Colorado Medicaid
Community Mental Health Services Program

FY 2010–2011 Site Review Report

for

Access Behavioral Care

February 2011

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

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 300 ◆ Phoenix, AZ 85016
Phone 602.264.6382 ◆ Fax 602.241.0757

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Overview of FY 2010–2011 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 (MCOs) 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 seventh year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2010–2011 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the three performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard III—Coordination and Continuity of Care.

The BHO's administrative records were also reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 20 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid denials that occurred between January 1, 2010, and September 15, 2010. For the record review, the BHO received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. For cases in which the reviewer was unable to determine compliance due to lack of documentation, a score of *Unknown* was used. Compliance with federal regulations was evaluated through review of the three standards and administrative denial records. The BHO received an overall percentage of compliance score for the standards and a separate overall percentage of compliance score for the record review.

This report documents results of the FY 2010–2011 site review activities for the review period—January 1, 2010, through the dates of the on-site review, December 6 and 7, 2010. Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Section 3 describes the extent to which the BHO was successful in completing corrective actions required as a result of the 2009–2010 site review activities. Appendices A and B contain details of the findings. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action process the BHO will be required to complete and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing the three standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key BHO personnel to determine compliance. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. Details of the findings from review of the three standards follow in Appendix A. Details of the findings from the on-site denials record review follow in Appendix B.

The three standards chosen for the FY 2010–2011 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

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

Objective of the Site Review

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

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

Summary of Results

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

Table 1-1 presents the score for **Access Behavioral Care** (**ABC**) for each of the standards. Details of the findings for each standard follow in Appendix A.

Table 1-1—Summary of Scores for the Standards

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Coverage and Authorization of Services	33	33	31	2	0	0	94%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	6	6	6	0	0	0	100%
	Totals	**51**	**51**	**49**	**2**	**0**	**0**	**96.1%**

Table 1-2—Summary of Scores for Record Review

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials Record Review	120	85	81	4	35	95.3%

2. Summary of Performance Strengths and Required Actions

for **Access Behavioral Care**

Overall Summary of Performance

For the three standards reviewed by HSAG, **ABC** earned an overall compliance score of 96.1 percent. **ABC**'s strongest performances were in Standard II—Access and Availability and Standard III—Coordination and Continuity of Care, both of which earned a compliance score of 100 percent. Although HSAG identified two required actions in Standard I—Coverage and Authorization of Services, (94 percent compliant), **ABC** demonstrated strong performance overall and an understanding of the federal regulations.

Standard I—Coverage and Authorization of Services

Summary of Findings and Opportunities for Improvement

ABC's policies and procedures included all of the required provisions. While **ABC**'s member handbook included the term "medical necessity," it did not define the term. HSAG suggests that **ABC** consider including the definition of medical necessity in its member handbook.

HSAG's on-site review of denial records demonstrated that the policies and procedures were implemented as written. The notices of action included all the required content, and there was evidence that decisions were made by qualified clinicians. Two records involved members who were dually diagnosed with a mental health diagnosis and another diagnosis that was not a covered diagnosis under the Medicaid managed care contract. In these two cases it was not clear whether the decision was based on the presenting symptoms at the time of the request for service or simply on the presence of a noncovered diagnosis. HSAG suggests that **ABC** consider reviewing its procedures to determine the basis of the decisions in these cases. HSAG also reviewed four records in which the reason cited in the notice of action letter was vague (e.g., "not medically necessary" or "the information available does not support the need for the service requested"). HSAG suggests that **ABC** consider including additional information in its notice of action letters to provide more meaningful information to the member.

In addition, **ABC**'s provider manual referred to the letter extending the authorization decision time frame as a notice of action. HSAG suggests that **ABC** consider clarifying this point to indicate that an action exists only when the time frames for authorization decisions are not met and the time frames are not extended in accordance with the Code of Federal Regulations (CFR) at 42 CFR 438.404(c)(4)(i).

Summary of Strengths

ABC had several policies, procedures, and program descriptions that described clear and uniform criteria for utilization review (UR). Its staff members were able to articulate procedures that corroborated what was written in the policies. **ABC** ensured consistent application of its utilization criteria through use of InterQual® UR criteria and interrater reliability studies. The on-site record review provided evidence that the medical directors were involved in clinical decisions and that peer-to-peer consultation was offered, as needed, to providers requesting services. **ABC**'s meeting minutes demonstrated routine review and monitoring of the utilization management (UM) program. **ABC** notified its providers and members of its utilization policies and procedures. In addition, many routine services were not subject to prior authorization, making access routine services easier for members.

Summary of Required Actions

Of the 20 denial records HSAG reviewed on-site, three records were out of compliance with the 10-calendar-day time frame for authorization decisions. One of these records did not include an

extension letter. Three of these records included an extension letter that was sent only to the requesting facility and not to the member. **ABC** must ensure that authorization decisions are made within the required time frames, and if **ABC** extends the time frame for making standard or expedited authorization decisions, it must give the enrollee written notice of the reason for the extension and inform the enrollee of the right to file a grievance if he or she disagrees with the decision.

Standard II—Access and Availability

Summary of Findings and Opportunities for Improvement

ABC employed several mechanisms to monitor the adequacy of its network services and provided numerous reports to ensure that it met the needs of its members. While **ABC** provided an adequate provider network for its members, its policies and procedures allowed for specialty care outside of its network if network providers were unavailable or inadequate to provide the service needed. The single-case agreement template provided out-of-network providers information and direction regarding billing and liability for payment. **ABC**'s grievance and appeal reports for FY 2010 and the first quarter of 2011 listed a total of only three grievances related to access.

ABC notified its providers of the access and availability standards through the provider manual. The provider manual also included the standards for assessment and service planning, which included addressing cultural and language information. **ABC** provided cultural competency training to providers, as requested. **ABC** employed various strategies to monitor provider compliance with its access standards and required corrective actions when necessary.

ABC informed its providers of the member's right to a second opinion. **ABC**'s member handbook informed members of their right to request a second opinion and included a telephone number to call for help obtaining a second opinion.

Summary of Strengths

ABC provided extensive evidence that it monitored the provider network with respect to the availability of services and provider compliance with access standards. **ABC** monitored its network on both a global level—with utilization reports, performance measures, and other quality initiatives—and on an individual provider level, with secret shopper audits and medical record reviews. This robust monitoring ensured that **ABC**'s provider network was compliant with access to care standards, as well as **ABC**'s standards for care and documentation.

Summary of Required Actions

There were no required actions for this standard.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

ABC had policies, procedures, and processes to ensure the facilitation of communication and coordination between providers and caregivers, members, families, and authorized representatives. **ABC** communicated with providers regarding provider care management responsibilities and **ABC**'s care management program for members with complex needs.

Summary of Strengths

ABC provided evidence of monitoring providers for the presence and content of individualized assessments and service plans and for the appropriateness of care provided. **ABC** provided evidence of comprehensive care coordination practices and provided comprehensive Health Insurance Portability and Accountability Act of 1996 (HIPAA) policies and procedures.

Summary of Required Actions

There were no required actions for this standard.

3. Follow-up on FY 2009–2010 Corrective Action Plan *for* Access Behavioral Care

Methodology

As a follow-up to the FY 2009–2010 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all requirements for which it received a score of *Partially Met* or *Not Met*. The BHO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with **ABC** until the BHO completed each of the required actions from the FY 2009–2010 compliance monitoring site review.

Summary of 2009–2010 Required Actions

As a result of the FY 2009–2010 compliance review, **ABC** was required to ensure that all grievances were acknowledged and resolved within the required time frames. Furthermore, **ABC** was required to ensure that letters of grievance disposition contained the resolution of the disposition process and the correct date on which the grievance was resolved.

Summary of Corrective Action/Document Review

ABC submitted its CAP to HSAG and the Department in June 2010. HSAG and the Department determined that if the CAP was implemented as written, **ABC** would achieve compliance with the specified requirements. **ABC** submitted documentation to demonstrate the implementation of its plan in July 2010. HSAG and the Department carefully reviewed all submitted materials and determined that **ABC** had successfully addressed all required actions.

Summary of Continued Required Actions

ABC successfully completed all FY 2009–2010 corrective actions. There were no required actions continued from FY 2009–2010.

The completed compliance monitoring tool follows this cover page.

