Colorado Medicaid
Community Mental Health Services Program

FY 2013–2014 Site Review Report

for

Access Behavioral Care

April 2014

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

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Introduction

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

This report documents results of the FY 2013–2014 site review activities for the review period of January 1, 2013, through December 31, 2013. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the two standard areas reviewed this year. Section 2 contains graphical representation of results for all 10 standards across two, three-year cycles, as well as trending of required actions. Section 3 describes the background and methodology used for the 2013–2014 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2012–2013 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials record reviews. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the BHO will be required to complete for FY 2013–2014 and the required template for doing so.

Summary of Results

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

Table 1-1 presents the scores for **Access Behavioral Care** (**ABC**) for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I Coverage and Authorization of Services	31	31	30	1	0	0	97%
II Access and Availability	15	15	14	1	0	0	93%
Totals	**46**	**46**	**44**	**2**	**0**	**0**	**96%**

Table 1-2 presents the scores for **ABC** for the denials record reviews. Details of the findings for the record review are in Appendix B—Record Review Tool.

Table 1-2—Summary of Scores for the Record Reviews

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials	70	44	44	0	26	100%
Totals	**70**	**44**	**44**	**0**	**26**	**100%**

Standard I—Coverage and Authorization of Services

Summary of Findings as Evidence of Compliance

The **ABC** provider manual included accurate and complete information about **ABC**'s utilization management (UM) program and informed providers how to access the list of services requiring authorization on the Web site. The Web site included the list of services requiring authorization, the provider manual, and preauthorization forms with clear directions on how to complete these forms.

ABC's UM program description was comprehensive and clearly described the structure and scope of the program as well as staff responsibilities, philosophies of care, processes for authorizing care and ensuring appropriate utilization control, and appropriateness of services furnished. **ABC** provided evidence that appropriate personnel and committees routinely reviewed utilization reports and results of quality improvement studies and projects to evaluate appropriateness of services furnished and to detect over- and underutilization.

On-site denials record review demonstrated that:

- Individuals with appropriate clinical expertise made preauthorization and denial decisions.
- UM determinations with appropriate notices were made well within the required time frames, and often exceeded requirements.
- **ABC** used standardized criteria to make authorization determinations.
- Documentation in the authorization system was complete and justified the determinations.
- Notice of action (NOA) letters were generally easy to understand.
- NOA letters notified members in English and Spanish that the notice was available in another language.
- NOA letters included all required elements.

On-site review of the authorization system demonstrated that:

- **ABC** had processes for consulting with the requesting provider when needed.
- The system included a dashboard which tracked timeliness and task lists to prompt staff members to complete reviews and provide notification well within/prior to time frame expiration.

Summary of Strengths

Policies addressed each of the requirements and described procedures rather than merely restating the regulations. Policies and procedures described processes for ensuring consistent application of utilization review criteria. During the on-site interview, **ABC** staff members described extensive interrater reliability training and testing.

During the on-site interview, staff members described how they used the Health Literacy Advisor tool, pointing out unique benefits it offered that more commonly used tools lacked. Staff described

documenting members' preferred language based on eligibility records and member contact and stated that **ABC** purchased the capability to use both English and Spanish versions of the Health Literacy Advisor tool.

ABC policies and procedures, as well as the **ABC** member handbook and provider manual, included accurate and complete information regarding how to obtain emergency, urgently needed, and poststabilization services. On-site discussion with staff members demonstrated that **ABC** staff had a clear understanding of poststabilization rules and requirements. Staff members reported that **ABC** does not perform retroactive review of emergency claims, and that the claims payment system is configured to pay for all emergency services based on place of service (emergency department). Providers were informed via the contract and the provider manual that members may not be held liable for payment of mental health or emergency services.

Summary of Findings Resulting in Opportunities for Improvement

While **ABC** had a process for reviewing template letter language for sixth-grade readability, member-specific information in the NOAs may or may not have been consistently written at the sixth-grade reading level. HSAG recommended that **ABC** conduct training with physician reviewers or develop a mechanism to use the language from the physician reviewer's decision, and then add information at the sixth-grade reading level to explain the physician reviewer's comments.

Summary of Required Actions

The Utilization Review Determinations policy described the extension notice as an NOA and stated that the member had a right to appeal, treating the extension notice as an NOA. While the extension letter template included notification of the member's right to file a grievance (not an appeal), the template also included a title header of "Notice of Action—Timeliness," which provides context of an action and an inherent right to appeal rather than to file a grievance. The extension of the authorization timeline is not an action; therefore, the member has no appeal right in this circumstance but may file a grievance. **ABC** must revise its applicable policies and templates to accurately describe the member's right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination.

ABC should also clarify that an NOA is not needed if the extension is used and that, although an NOA is required when the time frames expire, this notification period includes the extension time, if used.

Standard II—Access and Availability

Summary of Findings as Evidence of Compliance

ABC policies, quarterly Network Adequacy reports, and Access to Care reports demonstrated that **ABC** had an adequate network with a variety of provider types and specialties, including Essential Community Providers, to meet member needs. Reports documented that **ABC** routinely assessed members' distance to providers, provider-to-member ratios, and geographic distribution of network providers. **ABC** staff members stated that the anticipated needs of the Medicaid population were changing based on the integration of the Medicaid expansion populations, and that projections based on historic utilization patterns were inadequate to anticipate future needs in the network. Therefore, **ABC** leadership projected network needs based on the anticipated needs of the new, expanded populations. **ABC**'s network has been growing for many years, and staff members stated that **ABC** contracts with the most qualified providers in the service area. **ABC** focused its efforts on integrating substance abuse providers and identifying providers who can meet the more diverse cultural and linguistic needs of the expanding population. **ABC** provided members with an option for second opinions and out-of-network services when in-network services were not adequate to meet the member's needs. **ABC** executed single case agreements with providers for all out-of-network services to ensure there was no cost to the member for services provided, and **ABC** also attempted to contract with out-of-network providers who filled an unmet need within the network.

ABC provided in-network or out-of-network emergency care, and staff members stated that **ABC** automatically paid all emergency facility claims. The Colorado Access Provider Manual required providers to be available 24 hours a day, 7 days a week to respond to emergencies, and **ABC** provided and communicated to its members the availability of a 24-hour crisis line. **ABC** communicated all required appointment standards to providers and documented very active monitoring of appointment and access to care requirements through multiple data sources. Documents demonstrated active analysis of compliance with appointment standards, as well as feedback to providers and initiation of corrective actions, as necessary. **ABC** routinely monitored grievance data, Experience of Care and Health Outcomes (ECHO) Survey results, and other outreach studies, including focus group results, to determine member perceptions of accessibility and adequacy of services. **ABC** leadership staff reviewed all data sources regarding access and availability and reported results to the Quality Assessment Performance Improvement (QAPI) Committee.

