the notices of action directly to the member.	
	Required Actions: ABC must ensure that notices of action are easy for a member to understand and present information from the member's perspective.	
42CFR438.404(b) Contract: Exhibit G—8.209.4.A.2	3. Notices of action must contain: ◆ The action the Contractor has taken or intends to take. ◆ The reasons for the action. ◆ The member's (and provider's on behalf of the member) right to file an appeal and how to do so. ◆ The member's right to request a State fair hearing and how to do so. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that. ◆ The circumstances under which the member may have to pay for the costs of services if continued benefits are requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determination policy (CCS307) included all of the requirements. The notice-of-action template letter included all of the requirements either in the body of the letter or in attached information. The notices of action reviewed on-site used the template letters, which included the required information. Each letter sent included an attachment explaining the appeal and State fair hearing processes.	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.404(c) Contract: Exhibit G—8.209.4.A.3	4. The notice of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized, Medicaid-covered services, at least 10 days before the date of action (unless extenuating circumstances exist—found in Exhibit G) ◆ For denial of payment, at the time of any action affecting the claim ◆ For standard service authorization decisions that deny or limit service, within 10 calendar days ◆ For service authorization decisions not reached within 10 calendar days, on the date the time frames expire ◆ For expedited service authorization decisions, within three days	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determination policy included the time frames for sending a notice of action for standard and expedited actions related to the denial or limited authorization of requested services as well as the termination, suspension, or reduction of previously authorized services. The policy did not acknowledge that notices of action are sent for denial of payment.	
	Required Actions: ABC must revise its policy to include the process and time frame for sending notices of action related to denial of payment for services.	
42CFR438.404(c) Contract: Exhibit G—8.209.4.A.4	5. If the Contractor extends the time frame for authorization decisions (see Standard I) it provides the member: ◆ Written notice of the reason for the decision to extend the time frame. ◆ The right to file a grievance if the member disagrees with the decision. ◆ Issuance of its decision (and carries out the decision) as expeditiously as the member's health condition requires and no later than the date the extension expires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determination policy included the extension time frame and stated that ABC will send a notice of reason for the extension. ABC submitted an extension template. ABC staff reported that there were no examples of extending the time frame for authorization of services during the review period.	
	Required Actions: None	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.210(a)(3)(ii) Contract: II.J.a..d.2	6. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medical Criteria for Utilization Review policy (CCS302) stated that InterQual criteria are used for all Colorado Access lines of business, including ABC. One record reviewed on-site included documentation of the member requesting (and being sent) a copy of the InterQual criteria used for utilization determination. Results of interrater reliability (IRR) testing indicated overall IRR scores well above InterQual's benchmark of 80 percent. The on-site record review demonstrated that decisions to deny or limit services were not based solely on diagnosis or condition (i.e., developmental disability). Instead, decisions were due to lack of a co-occurring, covered diagnosis; a request for noncovered services; or lack of medical necessity. ABC staff reported that the executive director had received no direct calls related to denials of services to developmentally disabled individuals and that any complaints regarding that issue would be processed using the grievance system processes.	
	Required Actions: None	
42CFR438.210(a)(3)(iii) Contract: II.J.a.d.3	7. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medical Criteria for Utilization Review policy stated that the local delivery system and individual needs are considered when applying UM criteria to authorization decisions. ABC staff stated that difficult cases and those determined to be outliers for average length of stay were reviewed in rounds with the medical director to ensure that individual needs were considered when making utilization decisions.	
	Required Actions: None	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.210(b)(3) Contract: II.J.a.f	8. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Qualifications for Staff Engaged in Utilization Management Activities policy stated that all adverse determinations are made and signed by a physician. The on-site record review demonstrated that each notice of action was signed by the psychiatrist involved the adverse determination.	
	Required Actions: None	
42CFR438.210(c) Contract: II.J.a.h	9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. (Notice to the provider does not need to be in writing.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determination policy included the process for notifying the member and provider of utilization decisions. The on-site record review demonstrated that written notice was sent to the member and the provider.	
	Required Actions: None	

Results for Notices of Action							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	0	X	N/A	=	N/A
Total Applicable		=	9	**Total Score**		=	6

