COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2016–2017 Site Review Report

for

Access Behavioral Care—Denver and Access Behavioral Care—Northeast

May 2017

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), with revisions published May 2016, requires that states conduct a periodic evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & 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 2016–2017 site review activities for the review period of January 1, 2016, through December 31, 2016 for both **Access Behavioral Care—Denver** (**ABC-D**) and **Access Behavioral Care—Northeast** (**ABC-NE**). 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 three standard areas reviewed this year. Section 2 contains graphical representation of results for all standards reviewed over the past two three-year cycles. Section 3 describes the background and methodology used for the 2016–2017 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2015–2016 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 2016–2017 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

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 healthcare regulations.

Table 1-1 presents the scores for **ABC-D** 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 ABC-D Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Coverage and Authorization of Services	31	31	27	4	0	0	87%
II. Access and Availability	10	10	10	0	0	0	100%
Totals	**41**	**41**	**37**	**4**	**0**	**0**	**90%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

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

Table 1-2—Summary of ABC-D Scores for the Record Review

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	66	64	2	34	97%
Totals	**100**	**66**	**64**	**2**	**34**	**97%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Table 1-3 presents the scores for **ABC-NE** 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 1-3—Summary of ABC-NE Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Coverage and Authorization of Services	31	31	26	5	0	0	84%
II. Access and Availability	10	10	10	0	0	0	100%
Totals	**41**	**41**	**36**	**5**	**0**	**0**	**88%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Table 1-4 presents the scores for **ABC-NE** for the denials record review. Details of the findings for the record review are in Appendix B—Record Review Tool.

Table 1-4—Summary of ABC-NE Scores for the Record Review

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	58	54	4	42	93%
Totals	**100**	**58**	**54**	**4**	**42**	**93%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Standard I—Coverage and Authorization of Services

The following section summarizes findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

The policies and procedures for **ABC-D** and **ABC-NE** are applicable to both lines of business; therefore, findings of the on-site review are generally applicable to both **ABC-D** and **ABC-NE**. **ABC** had policies and procedures related to utilization management (UM) processes and emergency services that addressed most requirements. **ABC** conducted authorization reviews of all higher levels of service, but not of routine outpatient behavioral health services. **ABC** used InterQual criteria to screen requests for medical necessity and simultaneously applied a list of BHO-covered diagnoses/benefits to the clinical information contained in the member's record. **ABC** ensures consistent application of review criteria by UM staff and medical directors through interrater reliability audits. UM reviewers refer all questionable cases to a clinically qualified medical director for final determination. **ABC** records all notes regarding review and outcomes of authorization requests in the Altruista Health care management system. UM reviewers outreach providers when more information is required to make an authorization decision and offer the provider a peer-to-peer consultation when a denial is being considered. Providers are required to respond to **ABC** within two hours for any urgent or expedited authorization decision. **ABC**'s authorization and notification processes are highly efficient, with many decisions—whether urgent or standard requests—made within one to three days of receipt of request. All notices of action (NOAs) include the reason for the decision and offer treatment alternatives recommended by the medical director. On-site denials record review confirmed the following (combined **ABC-D** and **ABC-NE** records):

- Denials record reviews included 20 new requests—11 standard and nine expedited. HSAG reviewed no retrospective claim denials. **ABC** extended the decision time frame for one case.
- HSAG found cases reviewed 100 percent compliant with: decision was based on established criteria, decision was made by a qualified provider, and the NOA included required content.
- Nineteen of 20 records included a written NOA to the member and provider, and **ABC** sent 18 of 20 NOAs within the required time frame.
- HSAG found that 17 of 20 NOAs to the member were written using easy-to-understand language.
- NOAs for all cases denied for "not a covered service/diagnosis" and cases in which the member was EPSDT-eligible informed the member how to obtain covered fee-for-service or wraparound services.

Policies and procedures, the provider manual, and the member handbook accurately defined "emergency medical condition," including the prudent layperson definition. Policies and procedures and the member handbook stated that **ABC** pays emergency claims—in or out of network—without prior authorization, and the member handbook informed members that they are never liable for payment of emergency services. Claims processing procedures stated and staff members confirmed that all emergency service claims with a primary psychiatric diagnosis are paid without authorization and are not subject to UM

review. The Emergency and Post-Stabilization Care policy accurately defined post-stabilization services and all financial responsibility rules for post-stabilization care as outlined in the requirements.

Summary of Findings Resulting in Opportunities for Improvement

As observed in on-site denial record reviews, all NOAs informed the member of the responsibility to request a State fair hearing within 30 days of the date of the denial letter. Although not formally processed to date as a revision to the Colorado Code of Regulations (CCR), the Department advised BHOs that it executed an emergency rule change effective September 2016 to specify that members may request a State fair hearing within 60 days of the NOA. Staff members stated that **ABC** has not changed the information in any of its documents to the 60-day requirement. **ABC** should immediately modify language in NOA letters to inform members that they have 60 days from the date of the NOA to request a State fair hearing.

While **ABC** defined "medical necessity" equivalent to the medical necessity definition outlined in the contract, the definition of medical necessity outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—included the addition of EPSDT-specific criteria. Therefore, **ABC** is advised to immediately update the definition of medical necessity accordingly. HSAG recommends that **ABC** refer to 10-CCR 2505-10 8.076.1.8 (a-g) and 8.7016.1.8.1 for guidance.