ABC submitted multiple documents that demonstrated its commitment to providing culturally sensitive services to members, including recruitment of network providers with diverse language capabilities, translation of written member materials, provision of interpreter services, and cultural competency training for providers. **ABC** provided numerous services that addressed limited English proficiency, as well as speech, hearing, and visual impairments. Staff members stated that many provider sites have taken advantage of **ABC** training opportunities. **ABC** also demonstrated an understanding of the need to identify and address cultural beliefs and behaviors, beyond linguistic needs, for the diverse cultural subpopulations of the Medicaid program. During on-site interviews, staff discussed a variety of initiatives to enhance cultural competency activities, including development of tools and mechanisms to collect updated and more detailed information on

languages, cultural characteristics, and cultural specialties of providers. Specific member needs were identified through care management and customer services and reported to management to initiate development of strategies to meet emerging patterns of needs. Staff stated that **ABC** will use single case agreements to contract with out-of-network providers if they meet the specific cultural needs of a member, and that **ABC** targets culturally specialized providers for network recruitment.

Summary of Strengths

ABC was contracted with most available providers in the service area and has developed a comprehensive array of provider support and provider monitoring services to comply with contract requirements. In anticipation of the growth and changing demographics and needs of the expanded Medicaid population, **ABC** initiated several innovative network expansion strategies. **ABC** negotiated with its primary mental health provider to expand access to outpatient clinic services for Medicaid members and began credentialing behavioral health practitioners embedded in primary care offices. In addition, **ABC** began developing a tele-behavioral health services program that will provide real-time psychiatric consultation services to members in primary care or mental health counselor offices, thereby expanding access to psychiatrist services.

ABC demonstrated that it established a comprehensive base of services to meet the diverse linguistic needs of the Medicaid population. Nevertheless, **ABC** acknowledged the increasing diversity of cultural needs in the expanding Medicaid population and recognized the need for **ABC** and its providers to address the broader cultural behaviors and beliefs of members that may affect access or effectiveness of care. **ABC** initiated mechanisms to identify, in more detail, the cultural characteristics of individual providers and members in order to align members with appropriate providers. In anticipation of the expanding Medicaid populations, **ABC** began working with community centers to better understand the cultural needs of the refugee populations and initiated discussions with providers who specialize in treating inmates transitioning out of corrections facilities. **ABC** was using single case agreements as necessary to address specialized cultural needs. **ABC** staff members recognized the emerging cultural diversity of the Medicaid population as an evolving challenge and expressed commitment to respond accordingly.

Summary of Findings Resulting in Opportunities for Improvement

During on-site interviews, staff members described a number of activities related to gaining a better understanding of the increasingly diverse cultural beliefs and behaviors of the expanding Medicaid populations. Cultural competency initiatives were applicable to all Colorado Access lines of business. **ABC**/Colorado Access did not have an active Cultural Competency Committee or a written Cultural Competency Plan to guide those efforts. In the interest of coordinating cultural competency activities across all lines of business and providing a focal point for defining innovative approaches and priorities of the organization, **ABC**/Colorado Access may want to consider establishing an internal Cultural Competency Committee with provider involvement to examine ideas, establish priorities, and provide oversight for an organization-wide cultural competency plan.

Summary of Required Actions

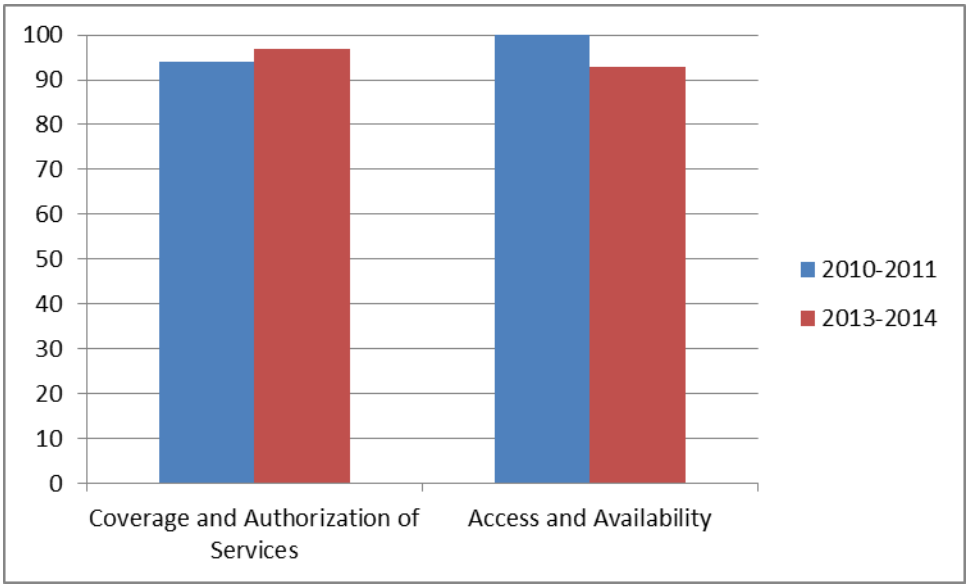
Neither the provider manual nor the provider contract included a requirement that the provider maintain hours of operation for Medicaid members that are no less than the hours of operation for commercial members. **ABC** must require its providers to maintain hours of operation for Medicaid members that are no less than hours of operation for commercial members.

Comparison of Results

Comparison of FY 2010–2011 Results to FY 2013–2014 Results

Figure 2-1 shows the scores from the FY 2010–2011 site review, when Standard I and Standard II were previously reviewed, compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **ABC**'s contract with the State may have changed, and may have contributed to performance changes.

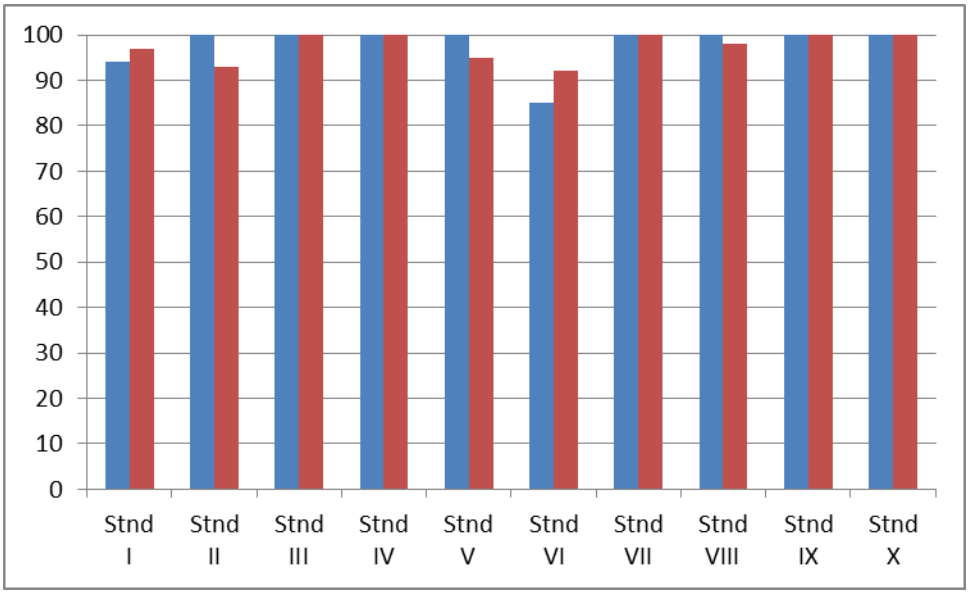
Figure 2-1—Comparison of FY 2010–2011 Results to FY 2013–2014 Results



Review of Compliance Scores for All Standards

Figure 2-2 shows the scores for all standards reviewed over the last two, three-year cycles of compliance monitoring. The figure compares the score for each standard across two review periods and may be an indicator of overall improvement.