Total Score ÷ Total Applicable	=	67%

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.402(a) Contract: Exhibit G—8.209.1	1. The Contractor has a system in place that includes an appeal process and access to the State fair hearing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The member handbook included a description of a member's right to access the appeal and State fair hearing processes. The Member Appeal Process policy described the procedures for members to access the appeal process, which included access to a State fair hearing. The provider manual informed providers of the appeal and State fair hearing processes. The member newsletters periodically contained articles reminding members of their right to appeal ABC decisions or request a State fair hearing.	
	Required Actions: None	
42CFR438.400(b) Contract: Exhibit G—8.209.2	2. The Contractor defines an appeal as a request for review of an action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The member handbook, the provider manual, and the Member Appeal Process policy each included a definition of an appeal that was consistent with the BBA.	
	Required Actions: None	
42CFR438.402(b)(1) Contract: Exhibit G—8.209.1	3. The Contractor has provisions for who may file: ◆ A member may file a PIHP-level appeal and may request a State fair hearing. ◆ A provider, acting on behalf of a member and with the member's written consent, may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member. (The State permits the provider to act as the member's authorized representative.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Appeal Process policy included provisions regarding who may file appeals that were consistent with BBA requirements. Providers were notified via the provider manual. Members were informed that DCRs may file via the member handbook, and the member handbook indicated that providers may be DCRs.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.402(b)(3) Contract: Exhibit G—8.209.4.F	4. The member may file an appeal either orally or in writing and must follow an oral request with a written request (unless the request is for expedited resolution).	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The Member Appeal Process policy stated that members or DCRs may file verbally or in writing. There was no discussion in the policy regarding a requirement to follow oral requests with written requests. The BBA requires that oral requests for an appeal be followed by a written request. The Department will send a clarification to the BHOs regarding this requirement.	
	Required Actions: None	
42CFR438.402(b)(2) Contract: Exhibit G—8.209.4.B	5. An appeal may be filed 20 calendar days from the date of the notice of action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Appeal Process policy stated that appeals may be filed within 20 calendar days from the date of the notice of action. Members were informed of the timeline to file via the member handbook. The provider manual mixed two types of appeals when defining timely filing (appeals related to the denial or limited authorization of requested services and appeals related to the termination, suspension, or reduction of previously authorized services). ABC may consider clarifying provider information regarding the two time frames for filing appeals based on the type of appeal.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.402(b)(3) Contract: Exhibit G—8.209.4.N	6. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing 20 days from the date of the notice of action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Appeal Process policy stated that members need not exhaust ABC's appeal process before requesting a State fair hearing. Members were informed via the member handbook. The provider manual informed providers that members (or DCRs) may request a State fair hearing any time during the appeal process. The request must be made no later than 20 days from the date of the notice of action. The notice-of-action template stated that State fair hearings may be requested "instead of ABC's appeal process or at any time during ABC's appeal process."	
	Required Actions: None	
42CFR438.406(a) Contract: Exhibit G—8.209.4.C	7. In handling appeals, the Contractor must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Appeal Process policy stated that ABC will provide assistance in navigating the appeal process. The member handbook offered members assistance with any part of the appeal process. The notice-of-action template offered assistance to the member or the DCR with any part of the appeal process. The provider manual offered assistance to members or DCRs. The records reviewed on-site contained documentation that assistance was provided to members during the appeal process.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.406(a) Contract: Exhibit G—8.209.4.D	8. The Contractor acknowledges each appeal in writing within two working days of receipt, unless expedited resolution is requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Appeal Process policy included the provision to acknowledge each appeal within two working days of receipt. Members were informed via the member handbook. Providers were notified of the process in the provider manual. Each of the records reviewed contained documentation that the acknowledgment letter was sent within two working days of receipt of the appeal.	
	Required Actions: None	
42CFR438.406(a) Contract: Exhibit G—8.209.4.E	9. The Contractor ensures that the individuals who make decisions on appeals are individuals who: ◆ Were not involved in any previous level of review or decision making. ◆ Have the appropriate clinical expertise in treating the member's condition or disease if they are deciding an appeal of a denial based on lack of medical necessity or an appeal of a denial that involves any clinical issues.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Appeal Process policy included the provision. Members were informed of the process in the member handbook and the notice-of-action letter. Providers were informed of the process in the provider manual. The on-site record review demonstrated that in each case reviewed the individual who made the appeal decision was an ABC psychiatrist and had not been involved in any previous level of review.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.406(b) Contract: Exhibit G—8.209.4.G—I	10. The Contractor's appeal process must provide: ◆ That oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution. ◆ The member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents considered during the appeals process. ◆ That either of the following individuals are included as parties to the appeal: ▪ The member and his or her representative ▪ The legal representative of a deceased member's estate	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy stated that ABC accepts appeals orally and in writing; however, the policy did not require that oral requests be followed by written requests. Appeal records reviewed on-site demonstrated that the oral filing date was used as the filing date for the appeals. The Member Appeal Process policy included all the required provisions. Members were informed in the member handbook and notice-of-action letter template of their and their DCR's right to examine case files or present evidence. Providers were informed of the process in the provider manual. The on-site review of records contained documentation that in some cases members reviewed files and presented evidence.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.408(b)&(d) Contract: Exhibit G—8.209.4.J	11. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires: ◆ For standard resolution of appeals, 10 working days from the day the Contractor receives the appeal ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Appeal Process policy included both time frames for resolution of appeals. Members were informed of both time frames in the member handbook. Providers were informed of both time frames in the provider manual. The on-site record review included only standard appeals. Each appeal reviewed was resolved with notice provided within the required time frame.	
	Required Actions: None	