HSAG observed during denial record reviews that all member NOAs included a clause, "If you are a member under 21 year of age…" followed by information on how the member may access EPSDT services. Because adults are ineligible for EPSDT services, this information is irrelevant and may be confusing for adults receiving an NOA. Therefore, HSAG recommends that **ABC** differentiate template NOA content for members 20 and under from the content of the NOA to adults.

UM policies and procedures described a peer-to-peer consultation process offered to a requesting provider when an adverse determination is made. HSAG reviewers also observed in denial record reviews several instances in which peer-to-peer consultation was offered and the outcome of the adverse determination was changed. This process avoids the necessity of the member or provider filing an appeal; therefore, HSAG encouraged **ABC** to ensure that it provides sufficient time and opportunity for the peer-to-peer consultation *prior* to sending an NOA, and advised that once the NOA is mailed the peer-to-peer consultation must be considered an appeal and treated as such.

During on-site interviews, staff members confirmed that **ABC** automatically pays all emergency service claims associated with a primary psychiatric diagnosis and pays emergency room (ER) practitioner claims for mental health and substance use disorder diagnoses. However, the Emergency and Post-Stabilization Care policy did not address the financial responsibility requirements per 2.2.4.3.11-13 of the contract with the Department. HSAG recommends that **ABC** add these requirements to internal policies and procedures.

Although the Emergency and Post-Stabilization Care policy accurately defined post-stabilization care and **ABC**'s financial responsibility related to post-stabilization services, the member handbook defined post-stabilization services as "services that the provider who saw you in an emergency says you need

before you can go home or go to another place for care." The HSAG reviewer noted that the language lacked clarity as to whether it provided a definition of "emergency services" or "post-stabilization services." Similarly, the provider manual—under the post-stabilization heading—included information applicable to emergency services rather than to post-stabilization services. HSAG recommends that **ABC** review language in both the member handbook and provider manual to clarify information related to post-stabilization services.

Summary of Required Actions

The Utilization Review Determinations policy accurately outlined the requirement to provide a written NOA to the member and provider. However, one record included in the **ABC-NE** denial record reviews failed to provide a written NOA to the member. **ABC-NE** must have a mechanism to ensure that it gives the member written notice of any decision to deny a service authorization request.

ABC policies and procedures addressed the requirement that NOAs to the member be written in language to ensure ease of understanding. Staff members stated that each NOA to the member is reviewed by a staff member for clarity of information prior to being mailed. However, during denial record reviews, HSAG observed that one **ABC-D** NOA to the member included information inappropriate for the member—instructing the member to "consider billing fee for service;" two **ABC-NE** NOAs included terminology describing the reason for the denial that may have been difficult for the member (and family) to understand; and several additional denial records included an NOA with language that may have been considered borderline with respect to either terminology used in the reason for the denial or included information that may not have been appropriate to the member. **ABC-D** and **ABC-NE** must have an effective mechanism to ensure that all information in the NOA to the member is appropriate to the member and written in language that ensures ease of understanding.

ABC's policies and procedures accurately addressed all time frames for mailing an NOA. However, in the denial record reviews, **ABC-D** had one case in which the NOA was mailed outside the required time frame for an expedited authorization decision and **ABC-NE** had one case in which the NOA was mailed outside the required time frame for a standard authorization decision. **ABC-D** and **ABC-NE** must have a mechanism to ensure that NOAs are mailed in the required time frames as outlined in the **ABC** policies and procedures.

ABC's Emergency and Post-Stabilization Care policy accurately addressed requirements related to the Contractor's financial responsibilities for post-stabilization care services not pre-approved. Emergency room claims payment procedures stated that **ABC** checks inpatient admissions following an ER visit (post-stabilization services) for whether or not an authorization was obtained for the inpatient admission. If **ABC** did not grant authorization for the inpatient admission, it denied the claim. Neither written UM procedures nor on-site interviews provided clarity that either claims payment or authorization decisions incorporated the criteria for financial responsibility for post-stabilization services which **ABC** has not pre-approved, as specified in the Emergency and Post-Stabilization Care policy. **ABC** must develop a process to ensure that both UM procedures and claims payment decisions are linked to the requirements for the Contractor's financial responsibilities for post-stabilization care services it has not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy.

Standard II—Access and Availability

The following section summarizes findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

ABC-D and **ABC-NE** generated quarterly network adequacy reports that delineated the numbers, types, and physical locations of contracted providers as well as areas of cultural specialty and languages spoken. **ABC** compared this data to the utilization patterns and physical locations of its members. **ABC** also considered the numbers of single case agreements (SCAs) issued and numbers of contracted providers not accepting new members. **ABC-D** and **ABC-NE** reviewed this information along with member grievances, provider appointment availability, the results of Experience of Care and Health Outcomes (ECHO) surveys, and expected Medicaid enrollment and use of services. Reports indicated that both networks are adequate to meet member demand; however, staff reported, for both networks, ongoing efforts to recruit psychiatrists, providers specializing in treatment for substance use disorders and intensive home-based treatment, and providers fluent in non-English languages.