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *42CFR438.210(a)(3)(i)* *Contract: II.I.1.d*	**Documents Submitted:** ◆ UM Program Description FY2011 ◆ CCS302-Medical Criteria for Utilization Review 11-30-09 **Description of Process:** The purpose of the Colorado Access Utilization Management program is to ensure appropriate, comprehensive and coordinated quality healthcare, to integrate health promotion and disease management, and to ensure services are provided in the most appropriate, cost effective and least restrictive setting. ◆ The UM program goals (Goals and Objectives, page 4) include: ▪ To review, monitor and evaluate appropriateness of health care services from practitioners, hospitals and other health care professionals, according to guidelines and criteria established or adopted by Colorado Access. ▪ To review professional services for appropriateness of and compatibility between diagnosis and treatment. Colorado Access Medical Criteria for Utilization Review policy (CCS 302) defines medical necessity. This definition supports the delivery of services that are reviewed and determined to be appropriate, necessary, and reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the symptoms, pain, or suffering of a diagnosed medical condition, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability (Definitions/Medically Necessary, page 2).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The UM Program Description and the Medical Criteria for Utilization Review policy described the oversight of and interrelationship between the UM program and ABC/Colorado Access committees such as the Quality Improvement Committee (QIC), the Medical/Behavioral Quality Improvement		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Committee (MBQIC), the Credentials Committee, and the Care Management Committee. The UM Program Description described the use of objective criteria and guidelines to make utilization decisions. Review of selected FY 2010 and FY 2011 QIC and MBQIC meeting minutes demonstrated oversight of service provision for efficiency and efficacy.		
Required Actions: None		
2. 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. *42CFR438.210(a)(3)(ii)* *Contract: II.I.1.e*	**Documents Submitted:** ◆ CCS302-Medical Criteria for Utilization Review 11-30-09 **Description of Process:** All UM staff follow Colorado Access Medical Criteria for Utilization Review policy (CCS302). Adherence to this policy prohibits arbitrary decisions to deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. This policy sets forth the use of specific criteria to determine the medical necessity of services using accepted managed care utilization review standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Medical Criteria for Utilization Review policy stated that ABC used InterQual® UM guidelines for UR determinations. The InterQual guidelines were symptom- and evidence-based. During the on-site interview, ABC staff members stated that there were a few guidelines developed over the years by participating providers for services that were not included in the InterQual guidelines. The Medical Criteria for Utilization Review policy's definition of medical necessity included "services within standards of good medical practice among the organized medical community." The policy described a secondary review by the medical director following the initial review by UM staff if the criteria were not initially met. The on-site record review confirmed that each record included a secondary review by the medical director prior to sending the notice of action to the member. The on-site record review also confirmed that denial decisions were based on the standardized criteria.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
3. 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. ◆ Consistent with the Contractor's published practice guidelines. ◆ On the basis of the Department's established utilization requirements or utilization review standards. *42CFR438.210(a)(3)(iii)* *Contract: II.I.1.f*	**Documents Submitted:** ◆ CCS302-Medical Criteria for Utilization Review 11-30-09 **Description of Process:** Colorado Access Medical Criteria for Utilization Review policy (CCS302) sets forth the use of specific criteria to determine the medical necessity of services using accepted managed care utilization review standards (InterQual®) (Section I.A., page 3). The policy also states that decisions are consistent with established guidelines and that decisions are based on medical necessity (Policy Statement, page 2). The definition of medically necessary includes that decisions are consistent with Benefit Program Requirements (Definitions, page. 2).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Medical Criteria for Utilization Review policy and the Utilization Review Criteria policy included the definition of medical necessity, which was consistent with the definition in the Medicaid managed care contract. The InterQual UR criteria appeared consistent with ABC's practice guidelines found in the links on ABC's Web site. The link to the practice guidelines was also found in the provider manual.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
4. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State Medicaid program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: • The prevention, diagnosis, and treatment of health impairments, • The ability to achieve age-appropriate growth and development, • The ability to attain, maintain, or regain functional capacity. *42CFR438.210(a)(4)* *Contract: I.A.23*	**Documents Submitted:** ◆ CCS302-Medical Criteria for Utilization Review 11-30-09 ◆ CCS307-Utilization Review Determinations 10-28-10 **Description of Process:** Colorado Access policies CCS302-Medical Criteria for Utilization Review (Definitions, page 2) and CCS 307-Utilization Review Determinations (Definitions, page 4) clearly define medical necessity in a manner that is no more restrictive that the State's Medicaid program. It also outlines that medical necessity includes services that "prevent, diagnose, cure correct, reduce, or ameliorate the symptoms, pain, or suffering of diagnosed medical condition, or the physical, mental, cognitive or development effects of an illness, injury, or disability."	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Medical Criteria for Utilization Review policy and the Utilization Review Criteria policy included the definition of medical necessity, which was consistent with the definition in the Medicaid managed care contract. Both policies indicated that medically necessary services are those covered services reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the symptoms, pain, or suffering of a diagnosed medical condition, or the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. While ABC used the term medical necessity in the member handbook, the term was not defined for members. HSAG suggests that ABC consider including a definition of medical necessity in the member handbook.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
5. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42CFR438.210(b)* *Contract: II.I.1.g*	**Documents Submitted:** ◆ CCS307-Utilization Review Determinations 10-28-10 **Description of Process:** Colorado Access Utilization Review Determinations policy (CCS307) outlines ABC's procedures for addressing initial and continuing requests for services (Section II, pages 10-17).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Utilization Review Determinations policy described the procedures for processing requests for initial and continuing authorization of services and retrospective review decisions. The policy included processes for receipt of the request and decision-making procedures, including review by supervisory and physician reviewers when necessary. The policy also included required time frames for decision making and notice to the member. The Medical Criteria for Utilization Review policy described the use of InterQual UR criteria and internally developed criteria for making authorization decisions. During the on-site interview, ABC staff members clarified that routine, office-based services (e.g., individual, family, and group therapy) did not require prior authorization unless they were requested by an out-of-network provider. Staff also stated that services requiring authorization included program-based services such as home-based services, residential treatment, and inpatient hospitalization.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
6. The Contractor's written policies and procedures include mechanisms to ensure consistent application of review criteria for authorization decisions. *42CFR438.210(b)(2)(i)* *Contract: II.I.1.j and II.I.1.q*	**Documents Submitted:** ◆ CCS302-Medical Criteria for Utilization Review 11-30-09 ◆ CCS301-Qualifications for Staff Engaged in Utilization Management Activities 11-30-09 **Description of Process:** Colorado Access Medical Criteria for Utilization Review policy (CCS 302) outline ABC's procedure to ensure the consistent review of requests for services. This includes the use of InterQual®, a nationally recognized, evidence based decision tool licensed by McKesson, and used by over 300 health plans nationwide. To ensure the consistent application of medical necessity decisions using InterQual®, inter-rater reliability is conducted annually (Section I.A.-C. and II.E., page 3). All decisions are made by staff qualified to make such decision, outlined in Colorado Access Qualifications for Staff Engaged in Utilization Management Activities policy (CCS 301).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Medical Criteria for Utilization Review policy described the use of objective criteria and established guidelines for making authorization decisions. The procedures included each staff member applying the same criteria and supervisory review in cases that do not initially meet the established criteria. The policy also indicated that interrater reliability studies were conducted annually. The Qualifications for Staff Engaged in Utilization Management Activities policy stated that all staff members engaged in UR activities were trained on the UM program and UR criteria. The policy also stated that UM staff members that were not licensed health care professionals worked under the direct supervision of licensed health care professionals. Review of the April 13, 2010, QIC meeting minutes demonstrated that the results of the interrater reliability studies were presented to the QIC for discussion and approval. The Qualifications for Staff Engaged in Utilization Management Activities policy described training for staff making UR decisions. During the on-site interview, ABC staff members described individualized training for new UM staff members and stated that new staff members making UR decisions worked with a supervisor before working independently.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
7. The Contractor's written policies and procedures include a mechanism to consult with the requesting provider when appropriate. *42CFR438.210(b)(2)(ii)* *Contract: II.I.1.j*	**Documents Submitted:** ◆ CCS307-Utilization Review Determinations 10-28-10 ◆ ABC Provider Manual Jan 2010 **Description of Process:** Colorado Access Utilization Review Determinations policy (CCS307) allows for a peer to peer conversation (Section II.B.6., page 12). The ABC Provider Manual (page 37) outlines the process for a peer-to-peer conversation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Utilization Review Determinations policy described the process for peer-to-peer conversation, if needed, before making the denial decision. Providers were notified via the provider manual of this mechanism. The on-site record review demonstrated that a peer-to-peer consultation was offered (via telephone) to the requesting provider prior to the determination, when applicable.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
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. *42CFR438.210(b)(3)* *Contract: II.I.1.h and Exhibit V.A.4*	**Documents Submitted:** ◆ CCS301-Qualifications for Staff Engaged in Utilization Management Activities 11-30-09 ◆ CCS307-Utilization Review Determinations 10-28-10 ◆ ABC Provider Manual Jan 2010 **Description of Process:** Decisions to deny or limit requests for services must be made by qualified physicians acting as a Colorado Access Medical Director. The qualifications of staff engaged in utilization management activities are outlined in Policy CCS301. Colorado Access Utilization Review Determinations policy (CCS307) requires that all notices of action be signed and dated by the physician issuing the adverse service determination (Section II.F.6., last bullet, page 17). The ABC Provider Manual states that only a Medical Director can deny a requested service for clinical reasons (page 37).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Qualifications for Staff Engaged in Utilization Management Activities policy stated that staff members who are not licensed may evaluate and approve services when clinical decision making is not required, and that every notice of adverse action must be made by a licensed physician familiar with the standards of care in Colorado. The policy also included the provision that board-certified physicians were consulted when subspecialty expertise was required. Providers were informed via the provider manual that only the medical director may deny services for clinical reasons. The Utilization Review Determinations policy stated that all notices of action must be signed by the physician who made the determination. The on-site record review demonstrated that all adverse determinations were made by a psychiatrist, as documented in the UM system notes.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
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 need not be in writing). *42CFR438.210I* *Contract: II.I.1.j*	**Documents Submitted:** ◆ CCS307-Utilization Review Determinations 10-28-10 ◆ ABC Provider Manual Jan 2010 ◆ ABC Member Handbook Feb 2010 **Description of Process:** Colorado Access Utilization Review Determinations policy (CCS307) states that the Member and requesting provider are notified in writing of any adverse determinations (Section II.F.1., page 14). This is also stated in the Provider Manual (Section VII., page 37) and in the Member Handbook (Member Rights, page 20).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Utilization Review Determinations policy included the procedures to notify the member and the requesting provider in writing if the UR determination was adverse to the member. Adverse determinations were defined in the policy as those determinations that involved a service that was denied, reduced, suspended, terminated/discontinued, or a limited authorization. The policy also included the required determination and notification time frames. Members were informed via the member handbook that notices of action were sent for actions defined in the member handbook. Providers were notified of ABC's processes via the provider manual. The on-site record review demonstrated that notice of action letters were sent to the member and to the requesting provider when ABC made the decision to deny services (which included termination, suspension, or reduction of previously authorized services and limited authorization).		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
10. The Contractor's written policies and procedures include the following timeframes for making standard and expedited authorization decisions: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 days. *42CFR438.210(d)* *Contract: Attachment K: 8.209.4.A.3.c and 8.209.4.A.6*	**Documents Submitted:** ◆ CCS307-Utilization Review Determinations 10-28-10 **Description of Process:** Colorado Access Utilization Review Determinations policy (CCS307) outlines timeframes for standard and expedited authorization decisions (Section II.B.2., page 11 and II.C.4., page 13).	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Utilization Review Determinations policy included the 10-calendar-day time frame for service authorization decisions. The time frame for expedited authorization decisions was stated as 72 hours or 3 calendar days. The on-site record review did not include any expedited requests. One record reviewed was out of compliance with the 10-calendar-day time frame and did not include an extension letter.		
Required Actions: ABC must ensure that authorization decisions are made within the required time frames.		
11. The Contractor's written policies and procedures include the following timeframes for possible extension of timeframes for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days. *42CFR438.210(d)* *Contract: None*	**Documents Submitted:** ◆ CCS307-Utilization Review Determinations 10-28-10 **Description of Process:** Colorado Access Utilization Review Determinations policy (CCS307) outlines timeframes for extensions of standard (see Section II.B.5a., and 5d., page. 12) and expedited (see Section II.C.3, page 13) authorization decisions.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Utilization Review Determinations policy included the required time frames for extending standard and expedited authorization decisions. Four records reviewed on-site were out of compliance with the 10-calendar-day time frame for authorization decisions. Three of these records contained extension letters; however, the letters were not sent to the member, as required. (If ABC had sent the extension letters to the member, the records would have been in compliance with the time frame requirements.) In addition, the provider manual indicated that the extension letter was considered a notice of action. ABC may want to consider clarifying this point to indicate that an action exists only when the time frames for authorization decisions are not met and the time frames are not extended in accordance with 42 CFR 438.404(c)(4)(i).		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Required Actions: If ABC extends the time frame for making standard or expedited authorization decisions, it must give the enrollee written notice of the reason for the decision to extend the time frame and inform the enrollee of his or her right to file a grievance if the enrollee disagrees with the decision.		
12. The Contractor maintains a comprehensive utilization management (UM) program to monitor the access to, use, consumption, levels and intensity of care, outcomes of, and appropriate utilization of covered services. *Contract:II.I.1.a*	**Documents Submitted:** ◆ UM Program Description FY2011 ◆ ABC Access to Care Plan FY2011 ◆ 2010 CoA QAPI Program Description ◆ ABC FY10 Q4 Access to Care Report ◆ ABC FY10 Q4 Secret Shopper Report ◆ Sept 2010 ABCD ADC Monthly Graphs ◆ Sept 2010 EOM Inpatient Graph ◆ Sept 2010 ER Report ◆ FY09 ABC Performance Measure Report ◆ QAPI Evaluation ABC FY2010 **Description of Process:** The Colorado Access Utilization Management Program outlines ABC's comprehensive UM program (Program Components pages 15-17). The Access to Care Plan (pages 8-12) and QI Program Description (page 14) also outlines the role of the UM program in monitoring and providing access to appropriate levels of covered services. Various routine reports monitor access, use consumption, levels, and intensity of care and utilization of covered services. These reports are reviewed through the QI structure and these reports include: ◆ ABC Access to Care Reports (see ABC FY10 Q4 Access to Care Report ◆ ABC Secret Shopper Reports (see ABC FY10 Q4 Secret Shopper Report) ◆ Sept 2010 OB Dashboard (available for on-site review)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	◆ Average Daily Census Reports (see Sept 2010 ABCD ADC Monthly Graphs) ◆ Monthly Inpatient Reports (see Sept 2010 EOM Inpatient Graph) ◆ Sept 2010 ER Report ◆ FY09 ABC Performance Measure Report ◆ QAPI Evaluation ABC FY2010	