Figure 2-2—ABC's Compliance Scores for All Standards



Note: The older results are shown in blue. The most recent review results are shown in red.

Table 2-1 presents the list of standards by review year.

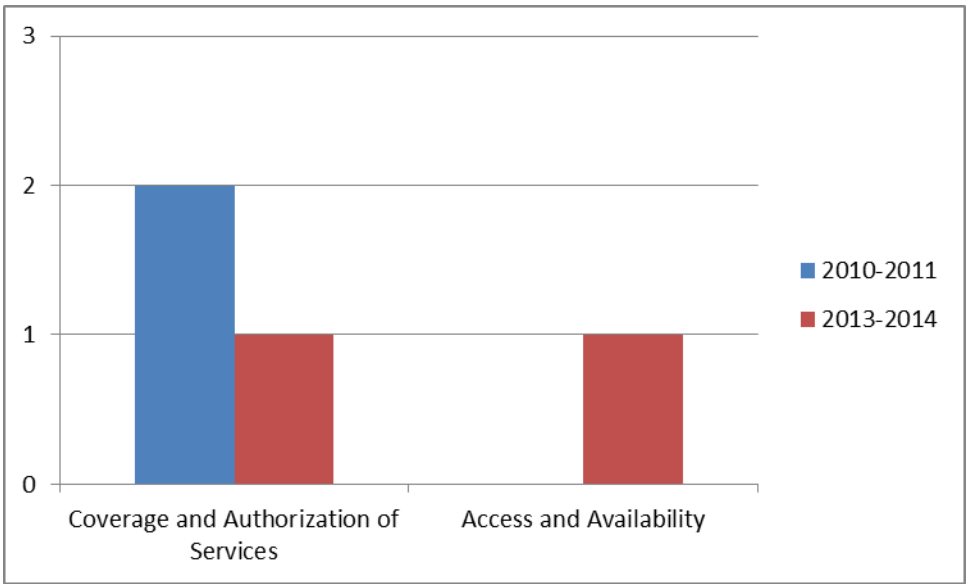
Table 2-1—List of Standards by Review Year

Standard	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14
I—Coverage and Authorization of Services			X			X
II—Access and Availability			X			X
III—Coordination and Continuity of Care			X		X	
IV—Member Rights and Protections		X			X	
V—Member Information	X			X		
VI—Grievance System		X		X		
VII—Provider Participation and Program Integrity		X		X		
VIII—Credentialing and Recredentialing		X			X	
IX—Subcontracts and Delegation		X		X		
X—Quality Assessment and Performance Improvement		X			X	

Trending the Number of Required Actions

Figure 2-3 shows the number of requirements with required actions from the FY 2010–2011 site review, when Standard I and Standard II were previously reviewed, compared to the results from this year's review. Although the federal requirements did not change for the standards, **ABC**'s contract with the State may have changed, and may have contributed to performance changes.

Figure 2-3—Number of FY 2010–2011 and FY 2013–2014 Required Actions per Standard

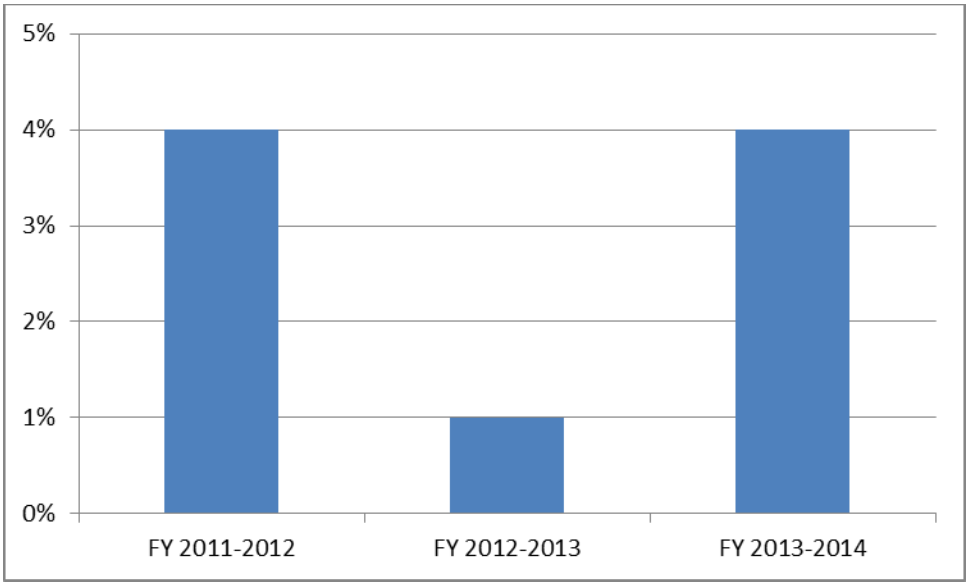


Note: **ABC** had no required actions assigned for Standard II—Access and Availability during the FY 2010-2011 site review.

Trending the Percentage of Required Actions

Figure 2-4 shows the percentage of requirements that resulted in required actions over the past three-year cycle of compliance monitoring. Each year represents the results for review of different standards.

Figure 2-4—Percentage of Required Actions—All Standards Reviewed



Overview of FY 2013–2014 Compliance Monitoring Activities

For the fiscal year (FY) 2013–2014 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two 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 records, documents, and materials provided on-site; and on-site interviews of key BHO personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to BHO service and claims denials. In addition, HSAG conducted a high-level review of the BHO's authorization processes through a demonstration of the BHO's electronic system used to document and process requests for BHO services.

A sample of the BHO's administrative records related to Medicaid service and claims denials was 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 15 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. For the record review, the BHO received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2013–2014 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, 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.

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

4. Follow-up on Prior Year's Corrective Action Plan

for **Access Behavioral Care**

FY 2012–2013 Corrective Action Methodology

As a follow-up to the FY 2012–2013 site review, each BHO that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the BHO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **ABC** until it completed each of the required actions from the FY 2012–2013 compliance monitoring site review.

Summary of 2012–2013 Required Actions

While Colorado Access/**ABC** had numerous and appropriate methods to prevent discrimination during credentialing and recredentialing processes, no methods were in place for monitoring to ensure nondiscriminatory credentialing practices, as required by NCQA. Colorado Access was required to develop monitoring processes to ensure nondiscriminatory credentialing practices.

Summary of Corrective Action/Document Review

ABC submitted its CAP, as well as documents demonstrating that the CAP had been implemented, to HSAG and the Department in May 2013. After careful review, HSAG and the Department determined that **ABC** had successfully completed the required action.

Summary of Continued Required Actions

ABC had no required actions continued from FY 2012–2013.