42CFR438.408(c) Contract: Exhibit G—8.209.4.K & 8.209.5.E	12. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if either: ◆ The member requests the extension. ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Appeal Process policy included the provision. The member handbook and notice-of-action letter template informed members about extensions. Providers were informed about extensions in the provider manual. ABC provided an extension letter template. In the on-site record review there were three examples of cases in which the time frame for resolution was extended either at the request of the member or because ABC did not have the clinical information required to make a decision.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.408(b)(3) Contract: Exhibit G—8.209.4.K & 8.209.5.E	13. If the Contractor extends the time frames, it must—for any extension not requested by the member—give the member written notice of the reason for the delay.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The extension letter template included a section to describe the reason. The Member Appeal Process policy included the process for notifying members of the reason the time frame is being extended. The member handbook informed members of the process. Providers were informed of the extension process via the provider manual. In each of the cases involving an extended time frame for resolution, ABC had sent a notice of extension to the member that explained the reason the extension was needed.	
	Required Actions: None	
42CFR438.408(d) Contract: Exhibit G—8.209.4.L	14. For notice of an expedited resolution of an appeal, the Contractor must also make reasonable efforts to provide oral notice of resolution.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Appeal Process policy included the provision. Providers were notified in provider manual. Members were notified of this process in the attachment to the notice-of-action letter. There were no examples of expedited appeals during the review period.	
	Required Actions: None	
42CFR438.408(e) Contract: Exhibit G—8.209.4.M	15. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: ▪ The right to request a State fair hearing and how to do so. ▪ The right to request that benefits continue while the hearing is pending and how to make the request. ▪ That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
	Findings: The Member Appeal Process policy addressed the content of appeal resolution letters and included all of the requirements. The on-site record review demonstrated that the required information was sent to members with the appeal resolution letter in all cases reviewed; however, the resolution letters in four of six cases were not easy to understand. While the letters included additional information for the member explaining the reason for the decision, the language used was very technical and appeared to be for a professional audience rather than for the member. For example, although the letter addressed the member, it was written in third person and included words such as "symptomatology," "psychopathology," and "disparity" (see Appendix C). These words, as well as the writing style, were well above the average reading level of a Medicaid member.	
	Required Actions: ABC must ensure that members can easily understand the appeal resolution letters.	
42CFR438.410 Contract: Exhibit G—8.209.4.P—R	16. The Contractor has an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes the following: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: ▪ Transfer the appeal to the time frame for standard resolution. ▪ Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two calendar days.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Appeal Process policy described ABC's expedited review process, which included the requirements. The expedited review process was described in the member handbook and the provider manual. There were no examples of expedited appeals during the review period.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.414 Contract: Exhibit G—8.209.3.B	17. The Contractor must provide the information about the grievance system specified in 42CFR438.10 to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The right to file grievances. ◆ The right to file appeals. ◆ The right to a State fair hearing. ◆ The requirements and time frames for filing grievances and appeals. ◆ The method for obtaining a State fair hearing. ◆ The rules that govern representation at the State fair hearing. ◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone. ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for a State fair hearing is filed within the time frames specified for filing. ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending if the final decision is adverse to the member. ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: All required information was in the provider manual. ABC staff reported that the provider manual is supplied to providers on hard copy when requested at the time of contracting and is available on the Web site. Welcome letters for new providers directed providers to the Web site.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.416 Contract: Exhibit G—8.209.3.C	18. The Contractor maintains records of all appeals and submits quarterly reports to the Department.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Review of case-specific appeal records on-site demonstrated compliance. In addition, ABC submitted quarterly reports of grievances and appeals for FY 2008.	
	Required Actions: None	
42CFR438.420(b) Contract: Exhibit G—8.209.2 & 8.209.4.S	19. The Contractor continues the member benefits if: ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice of action ▪ The intended effective date of the proposed action ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: Members were informed in the member handbook of the right to request that benefits continue during the appeal and State fair hearing processes. ABC may consider informing members of the requirements/qualifications for requesting continued benefits. The Member Appeal Process policy included the provision; however, the policy stated that filing must occur within 20 days.	
	Required Actions: ABC must revise its applicable policies and related documents to accurately reflect the requirements and time frames for continuation of benefits during the appeal and State fair hearing processes.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.420(c) Contract: Exhibit G—8.209.4.T	20. If the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal ◆ Ten days pass after the Contractor mails the notice providing the resolution of the appeal against the member, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached ◆ A State fair hearing officer issues a hearing decision adverse to the member ◆ The time period or service limits of a previously authorized service has been met	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: ABC's Member Appeal Process policy included the provision to continue benefits during the appeal and State fair hearing processes. There were no examples of this type of appeal in the record review. Members and providers were informed of the processes, as well.	
	Required Actions: None	
42CFR438.420(d) Contract: Exhibit G—8.209.4.U	21. If the final resolution of the appeal is adverse to the member—that is, it upholds the Contractor's action—the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this rule.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: ABC's Member Appeal Process policy included the provision to continue benefits during the appeal and State fair hearing processes. There were no examples of this type of appeal in the record review. Members and providers were informed of the processes, as well.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.424 Contract: Exhibit G—8.209.4.V	22. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: ABC's Member Appeal Process policy included the provision to continue benefits during the appeal and State fair hearing processes. There were no examples of this type of appeal in the record review. Members and providers were informed of the processes, as well.	
	Required Actions: None	
42CFR438.424 Contract: Exhibit G—8.209.4.W	23. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: ABC's Member Appeal Process policy included the provision to continue benefits during the appeal and State fair hearing processes. There were no examples of this type of appeal in the record review. Members and providers were informed of the processes, as well.	
	Required Actions: None	