Policies and procedures, member handbooks, and the provider manual stated that if the BHO is unable to provide covered services within its network it will make arrangements for the member to receive services out of network. Both BHOs provided evidence of having implemented SCAs during the review period to ensure appropriate access. SCAs included language that prohibited providers from billing members for covered services.

ABC-D and **ABC-NE** notified providers about expected hours of operation and appointment availability standards using new provider orientation, the provider manual, the provider website, and periodic mailings. **ABC-D** and **ABC-NE** required largest-volume providers to participate in regular access-to-care reporting and monitored smaller-volume providers using secret shopper calls. Staff members associated with both BHOs estimated that between 80 and 90 percent of members receive services from the 10 highest-volume providers.

ABC had a cultural competency plan that delineated goals for ensuring the provision of culturally and linguistically appropriate services. The Culturally Sensitive Services for Diverse Populations policy and procedure identified the departments responsible for developing and distributing information related to cultural competency—including information related to the healthcare attitudes, beliefs, and practices of diverse populations; how to work with members with varying levels of health literacy; and how staff and members can submit a grievance related to the delivery of services, improper conduct, and/or discrimination. **ABC-D** and **ABC-NE** required that staff members participate in annual cultural competency training and offered training to all contracted providers.

The **ABC-D** Annual Quality Report listed numerous agencies and programs within its network designed to respond to the needs of its culturally diverse populations. Examples included programs designed to address needs for the Latino community, persons with developmental and intellectual disabilities, teenagers, survivors of torture and war trauma, and refugees. During the on-site interview, **ABC-NE**

staff members described similar programs available to its members as well as culturally diverse community events sponsored by **ABC-NE**.

Summary of Findings Resulting in Opportunities for Improvement

Member handbooks and the provider manual stated that **ABC-D** and **ABC-NE** would provide members with a second opinion and that members could call customer service for assistance with arranging for a second opinion. While Colorado Access had policy statements addressing the provision of second opinions, the information in the procedures was vague. HSAG suggested that Colorado Access could strengthen its policy by more clearly stating that if a qualified professional is not available in network, Colorado Access will make arrangements for the member to see a qualified healthcare professional out of network at no cost to the member.

Summary of Required Actions

HSAG identified no required corrective actions for this standard.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

The following section summarizes findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

Colorado Access is developing policies and procedures and communications related to EPSDT requirements corporate-wide and had not differentiated processes applicable to **ABC-D** and **ABC-NE**. Therefore, scores and recommendations are consistent for both lines of business.

ABC had clearly outlined procedures for providing BHO care coordination to assist members with access to EPSDT services not covered by the BHO, including coordinating with community agencies and programs, arranging transportation, coordinating wraparound benefits, and coordinating with Healthy Communities. Colorado Access integrated BHO and Regional Care Collaborative Organization (RCCO) care coordination activities to improve efficiencies and processes related to coordinating behavioral and physical health care services for members. During the on-site interview, staff members stated that care coordinators have contacts and referral resources for coordinating with all necessary EPSDT service providers. The member NOA letters included information for members aged 20 and under indicating that a BHO care coordinator would contact them to assist with referrals to needed services. **ABC**'s EPSDT strategic plan also included developing with Healthy Communities in five counties formal agreements that will delineate care coordination responsibilities applicable to each organization—i.e., "coordinating the coordinators." The EPSDT Strategic Plan also indicated **ABC**'s

intent to establish a process for sharing member data between Healthy Communities and Colorado Access. The Care Coordination policy indicated that care coordinators are communicating essential member information with Healthy Communities. Care coordination for members needing services not covered by the BHO is the most well-developed aspect of **ABC**'s EPSDT program to date.

Despite the opportunities for improvement and recommendations outlined below, **ABC** has made significant efforts over the past year to implement processes that address the BHOs' responsibilities related to EPSDT. All components of EPSDT requirements were at least partially met. Many EPSDT requirements are related to primary care and physical health services; therefore, Colorado Access has defined an EPSDT Strategic Plan for implementing comprehensive EPSDT requirements organization-wide, incorporating both BHOs and the two corresponding RCCOs. Various components of the EPSDT Strategic Plan are to be implemented throughout the 2017 calendar year and include activities related to:

- Improving the internal infrastructure to support EPSDT requirements, including developing webinars and completing training for care management, utilization management, and customer service staff.
- Developing messaging for members or their families regarding EPSDT services, including coordinating with Healthy Communities related to education for new members, obtaining input from the member advisory committee to identify additional opportunities for member communications, and integrating the Department's "Just Ask" campaign into member materials.
- Developing provider education and support, including an EPSDT webinar for providers, incorporating an EPSDT module into provider orientation training, and educating provider engagement department staff.
- Collaborating with community partners (e.g., Healthy Communities and school districts) to improve member access to EPSDT services.

Colorado Access had been working closely with the Department to address all EPSDT requirements, including staff training and defining effective mechanisms for working with the Department's fee-for-service systems.

Summary of Findings Resulting in Opportunities for Improvement

It appeared that Colorado Access was developing multiple policies and procedures to address the individual components of the EPSDT program and the roles of various BHO departments in implementing each component. HSAG suggested that Colorado Access consider defining one umbrella EPSDT service policy to address all EPSDT requirements, with procedures for implementing the policy defined within individual applicable departments.