Findings:
ABC's UM program included a program description, policies, and procedures that described components of ABC's UM program, including committee structure, criteria for authorization decisions, processes for UR, and processes for making service authorization determinations. The UM Program Description included the goals and objectives of the program and described how the UM program was integral to the quality assessment and performance improvement (QAPI) program. The UM Program Description also listed ABC's UM team members: the chief medical officer, the vice president of clinical services, senior and associate medical directors, the director of coordinated clinical services, and the director of pharmacy services. The Access to Care Plan 2010–2011 described the standards and requirements for access to care and ABC's administrative structure and arrangements designed to achieve systemwide compliance with those standards. The plan also described the secret shopper program as one of ABC's strategies for monitoring provider compliance with access to care standards. The Access to Care Report and the Secret Shopper Report provided the results of ABC's provider monitoring regarding access to care standards. Review of UM Committee meeting minutes demonstrated review of key UM and management reports to monitor the appropriateness and efficacy of services provided.

Required Actions:
None

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
13. The Contractor evaluates the medical necessity, appropriateness, efficacy, and efficiency of health care services, referrals, procedures, and settings. *Contract:II.I.1.a*	**Documents Submitted:** ◆ CCS302-Medical Criteria for Utilization Review 11-30-09 ◆ UM Program Description FY2011 **Description of Process:** Colorado Access Medical Criteria for Utilization Review policy (CCS302) states that UR determinations are based on standard criteria (CCS302 Policy Statement and Definitions, pages 2-3). The purpose of the Colorado Access Utilization Review Determinations policy is to ensure that the process for UR determinations is appropriate and timely. The UM Program provides a framework, formal methods, and measurable standards for continuous assessment and improvement in the utilization management aspects of healthcare delivery (Goals and Objectives, page 4).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: During the on-site interview, ABC staff members described UM Committee and management team review of provider profile reports, UM reports such as emergency room (ER) utilization, inpatient admission/readmission, and cost variance reports. Review of QIC, MBQIC, and UM Committee meeting minutes confirmed review of a variety of key management and UM reports, as well as review of performance measure indicators.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
14. The Contractor's UM program is under the direction of an appropriately qualified clinician and includes policies and procedures that have been reviewed by the Department. *Contract:II.I.1.a*	**Documents Submitted:** ◆ UM Program Description FY2011 ◆ CCS301-Qualifications for Staff Engaged in Utilization Management Activities 11-30-09 **Description of Process:** The Colorado Access UM Program Description ensures the appropriate oversight of the program in general (pages 4-15). Colorado Access Qualifications for Staff Engaged in Utilization Management Activities policy (CCS301) mandates that the Colorado Access CMO is a licensed physician with overall responsibility for the UM Program (Section I, page 2). All Senior and Associate Medical Directors making UR determinations must meet the same criteria outlined in this policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The UM Program Description indicated that the staff member responsible for day-to-day UM activities was the director of coordinated clinical services, a registered nurse licensed in the State of Colorado. Managerial oversight of the program was conducted by the vice president of clinical services, also a registered nurse licensed in the State of Colorado. Review of UM Committee and QIC meeting minutes demonstrated medical director and management oversight and approval of the UM Program Description as well as the UR criteria.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
15. The Construction of the UM program does not impede Member's timely access of services. *Contract:II.I.1.b*	**Documents Submitted/Location Within Documents:** ◆ UM Program Description FY2011 ◆ CCS307-Utilization Review Determinations 10-28-10 ◆ ABC Provider Manual Jan 2010 ◆ FY11 Access to Care Plan ◆ ABC FY10 Q4 Access to Care Report ◆ ABC FY10 Q4 Secret Shopper Report **Description of Process:** The Colorado Access UM Program is designed to ensure that members receive access to quality care and services in an appropriate, comprehensive and coordinated manner. The Colorado Access Utilization Management Program reflects an objective, systematic, continuous measurement and feedback paradigm with equal emphasis on internal and external services, affecting the access, appropriateness and timeliness of care (page 2). Each enrollee has a right to timely access to network providers and to all services covered by the plan per the FY11 Access to Care Plan (Section I., page 1). The purpose of the Utilization Review Determinations policy (CCS307) is to ensure that Colorado Access will maintain processes for utilization review determinations that ensure the appropriate and timely determination and notification of authorizations and denials (Policy Statement, page 2). To ensure that providers are aware of and adhere to access standards, these are indicated in the Provider Manual (page 11) and monitored per our Access to Care Plan (pages 13-14) through access to care reporting (see ABC FY10 Q4 Access to Care Report) and our Secret Shopper Program (see ABC FY10 Q4 Secret Shopper Report).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Colorado Access does not impede ABC Member access to routine services. We do not require prior authorization for routine outpatient services (Provider Manual, page 11).	
Findings: UM Program Description indicated that the ABC Customer Service Department hours were 8 a.m. to 6 p.m. and that customer service representatives were available to answer questions about Medicaid-covered benefits and the authorization process and to assist members in finding providers. During the on-site interview, ABC staff members reported that routine outpatient services were available without prior authorization. The Utilization Review Determinations policy described the procedures for processing requests for service and timely review of the requests using objective criteria. The Secret Shopper and the Access to Care reports provided evidence of monitoring access to care. Providers were notified via the provider manual of timely access standards for services not requiring prior authorization. The on-site record review demonstrated timely review of requests for services.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
16. The Contractor ensures that the UM program incorporates mechanisms to continuously update guidelines, policies and procedures used in making determinations based on evaluation of new medical technologies and new application of established technologies, including medical procedures, drugs, and devices. *Contract:II.I.1.k*	**Documents Submitted:** ◆ UM Program Description FY2011 ◆ CCS302-Medical Criteria for Utilization Review 11-30-09 ◆ ADM210-Evaluation of New Medical Technologies 4-23-10 **Description of Process:** The Colorado Access UM Program Description and all related UM policies are updated annually (page 18). The UM Program Description is approved annually by the Board of Directors, Colorado Access Quality Improvement Committee and the Medical/Behavioral Quality Improvement Committee. All policies are updated, reviewed and approved annually by the Colorado Access Core Policy Team (CPT). Minutes of these meetings can be reviewed during the site visit. Colorado Access Medical Criteria for Utilization Review policy (CCS302) states that Colorado Access' licenses InterQual® from McKesson. UR criteria are updated by McKesson annually and distributed to Colorado Access (Section I.A. and I.C., page 3). Colorado Access New Medical Technologies policy (ADM210) outlines the process for the review of new, outdated or unconventional medical technologies (Policy Statement, page 2).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The UM Program Description indicated annual review of UM policies and procedures, UR criteria, and the process for updating UR criteria as needed. The minutes for the June 28, 2010, QIC meeting and the July 6, 2010, MBQIC meeting demonstrated committee review of the UM Program Description and use of the InterQual criteria. Each policy cover page indicated the date of the last review/approval.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
17. The Contractor maintains mechanisms to evaluate the effects of the UM program. *Contract:II.I.1.l*	**Documents Submitted:** ◆ UM Program Description FY2011 ◆ ABC FY2011 QAPI Work Plan ◆ ABC FY2010 QAPI Evaluation ◆ Sept 2010 LOB Dashboard (available for on-site review) ◆ Sept 2010 ABCD ADC Monthly Graphs) ◆ Sept 2010 EOM Inpatient Graph) ◆ Sept 2010 ER Report ◆ FY09 ABC Performance Measure Report ◆ ABC Category of Service Trend Report Oct 2010 **Description of Process:** In addition to the annual updates described in item #16, The Colorado Access UM Program Description outlines the broad structure for the evaluation of the UM program. The ABC QAPI Work Plan outlines specific areas of the UM Program measurement (pages 3, 11). ABC also monitors key trends on a routine basis that provide continuous feedback about the UM program's effectiveness (see ABC FY2010 QAPI Evaluation). Monthly Category of Service trend (see ABC Category of Service Trend Report Oct 2010) and dashboard reports (available for on-site review) provide trending for all levels of service and by clinical condition. These reports are reviewed in monthly medical and behavioral health trends meetings that include Executive Directors, Medical Directors, Clinical Staff, Quality Management, Decision Support, and Accounting. The Annual Impact and Analysis Report (ABC FY2010 QAPI Evaluation) and Annual Performance Measure report (FY09 ABC Performance Measure Report) also provide routine trending and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	analysis of utilization. The monthly EOM Inpatient Report provides inpatient utilization trending and analysis by facility. The most current report includes inpatient admissions incurred between January 2008 and August 2010 with payments through 8/31/2010 (see Sept 2010 EOM Inpatient Graph). The monthly ER Reports provide emergency services utilization trending and analysis (see Sept 2010 ER Report). The monthly Average Daily Census Reports provide monthly trending information for Level II and III services (see Sept 2010 ABCD ADC Monthly Graphs). Both the EOM and ADC reports are sent monthly to the Executive Director, Director of QM, Director of CCS, VP of Clinical Operations, and Medical Directors. They are also reviewed in the monthly Medical Trends meetings.	
Findings: The FY 2010–2011 QAPI Work Plan included UM program goals and methods of measuring goal achievement. The FY 2009–2010 QAPI Evaluation contained an evaluation of FY 2009–2010 UM program goal achievement and strategies for continued progress in FY 2010–2011 toward UM program goal achievement. Monthly utilization graphs, the FY 2009 Performance Measurement Report, and utilization trend reports demonstrated ABC management's evaluation of utilization data.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
18. The Contractor has UM review standards that are the same for network providers as they are for out-of-network or unaffiliated providers. *Contract: II.I.1.n*	**Documents Submitted:** ◆ CCS307-Utilization Review Determinations 10-28-10 **Description of Process:** Colorado Access Utilization Review Determinations policy (CCS 307) is applicable to all providers regardless of contracting status with Colorado Access (Section II. Pages 10-17).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The provider manual, which informed providers of the UR process, was available to all providers on ABC's Web site. While routine services were subject to prior authorization if provided by out-of-network providers and were not subject to prior authorization if provided by in-network providers, ABC conducted prior-authorization reviews using InterQual criteria. The InterQual UR criteria are nationally accepted UR criteria and do not distinguish between populations or providers.		
Required Actions: None		