Results for Appeals							
Total	Met	=	20	X	1.00	=	20
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	1	X	N/A	=	N/A
Total Applicable		=	22	**Total Score**		=	20

Total Score ÷ Total Applicable	=	91%

Component 4 —Underutilization: Partial Review of Standard X—Quality Assessment and Performance Improvement		
References	**Requirement**	**Score**
42CFR438.240(b)(3) Contract: II.I.e	1. The Contractor's QAPI program includes mechanisms to detect both underutilization and overutilization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: ABC staff described the process of monitoring the continuum of care for overutilization and underutilization relationships. Trend reports included average daily census for all programs and the capability to sort data by week, quarter, or year to compare the period chosen to the previous period. Staff reported that the ER Heavy Hitter Report was cross-checked with reports of outpatient service use and was used to determine if outreach to members by the customer service department was warranted.	
	Required Actions: None	
UM Criteria – Section IV	2. The Contractor has policies and procedures outlining the activities undertaken to specifically identify and address underutilization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The QAPI Impact Analysis report included data for follow-up after hospitalization. The provider manual included expectations for providers regarding missed appointments and offered customer service staff resources. ABC provided documentation of follow-up calls made by the ABC customer service department following member discharge from inpatient hospitalization. The medical record audit tool included a section for the reviewer to document whether the treatment record contained evidence of appropriate coordination of care during member transition between levels of care.	
	Required Actions: None	