HSAG encouraged **ABC** to consider enhancing responsibilities and mechanisms for EPSDT communications with members at the provider point of service and to identify ongoing and periodic—not just enrollment—mechanisms for communicating information about EPSDT services to members.

The provider manual directs providers to obtain a release of information from the member in order to share behavioral health information with the primary care provider (PCP). However, the manual does not extend this requirement to sharing protected health information (PHI) with Healthy Communities for treatment or operations purposes. HSAG recommends that **ABC** enhance provider communications to clarify that the provider can and should share member PHI with Healthy Communities.

The proposed Adverse Determinations and EPSDT procedure included the EPSDT definition of "medical necessity". **ABC** should note that the definition of medical necessity outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—includes the EPSDT-specific criteria per 8.280.4.E. HSAG strongly recommends that **ABC** incorporate the definition of medical necessity as outlined in the Findings section of Standard I, element 4 of the compliance monitoring tool.

The medical record audit tool—in development at the time of on-site review—included monitoring for limited information related to EPSDT screenings, such as performance of developmental screening by the BHO provider and any documentation of follow-up referrals. During on-site interviews, staff stated that the medical record audit tool was being updated to monitor for documentation related to EPSDT requirements, although it did not appear that the elements of the audit tool would monitor for documentation to ensure compliance with the provider expectations outlined in the provider manual (e.g., documentation of EPSDT screening results obtained from PCPs). In addition, the medical record audit tool would apply to only a subset (members aged 20 and under) of the 50 total records reviewed annually across the BHO. During on-site interviews, HSAG suggested that **ABC** consider a focused EPSDT medical record audit, conducted and self-reported by the provider, to enable a more comprehensive assessment and reinforce provider responsibilities related to assisting members with obtaining EPSDT periodic health screens.

HSAG clarified during on-site discussions with staff members that "systematic" communication with providers required that the BHO address mechanisms for ongoing and periodic communication with providers. HSAG encourages **ABC** to identify additional mechanisms for systematic EPSDT communications with network providers rather than only infrequently accessed information sources such as the provider manual, provider website, or provider orientation training modules.

During on-site denial record reviews, HSAG noted that some NOA letters to members eligible for EPSDT services referred the member directly to the Department's Office of Clinical Services. Staff members stated that the most current revision of the letter eliminated that information. Nevertheless, HSAG and the Department advised that the BHO care coordinators or providers are the most appropriate persons to contact the Office of Clinical Services and that **ABC** should not refer members directly to the Department.

Although Colorado Access had outlined a strategic plan for implementing the various components of EPSDT program, implementation was scheduled over the 2017 calendar year. HSAG recommends that **ABC** remain focused and expedite implementation to address the recommendations related to EPSDT. HSAG encourages **ABC** to continue working with the Department's EPSDT Administrator (Gina Robinson) to obtain guidance and trainings related to implementation of the Department's EPSDT requirements.

Summary of Findings Resulting in Recommendations

ABC submitted policy and procedure information which addressed EPSDT UM processes and coordination among the UM staff and Colorado Access care coordinators related to any services denied for members 20 and under. **ABC** had no defined policies related to informing members of EPSDT services, ensuring screening services are performed, performing mental health diagnostic or treatment services related to EPSDT, providing referrals and care coordination for EPSDT services other than services denied by the BHO, or providing transportation and scheduling assistance for EPSDT services. HSAG recommends that **ABC** revise existing or develop new policies and procedures to address all components of EPSDT service requirements.

ABC drafted an update to the **ABC** member handbook to provide information about the benefits and services of the EPSDT program; however, at the time of review **ABC** had not yet published these changes. **ABC** developed EPSDT information to be included in the January 2017 member newsletter. The EPSDT Strategic Plan addressed plans to develop education materials for new members which will include information on accessing EPSDT services and to work with **ABC**'s Member Advisory Council to identify additional opportunities to share EPSDT information with members. HSAG recommends that **ABC** implement effective mechanisms to inform members aged 20 and under (or their families) about services available under the EPSDT program and where and how to obtain those services.

The provider manual stated, "providers are expected to contact the PCP for results of EPSDT exams." The manual stated that providers should determine if the PCP performed an EPSDT screening, can obtain and review results of the screening, and/or should refer the member to a PCP to perform a screening if needed. The manual defined no specific components of EPSDT periodic health screens. **ABC** had no defined policies or detailed procedures to reinforce or implement this process with providers and had conducted no provider training specific to this expectation. Staff stated that **ABC** was updating the medical record audit tool to monitor for documentation related to EPSDT requirements; however, it did not appear that the elements of the audit tool would monitor compliance with the provider expectations outlined in the provider manual. HSAG recommends that **ABC** develop or enhance policies and procedures and provider communications to clarify mechanisms that will reasonably ensure the provision of all components of EPSDT periodic health screens to EPSDT beneficiaries.

ABC had no policies and procedures that addressed the requirement for documenting EPSDT results in a child's medical record. **ABC** provided no evidence that providers had been informed of the requirement for documenting results and required components of EPSDT screenings in a member's medical record. The medical record audit tool that **ABC** was developing did not appear to monitor for documentation of screening results obtained from PCPs. HSAG recommends that **ABC** clarify expectations related to documenting in a child's medical record results of EPSDT screenings and examinations.