19. The Contractor's written policies and procedures provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42CFR438.210(e)* *Contract: II.D.6.a.1 and II.I.1.c*	**Documents Submitted:** ◆ CCS301-Qualifications for Staff Engaged in Utilization Management Activities 11-30-09 **Description of Process:** Colorado Access Colorado Access Qualifications for Staff Engaged in Utilization Management Activities policy (CCS 301) states that compensation is not structured to incent the denial, limitation, or discontinuation of medically necessary of services (Section V., page 3).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Qualifications for Staff Engaged in Utilization Management Activities policy included the provision that ABC does not provide financial or other incentives to any staff making UR decisions. Providers were informed of the policy via the provider manual.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
20. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, ◆ Serious impairment to bodily functions, ◆ Serious dysfunction of any bodily organ or part. *42CFR438.114(a)* *Contract: I.A.10*	**Documents Submitted:** ◆ CCS307-Utilization Review Determinations 10-28-10 (pg 3) ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 (pg 2) ◆ ABC Member Handbook Feb 2010 (pg 8) **Description of Process:** Colorado Access defines an emergency medical condition exactly as stated in 42CRF438.114(a). This is cited in the Definitions of Colorado Access Utilization Review Determinations policy (CCS307) on page 3. It is also cited in the Emergency and Post-Stabilization Care policy (CCS309) in the Definition of page 2. The definition is also cited in the ABC Member Handbook (Page 8).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Utilization Review Determinations policy and the Emergency and Post-Stabilization Care policy included the Medicaid managed care definition of emergency medical condition. The member handbook included a definition of emergency medical condition that was consistent with the definition in the Medicaid managed care contract.		
Required Actions: None		
21. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition. *42CFR438.114(a)* *Contract: I.A.11*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 (pg 2) **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy defines emergency services according to 42CRF438.114(a) within Colorado Access the Emergency and Post-Stabilization Care policy (CCS309) on page 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Utilization Review Determinations policy and the Emergency and Post-Stabilization Care policy included the Medicaid managed care definition of emergency services. The member handbook included a definition of emergency services that was consistent with the definition in the Medicaid managed care contract.		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Required Actions: None		
22. The Contractor defines Poststabilization Care Services as covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42CFR438.114(a)* *Contract: I.A.29*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 ◆ ABC Provider Manual Jan 2010 ◆ ABC Member Handbook Feb 2010 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) defines poststabilization care as outlined in 42CFR438.114(a) on page 2. This definition is also included in the Provider Manual (page 30) and Member Handbook (Pages 9-10).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post-Stabilization Care policy included the Medicaid managed care definition of poststabilization services. The member handbook definition was consistent with Medicaid managed care regulations.		
Required Actions: None		
23. The Contractor makes emergency services available to members without preauthorization. *42CFR438.10(f)(6)(viii)(B)* *Contract: II.I.1.p.1*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 ◆ ABC Provider Manual Jan 2010 ◆ ABC Member Handbook Feb 2010 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) states that emergency services available to members without preauthorization (page 2). The ABC Member Handbook (pages 9, 10) and Provider Manual (page 31) also states that prior authorization is not required.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The Emergency and Post-Stabilization Care policy included the provision that emergency services were available without prior authorization. Providers were informed via the provider manual. The member handbook informed members that no prior authorization for emergency services was required. During the on-site interview, ABC staff members described periodic reviews of emergency claims to ensure that ER claims were not denied inappropriately.		
Required Actions: None		
24. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42CFR438.114(c)(1)(i)* *Contract: II.D.6.a.1*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 ◆ ABC Provider Manual Jan 2010 ◆ ABC Member Handbook Feb 2010 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) states that Colorado Access is financially responsible for emergency and urgently needed care including post-stabilization services in accordance with applicable Federal laws" (Section V., page 3). This statement references 42CRF438.114(c). If needed, our systems configuration can be demonstrated during the site review. The Provider Manual states that ABC will pay for emergency services provider by out-of-network medical and hospital facilities (page 49). The Member Handbook states that Members can seek emergency care from any hospital and by calling 911 (pages 8-10).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The member handbook directed members to go to the nearest hospital in case of an emergency, even if the hospital is not in the BHO's network. Providers were informed that members may receive emergency services from any ER provider in or out of the geographic service area. During the on-site interview, ABC staff members described periodic reviews of emergency claims to ensure that ER claims were not denied.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
25. The Contractor may not deny payment for treatment obtained under either of the following circumstances: ◆ A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: ▪ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, ▪ Serious impairment to bodily functions, ▪ Serious dysfunction of any bodily organ or part, ◆ A representative of the Contractor's organization instructed the member to seek emergency services. *42CFR438.114(c)(1)(ii)* *Contract: II.D.6.a.2*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care ◆ Member Handbook Feb 2010 ◆ ABC Provider Manual Jan 2010 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) states that Colorado Access is financially responsible for emergency and urgently needed care including post-stabilization services in accordance with applicable Federal laws" (Section V., page 3). This statement references 42CRF438.114(c). Members are also informed of this requirement within the Member Handbook (pages 3, 4). This information is also in the Provider Manual (page 49).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post-Stabilization Care policy stated that Colorado Access/ABC covered emergency services in cases in which a prudent layperson with average knowledge of health services and medicine would have believed that an emergency medical condition existed. The member handbook informed members of the definition of emergency medical condition, which included the prudent layperson standard.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
26. The Contractor does not: ◆ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42CFR438.114(d)(1)* *Contract: II.D.6.b*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 ◆ ABC Member Handbook Feb 2010 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) specifies that ABC does not "limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms that are otherwise covered under its contracts", nor does ABC "refuse to cover emergency services based on the emergency room provider, hospital, or agent not notifying the member's primary care provider, Colorado Access, or the applicable State entity of the member's screening and treatment within ten (10) calendar days of presentation for emergency services" (Section IV, page 3). Members are also informed of this requirement within the Member Handbook (page 4).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post-Stabilization Care policy included the provision that Colorado Access/ABC did not limit what constitutes an emergency based on a list of diagnoses or symptoms. The policy also included the provision that Colorado Access/ABC did not refuse to cover emergency services based on the provider's failure to notify Colorado Access within 10 days. The provider manual stated that ABC "must" be informed of the provision of emergency care within 24 hours, but did not indicate that payment would be denied if notification did not occur. During the on-site interview, ABC staff members stated that all appropriate ER claims were paid regardless of whether notification had occurred.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
27. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42CFR438.114(d)(2)* *Contract: II.D.6.c*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 ◆ ABC Member Handbook Feb 2010 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) specifies that "A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member" (Section VII, page 4). Members are informed that they are not liable for payment in this circumstance within the Member Handbook (page 9).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post-Stabilization Care policy included the required provision. The provider manual informed providers that they may not charge a co-pay or balance bill members.		
Required Actions: None		
28. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42CFR438.114(d)(3)* *Contract: II.D.6.d*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 ◆ ABC Member Handbook Feb 2010 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) specifies that, "The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. That determination is binding on Colorado Access being responsible for coverage and payment" (Section VIII, page 4). Members are also informed within the Member Handbook that they are not liable for payment in this circumstance (page 9).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The Emergency and Post-Stabilization Care policy included the required provision. Members were informed via the member handbook that they will not have to pay for emergency services if they call 911 or go to the nearest hospital for an emergency.		
Required Actions: None		
29. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are pre-approved by a plan provider or other organization representative. *42CFR438.114(e)* *42CFR422.113(c)(2(i)* *Contract: II.D.6.e*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) states that ABC is financially responsible for post-stabilization services (Section V., pg 3).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post-Stabilization Care policy included the required provision. During the on-site interview, staff confirmed that all emergency claims, including poststabilization services, were paid unless eligibility issues existed or the services provided were to treat a diagnosis that was not a covered diagnosis.		
Required Actions: None		
30. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within 1 hour of a request to the organization for pre-approval of further post-stabilization care services. *42CFR438.114(e)* *42CFR422.113(c)(2)(ii)* *Contract: II.D.6.a*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 ◆ ABC Provider Manual Jan 2010 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) states that ABC is financially responsible for poststabilization services delivered within 1 hour without authorization (Section V.C., page 3). Providers are notified of this in the Provider Manual (page 49).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The Emergency and Post-Stabilization Care policy included the required provision. During the on-site interview, staff confirmed that all emergency claims, including poststabilization services, were paid unless eligibility issues existed or the services provided were to treat a diagnosis that was not a covered diagnosis.		
Required Actions: None		
31. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: ◆ The organization does not respond to a request for pre-approval within 1 hour, ◆ The organization cannot be contacted, The organization representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in requirement number 33 is met. *42CFR438.114(e)* *42CFR422.113(c)(2)(iii)* *Contract:II.D.6.f*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) states that ABC is financially responsible for poststabilization services unless ABC responds to a request within one hour (section V.D., pg 4).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post-Stabilization Care policy included the required provision. During the on-site interview, staff confirmed that all emergency claims, including poststabilization services, were paid unless eligibility issues existed or the services provided were to treat a diagnosis that was not a covered diagnosis.		
Required Actions: None		