Component 4 —Underutilization: Partial Review of Standard X—Quality Assessment and Performance Improvement		
References	**Requirement**	**Score**
UM Criteria – Section IV	3. The Contractor's policies and procedures include the mechanism for routine trending and analysis of data by levels of care and by provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The End of Month inpatient report trended inpatient utilization by facility. ABC staff reported that the database had the capability to run reports by service or by organizational provider to identify high- and low-volume outliers. Examples of reports were reviewed on-site. Trend reports included average daily census for all programs (examples included acute, inpatient, day treatment, and home-based services).	
	Required Actions: None	
UM Criteria – Section IV	4. Trending includes services prior authorized and not prior authorized.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: During the review period routine services provided by contracted providers required authorization. Routine services provided by MHCD did not require authorization. Intensive levels of service regardless of provider (residential, inpatient, etc.) did require authorization. All services provided by all providers were included in the data analyzed and trended. ABC staff reported that ABC is currently in the process of changing its utilization management policies to discontinue the requirement for authorization of any routine services regardless of provider. All data will continue to be included in the data used for analysis and trending.	
	Required Actions: None	

Results for Underutilization							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	0	X	N/A	=	N/A
Total Applicable		=	4	**Total Score**		=	4

Total Score ÷ Total Applicable	=	100%

Appendix B. Notice of Action Record Review Tool for Access Behavioral Care

The completed notice of action record review tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Behavioral Health Organization (BHO) Actions Record Review Tool *for* Access Behavioral Care

Review Period:	July 1, 2007–June 30, 2008
Date of Review:	March 31, 2009
Reviewer:	Rachel Henrichs and Barbara McConnell
Participating BHO Staff Member:	Christine Gillaspie, Stephanie Dohrman, and Reyna Garcia

1	2	3	4	5	6	7	8	9	10	11
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for all Notices		
File #	Member ID	Date of Initial Request	Date Notice Sent	Number of Days for Decision	Notice Sent Within Time Frame	Date Notice Sent	Notice Sent Within Time Frame	Reasons are Easily Understood	Decision Made by Qualified Clinician	Notice Includes all Required Content
1	XXXXX	7/18/07	7/24/07	6	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: A request for inpatient admission was denied because the member's illness was a medical condition. A notice of action was mailed to both the member and the provider (DHHA).										
2	XXXXX	9/24/07	9/28/07	4	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☐ N ☒	M ☒ N ☐	M ☒ N ☐
Comments: The request for inpatient admission was denied based on the primary diagnosis (dementia) not being a covered diagnosis. A notice of action was mailed to both the member and the provider (DHHA). The letter to the provider stated that dementia is not a covered diagnosis; however, the letter to the member did not state that dementia is not covered.										
3	XXXXX	2/11/08	2/18/08	7	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: A request for inpatient services was denied based on the admitting diagnosis (alcohol dependency) not being a covered diagnosis. A notice of action was mailed to both the member and the provider (DHHA).										
4	XXXXX	7/28/07	8/7/07	10	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: A request for inpatient services was denied based on drug dependence not being a covered diagnosis. A notice of action was mailed to both the member and the provider (DHHA).										
5	XXXXX	8/9/07	8/15/07	6	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: A request for inpatient psychiatric admission was denied based on symptoms being more closely related to substance abuse and neurologic illness (which are not covered diagnoses). A notice of action was mailed to both the member and the provider (Swedish Medical Center).										
6	XXXXX	12/18/07	12/27/07	9	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: A request for inpatient services was denied because the patient's benefit allowance had been exhausted.										
7	XXXXX	5/19/08	5/20/08	1	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: A request for inpatient admission was denied based on lack of medical necessity (no acute psychiatric problem). A notice of action was mailed to both the member and the provider (Colorado Mental Health Institute at Fort Logan).										