Appendix A. Compliance Monitoring Tool *for* Access Behavioral Care

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor established and 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. The Contractor evaluates the medical necessity, appropriateness, efficacy, efficiency of health care services, referrals, procedures, and settings. The Contractor's Utilization Management Policies and Procedures include: ◆ Prior authorization for identified intensive levels of care. ◆ Description of activities undertaken to specifically identify and address underutilization. ◆ Routine trending and analysis of data by level of care (including care not prior-authorized). ◆ Routine trending of services by provider. Contract: II.I.1.a., II.I.1.s, Exhibit V, IV.A and IV.B	**Documentation:** 1. UM Program Description FY2013-2014 2. ABC Access to Care Plan FY2014 3. ABC Access to Care Report a. Q 1-4 4. QAPI Program Description 2013 5. QAPI Evaluation ABC FY2013 6. Facility Reports Base on Claims Data CY13 7. ABCD Trend Report-20140120 8. ABC ER Follow Up Visits Report 10-01-12 to 09-30-13 9. Provider Manual a. Pg 60 last paragraph The Colorado Access Utilization Management Program outlines ABC's comprehensive UM program (Program Components pages 15-18).The Access to Care Plan (pages 8-12) and QI Program Description(page 13) 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 FY13 Q1-4Access to Care Reports, ABC ER Follow Up Visits Report 10-1-12 to 9-30-13, ABCD Trend Report-20140120 and· QAPI Evaluation ABC FY2013 Pg 8-9 #2. UM staff refer to the master authorization list to verify what procedures require preauthorization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. The Contractor's Utilization Management Program Description is written so that staff members can understand the program and includes: ◆ Program goals. ◆ Program structure, scope, processes, and information sources, including the identification of all intensive levels of care. ◆ Roles and responsibilities. ◆ Evidence of Medical Director leadership in key aspects of the UM Program to include denial decisions and criteria development. ◆ A description of how oversight of any delegated UM function will occur. ◆ A description of how staff making utilization review decisions are supervised. ◆ A statement regarding staff availability at least eight hours a day during normal business hours for inbound calls regarding UM issues. ◆ The mechanisms used to ensure that members receive equitable access to care and services across the network. ◆ The mechanisms used to ensure that the services authorized are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished. *42CFR438.210(a)(3)(i)* Contract: II.I.1.s, Exhibit V, I.A	**Documentation:** 1) Access to Care Plan 2014 a) Page 2; Paragraph 3: Access and Availability Standard b) Page 4; Paragraph 1 & 2 under - Twenty-four Hour Availability of Services 2) CCS305 – Care Coordination a) Page 3: Procedure I. A-J. Page 4 & 5: III Facilitation of Care Coordination. A –C 3) CCS307 – Utilization Review Determinations a) Page 6 & 7; Paragraph 7: Utilization Review (UR) b) A – J 4) CCS310 - Primary and Specialty Care Access a) Page 2, Policy Statement b) Page 4 and 5: Access to Primary Care, c) Specialty and Ancillary Services d) Direct Access 5) PNS306 – Availability of After Hours Coverage a) Page 2, Policy Statement: b) Page 3, II, A, B, C c) Page 4, C-2&3; D-H 6) UM Program Description a) Page 3; Paragraphs 2,3,4 Co Acc Mission and Philosophy of the Utilization Management Program b) Page 3-4; Paragraph 5 Utilization Management Program Framework (entire section) c) Page 5; Goals and Objectives (all bullets) d) Page 6; Goals and Objectives cont. (all bullets)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor's UM Program is conducted under the auspices of a qualified clinician and has: ◆ Evidence of formal staff training designed to improve the quality of UR decisions. ◆ Policies and procedures to evaluate and improve the consistency with which UR staff apply criteria (e.g. inter-rater reliability) across multiple levels of care. ◆ Policies, procedures, and job descriptions to specify the qualifications of personnel responsible for each level of UR decision-making (e.g. review, denial). ◆ Policies and procedures to ensure that a practitioner with appropriate clinical expertise in treating the member's condition reviews any potential denial based on medical necessity. *42CFR438.210(b)(3)* Contract: II.I.1.a, II.I.1.h. Exhibit V, VA	Page 2, Policy Statement Documentation: 1) CCS302 Medical Criteria for Utilization Review a) Page 3, II. Application of Criteria, D. b) Pg 4 II.E. 2) Provider Manual a) Page 62, Bullet 3 - Adverse Service Determination("Denied") 3) CCS301 Qualifications for Staff Engaged in Utilization Management Activities **a)** b) Page 2, Procedure I. c) Page 2-3, Procedure II. CCS301 outlines the procedures that Colorado Access uses to verify the qualifications of staff making UR decisions. Job descriptions are available upon request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. 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.	1) CS307 – Utilization Review Determination a) Page 13, Process II, A. 6. 2) UM Processing with Interqual Desktop procedure a) Page 2, all of Procedure I 3) Provider Manual a) Page 61, Paragraph 2 - Medical necessity determinations are based on the following: All three bullets 4) ADM205 Nondiscrimination a) Page 2, Policy Statement b) Page 3, Procedure III, IV, V	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. 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. *42CFR438.210(a)(3)(iii)* Contract: II.I.1.f.1. and II.I.1.f.2.	1) CCS307 – Utilization Review Determinations a) Page 3, paragraph 1 – Adverse Service Determination b) Page 4, paragraph 3 – Medical Necessity; 1-4 c) Page 6, paragraph 7 – Utilization Review, (e) d) Page 19, #6, (e) 2) 2. UM Program Description a) Page 5, Goals and Objectives, bullet 6 b) Page 6, 9th bullet c) Page 17, K. 3) 3. Provider Manual a) Page 61, Medical Necessity, bullets 1-5 b) Page 61, Medical necessity determinations are based on the following: Bullets 1-3 4) 4. CCS306 Delivering Continuity and Transition of Care a) Page 3, Procedure II. B, C-2 & 3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
6. 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.25.	1) CCS302-Medical Criteria for Utilization Review a) Pg 2 2) CCS307-Utilization Review Determinations a) Pg 4 3) Provider Manual a) Pg 61 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
7. 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.	1) ABC Member Handbook a) Pg 5 b) Pg 12 2) ADM219 Member Appeal Process a) Pg 17 L and M 3) 2. CCS307 Utilization Review Determinations a) Page 1, Policy Statement b) Pg 3 Concurrent Review c) Page 13, II. General Procedure, A-E 4) 3. CCS306 Delivering Continuity and Transition of Care a) Page 4, C. 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	5) 4. UM Program Description a) Page 16, D. Prospective Reviews b) Page 17, I. Drug Utilization and Review Program 6) 5. Access to Care Plan a) Pate 7-8, IV. Coordinated Clinical Services, Paragraph 1 b) Page 9, D. Authorizations	
8. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure that each staff member is applying criteria consistently, such as inter-rater reliability testing. The contractor takes action to improve consistency where possible. *42CFR438.210(b)(2)(i)* Contract: II.I.1.q	1) CCS302-Medical Criteria for Utilization Review a) Pg 4 II.E 2) CCS301-Qualifications for Staff Engaged in Utilization Management Activities 3) 2012 IRR Department Summary 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 4). 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