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
32. The Contractor must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the contractor. *42CFR438.114(e)* *42CFR422.113(c)(2)(iv)* *Contract: II.D.6.g*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 ◆ ABC Member Handbook Feb 2010 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) states that Colorado Access does not charge Members for post-stabilization care services, regardless of whether the care was received by a network or non-network provider (Section VII., page 4). Members are informed of this policy in the Member Handbook (page 9).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post-Stabilization Care policy stated that members were not liable for any payment for emergency services. The member handbook informed members that they were not responsible for any payment or co-pays for mental health services.		
Required Actions: None		
33. The Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when: ◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care, ◆ A plan physician assumes responsibility for the member's care through transfer, ◆ A plan representative and the treating physician reach an agreement concerning the member's care, ◆ The member is discharged. *42CFR438.114(e)* *42CFR422.113(c)(3)* *Contract: II.D.6.h*	**Documents Submitted:** ◆ CCS309-Emergency and Post-Stabilization Care 1-4-10 **Description of Process:** Colorado Access Emergency and Post-Stabilization Care policy (CCS309) states that ABC's financial responsibility for poststabilization services ends according the criteria outlined in Section VI.A-D. (page 4).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I— Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The Emergency and Post-Stabilization Care policy included the required provision. During the on-site interview, ABC staff members described periodic reviews of emergency claims to ensure that ER claims had not been denied.		
Required Actions: None		

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	N/A
Total Applicable		=	33	**Total Score**		=	31

Total Score ÷ Total Applicable	=	94%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
1. The Contractor ensures that all covered services are available and accessible to members. *42CFR438.206(a)* *Contract: II.E*	**Documents Submitted** ◆ FY10 Q4 ABC Network Adequacy Report ◆ ABC FY10 Q4 Access to Care Report ◆ ABC FY10 Q4 Secret Shopper Report ◆ ABC FY2010 QAPI Evaluation **Description of Process:** ABC maintains a broad and diverse network of over 1000 individual practitioners throughout the State of Colorado. We routinely monitor network adequacy (see FY10 Q4 ABC Network Adequacy Report) and access. Access is measured quarterly through Access to Care reporting (see ABC FY10 Q4Access to Care Report) and our Secret Shopper program (see ABC FY10 Q4 Secret Shopper Report). The quality of services is monitored through our Quality Assessment and Improvement Program (see ABC FY2010 QAPI Evaluation).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The first quarter of FY 2011 Network Adequacy Report included a current list of the number of organizational providers and individual practitioners available within each county where ABC members resided. The first quarter of FY 2011 Access to Care report indicated 100 percent compliance for timely access to routine and urgent services and for return of emergency telephone calls. The report also indicated 98.5 percent compliance for the quarter for emergency face-to-face evaluations. The Secret Shopper Survey results for the first quarter of FY 2011 described monitoring independently contracted providers in ABC's network for compliance with appointment availability standards. The FY 2010 QAPI Evaluation reported an overall penetration rate of 12.2 percent for FY 2010. The QAPI evaluation included goals for monitoring and improving access to care. During the on-site interview, ABC staff members clarified that the Access to Care reports and data submitted to the Department were based only on new requests for routine services and on any request for urgent and emergent services.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
2. The Contractor maintains and monitors a comprehensive provider network capable of serving the behavioral health needs of all members in the program. *42CFR438.206(b)(1)* *Contract: II.E.1.c.1*	**Documents Submitted:** ◆ FY10 Q4 ABC Network Adequacy Report ◆ FY10 Annual ABC Network Adequacy Report ◆ PNS202-Selection and Retention of Providers 1-14-10 **Description of Process:** ABC maintains a comprehensive provider network capable of meeting the needs of our Members. Our quarterly and annual network adequacy reports monitor all the requirements under section II.E.c.1 of our contract. The Colorado Access Selection and Retention of Providers policy (PNS202) outlines our process for maintaining a comprehensive provider network.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Selection and Retention of Providers policy described the process for identifying providers for addition to the network. The FY 2010 Annual Network Adequacy Report and the first quarter of FY 2011 Network Adequacy Report described the numbers and types of individual practitioners and organizational providers in the ABC network. The reports indicated an increase in the size of the network for the first quarter of 2011 compared to FY 2010. ABC's grievance and appeals reports indicated that there were no grievances related to access and availability in the fourth quarter of 2010 or the first quarter of 2011. During the on-site interview, ABC staff members reported that the additional providers were primarily providers added as a result of new contracts with federally qualified health centers (FQHCs).		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
3. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated Medicaid enrollment, ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. ◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services, ◆ The numbers of network providers who are not accepting new Medicaid patients, ◆ The geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities, ◆ The potential physical barriers to accessing provider's locations, ◆ The cultural and language expertise of providers, ◆ Provider to member ratios for behavioral health care services. *42CFR438.206(b)(1)(i) through (v)* *Contract: II.E.1.c.1*	**Documents Submitted:** ◆ FY10 Q4 ABC Network Adequacy Report ◆ FY10 Annual ABC Network Adequacy Report ◆ ABC FY10 Q4 Access to Care Report ◆ ABC FY10 Q4 Secret Shopper Report ◆ ABC FY10 Q4 Grievance and Appeals Report **Description of Process:** ABC has historically maintained a robust and comprehensive network, capable of meeting the increased capacity demands of a growing Membership. We have anticipated the additional demands of new Members and our network remains adequate to meet the extra demand without a large increase in the number of network providers. Continued high marks on Access to Care reports and our Secret Shopper program is evidence of this. Each quarter's network Adequacy Report considers the numbers and types of providers in our network and those providers who are not accepting new Members. Analysis of the geographic location of providers and our Members is conducted using GeoAccess software. The State's standard is one provider no more than 30 miles distance to a Member. In our Denver Service Area, ABC Members are no more than 1.7 miles from a network provider. ABC takes physical access to our provider's location seriously. ABC's quarterly Grievance and Appeals report captures any issues with physical access to a provider's location. In FY10, the Q4 report included a report that a Member was refused access to a provider's facility because her service dog did not have the proper identification (a service vest). The provider was able to resolve the issue with the Member. No other access issues were noted in FY10.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	The cultural and language expertise of providers is monitored in the quarterly Network Adequacy reports. In the fourth quarter of FY10, ABC has 52 Spanish speaking providers and 34 additional providers fluent in a number of other languages (page 6). To meet the diverse cultural needs of our Members we contract with providers such as the Asian Pacific Development Center, Jewish Family Services, Servicios de la Raza, and MHCD's El Centro clinic. ABC currently has a one provider for every 81 Members (93,983 members/1160 practitioners). Considering our current penetration rate of 12.2%, our provider to Member ratio is 1:10. This demonstrates a network that is more than adequate and can absorb additional Members as the Medicaid population continues to grow.	
Findings: The Selection and Retention of Providers policy described factors considered when establishing the network and included the required elements. The Network Adequacy reports provided analysis of required elements for establishing and maintaining the network. The Secret Shopper, Access to Care, and Grievance and Appeal reports demonstrated monitoring of access to care and assessing the possible need for additions to the provider network. During the on-site interview, ABC staff members reported that although site visits were no longer required (based on the National Committee for Quality Assurance [NCQA] *2010 MBHO Standards and Guidelines*) prior to contracting with new providers, the provider network support staff provided on-site orientations for newly contracted providers. Physical site assessments were conducted at that time, as needed.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
4. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. *42CFR438.206(b)(3)* *Contract: II.E.1.a.12*	**Documents Submitted/Location Within Documents:** ◆ ABC Provider Manual Jan 2010 ◆ ABC Member Handbook Feb 2010 ◆ CCS302-Medical Criteria for Utilization Review 11-30-09 ◆ CCS307-Utilization Review Determinations 10-28-10 **Description of Process:** Colorado Access Medical Criteria for Utilization Review (CCS302) and Utilization Review Determinations (CCS307) policies cite the second opinion process as part of the Utilization Review definition (see definitions on CCS302, page 2 and CCS307, pg 5). The Access to Primary and Specialty Care policy (CCS310) states that Members can obtain a second opinion at no cost (Section III.I., page 5) The second opinion process is outlined the Provider Manual (page 19) and the Member Handbook (page 14).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Access to Primary and Specialty Care policy stated that members can obtain a second opinion at no cost. The provider manual informed providers of the member's right to a second opinion. The member handbook informed members of the right to request a second opinion and the telephone number to call for help obtaining a second opinion. During the on-site interview, ABC staff members reported that there had been a few second opinions arranged through the Mental Health Center of Denver (MHCD), but that it was very rare that a member requested a second opinion.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
5. If the Contractor is unable to provide necessary services to a member in-network, the Contractor must adequately and timely cover the services out of network for the member, for as long as the Contractor is unable to provide them. *42CFR438.206(b)(4)* *Contract: II.E.1.c.3 and II.E.1.d.1*	**Documents Submitted/Location Within Documents:** ◆ CCS310-Access to Primary and Specialty Care 11-30-09 ◆ ABC Provider Manual Jan 2010 ◆ ABC Member Handbook Feb 2010 **Description of Process:** Our Access to Primary and Specialty Care policy (CCS310) states that Colorado Access will arrange for specialty care outside of the Colorado Access network when network providers are unavailable or inadequate to meet an enrollee's needs (Section II, D., page 4). If Colorado Access is unable to provide covered services to a particular member, Colorado Access shall adequately and timely provide the covered services out of network at no cost to the member (Section III.J., page 5). The ABC Provider Manual (pg 10) states that at the request of any Member, we will consider any eligible provider for inclusion in our network. ABC Members have the right to seek services from a non-network provider if we are unable to provide the services within our network (ABC Member Handbook, page 20).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Access to Primary and Specialty Care policy stated that Colorado Access/ABC will arrange for specialty care outside the network if network providers are unavailable or inadequate to provide the service needed. The first quarter of FY 2011 Network Adequacy Report stated that during the quarter, six ABC members received services from out-of-network providers. The provider manual informed providers that members may request that a provider be included in the network. The list of member rights in the member handbook included the right to seek services from a non-network provider if ABC is unable to provide the service. During the on-site interview, ABC staff members reported that due to ABC's expansive network, the services provided out of network were related to transitioning members and continuity of care rather than a specialty or service not being available within the network. The FY 2010 and first quarter of FY 2011 Grievance and Appeal reports listed very few grievances related to access issues (one in the first quarter of FY 2010, one in the third quarter of FY 2010, and no grievances related to access issues in the first quarter of FY 2011) .