Appendix B. Colorado Behavioral Health Organization (BHO) Actions Record Review Tool *for* Access Behavioral Care

1	2	3	4	5	6	7	8	9	10	11
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for all Notices		
File #	Member ID	Date of Initial Request	Date Notice Sent	Number of Days for Decision	Notice Sent Within Time Frame	Date Notice Sent	Notice Sent Within Time Frame	Reasons are Easily Understood	Decision Made by Qualified Clinician	Notice Includes all Required Content
8	XXXXX	6/27/07	7/3/07	6	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: A request for psychological testing was denied based on lack of medical necessity. The letter suggested that testing for cognitive abilities can be performed by the school and that if further testing is required, ABC would reconsider the request.										
9	XXXXX	11/16/07	11/20/07	4	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: A request for psychological testing was denied due to it being the school's responsibility to assess cognitive abilities. The letter also stated that the suspected cause of the cognitive problems was drug toxicity, which is a medical problem, not a psychiatric problem.										
10	XXXXX	9/18/07	9/19/07	1	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☐ N ☒	M ☒ N ☐	M ☒ N ☐
Comments: A request for psychological testing was denied based on lack of medical necessity. This reason was clearly stated in the letter to Children's Hospital Association; however, it was not made clear in the letter mailed to the member.										
# Applicable Elements					10		0	10	10	10
# Compliant Elements					10		0	8	10	10
Percent Compliant										

Legend:
M = Met
N = Not met
N/A = Not applicable

Total Applicable Elements:	**40**
Total # Compliant Elements:	**38**
Total Percent Compliant:	**95%**

Appendix C. Appeals Record Review Tool for Access Behavioral Care

The completed appeals record review worksheet follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix C. Colorado Behavioral Health Organization (BHO) Appeals Record Review Tool *for* Access Behavioral Care

Review Period:	July 1, 2007–June 30, 2008
Date of Review:	March 31, 2009
Reviewer:	Barbara McConnell
Participating BHO Staff Member:	Christine Gillaspie, Stephanie Dohrman, Reyna Garcia

1	2	3	4	5	6	7	8	9	10	11	12	13	14
File #	**Member ID**	**Date Appeal Received**	**Evidence of Reasonable Assistance**	**Date of Acknow-ledgment Letter**	**Acknow-ledgment Within 2 Working Days**	**Decision-maker—Previous Level**	**Decision-maker—Clinical Expertise**	**Expedited**	**Time Frame Extended**	**Date Resolution Letter Sent**	**Resolved in Time Frame**	**Resolution Notice Includes Required Content**	**Resolution Notice Easily Understood**
1	XXXXX	7/12/07	M☒ N☐ U☐	7/12/07	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	8/9/07	M☒ N☐	M☒ N☐	M☐ N☒
Comments: The decision was made by an M.D. The appeal was received July 12, 2007. The resolution was due July 26, 2007. An extension letter was sent July 26, 2007, making the new resolution due date August 9, 2007. The resolution was sent on August 9, 2007. The original decision was upheld. The resolution letter appeared to be written to the provider rather than to the member. The letter would not be easily understood by a member reading at a sixth-grade or similar reading level.													
2	XXXXX	11/12/07	M☒ N☐ U☐	11/13/07	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐		M☒ N☐	M☒ N☐	M☐ N☒
Comments: The denial had been for residential treatment as the member did not meet medical necessity criteria for the requested level of care. The decision was made by an M.D. The appeal was received November 12, 2007. The resolution was due November 26, 2007. An extension letter was sent November 23, 2007, making the new resolution due date December 10, 2007. The resolution was sent November 30, 2007. The resolution letter appeared to be written to the provider rather than to the member, using terms such as "symptomatology." The letter would not be easily understood by a member reading at a sixth-grade or similar reading level. The original decision was upheld.													
3	XXXXX	11/26/07	M☒ N☐ U☐	11/26/07	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	12/4/07	M☒ N☐	M☒ N☐	M☒ N☐
Comments: This case was a denial of day treatment services at the Neuropsychiatric Special Care Program through The Children's Hospital (TCH). The original decision was upheld because the member did not meet the criteria for the requested level of care. The decision was made by an M.D.													
4	XXXXX	1/7/08	M☒ N☐ U☐	1/7/08	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	1/22/08	M☒ N☐	M☒ N☐	M☐ N☒
Comments: This case was a denial of day treatment at a therapeutic preschool. ABC received the appeal January 7, 2008. The resolution was due January 21, 2008. An extension was sent January 18, 2008, making the new resolution due date February 4, 2008. The resolution was sent January 22, 2008. The decision was made by an M.D. The resolution letter appeared to be written to the provider rather than to the member's guardian, using terms such as "psychopathology" and "disparity." The letter would not be easily understood by a member reading at a sixth-grade or similar reading level. The original decision was upheld. In addition, the letter discussed the mother's poor parenting skills in professional language rather than in language acknowledging that the mother would be reading the letter.													
5	XXXXX	3/26/08	M☒ N☐ U☐	3/26/08	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	4/3/08	M☒ N☐	M☒ N☐	M☐ N☒
Comments: This case was a denial for day treatment at the TCH Neuropsychiatric Special Care Program. The decision was made by an M.D. The resolution letter was somewhat technical and stated that the neuropsychiatric program at TCH is not a benefit of the plan. A more accurate statement would have been that the particular services requested or the diagnosis for which the member was requesting services were not covered, whichever was the case.													