The EPSDT section of the provider manual stated, "any service necessary to treat healthcare needs identified through an EPSDT screening must be provided." However, the language in the provider manual did not suggest the types of BHO-covered services that may apply to EPSDT-eligible members

or specifically require that BHO providers deliver those services. UM policies and procedures did not address the application of EPSDT medical necessity criteria to authorizations for services for members 20 and under; nor was there evidence to suggest that UM reviewers would be aware whether or not a specific requested service is related to EPSDT. **ABC** conducted no staff training to alert UM staff to examples of EPSDT contractor-covered services or how to implement EPSDT-specific procedures for authorization decisions. Therefore, **ABC** did not appear to have adequate procedures to operationalize processes to ensure delivery of BHO-covered services to EPSDT-eligible members. HSAG recommends that **ABC** enhance and implement policies and procedures and provider and staff communications to adequately operationalize processes to ensure delivery of EPSDT BHO-covered services.

ABC developed policies and procedures which outlined the process for UM staff to coordinate with care coordination staff to assist members with access to any EPSDT services denied by the BHO but potentially available through fee-for-service programs. The most current version of the member NOA letter included a statement informing EPSDT-eligible members that if the requested service was denied because it was not a covered benefit, "you will be contacted by a Care Manager for assistance with additional resources." However, **ABC** had not fully implemented the EPSDT-specific UM and care coordination procedures; and staff stated that **ABC** had not yet trained UM and care coordination staff. The EPSDT Strategic Plan indicated that staff training would be completed in the second quarter of calendar year 2017. In addition, the provider manual did not explicitly address the requirement that BHO practitioners provide diagnostic services in addition to treatment of all mental illnesses or conditions (including substance abuse) discovered by any EPSDT screening and diagnostic procedure, and **ABC** had not trained providers regarding this requirement. HSAG recommends that **ABC** implement its proposed procedures and provide appropriate staff and providers with training to operationalize the intent to provide or coordinate diagnostic and treatment services needed as a result of EPSDT screenings or diagnostic services.

Neither the provider manual nor other provider communications stated that the provider is responsible to refer the member to an appropriate practitioner or to Healthy Communities; nor did provider communications direct the provider to contact the BHO care coordinators for assistance. Therefore, it was not clear how the provider or the BHO would consistently refer the member to an appropriate practitioner or Healthy Communities when the "provider is not licensed or equipped to render necessary treatment or further diagnosis." HSAG recommends that **ABC** more clearly outline this requirement to providers and/or establish a link between providers and BHO care coordination processes to ensure that members are referred to appropriate providers when the current provider is not licensed or equipped to render necessary treatment or further diagnosis.

The proposed Adverse Determinations and EPSDT procedure included the EPSDT definition of "medical necessity" but did not include the criteria for approval of EPSDT requested services as outlined in the requirement. The procedure was pending approval and had not yet been implemented. UM policies and procedures did not include the EPSDT definition of "medical necessity" or the criteria for approval of EPSDT services outlined in the requirement. **ABC** had not trained UM staff regarding the specific criteria to be applied to authorization of EPSDT-related procedures. During the on-site interview, staff members could not articulate how EPSDT medical necessity and authorization criteria are applied within existing UM authorization processes. HSAG recommends that **ABC** establish

mechanisms to apply EPSDT "medical necessity" definitions and criteria in its service authorization processes for members 20 and under.

The provider manual included an EPSDT-specific section that generally describes EPSDT services but does not define the components of periodic health screens or clearly define all provider expectations related to EPSDT requirements. The EPSDT Strategic Plan indicated that **ABC** would develop and deploy provider training modules in quarters 2 and 3 of calendar year 2017, including a web-based EPSDT webinar and a provider orientation EPSDT module. "Systematic" communication with providers requires that the BHO address mechanisms for ongoing and periodic communication with network providers, rather than one-time or infrequently accessed information sources. **ABC** had not implemented sufficient systematic communication with network providers regarding the Department's EPSDT requirements. HSAG recommends that **ABC** enhance and implement communications with its network providers regarding the EPSDT program and requirements to ensure that providers understand EPSDT services for members—periodic health screens—as well as well as communicate clear expectations to providers and inform providers about BHO or external resources available to assist providers with implementing EPSDT requirements.