Required Actions:
None

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
6. The Contractor requires out-of-network providers to coordinate with the Contractor with respect to payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42CFR438.206(b)(5)* *Contract: II.E.1.d.2*	**Documents Submitted/Location Within Documents:** ◆ CCS310-Access to Primary and Specialty Care 11-30-09 **Description of Process:** Our Access to Primary and Specialty Care policy (CCS310) states that if Colorado Access is unable to provide covered services to a particular member, Colorado Access shall adequately and timely provide the covered services out of network at no cost to the member(Section III.J, page 5). Providers would need to coordinate with Colorado Access for payment. The ABC Provider Manual states that Medicaid Members are not liable for the cost of their care (page 15).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Access to Primary and Specialty Care policy included the provision that Colorado Access/ABC will provide services out of network if the BHO is unable to do so in network, at no cost to the member. The member handbook informed members that there are no fees or co-pays for Medicaid-covered services received from ABC and the circumstances under which the member may have to pay for services. The provider manual informed providers that members are not held liable for the cost of services and that providers may not balance bill members. The single-case agreement template instructed out-of-network providers about how to bill ABC and that members may not be held liable in any way for services provided.		
Required Actions: None		
7. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Emergency services are available: • By phone, including TTY accessibility, within 15 minutes of the initial contact, • In-person within one hour of contact in urban and suburban areas, • In-person within two hours of contact in rural and frontier areas.	**Documents Submitted/Location Within Documents:** ◆ ABC Provider Manual Jan 2010 ◆ ABC Member Handbook Feb 2010 ◆ ABC FY10 Q4 Access to Care Report ◆ FY09 ABC Performance Measure Report ◆ FY10 Q4 ABC Network Adequacy Report **Description of Process:** ABC and its network providers adhere to contracted access to care requirements. These are outlined in the Provider Manual (page 11) and in the Member Handbook (pages 9, 13).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
◆ Urgent care is available within twenty four hours from the initial identification of need ◆ Routine services are available upon initial request within 7 business days. ◆ Outpatient follow-up appointments within seven business days of an inpatient psychiatric hospitalization or residential facility. ◆ Providers are located throughout the Contractor's service area, within thirty miles or thirty minutes travel time, to the extent such services are available. *42CFR438.206(c)(1)(i)* *Contract: II.E.1.a.6 through II.E.1.a.8*	Emergency services are available by phone by calling ABC 24/7. During business hours, a Service Coordinator (a licensed BH clinician) is also immediately available. After hours, phones are answered by licensed clinicians through our vendor, ProtoCall. Emergency services are available in person within one hour. This is monitored quarterly through the Access to Care Reports (see ABC Access to Care Report Q4 FY10). Urgent care is available as needed within 24 hours and monitored quarterly through the Access to Care Reports (see ABC Access to Care Report Q4 FY10). Routine services are available with 7 business days and monitored quarterly through the Access to Care Reports (see ABC Access to Care Report Q4 FY10). Outpatient follow-up appointments are to occur within 7 days from inpatient hospital discharge. This is stated within the Member Handbook (page 10).Provider Manual (page 8). This performance measure is monitored annually (see FY09 ABC Performance Measure Report, Indicator #4, page 7). Providers are located throughout the ABC service area, as evidenced by quarterly Network Adequacy Reports. Members are no less than 1.7 miles distance to a network provider (FY10 Q4 ABC Network Adequacy Report, page 9).	
Findings: The FY 2010 Annual Network Adequacy Report included a GeoAccess map analysis of member distance from provider locations. The first quarter of FY 2011 Network Adequacy Report also included an analysis of which members were more than 30 miles from a provider (these members were typically outside of ABC's service area, but eligible for ABC services). The provider manual informed providers of the timely access standards. The fourth quarter of FY 2010 and the first quarter of FY 2011 Access to Care reports and the Performance Measures Report provided an evaluation of provider compliance with the timely access standards.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
8. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members. *42CFR438.206(c)(1)(ii)* *Contract: II.E.1.a.4*	**Documents Submitted/Location Within Documents:** ◆ ABC Provider Manual (Revision Draft 10-28-10) ◆ Hours of Operation Survey Results **Description of Process:** The ABC Provider Manual (Jan 2010) does not currently mention the requirement that hours of operation must be no less than those offered to non-Medicaid. The attached revision draft should be approved ahead of the Dec 6 site visit (see page 15). In October 2009, ABC surveyed the hours of operation for network providers to ensure our network offers adequate hours of operation. The attached Hours of Operation Survey demonstrates at least 25 provider with hours of operation outside M-F, 8-5. This information is now routinely collected by Provider Network Services at contracting and re-credentialing and entered into our provider management system, Apogee.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: ABC provided the results of a provider survey of office hours for providers within the network. During the on-site interview, ABC staff members reported that the purpose of this survey was internal management review to confirm that office-hour practices met requirements. Staff reported that in the future, ABC will include office hours in the provider directory.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
9. The Contractor makes Services available 24 hours a day, 7 days a week, when medically necessary. *42CFR438.206(c)(1)(iii)* *Contract: II.E.1.a.5*	**Documents Submitted/Location Within Documents:** ◆ ABC Provider Manual Jan 2010 ◆ ABC Member Handbook Feb 2010 **Description of Process:** ABC and its providers make medical necessary services available 24/7. Providers are notified of this requirement within the Provider Manual (pages 14, 15, 30). Members are made aware that services are available 24/7 in the Member Handbook (pages 8, 9, 20). Emergency services are available to Members at any hospital 24/7, and ABC clinical staff (or through its vendor, ProtoCall) are available 24/7. Inpatient psychiatric services are available at any of our network hospitals 24/7.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The provider manual stated that providers must provide access to services 24 hours a day, 7 days per week, or arrange for coverage, and that members have access to emergency services 24 hours a day via any hospital ER or by calling ABC. The member handbook informed members of the emergency services access to care standards and that members may go to the nearest ER for immediate emergency services.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
10. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, and has mechanisms to monitor providers regularly to determine compliance and to take corrective action if there is failure to comply. *42CFR438.206(c)(1)(iv) through (vi)* *Contract: II.E.1.a. 9 through II.E.1.a. 11*	**Documents Submitted/Location Within Documents:** ◆ ABC FY10 Q4 Access to Care Report ◆ ABC FY10 Q4 Secret Shopper Report ◆ ABC FY2010 QAPI Evaluation ◆ FY10 Q4 ABC Network Adequacy Report **Description of Process:** Adherence to access to service requirements is monitored through: 1. Quarterly Access to Care reports (see ABC FY10 Q4 Access to Care Report). 2. Quarterly Secret Shopper reports (see ABC FY10 Q4 Secret Shopper Report). 3. Annual performance measurements of 7-day post hospital discharge follow-up appointments (ABC FY2010 QAPI Evaluation, pages 4, 31-32). FY10 results are due 12/1 and will be available during the site visit if requested. 4. Quarterly Network Adequacy reports (see FY10 Q4 ABC Network Adequacy Report). If a provider fails to meet any of the requirements, a corrective action plan is initiated. No providers are currently under a corrective action for access to service requirement violations.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Access to Care reports provided information about the timeliness of access to care. The fourth quarter of FY 2010 and the first quarter of FY 2011 Secret Shopper reports demonstrated ABC's mechanism to monitor providers for compliance with the timely access requirements. Although no providers were under a CAP related to timely access at the time of the site review, staff members reported that there had been CAPs imposed in the past.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
11. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by: ◆ Addressing the language and cultural expertise of providers in the network plan, ◆ Ensuring members' right to receive culturally appropriate and competent services from participating providers, ◆ Assessing member demographics, cultural, and racial affiliations, language and reading proficiency, ◆ Evaluating members' cultural and linguistic needs, ◆ Utilizing information gathered [regarding cultural and linguistic needs] in the service plan. *42CFR438.206(c)(2)* *Contract: II.E.1.c.1.v; II.F.4.j.3.iv; II.F.7.d.1; II.F.7.e.2; and II.F.9.a*	**Documents Submitted/Location Within Documents:** ◆ ADM206-Culturally Sensitive Services for Diverse Populations 10-22-09 ◆ ABC Provider Manual Jan 2010 ◆ ABC Member Handbook Feb 2010 ◆ ABC FY10 Q4 Grievance and Appeals Report **Description of Process:** ABC promotes the delivery of services in a culturally competent manner, to all Members, including those with limited English proficiency or limited reading skills, including those with diverse cultural and ethnic backgrounds. The Colorado Access Culturally Sensitive Services for Diverse Populations policy (ADM206) outlines our process for ensuring adherence to these contract requirements. ABC provides communication assistance at all points of Member contact. ABC's quarterly Partnership Meetings regularly have American sign language and/or Spanish language translators present. Our Customer Services software, Access Connect, can track a Member's language preference. This ensures we use the Member's preferred language. Within the ABC Provider Manual, the delivery of culturally competent services is addressed. It is a provider's responsibility to provide culturally competent services (page 14). It is the provider's responsibility to provide effective services to Members with limited English proficiency or who are sensory-impaired or speech impaired (pgs 19-20). ABC's Cultural Competency Training Program is outlined on page 20 of the Provider Manual. The importance of cultural competency is highlighted on page 54. Cultural awareness is also crucial in treatment planning process (pages 55, 69, 71, and 72).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Members are informed in the Member Handbook that they should expect the services they receive to be culturally competent (pages 12, 20). Grievances in this area are tracked quarterly. In FY10, there were no Member grievances related to language/cultural barriers (see ABC FY 10 Q4 Grievance and Appeals Report).	

Findings:
The Access to Care reports listed providers and the languages each provider spoke. The Colorado Access 2010–2011 Access to Care Plan addressed cultural competency and described training modules available for providers. The fourth quarter of FY 2010 and first quarter of FY 2011 Grievance and Appeal reports indicated that there were no grievances filed during the fourth quarter of FY 2010 or the first quarter of FY 2011 related to cultural issues. The member rights list in the member handbook included the right to have culturally appropriate services. The member handbook informed members that they may request a provider with a particular cultural background or who speaks a particular language. The member handbook also informed members how to receive a handbook in large print, on tape, or in another language. During the on-site interview, ABC staff members confirmed that ABC had Spanish versions of member materials readily available and that materials could be translated into any other language upon request. The provider manual offered providers cultural competency training. Staff members reported that the training was provided, as requested. The provider manual also included the standards for assessment and service planning, which included addressing cultural and language information.