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *42CFR438.210(b)(2)(ii)* Contract: II.I.1.j.	1) CCS307 Utilization Review Determination a) Page 14, paragraph 1, d. b) Page 15, paragraph 5, #6. 2) UM Program Description a) Page 16, paragraph 3, E. Prospective Review b) Page 17, paragraph 1, H. Care Management 3) CCS305 Care Coordination a) Page 2, Policy Statement b) Page 3, Procedure I. Goals of Care Coordination, G. c) Page 4, Procedure III. Facilitation of Care Coordination d) C. 1 – 9.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor has in place and follows written policies and procedures that 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). *42CFR438.210(c)* Contract: II.I.1.j	1) . CCS307 – Utilization Review Determinations i) Page 14, B. 3, 4, 6 ii) Page 16, #3 iii) Page 16, D. 4. iv) Page 16, E. 2. v) Page 17, F. 1. A-F vi) Page 19, 6. A-N 2) 2. ABC Member Handbook a) Pg 28 Appeals 3) 3. Provider Manual a) Page 97 paragraph 3 4) 4. Notice of Action letter **Additional Documents Submitted On-site:** • Notice of Action Templates	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member's health condition requires not to exceed: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 business days. *42CFR438.210(d)* Contract: II.F.10, 10CCR2505—10, Sec 8.209.4.A.3.c	1. CCS307 – Utilization Review Determinations Page 10, B. 5 Page 14, B. 1-6 Page 15, C. 1-3 Page 16, D. 1-4 Page 16, E. 1-3 (a-e)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The notices of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the time frames specified in 431.211: • The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214). ◆ For denial of payment, at the time of any action affecting the claim. ◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. ◆ For service authorization decisions not reached within the required time frames on the date time frames expire.	1) CCS307 Utilization Review Determination a) Page 14, B. 2 b) Page 18, 2. (b) c) Page 15, C. 1 2) Notice of Action Letter a) Page 3, The Expedited Appeals Process	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
◆ For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 business days after receipt of the request for services. *42CFR438.404(c)* *42CFR438.400(b)(5)* Contract: II.F.10, 10CCR2505—10, Sec 8.209.4.A.3.a		
13. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42CFR438.404(a)* Contract: II.F.4.e, II.F.10 10CCR2505—10, Sec 8.209.4.A.1	1. ADM 207 – Effective Communication with LEP & SI/SI Persons Page 2, Policy Statement Page 3, Procedure I. A-B Page 4, paragraph 3, #2 Page 4, II. B. 2. Language selection on Co Acc Website 3. Health Literacy Advisory tool for the 6th grade language a. -demo available upon request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. Notices of action must contain: ◆ The action the Contractor (or its delegate) has taken or intends to take. ◆ The reasons for the action. ◆ The member's, the member's authorized representative's, or provider's (on behalf of the member) right to file an appeal and procedures for filing. ◆ The date the appeal is due. ◆ The member's right to a State fair hearing.	1) ADM219 - Member Appeal Process a) Page 2, Policy Statement b) Page 4, Definition: Appeal c) Page 15, Clinical Appeal Process A – S (S. 1-9) 2) ADM203 – Member Grievance Process a) Page 2, Policy Statement b) Page 3, procedure I. A. 1-9	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
◆ The procedures for exercising the right to a State fair hearing. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. ◆ The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). ◆ Language clarifying that oral interpretation is available for all languages and how to access it. *42CFR438.404(b)* Contract: II.F.4.e, II.F.10, 10CCR2505—10, Sec 8.209.4.A.2	3) CCS307 – Utilization Review Determinations a) Page 14, B. 1, 3, 4(a) b) Page 15, C - Prospective Expedited Review Request, Determination and Notification (Urgent Care Requests) 1-3. c) Page 19, #6. a. – n. d) Page 20, l 4) Notice of Action Letter	
15. The Contactor may extend the authorization decision time frame if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. The Contractor's written policies and procedures include the following time frames for possible extension of time frames for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days. *42CFR438.210(d)* Contract: II.F.10, 10CCR2505—10, Sec 8.209.4.A.3	1. CCS307 Utilization Review Determination Page 14, B. 5 Page 15, C. 2	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Utilization Review Determinations policy included the processes for requesting an extension if ABC determined it to be in the member's best interest and for accepting member requests for an extension. However, the policy described the extension notice as a notice of action (NOA) and stated that the member had a right to appeal, treating the extension notice as an NOA. The extension letter template also included a title header of "Notice of Action—Timeliness." The extension of the authorization timeline is not an action; therefore, the member has no appeal right in this circumstance but may file a grievance.		
Required Actions: ABC must revise its applicable policies and templates to accurately describe the member's right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination. ABC must also clarify the Utilization Review Determinations policy to clearly depict the process of notifying members of an action due to the expiration of time frames. ABC should also clarify that notice is not needed if the extension is used and that, although notice is required when the time frames expire, this notification period includes the extension time, if used.		
16. If the Contractor extends the time frame for making a service authorization decision, it: ◆ Provides the member written notice of the reason for the decision to extend the time frame. ◆ Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. ◆ Carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires. *42CFR438.404(c)(4) and 438.210(d)(2)(ii)* Contract: II.F.10, 10CCR2505—10, Section 8.209.4.A.3.c	1. CCS307 Utilization Review Determinations a. Page 14, B. 5. a-d b. Page 15, C. 2. c. Page 16, E. 3. a-e d. Page 16, C. 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
17. The Contractor has in place and follows written policies and procedures that provide 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.	1. CCS301 – Qualifications for Staff Engaged in Utilization Management Activities a. Page 3. IV	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
42CFR438.210(e) Contract: II.I.1.c.		
18. 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.12	1. ABC Member Handbook a. Pg 9 2. Provider Handbook a. Page 63: Definition of an Emergency Medical Condition 3. CCS309 –Emergency and Post-Stabilization Care a. Page 2. Definitions: Emergency Medical Condition b. Page 3. Procedure IV. 4. CCS 307 – Utilization Review Determinations a. Page 3 – Definition: Emergency Medical Condition	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. 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: II.A.13	1. CCS309 –Emergency and Post-Stabilization Care a. Page 2. Definitions – Emergency Services, A & B 2. CCS307 – Utilization Review Determinations a. Page 3. Definitions – Emergency Services, 1 & 2 3. Provider Manuel a. Page 64 - Definition of an Emergency Medical Condition	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
20. 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	1. CCS309 –Emergency and Post-Stabilization Care a. Page 3, Procedure III. 2. ABC Member Handbook a. Pg 10 3. Provider Manual a. Page 64 - Definition of an Emergency Medical Condition	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor does not require prior authorization for emergency services. *42CFR438.10(f)(6)(viii)(B)* Contract: II.I.1.p.1.	1. CCS309 –Emergency and Post-Stabilization Care Page 2. Definition - Prior Authorization Page 3. Procedure II. 5. ABC Member Handbook a. Pg 11 2. Provider Manual Page 64: Emergency and Urgent Care	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor may not deny payment for treatment obtained under the following circumstances: ◆ A member had an emergency medical condition, and the absence of immediate medical attention would ***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.	6. CCS309 –Emergency and Post-Stabilization Care a. Page 2. Definition – Emergency Medical Condition b. A - C 7. ABC Member Handbook a. Pg 4, and 11 8. Provider Manual a. Page 65-66. Definition of Emergency Medical Condition	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
◆ Situations which a reasonable person outside the medical community would perceive as an emergency medical condition but 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.	b. Paragraph 2, 3, and 4 9. CCS307 – Utilization Review Determinations a. Page 3. Definition: Emergency Medical Condition b. Page 5. Urgent Care Requests. 1. A.	
23. The Contractor does not: ◆ Limit what constitutes an emergency medical condition on the basis of 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.	1. CCS309-Emergency and Post-Stabilization Care 1-4-10 a. Pg 3 IV 2. ABC Member Handbook a. Pg. 4 and 9	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
24. The Contractor will be responsible for Emergency Services when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. Contract: II.D.6.i.2.	1. CCS309 –Emergency and Post-Stabilization Care a. Page 3. IV. 2. Provider Manual a. Page 60 – Medical Necessity, bullet 1. b. Page 63 Top of page 3. CCS307 – Utilization Review Determinations a. Page 2. Definitions – Medical Necessity, 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. 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.	1. CCS309 –Emergency and Post-Stabilization Care a. Page 4. VIII. 2. ABC Member Handbook a. Page 3 3. Provider Manual a. Pg 55	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
26. 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.	1) CCS309 –Emergency and Post-Stabilization Care a) Page 3. Procedure V 2) ABC Member Handbook a) Page 11 & 12 3) Provider Manual a) Pg 62	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
27. The Contractor defines Poststabilization Care 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: II.A.32.	1) CCS309 –Emergency and Post-Stabilization Care a) Page 2. Definition – Post Stabilization Care 2) ABC Member Handbook a) Page 11&12 3) Provider Manual a) Pg 62	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
28. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42CFR438.114(e)* *42CFR422.113(c)* Contract: II.D.6.e.	1) ABC Member Handbook a) Page 11&12 2) Provider Manual a) Pg 62 3) CCS309 – Emergency & Post-Stabilization Care a) Page 3. VI.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances: ◆ Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. ◆ The Contractor does not respond to a request for pre-approval within 1 hour. ◆ The Contractor cannot be contacted. ◆ The Contractor's representative and the treating physician cannot reach an agreement concerning the	1) CCS309 –Emergency and Post-Stabilization Care a) Page 3. VI. B. b) Page 3. VI. C. 1, 2, 3 2) ABC Member Handbook a) Page 11&12 3) Provider Manual a) Pg 62	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached, or the Contractor's financial responsibility for poststabilization care services it *has not* pre-approved ends. *42CFR438.114(e)* *42CFR422.113(c)* Contract: II.D.6.f.1–3.		
30. The Contractor's financial responsibility for poststabilization 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)* Contract: II.D.6.g.	1. CCS309 –Emergency and Post-Stabilization Care Page 4. VII. A – D	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
31. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42CFR438.114(e)* *42CFR422.113(c)* Contract: II.D.6.f.4.	1) ABC Member Handbook 2) Page 11&12	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	30