Appendix C. Colorado Behavioral Health Organization (BHO) Appeals Record Review Tool *for* Access Behavioral Care

1	2	3	4	5	6	7	8	9	10	11	12	13	14
File #	Member ID	Date Appeal Received	Evidence of Reasonable Assistance	Date of Acknow-ledgment Letter	Acknow-ledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
6	XXXXX	6/23/08	M☒ N☐ U☐	6/24/08	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	6/25/08	M☒ N☐	M☒ N☐	M☒ N☐
Comments: This case was a denial for day treatment. The decision was made by an M.D.													
# Applicable Elements			6		6	6	6				6	6	6
# Compliant Elements			6		6	6	6				6	6	2
Percent Compliant													

Legend:
M = Met
N = Not met or No
U = Unable to determine
Y = Yes

Total # Applicable Elements	**42**
Total # Compliant Elements	**38**
Total Percent Compliant	**90%**

Appendix D. Site Review Participants for Access Behavioral Care

Table D-1 lists the participants in the FY 2008–2009 site review of **ABC**.

Table D-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Rachel Henrichs	Project Coordinator
ABC Participants	**Title**
Carrie Bandell	Director, Quality Management
Robert Bermer	Deputy Director of Access Behavioral Care
Guinevere Blodgett	Behavioral Health Quality Coordinator
Stephanie Dohrman	Grievances and Appeals Manager
Rich Duncan	Manager, Behavioral Health Services
Reyna Garcia	Director of Customer Service
Christine Gillespie	Manager of Utilization Management
Claudine McDonald	Director, Office of Member and Family Affairs
Mike McKitterick	Vice President of Clinical Services
Cynthia Pechon	Staff Attorney
LeNore Ralston	Executive Director of Access Behavioral Care
Marie Steckbeck	Vice President of Operations
Department Observers	**Title**
Marceil Case	Behavioral Health Specialist
Jerry Ware	Quality Compliance Specialist

Appendix E. Corrective Action Plan Process for FY 2008–2009 for Access Behavioral Care

ABC is required to submit to the Department a CAP for all elements within each component scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each element that requires correction, the health plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. Supporting documents should not be submitted and will not be considered until the plan has been approved by the Department. Following Department approval, the BHO must submit documents per the timeline that was approved.

Table E-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each BHO will submit a CAP to the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or the file transfer protocol (FTP) site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must address the planned intervention(s) to complete the required actions, and the timeline(s) for the intervention(s).
Step 2	**Prior approval for timelines exceeding 30 days**
	If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, the BHO must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	The Department will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan, or ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the plan, the BHO should implement all the planned interventions and submit evidence of such intervention to HSAG via e-mail or the FTP site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

Table E-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department 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 CAP follows.