Required Actions:
None

12. The Contactor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor: ◆ Offers an appropriate range of preventative, primary care, and specialty services that is adequate for the anticipated number of members for the services area, ◆ Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area, ◆ Certifies that the network meets the requirements set forth in 438.206 and 438.207. *42CFR438.207(b)* *Contract: II.E.1.b.1*	**Documents Submitted/Location Within Documents:** ◆ FY10 Q4 ABC Network Adequacy Report ◆ FY10 Annual ABC Network Adequacy Report ◆ ABC Network Adequacy 4Q FY10 Cert Letter **Description of Process:** ABC submits a quarterly and annual Network Adequacy report and certifies the information provided to the Department is accurate, complete and truthful.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: ABC submitted both annual and quarterly Network Adequacy Reports and evidence that the data was certified by the CEO of ABC. During the on-site interview, ABC staff members confirmed that both annual and quarterly network adequacy reports were submitted to the Department of Healthcare Policy & Financing for approval.		
Required Actions: None		

Results for Standard II—Access and Availability							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	N/A
Total Applicable		=	12	**Total Score**		=	12

Total Score ÷ Total Applicable	=	100%

Standard III— Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
1. The Contractor has written policies and procedures to ensure timely coordination of the provision of covered services to its members and to ensure service accessibility attention to individual needs and continuity of care to promote maintenance of health and maximize independent living. *Contract: II.E.1.g.1*	**Documents Submitted:** ◆ CCS305-Care Coordination 2-3-10 ◆ ABC Provider Manual Jan 2010 **Description of Process:** Colorado Access Care Coordination policy (CCS305) outlines our care coordination program. The CCS305 policy statement (page 2) reads: Through Care Coordination efforts, Colorado Access will develop and maintain means to identify, screen, assess and assist in the management of members with complex physical, mental, and cultural healthcare needs. Colorado Access' efforts will effectively coordinate care with multiple providers, human service agencies, and payers, on behalf of the member. The activities focus on coordinating provision of services, promoting and assuring service accessibility, with attention to the individual needs, continuity of care, comprehensive and coordinated service delivery, cultural competence and fiscal and professional accountability. This policy also details member identification for care coordination through methods such as: 1. Internal data sources such as condition specific profiles, emergency room visits reports, inpatient census reports, readmission reports and historical costs; 2. Telephonic outreach and screening; 3. Referrals from members, DCRs, Authorized Representative, or family members; 4. Referrals from primary care, specialty care including mental health providers, schools, home health care or	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III— Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	ancillary service providers, human service agencies, the State, and other community agencies; 5. Institutional providers (e.g., hospitals, skilled nursing, rehabilitation, residential, and sub-acute facilities); and 6. Referrals from other Colorado Access departments (Section II.A.1-6., page 4). In addition, the Facilitation of Care Coordination (Section III,A-C., pages 4-5) support this requirement. The ABC Provider Manual also requires providers to coordinate care (page 26).	
Findings: The Care Coordination policy listed goals for care coordination, including ensuring member access to services, monitoring individual care plans, and facilitating communication among providers and caregivers. The provider manual described the provider responsibilities, the Colorado Access Care Management program, and the responsibilities of Colorado Access care managers for members eligible for the care management program. The provider manual included a description of the importance of coordinating with other providers and agencies, including the member's primary care provider (PCP). The Delivering Continuity and Transition of Care for Members policy included procedures for continuity of care for members new to ABC and for members when the provider had terminated and care must be transitioned to a new provider. During the on-site interview, ABC staff members reported that approximately the top 2 to 3 percent of the users of ABC services were targeted to receive care management services.		
Required Actions: None		
2. Policies and procedures address: ◆ The coordination of services furnished to the member by the Contractor with the services the member receives from any other MCO or PIHP. ◆ The coordination and provision of services in conjunction with other behavioral health care providers, physical health care providers, long term care providers, waiver service providers, pharmacists, county and state agencies, and other organizations that may be providing wrap around services.	**Documents Submitted:** ◆ CCS305-Care Coordination 2-3-10 ◆ ABC Provider Manual Jan 2010 ◆ QM302-Review of Provider Medical Records 11-30-09 ◆ QM302 Attachment A. Chart Standards ◆ 2009 ABC Medical Record Documentation Study **Description of Process:** Colorado Access Care Coordination policy (CCS305) addresses the coordination of services with primary care as one of the specific	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III— Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
42CFR438.208(b)(2) *Contract: II.E.1.g.1 and II.E.1.g.2*	care management interventions (Section III.C., pg 4-5). This section also outlines the process for care coordination with behavioral health care providers, physical health care providers, long term care providers, waiver service providers, pharmacists, county and state agencies, and other organizations that may be providing wrap around services. This is also addressed in the definition of care coordination (page 2). Coordination between ABC providers and a member's PCPs is primarily the direct responsibility of our providers. This is explicitly stated in the Provider Manual (pages 26-29). In addition, Appendix A of the Provider Manual requires documentation of coordination with medical providers and other ancillary service providers (Assessment Standards #7-8, page 70). Documentation of active treatment must include documentation of continuity and coordination of care with the member's PCP and other ancillary service providers (#7, page 73). The Provider Manual also includes a web link to the sample PCP communication form (page 77). This form is available on our website at http://www.coaccess.com/access-behavioral-care-provider-information. Clinical documentation standards in Appendix A are reviewed during routine random provider chart audits. Colorado Access policy QM302 outlines the process for provider medical chart reviews to ensure providers are following these requirements. The 2009 Medical Record Documentation Study documents the outcomes of our most recent review.	

Findings:
The Care Coordination policy described care coordination interventions. Interventions included facilitation of communication and coordination between providers and caregivers, members, families, and authorized representatives. The provider manual described ABC's care management program and the importance of care management activities. The provider manual also directed providers to coordinate their services with various caregivers and service providers such as PCPs, the treating psychiatrist, schools, and the counties' Department of Human Services (DHS) caseworkers. The Review of Provider

Standard III— Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Medical Records policy included the provision that the individualized service plan must identify the person responsible for overseeing and coordinating care. The 2009 ABC Medical Record Documentation Study (completed in April 2010) described the elements evaluated, which included evidence of family/guardian involvement and coordination with school personnel, documentation of communication between mental health and medical providers, referrals to meet medical needs as applicable, and that the treatment record reflected coordination of care activities. During the on-site interview, ABC staff members reported that the agencies that care coordinators typically worked with were long-term care facilities, single point of entry agencies, and the community-centered board (CCB) in the Denver area serving individuals with developmental disabilities. In addition, ABC staff members described alternative models to accomplish care coordination activities, which included two grant-funded medical clinics at the Mental Health Center of Denver (MHCD) that provided primary care services.		
Required Actions: None		
3. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* *Contract: None*	**Documents Submitted** ◆ CCS305-Care Coordination 2-3-10 ◆ ABC Provider Manual Jan 2010 **Description of Process:** Colorado Access Care Managers, Service Coordinators, and Peer Specialists routinely communicate their activities to providers and others involved in the member's care. This activity is implicit in the definition of Care Coordination (CCS305, page 2). One of the stated goals of our care coordination program is to "to facilitate communication and coordination among providers, caregivers, and stakeholders" (CCS305, I.G, pg 3). "To create efficiencies by decreasing the duplication of services" is another stated goal of the program (CCS305, I.H, pg 3). In addition, it is expected that care coordination interventions are "non-duplicative (CCS305, Section I.H., page 3 and III.C.2, pgs 4-5) and collaborative. In addition, the Care Coordination section of the ABC Provider Manual outlines a process to be followed by providers that facilitates the sharing and coordination of services (pages 26-29), preventing the duplication of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III— Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The Care Coordination policy included facilitating communication among providers and decreasing duplication of services as goals for care coordination activities. The policy included a variety of care coordination interventions, including sharing assessment findings and developing an agreed-upon care plan. The provider manual informed providers of their responsibilities for care coordination and how to access communication forms at ABC's Web site. During the on-site interview, ABC staff members confirmed that care coordination with the agencies indicated in Requirement 2 routinely included sharing of assessment information.		
Required Actions: None		
4. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E (HIPAA), to the extent that they are applicable. *42CFR438.208(b)(4)* *Contract: II.E.1.g.1*	**Documents Submitted:** ◆ HIP201-Protection of Health Information 2-3-10 ◆ HIP204-Security of Electronic Protected Health Information 11-30-09 ◆ CCS305-Care Coordination 2-3-10 ◆ ABC Provider Manual Jan 2010 ◆ 2009 ABC Medical Record Documentation Study **Description of Process:** The sharing of member information for the purposes of continuity and coordination of care is handled in accordance with State and Federal laws and regulations outlined in Colorado Access Protection of Health Information policy (HIP201). In addition, Colorado Access Security of Electronic Protected Health Information policy (HIP204) outlines the policies for sharing electronic health information. Colorado Access Care Coordination policy (CCS305) states care coordination will work to ensure that member confidentiality is maintained, in accordance with 45 CFR Parts 160 and 164 and other applicable law and regulation, at all times when collaborating with both internal and external parties, as well as assuring that all confidential member information is maintained in an orderly fashion within the member's file (Section III.C.6., page 5).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III— Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	The ABC Provider Manual (pages 16-17) outlines member privacy requirements. These requirements are checked during routine random provider chart audits (see 2009 ABC Medical Record Documentation Study). These policies and procedures pertain to all activities undertaken by Colorado Access staff.	

Findings:
The Protection of Health Information policy addressed the applicability of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements (including employees, subcontractors, providers, and consultants). The policy also addressed use and disclosure of protected health information (PHI), use of authorizations to disclose information, use of confidentiality agreements for those with access to PHI, and limiting access to information to the minimum necessary. Examples of the authorization to release information and the confidentiality agreement were attached to the policy. The Security of Electronic Protected Health Information policy addressed the use of access cards to limit physical access to areas containing physical or electronic information, the physical security of work stations, the use of passwords based on job descriptions and the need for information, and methods for reporting security breaches. The Care Coordination policy stated that ensuring member confidentiality is a goal of care coordination. The provider manual informed providers of their responsibility to follow HIPAA requirements regarding disclosure of clinical record information and provided the Web site address for more information about HIPAA. The 2009 ABC Medical Record Documentation Study included an assessment of whether clinical records contained a signed authorization to release information. During the on-site interview, ABC staff confirmed that HIPAA training occurred for internal staff at initial orientation and annually, and for providers, as requested.