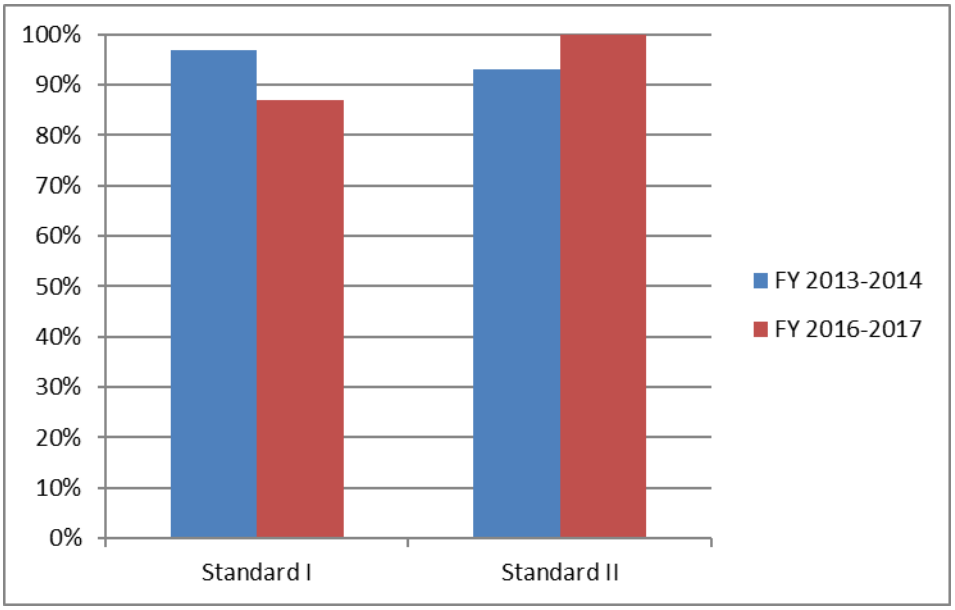
Comparison of Results

This is the third year of the **ABC-NE** contract with the Department. Therefore, prior results are limited. HSAG included information for **ABC-NE** where applicable.

Comparison of FY 2013–2014 Results to FY 2016–2017 Results

Figure 2-1 shows **ABC-D**'s the scores from the FY 2013–2014 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-D**'s contract with the State may have changed, and may have contributed to performance changes.

Figure 2-1—Comparison of FY 2013–2014 Results to FY 2016–2017 Results for ABC-D

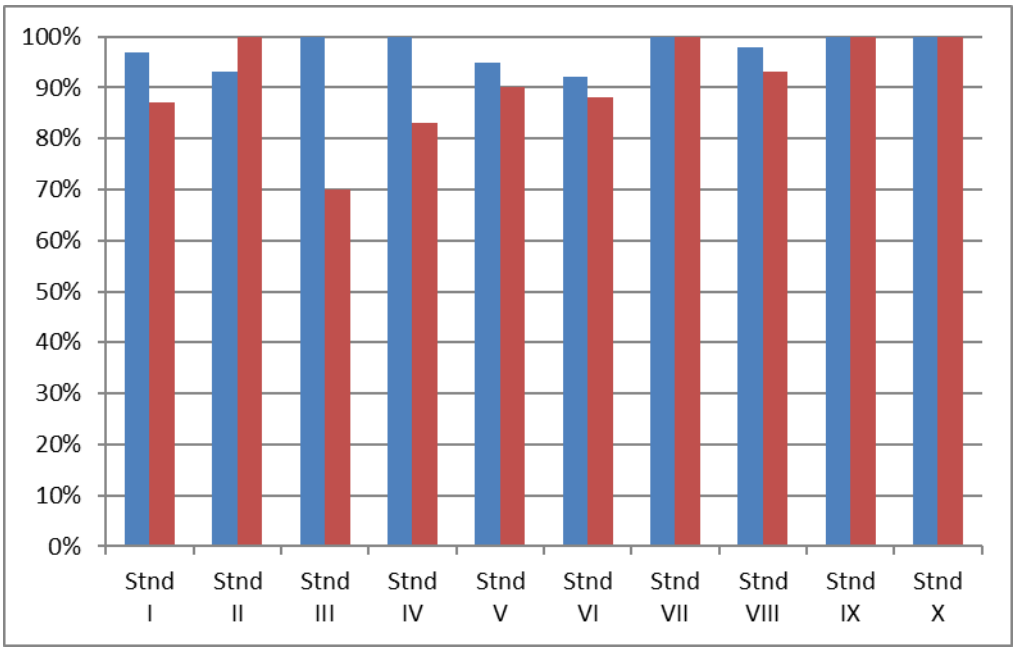


This is the first year that HSAG reviewed Standard I, Standard II, and Standard XI for **ABC-NE**; therefore, comparison to prior results is not available.

Review of Compliance Scores for All Standards

Figure 2-2 shows **ABC-D**'s 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-D's Compliance Scores for All Standards



Note: Results shown in blue are from FY 2011–2012, FY 2012–2013, and FY 2013–2014. Results shown in red are from FY 2014–2015, FY 2015–2016, and FY 2016–2017.

Figure 2-3 shows **ABC-NE**'s scores for all standards reviewed in FY 2014–2015, FY 2015–2016, and FY 2016–2017.

Figure 2-3—ABC-NE's Compliance Scores for All Standards

Note: Results shown are from FY 2014–2015, FY 2015–2016, and FY 2016–2017.

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

Table 2-1—List of Standards by Review Year

Standard	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17
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	
XI—EPSDT Services						X

3. Overview and Background

Overview of FY 2016–2017 Compliance Monitoring Activities

For the fiscal year (FY) 2016–2017 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability.

HSAG reviewed an additional EPSDT standard for all BHOs during the FY 2016–2017 compliance site reviews. This standard was developed collaboratively by HSAG and the Department using federal EPSDT regulations and guidance in addition to State statutes that address EPSDT. The FY 2016–2017 findings for this standard can be found in Appendix A. A narrative summary of findings for this standard is also presented in the Executive Summary. During the on-site reviews, the Department identified that, while the BHO contracts require BHOs to comply with "all federal and State EPSDT regulations," the BHO contracts did not include the specificity delineated in the compliance monitoring tool. Therefore, the EPSDT findings will be used only to inform the development and implementation of EPSDT contracting provisions for the Regional Accountable Entities (RAEs) that will assume the capitated behavioral health contracts beginning in FY 2018–2019. No corrective actions are required based on this compliance monitoring review. The State's EQRO vendor will review the EPSDT standard again in FY 2019–2020.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued May 6, 2016. 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.