Total Score ÷ Total Applicable	=	97%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains a comprehensive provider network capable of serving the behavioral health needs of all members in the Medicaid Program, including any new populations. *42CFR438.206(b)(1)* Contract: II.E.1.c.1.	**Documentation:** 1) FY13 Network Adequacy Reports Q1-4 a) Entire report 2) FY 13 Access to Care Reports Q1-4 a) Entire report 3) ABC FY13 QAPI Evaluation a) Pg 2&4 4) PNS202 Selection and Retention of Providers a) Pg 3&4 II.C pg 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
2. 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. *42CFR438.206(b)(1)(i) through (v)* Contract: II.E.1.c.1.	**Documentation:** 1) FY13 Network Adequacy Reports Q1-4 a) Entire report 2) FY 13 Access to Care Reports Q1-4 a) Entire report b) Pg 2&3 example of access to care reporting. 3) ABC FY13 QAPI Evaluation a) Pg 2 4) PNS202 Selection and Retention of Providers a) II.C pg 3&4. 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	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	network providers. Continued high marks on Access to Care reports 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. ABC takes physical access to our provider's location seriously. ABC's quarterly Grievance and Appeals report captures any issues related to access to care. In FY13, the Q1 pg 2&3 there were two reports in the access to care section in the "other" section. The provider was able to resolve the issue with the Members.	
3. The Contractor has a network plan and it, at a minimum, addresses the following: ◆ The numbers, types, and specialties of providers required to furnish the contracted Medicaid services, including care coordination. ◆ The number of network providers accepting/not accepting new Medicaid members. ◆ The geographic location of providers in relationship to where Medicaid members live. ◆ The potential physical barriers to accessing providers' 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.i–vi.	**Documentation:** 1. FY13 Network Adequacy Reports Q1-4 entire report 2. FY 13 Access to Care Reports Q1-4 entire report 3. FY 13 Grievance and Appeals Reports Q1-4 entire report 4. ABC FY13 QAPI Evaluation pg 2 5. ABC Providers Fluent in Languages other than English **Process description:** Access Behavioral Care Management and PNS Management reviews the quarterly the network adequacy reports to insure the network is able to address member needs related to members needs for specialty providers, location, access, cultural and language expertise and provider member ratios. 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 30miles distance to a Member. In our Denver Service Area, ABC Members are no more than 1.2 miles from a network provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	The language expertise of providers is monitored in the data base tool Apogee (ABC Providers Fluent in Languages other than English). 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. In FY13 there were an average of 114309 ABC members with an average penetration rate of 12.3%(14067 members). In FY13 there were 1687 providers and organizations. There are currently 68 members per provider and with a member ratio 1:8 (14067/1687).	
4. The Contractor ensures that its members have access to a provider within 30 miles or 30 minutes travel time, whichever is larger, to the extent such services are available. Contract: II.E.1.a.8.	**Documentation:** 1. FY13 Network Adequacy Reports Q1-4 Outliers tab. Access Behavioral Care monitors the access to a provider within 30 miles as evidenced in the quarterly Network Adequacy reports. The average distance for a member in Denver is 1.2 miles.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The contractor offers to contract with essential community providers located in the Contractor's geographic service area, as defined in Section 25.5-5-404(2) C.R.S. The Contractor's network shall include both essential community providers and other private/non-profit providers, thus allowing members choice and facilitating continuity of care. Contract: II.E.1.c.2.	**Documentation:** 1. ABC Provider Directory 2. Colorado Access Online Provider Directory- https://providers.coaccess.com/ProviderSearch/home.jsf 3. FY13 Network Adequacy Reports Q1-4 entire report 4. ABC SUD Benefit Communication Report HCPF identifies essential community providers and both the Provider Directory and Online directory are evidence that Access Behavioral Care contracts with essential community providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
6. 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.	**Documentation:** 1. ABC Member Handbook a. pg 15 1st paragraph 2. CCS302-Medical Criteria for Utilization Review b. pg 3-explains how Medical Criteria will be used for reviews including second opinions. 3. CCS307-Utilization Review Determinations c. pg6-explains the utilization review process to included second opinions. 4. Provider Manual 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 3 and CCS307, pg 6). The second opinion process is outlined in the Member Handbook (page 15).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network at no cost to 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.	**Documentation:** 1. CCS310-Access to Primary and Specialty Care a. pg 4 & 5 2. ABC Member Handbook b. pg 20 last sentence. 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