Required Actions:
None

Standard III— Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
5. The Contractor ensures that each member accessing services receives an individual intake and assessment within contractual timeframes for the level of care needed. The individual intake and assessment shall not be performed as part of any group orientation or therapy session. *42CFR438.208(c)(2)* *Contract: II.F.7.a and II.F.7.c*	**Documents Submitted/Location Within Documents:** ◆ ABC Provider Manual Jan 2010 ◆ QM302-Review of Provider Medical Records 11-30-09 ◆ QM302 Attachment A. Chart Standards ◆ 2009 ABC Medical Record Documentation Study **Description of Process:** The ABC Provider Manual states that every member shall receive an individual intake and assessment (page 16). This is also mentioned in the section related to initial triage assessment (pages 34-35). The requirements for documentation of intake assessments are outlined in Appendix A (pages 69-72). The intake assessment for services is required to take place within the access standards referenced on page 11. Allowed procedures codes stipulate that assessments are individual or family services. Compliance with this requirement is reviewed during medical record reviews as required per Colorado Access Review of Provider Medical Records (QM302) policy (see 2009 ABC Medical Record Documentation Study).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The provider manual directed providers to complete an individualized assessment for each member receiving services. Appendix A of the provider manual included instructions for completing the Colorado Client Assessment Record (CCAR) and listed specific content requirements for an individualized assessment. The 2009 ABC Medical Record Documentation Study demonstrated the BHO's monitoring of provider records for the presence and required content of the member assessment.		
Required Actions: None		

Standard III— Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
6. Each member actively seeking services shall have an individualized service plan (treatment plan), developed by the member and/or the designated member representative and the member's provider or treatment team and: ◆ Utilizes the information gathered in the member's intake and assessment to build a comprehensive plan of service, ◆ Includes measurable goals, strategies to achieve the stated goals and a mechanism for monitoring and revising the service plan as appropriate, ◆ Is signed by the member and reviewing professional. If the member chooses not to sign his/her service plan, documentation is provided in the member's medical record stating the member's reason for not signing the plan, ◆ Service planning occurs annually or if there is a change in the member's level of functioning. *42CFR438.208(c)(3)* *Contract: II.F.9*	**Documents Submitted:** ◆ ABC Provider Manual Jan 2010 ◆ 2009 ABC Medical Record Documentation Study ◆ QM302-Review of Provider Medical Records 11-30-09 ◆ QM302 Attachment A. Chart Standards **Description of Process:** The ABC Provider Manual states that each member receiving treatment shall have an appropriate ISP (pages 14, 16, 20, 28, 38, 55, 71-72). Compliance with this requirement is audited during routine random medical record reviews as required per Colorado Access Review of Provider Medical Records (QM302) policy (see 2009 ABC Medical Record Documentation Study).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The provider manual directed providers to complete an individualized service plan for each member receiving services. Appendix A of the provider manual included instructions and listed the required content of the service plan. The 2009 ABC Medical Record Documentation Study demonstrated the BHO's monitoring of provider records for the presence and required content of the service plan.		
Required Actions: None		

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	N/A
Total Applicable		=	6	**Total Score**		=	6

Total Score ÷ Total Applicable	=	100%

The completed compliance monitoring tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Denials Record Review Tool
for Access Behavioral Care

Review Period:	January 1, 2010–September 15, 2010
Date of Review:	December 6, 2010
Reviewer:	Barbara McConnell and Rachel Henrichs
Participating Plan Staff Member:	Rich Duncan

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
1	*****	1/16/10	1/22/10	6	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: The reason for the denial decision, as stated in the notice of action letter, was: "The member does not meet the criteria for medical necessity." While this statement represents the reason that ABC made the decision, HSAG suggests that ABC consider including additional information in the notice of action letters that would be more meaningful to the member.											
2	*****	3/5/10	3/12/10	7	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
3	*****	1/19/10	1/22/10	3	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
4	*****	1/15/10	2/1/10	17	Y ☐ N ☒ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: The notice of action letter was sent 17 days after the request for service. There was no extension letter in the record. In addition, the reason for the denial decision, as stated in the notice of action letter, was: "The member does not meet the criteria for medical necessity." While this statement represents the reason that ABC made the decision, HSAG suggests that ABC consider including additional information in the notice of action letters that would be more meaningful to the member.											
5	*****	1/21/10	2/1/10	11	Y ☐ N ☒ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments: The notice of action letter was sent 11 days following the request for service. Although there was an extension letter in the record, the letter was sent only to the requesting facility and not to the member. Therefore, ABC was not in compliance with the requirement to send the notice of action within 10 calendar days following the request for service.											
6	*****	2/15/10	2/16/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: ABC denied the service because the member had a diagnosis of autism in addition to the mental health diagnosis documented in the file. While denying services under the Medicaid managed care contract due to autism not being a covered diagnosis is a valid reason, HSAG suggests that ABC consider reviewing its processes and specific cases. The recommended review would allow ABC to ensure that decisions to deny services in dually diagnosed members were not simply due to the presence of the additional diagnosis. The review would ensure that ABC's decisions were not due to the presenting symptoms being related to the additional diagnosis (whether primary or secondary) rather than the mental health diagnosis.											
7	*****	2/2/10	2/12/10	10	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
8	*****	1/22/10	1/25/10	3	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Denials Record Review Tool
for Access Behavioral Care

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
9	*****	5/10/10	5/21/10	21	Y ☐ N ☒ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments: The notice of action letter was sent 21 days after the request for service. Although there was an extension letter in the record, the letter was sent only to the requesting facility and not to the member. Therefore, ABC was not in compliance with the requirement to send the notice of action within 10 calendar days following the request for service. The reason for the denial decision, as stated in the notice of action letter, was: "The information available does not support the psychiatric need for day treatment." While this statement represents the reason that ABC made the decision, HSAG suggests that ABC consider including additional information in the notice of action letters that would be more meaningful to the member.											
10	*****	4/19/10	4/22/10	3	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
11	*****	5/7/10	5/11/10	4	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: The reason for the denial decision, as stated in the notice of action letter, was: "The information available does not support the need for residential level of treatment at this time." While this statement represents the reason that ABC made the decision, HSAG suggests that ABC consider including additional information in the notice of action letters that would be more meaningful to the member.											
12	*****	5/20/10	5/24/10	4	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: ABC denied the service because the member had a diagnosis of substance abuse in addition to the mental health diagnosis documented in the file. While denying services under the Medicaid managed care contract due to substance abuse not being a covered diagnosis is a valid reason, HSAG suggests that ABC consider reviewing its processes and specific cases. The recommended review would allow ABC to ensure that decisions to deny services in dually diagnosed members were not simply due to the presence of the additional diagnosis. The review would ensure that ABC's decisions were due to the presenting symptoms being related to the additional diagnosis (whether primary or secondary) rather than the mental health diagnosis.											
13	*****	6/6/10	6/10/10	4	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
14	*****	6/17/10	6/21/10	4	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
15	*****	7/9/10	7/13/10	4	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
16	*****	7/25/10	8/2/10	8	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
17	*****	8/5/10	8/10/10	5	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
18	*****	8/13/10	8/17/10	4	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
19	*****	8/26/10	8/27/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Denials Record Review Tool
for Access Behavioral Care

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
20	*****	8/31/10	9/13/10	13	Y ☐ N ☒ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: The notice of action letter was sent 13 days following the request for service. Although there was an extension letter in the record, the letter was sent only to the requesting facility and not to the member. Therefore, ABC was not in compliance with the requirement to send the notice of action within 10 calendar days following the request for service.											
21	*****				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments: Oversample cases were not required to obtain and review 20 records.											
22	*****				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:											
23	*****				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:											
24	*****				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:											
25	*****				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:											
# Applicable Elements					20		0	20	20	5	20
# Compliant Elements					16		0	20	20	5	20
Percent Compliant					80%		N/A	100%	100%	100%	100%

Total # Applicable Elements	**85**
Total # Compliant Elements	**81**
Total Percent Compliant	**95.3%**

Appendix C. Site Review Participants for Access Behavioral Care

Table C-1 lists the participants in the FY 2010–2011 site review of **ABC**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Rachel Henrichs	Project Coordinator
Access Behavioral Care Participants	**Title**
Carrie Bandell	Director, Quality Management
Robert Bremer	Executive Director
Rich Duncan	Manager, Behavioral Health
Reyna Garcia	Senior Director, Claims and Customer Service
Alexis Giese	Vice President, Behavioral Health
Rhiannon Longmore	Outcomes and Quality Coordinator
Mike McKitterick	Vice President, Clinical Operations
Gary Smith	Director, Provider Network Services
Department Observers	**Title**
Marceil Case (participated telephonically)	Behavioral Health Specialist
Kimberly de Bruyn Kops (participated telephonically)	Quality/Compliance Specialist
Jerry Ware	Quality/Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2010–2011 for Access Behavioral Care

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

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each BHO will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting. The BHO will submit the CAP using the template provided. 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 describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the plan, the BHO should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department 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 D-2—FY 2010–2011 Corrective Action Plan *for* Access Behavioral Care					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
I. Coverage and Authorization of Services 10. The Contractor's written policies and procedures include the following timeframes for making standard and expedited authorization decisions: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 days.	One record reviewed was out of compliance with the 10-calendar-day time frame and did not include an extension letter. ABC must ensure that authorization decisions are made within the required time frames.				

Table D-2—FY 2010–2011 Corrective Action Plan *for* Access Behavioral Care					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
11. The Contractor's written policies and procedures include the following timeframes for possible extension of timeframes for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days.	Four records reviewed on-site were out of compliance with the 10-calendar-day time frame for authorization decisions. Three of these records contained extension letters; however, the letters were not sent to the member, as required. If ABC extends the time frame for making standard or expedited authorization decisions, it must give the enrollee written notice of the reason for the decision to extend the time frame and inform the enrollee of his or her right to file a grievance if the enrollee disagrees with the decision.				

Appendix E. 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 E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences and a meeting at the Department 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 attended Behavioral Health Quality Improvement Committee (BQUIC) meetings and discussed the FY 2010–2011 compliance monitoring review process as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions from the BHO via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the BHO was prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the BBA Medicaid managed care regulations and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, desk audit request, on-site agenda, record review tool, 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 via delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk audit request included instructions for organizing and preparing the documents related to the review of the three standards. Thirty days prior to the review, the BHO provided documentation for the desk audit, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk audit form, the compliance monitoring tool with the BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.) ◆ HSAG reviewed additional documents requested as a result of 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. ◆ HSAG used the FY 2010–2011 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions required of the BHO to achieve full compliance with Medicaid managed care regulations and associated contract requirements.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2010–2011 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG incorporated the Department's comments. ◆ HSAG distributed a second draft report to the BHO for review and comment. ◆ HSAG incorporated the BHO's comments and finalized the report. ◆ HSAG distributed the final report to the BHO and the Department.