Table E-2—FY 2008–2009 Corrective Action Plan *for* ABC				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
2. Notices of Action 1. The Contractor defines action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals. **Findings:** The documents reviewed were not complete and were not consistent with each other. One bullet in the definition of action contained in the	ABC must revise all applicable policies and related documents to include a definition of an action that is consistent with the BBA definition and is consistent across policies and related documents.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* ABC				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
Utilization Review Determination policy simply stated: "failure to act within the timeframes below," as it was stated in Exhibit G to the contract; however, the time frames for resolution of grievances and appeals were not addressed in this particular policy. The Member Appeal Process policy did not include the failure to act within the time frames for grievances and appeals. The Member Appeal Process policy also included exceptions to the denial-of-payment bullet. The bullet stated, "The denial, in whole or part, of payment for a service (except payment denials issued by a mental health prepaid inpatient health plan) which makes the member liable for payment." This language was inconsistent with the BBA definition of an action. The definition of action in the member handbook did not include the denial-of-payment bullet, and the definition of an action in the provider manual was vague.				

Table E-2—FY 2008–2009 Corrective Action Plan *for* ABC				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
2 Notices of action must meet the language and format requirements of 42CFR438.10 and ensure ease of understanding. **Findings:** There were two notices of action in the record review that the reason for the action was unclear. . In addition, while the notices of action sent to the members were addressed to the member, the letter referred to the member in the third person and was written as if the reader was the provider rather than the member. The result was a letter that was impersonal and not member friendly.	ABC must ensure that notices of action are easy for a member to understand and present information from the member's perspective.			
4. The notice of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized, Medicaid-covered services, at least 10 days before the date of	ABC must revise its policy to include the process and time frame for sending notices of action related to denial of payment for services.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* ABC				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
action (unless extenuating circumstances exist—found in Exhibit G) ◆ For denial of payment, at the time of any action affecting the claim ◆ For standard service authorization decisions that deny or limit service, within 10 calendar days ◆ For service authorization decisions not reached within 10 calendar days, on the date the time frames expire ◆ For expedited service authorization decisions, within three days **Findings:** The Utilization Review Determination policy did not acknowledge that notices of action are sent for denial of payment.				

Table E-2—FY 2008–2009 Corrective Action Plan *for* ABC				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
3. Appeals 15. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: ▪ The right to request a State fair hearing and how to do so. ▪ The right to request that benefits continue while the hearing is pending and how to make the request. ▪ That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action.	ABC must ensure that members can easily understand the appeal resolution letters.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* ABC				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
Findings: While the letters included additional information for the member explaining the reason for the decision, the language used was very technical and appeared to be for a professional audience rather than for the member. For example, although the letter addressed the member, it was written in third person and included words such as "symptomatology," "psychopathology," and "disparity" (see Appendix C). These words, as well as the writing style, were well above the average reading level of a Medicaid member.				
19. The Contractor continues the member benefits if: ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice	ABC must revise its applicable policies and related documents to accurately reflect the requirements and time frames for continuation of benefits during the appeal and State fair hearing processes.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* ABC				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
of action ▪ The intended effective date of the proposed action ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits. **Findings:** The Member Appeal Process policy included the provision; however, the policy stated that filing must occur within 20 days.				

Appendix F. Compliance Monitoring Review Activities for Access Behavioral Care

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

Table F-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 on October 3, 2008, for the BHO and the Department to preview the FY 2008–2009 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. ◆ HSAG provided a presentation to the Department and the BHOs on January 27, 2009, titled "Developing and Implementing Corrective Action Plans." In this presentation, HSAG reviewed the timeline and requirements for the corrective action plan process. ◆ 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 the BHO's 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 BHO's contract, dated March 1, 2007, to develop the 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 four components. ◆ Documents requested included applicable policies and procedures, minutes of key BHO committee or other group meetings, reports, logs, and other documentation.

Table F-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents needed that HSAG identified during its desk audit. ◆ HSAG requested and reviewed additional documents needed that HSAG identified 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 2008–2009 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 required of the BHO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2008–2009 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.