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor coordinates with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42CFR438.206(b)(5)* Contract: II.E.1.d.2.	**Documentation:** 1. CCS310-Access to Primary and Specialty Care a. pg 5, III.J	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary. *42CFR438.206(c)(1)(iii)* Contract: II.E.1.a.5.	**Documentation:** 1. ABC Provider Manual a. Pg 13 1st table b. Pg 22 last paragraph c. Pg 84 ABC Crisis Line d. Pg 93 last paragraph e. Pg 94 top of page 2. ABC Member Handbook a. pg 8-18 and 20. 3. PNS306 Availability of After Hours Coverage b. Page 2, Policy Statement c. Page 4, Procedure I. B. d. Page 4, Procedure I. D. 1. a – c	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members. *42CFR438.206(c)(1)(ii)* Contract: II.E.1.a.4.	**Documentation:** 1. ABC EBP Survey results a. Survey was sent to entire provider network and included a question regarding early, afterhours and weekend appointments 2. Provider manual a. Page 21, III. Provider Responsibility b. Bullet 2 3. Access to Care Plan a. Page 2, II. A.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Colorado Access Provider Manual, applicable to all lines of business, stated that provider responsibilities included being accessible to members 24 hours a day, 7 days a week. However, neither the provider manual nor the provider contract included a requirement that the provider maintain hours of operation for Medicaid members that are no less than the hours of operation for commercial members.		
Required Actions: ABC must require its providers to maintain hours of operation for Medicaid members that are no less than hours of operation for commercial members.		
11. 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 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. ◆ Urgently needed services are provided within 24 hours from the initial identification of need. ◆ Routine services are available upon initial request within 7 business days. (Routine services include but are not limited to an initial individual intake and assessment appointment. Placing members on waiting lists for initial routine service requests is not acceptable.) ◆ Outpatient follow-up appointments within 7 business days of an inpatient psychiatric hospitalization or residential facility. *42CFR438.206(c)(1)(i)* Contract: II.E.1.a.6 and 7	**Documentation:** 1. FY13 Access to Care Reports Q1-4 2. CY13 Access to Care Plan 3. FY13 QAPI Evaluation a. pg2,3,6,7, 11,12,13 4. Provider Bulletin October 2013 5. Provider Manual a. Pg 8, paragraph one, 2nd bullet. b. Pg 12-13. 6. ABC Member Handbook a. Pg. 12 Emergency Services b. Pg. 11 7 day appointment post inpatient discharge c. Pg 21 Urgent Services and Routine 7. ABC Care Management Dashboard - 2013-12 Access Behavioral Care Care Management Dashboard tracks follow discharges from inpatient discharges by tracking claims post discharge. Results are discussed in team meetings and supervision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
12. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access. *42CFR438.206(c)(1)(iv) through (vi)* Contract: II.E.1.a.9–11	**Documentation:** 1. FY13 Access to Care Reports Q1-4 2. ABC FY13 QAPI Evaluation a. Pg. 4, 28-29 3. Access To Care Corrective Action Plan Template 4. Access To Care Corrective Action Plan Examples 5. 12_2013 MHCD Profile Report 6. ED Meeting Log 7. MHCD Trending Report Adherence to access to service requirements is monitored through: 1. Quarterly Access to Care reports 2. Annual performance measurements of 7-day post hospital discharge follow-up appointments (ABC FY13 QAPI Evaluation, pages 7, 28-29). 3. Quarterly Network Adequacy reports If a provider fails to meet any of the requirements, a corrective action plan is initiated. There are currently 3 providers with corrective action plans which are in the Access to Care CAP examples folder.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor has developed policies and procedures for monitoring the performance of providers on an ongoing basis related to the timeliness of services, and has monitored providers annually to determine compliance. Contract: II.G.10.a.3, II.G.10.a.4, Exhibit S, IV.A	**Documentation:** 1. CCS310 Access to Primary and Specialty Care 2. ABC Desktop Procedure for Access To Care Monitoring pg2 3. FY 13 Grievance and Appeals Reports Q1-4 entire report	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
14. 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: ◆ Developing, implementing, and promoting a written strategic Cultural Competency Plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services. ◆ Maintaining policies that support the provision of health care services that respect individual health care attitudes, beliefs, customs and practices of members related to cultural affiliation. ◆ Having sufficient cultural competency staff to implement and oversee compliance with the Contractor's Cultural Competency Plan, policies, and contract requirements and to oversee compliance with all cultural competency requirements and limited English proficiency needs. ◆ Making a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include: • Inquiries conducted by the Contractor of the language proficiency of members during the Contractor's orientation calls. • Being served by participating providers. • Improving access to health care through community outreach and Contractor publications. ◆ Developing and/or providing cultural competency	**Documentation:** 1. ABC Access to Care Plan pg3-4&6-7 2. Colorado Access Provider Manual pg7-8, 3. Coaccess.com top of homepage-choice of language 4. ABC304- Member Choice of Behavioral Health Providers p2 II.E 5. ABC Member Handbook, welcome page, pg 12-13 **6.** PNS202 Selection and Retention of Providers pg 2 I.B 7. ADM206-Culturally Sensitive Services for Diverse Populations pg1-3 8. ABC Access to Care Focus Group Flyer in Spanish 9. ABC Flyer 102013 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. 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 21). It is the provider's responsibility to provide effective services to Members with limited English proficiency or who are sensory-impaired or speech impaired (pg 8). ABC's Cultural Competency Training Program is outlined on page 7 of the Provider Manual. Members are informed in the Member Handbook that they should expect the services they receive to be culturally competent (pages 21).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
training programs, as needed, to the network providers and Contractor staff regarding: • Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. • The medical risks associated with the client population's racial, ethnic, and socioeconomic conditions. ◆ Making a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse, and culturally competent clinical providers that represent the racial and ethnic communities being served. ◆ Providing access to interpretive services by a qualified interpreter for deaf or hard of hearing members in such a way that it promotes accessibility and availability of covered services. ◆ Providing to members in their preferred language verbal offers and written notices, upon request, informing them of their rights to receive language assistance services. ◆ Materials, including member handbook, correspondence, and newsletters. Written member information and correspondence shall be made available in languages spoken by prevalent non-English-speaking member populations within the Contractor's service area. ◆ Providing language assistance services, including bilingual staff and interpreter services, at no cost to any member with limited English proficiency at all points of contact, in a timely manner during all hours of operation.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
◆ Ensuring the competence of language assistance provided to limited English proficient members by interpreters and bilingual staff. Family and friend should not be used to provide interpretation services (except on request by the member). ◆ Making available easily understood member-related materials and posting signage in the languages of the commonly encountered groups and/or groups represented in the service area. ◆ Developing policies and procedures, as needed, on how the contractor responds to requests from participating providers for interpreter services by a qualified interpreter. ◆ Ensuring that when providing or arranging for the provision of all medically necessary covered behavioral health services that they are linguistically and culturally accessible to all members, including racially and ethnically diverse communities, the disability community, and deaf and hard of hearing members. ◆ Addressing the language and cultural expertise of providers in the network plan. ◆ Evaluating members' cultural and linguistic needs in the individual needs assessment and using 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.d.8; and II.F.9.a; II.I.9; Exhibit N, I.A.4		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
15. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor uses tools including member surveys, anecdotal information, and grievance and appeals data. Contract: II.H.2.m.1	**Documentation:** 1. ECHO Survey 2. ABC Focus Group Summary 4-14-13 3. ABC Focus Group Summary 5-2013 4. FY 13 Access to Care Reports Q1-4 entire report 5. ABC YourChildandMentalHealth Flyer 6. ABC Access to Care Focus Group Flyer in Spanish 7. ABC Routine Call out Summary-August **8.** ABC Quality Update Partnership Meeting February 2013 Access Behavioral Care monitors member perceptions in the quarterly member partnership meetings. In 2013 Access Behavioral Care conduct two focus groups to get direct feedback about overall satisfaction including accessibility and adequacy of services. Colorado Access reviews all grievances related to access and accessibility and follows up with providers for resolution.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	14