A sample of the BHO's administrative records related to Medicaid service and claims denials was 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 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid service and claims denials that occurred between January 1, 2016, and December 31, 2016. For the record review, the BHO received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each required element. 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.[3-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The three standards chosen for the FY 2016–2017 site reviews represent a portion of the Medicaid managed care requirements. The following 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 three areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the BHO into compliance with federal health care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, 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.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Aug 24, 2016.

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

FY 2015–2016 Corrective Action Methodology

As a follow-up to the FY 2015–2016 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-D** and **ABC-NE** until they completed each of the required actions from the FY 2015–2016 compliance monitoring site review.

Summary of FY 2015–2016 Required Actions

As a result of the FY 2015–2016 site review, **ABC-D** and **ABC-NE** were required to address three *Partially Met* elements in the Coordination and Continuity of Care standard, one *Not Met* element in the Member Rights and Protections standard, and three *Partially Met* elements in the Credentialing and Recredentialing standard.

Summary of Corrective Action/Document Review

ABC submitted its proposal to HSAG and the Department in April 2016. HSAG and the Department required **ABC** to revise its initial plan before submitting documents that demonstrated compliance. **ABC** began submitting evidence of having completed proposed actions to HSAG and the Department in June. HSAG and the Department participated in telephone calls with **ABC** staff members to provide additional assistance and clarification, as needed.

In December 2016, HSAG and the Department determined that **ABC** had addressed all but one required action. The outstanding action item is included in its entirety along with additional EPSDT-related requirements as part of the FY 2016–2017 compliance monitoring tool (see Standard XI, Element 9, in Appendix A). For this reason, HSAG and the Department deferred additional review and approval of the FY 2015–2016 corrective action to the findings determined in this FY 2016-2017 compliance audit. Any unmet required actions have been added to the FY 2016–2017 corrective action plan.

Summary of Continued Required Actions

ABC had no required actions continued from FY 2015–2016.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Compliance Monitoring Tool
for Access Behavioral Care—Denver and Access Behavioral Care—Northeast