Total Score ÷ Total Applicable	=	93%

Appendix B. Record Review Tool *for* Access Behavioral Care

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Access Behavioral Care

Review Period:	January 1, 2013–December 31, 2013
Date of Review:	February 18, 2014
Reviewer:	Barbara McConnell
Participating Plan Staff Member:	Laura Coleman

Requirement	File 1	File 2	File 3	File 4	File 5
1. Member ID	******	******	******	******	******
2. Date of initial request	6/6/13	8/22/13	9/9/13	12/9/13	
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR	NR	NR	NR	
4. Standard (S) or Expedited (E)	S	S	S	S	
5. Date notice of action sent	6/6/13	8/28/13	9/12/13	12/9/13	
6. Notice sent to provider and member? (C or NC)	C	C	C	C	
7. Number of days for decision/notice	0	6	3	1	
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	
10. Notice of Action includes required content? (C or NC)	C	C	C	C	
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C	C	NA	
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	C	NA	NA	C	
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	
15. Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	
Total Applicable Elements	7	6	6	6	
Total Compliant Elements	7	6	6	6	
Score (Number Compliant / Number Applicable) = %	100%	100%	100%	100%	

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar days/Bus = business days

Requirement	File 6	File 7
1. Member ID	******	******
2. Date of initial request		4/24/13
3. What type of denial? (termination [T], new request [NR], or claim [CL])		NR
4. Standard (S) or Expedited (E)		S
5. Date notice of action sent		4/30/13
6. Notice sent to provider and member? (C or NC)		C
7. Number of days for decision/notice		6
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)		C
9. Was authorization decision timeline extended? (Y or N)		N
a. If extended, extension notification sent to member? (C or NC, or NA)		NA
b. If extended, extension notification includes required content? (C or NC, or NA)		NA
10. Notice of Action includes required content? (C or NC)		C
11. Authorization decision made by qualified clinician? (C or NC, or NA)		C
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)		NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)		NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)		C
15. Was correspondence with the member easy to understand? (C or NC)		C
Total Applicable Elements		6
Total Compliant Elements		6
Score (Number Compliant / Number Applicable = %)		100%

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar days/Bus = business days

Requirement	OS 1	OS 2	OS 3	OS 4	OS 5
1. Member ID	******	******	******	******	******
2. Date of initial request	8/25/13	1/2/13			
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR	NR			
4. Standard (S) or Expedited (E)	S	S			
5. Date notice of action sent	8/27/13	1/2/13			
6. Notice sent to provider and member? (C or NC)	C	C			
7. Number of days for decision/notice	2	1			
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C			
9. Was authorization decision timeline extended? (Y or N)	N	N			
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA			
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA			
10. Notice of Action includes required content? (C or NC)	C	C			
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C			
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA			
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	C	NA			
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C			
15. Was correspondence with the member easy to understand? (C or NC)	C	C			
Total Applicable Elements	7	6			
Total Compliant Elements	7	6			
Score (Number Compliant / Number Applicable = %)	100%	100%			

Comments:
Records 5 and 6 were removed from the sample as these dates for decision represented decisions on appeals rather than the original authorization determination. Oversamples 1 and 2 were reviewed instead.

Total Record Review Score	Total Applicable Elements: 44	Total Compliant Elements: 44	Total Score: 100%

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar days/Bus = business days

Appendix C. Site Review Participants for Access Behavioral Care

Table C-1 lists the participants in the FY 2013–2014 site review of **ABC**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
ABC Participants	**Title**
Carrie Bandell	Director, Quality Management
Robert Bremer	Executive Director, Access Behavioral Care, CO Access
Laura Coleman	Director, Clinical Services
Jen Conrad	Manager, Care Management
Irene Girgus	Pharmacy Director
Bethany Himes	Colorado Access
John Kiekhaefer	ABC Operations Manager
Suzanne Kinney	Behavioral Health Quality Program Manager
Gretchen McGinnis	Senior VP, Public Policy and Performance Improvement
Janet Milliman	CHP+ Program Manager, CO Access
Marina Osovskaya	CHP+ Program Specialist, CO Access
Terri Travis	Provider Liaison
Chris Gillespie	Clinical Appeals Manager
Department Observers	**Title**
Russell Kennedy	Quality and Health Improvement Unit

Appendix D. Corrective Action Plan Template for FY 2013–2014 *for* Access Behavioral Care

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

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	If applicable, the BHO will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification to HSAG and the Department. The BHO must submit the CAP using the template provided. For each element 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 or HSAG will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the CAP, the BHO should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

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

The template for the CAP follows.

Table D-2—FY 2013–2014 Corrective Action Plan *for* ABC		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. The Contactor may extend the authorization decision time frame if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. The Contractor's written policies and procedures include the following time frames for possible extension of time frames for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days.	The Utilization Review Determinations policy described the extension notice as a notice of action (NOA) and stated that the member had a right to appeal, treating the extension notice as an NOA. The extension letter template also included a title header of "Notice of Action—Timeliness." The extension of the authorization timeline is not an action; therefore, the member has no appeal right in this circumstance but may file a grievance.	ABC must revise its applicable policies and templates to accurately describe the member's right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination. ABC must also clarify the Utilization Review Determinations policy to clearly depict the process of notifying members of an action due to the expiration of time frames. ABC should also clarify that notice is not needed if the extension is used and that, although notice is required when the time frames expire, this notification period includes the extension time, if used.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-3—FY 2013–2014 Corrective Action Plan *for* ABC		
Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
10. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members.	The Colorado Access Provider Manual, applicable to all lines of business, stated that provider responsibilities included being accessible to members 24 hours a day, 7 days a week. However, neither the provider manual nor the provider contract included a requirement that the provider maintain hours of operation for Medicaid members that are no less than the hours of operation for commercial members.	ABC must require its providers to maintain hours of operation for Medicaid members that are no less than hours of operation for commercial members.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol 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' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	◆ HSAG attended the Department's Behavioral Health Quality Improvement Committee (BQuIC) meetings and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the request for desk review documents via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the two standards and on-site activities. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The BHOs also submitted a list of all Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. HSAG used a random sampling technique to select records for review during the site visit. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 3:	**Conduct Site Visit**
	◆ 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. ◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to BHO service and claims denials and notices of action.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ Also while on-site, 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 confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with BHO staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	◆ HSAG used the FY 2013–2014 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. ◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	◆ HSAG populated the report template. ◆ HSAG submitted the site review report to the BHO and the Department for review and comment. ◆ HSAG incorporated the BHO's and Department's comments, as applicable and finalized the report. ◆ HSAG distributed the final report to the BHO and the Department.