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor must ensure that the services provided are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished. • No less than the amount, duration, and scope furnished under fee-for-service Medicaid. *42 CFR 438.210(a)(3)(i)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.2.8, 2.2.7	Documentation: 1. CCS305 – Care Coordination a) Page 2: Procedure I. A-J. b) Page 2-3: Procedure III. A –D 2. CCS307 – Utilization Review Determinations a) Page 4-11: Procedure I. A-J. 3. CCS310 - Primary and Specialty Care Access a) Page 4: Procedure II. A-D. b) Page 5: Procedure III. A-J. 4. UM Program Description a) Page 3: Mission and Philosophy of the Utilization Management Program b) Page 3-5: Utilization Management Program Framework c) Page 5-6: Goals and Objectives	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Amendment 6, Exhibit A-2—2.2.9	**Documentation:** 1. CCS307 – Utilization Review Determination a) Page 5: Procedure I. A Bullet 6. 2. UM DP42 Processing with Interqual a) Page 2: Procedure 3. Provider Manual- Page 55: Medical Necessity 4. ADM205 Nondiscrimination a) Page 2: Policy Statement b) Page 2: Procedure I. D.	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ 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 may place appropriate limits on a service: • 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 purposes. *42 CFR 438.210(a)(4)(i) and (ii)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.2.10	Documentation: 1. CCS307 – Utilization Review Determinations a) Page 1: Adverse Determination definition b) Page 2: Medical Necessity definition c) Page 3-4: Utilization Review definition 2. UM Program Description a) Page 3: Mission and Philosophy of the Utilization Management Program b) Page 3-5: Utilization Management Program Framework c) Page 5-6: Goals and Objectives 3. Provider Manual- Page 55: Medical Necessity (entire section).	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor specifies what constitutes "medically necessary services" in a manner that: • Is no more restrictive than that used in the State Medicaid program. – Is in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care. – Is reasonably necessary for the diagnosis or treatment of a covered behavioral health disorder or to improve, stabilize, or prevent deterioration of functioning resulting from such a disorder. – Is clinically appropriate in terms of type, frequency, extent, site, and duration.	Documentation: 1. CCS307 – Utilization Review Determination a) Page 5: Procedure I. A Bullet 6. 2. UM DP42 Processing with Interqual a) Page 2: Procedure 3. Provider Manual Page 55 Medical Necessity 4. CCS302-Medical Criteria for Utilization Review	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– Is furnished in the most appropriate and least restrictive setting where services can be safely provided. – Cannot be omitted without adversely affecting the member's behavioral health and/or physical health conditions associated with the member's covered behavioral health diagnosis or the quality of care rendered. • 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. *42 CFR 438.210(a)(5)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—1.1.1.34		
Findings: While ABC defined "medical necessity" equivalent to the medical necessity definition outlined in this requirement, the definition of medical necessity outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—included the addition of EPSDT-specific criteria. Therefore, ABC is advised to immediately update the definition of medical necessity accordingly. Please reference 10-CCR 2505-10 8.076.1.8 (a-g) and 8.7016.1.8.1 for guidance:		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8.076.1.8. Medical necessity means a Medical Assistance program good or service: a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. b. Is provided in accordance with generally accepted professional standards for health care in the United States. c. Is clinically appropriate in terms of type, frequency, extent, site, and duration. d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. e. Is delivered in the most appropriate setting(s) required by the client's condition. f. Is not experimental or investigational. g. Is not more costly than other equally effective treatment options. 8.076.1.8.1 For EPSDT-specific criteria, see 10 C.C.R. 2505-10, Section 8.280.4.E. For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living; and meets the criteria set forth in Section 8.076.1.8(b-g)."		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. The Contractor has in place written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.9	Documentation: 1. ABC Member Handbook- Page 3: If You Already Get Behavioral Health Services-Page 6: Service Authorizations 2. ADM219 Member Appeal Process 3. CCS307 Utilization Review Determinations- Page 1, Policy Statement Pg 1: Concurrent Review definition Page 3: Prospective Review definition, Page 3-4: Utilization Review definition Page 5, Procedure I. B, C & D. 4. CCS306 Delivering Continuity and Transition of Care addresses "continuing authorization of services" for new members who have current ongoing care needs and for established members that have current ongoing care needs with a provider terminating COA participation. Page 1: Policy Statement, Page 2-3: Procedure 2. A-H. Page 3-5: Procedure 3. A-C. 5. UM Program Description Page 16-17, D. Prospective Reviews; E. Concurrent Review and G. Transition of Care, Page 18, I. Drug Utilization and Review Program 6. Access to Care Plan Page 7-8, IV. Coordinated Clinical Services, Paragraph 1, Page 9, D. Authorizations	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ 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 has in place and follows written policies and procedures that include effective mechanisms to ensure consistent application of review for authorizing decisions. *42 CFR 438.210(b)(2)(i)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.15	Documentation: 1. CCS302-Medical Criteria for Utilization Review 2. Page 2 II.E 3. CCS301-Qualifications for Staff Engaged in Utilization Management Activities 4. 2016 IRR Department Summary- This will be made available during the onsite portion 5. UM Program Description-Page 18: Utilization Management Program Components 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 2). 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).	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *4 2CFR 438.210(b)(2)(ii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.16	Documentation: 1. CCS307 Utilization Review Determination a) Page 5: Procedure I. A. Bullet# 6 d. b) Page 6: Procedure I. B. Bullet #6. c) Page 3-4: Utilization Review definition – bullet# 10 2. UM Program Description a) Page 17, E. Concurrent Review b) Page 17, H. Care Management 3. CCS305 Care Coordination a) Page 1, Policy Statement b) Page 1. Care Coordination definition. c) Page 2, Procedure I. Goals of Care Coordination, G. d) Page 2, Procedure III. Facilitation of Care Coordination e) C. 1 – 9.	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor's UM program ensures that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease. *42 CFR 438.210(b)(3)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.15.3	Documentation 1. CCS 301: Qualifications for Staff Engaged in UM Activities III. A. 2. 2. ADM 219: Appeals Process a) Page 12: Clinical Appeals Process H.	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ 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 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). *42 CFR 438.210(c)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.1 10 CCR 2505-10 8.209.4.A	**Documentation:** 1. CCS307 – Utilization Review Determinations a) Page 5:B. Bullet #4 and #6. b) Page 6: C., Bullet #3 c) Page 7: D. Bullet #4. 2. ABC Member Handbook a) Page 22: Your Rights Bullet #4. 3. Provider Manual a) Page 97 paragraph 3 4. Notice of Action letter	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Utilization Review Determinations policy accurately outlined this requirement; however, one of the ABC-NE denial records reviewed on-site documented no written notice of action (NOA) to the member.		
Required Actions: ABC-NE must have a mechanism to ensure that it gives the member written notice of any decision to deny a service authorization request.		
10. The Contractor provides notice of standard authorization decisions as expeditiously as the member's health condition requires and not to exceed 10 calendar days from receipt of the request for service. *42 CFR 438.210(d)(1)* Contract: Amendment 6, Exhibit A-2—2.5.15.1 10CCR2505—10, Sec 8.209.4.A.3.c	Documentation: 1. CCS307 – Utilization Review Determinations a) Page 5, B. Bullets #1-4 b) Page 7, E. Bullets #1-2	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11. For cases in which a provider indicates, or the Contractor determines, that the standard authorization time frame could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not to exceed 3 working days from receipt of the request for service. *42 CFR 438.210(d)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.15.2	Documentation: 1. CCS 307 Utilization Review Determinations a) Page 6: Procedure 1. C. Bullets #1&3 b) Page 6: Procedure 1. D. Bullets #1-4	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days 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. *42 CFR 438.210(d)(1)(2)* Contract: Amendment 6, Exhibit A-2—2.5.15.1 and 2.5.15.2.1	**Documentation:** 1. CCS307 Utilization Review Determination a) Page 5-6: Procedure 1. B. Bullet #5. A- b) Page 6, Procedure 1. C. Bullet #2. c) Page 7-8: Procedure 1. E. Bullet #3. a-f.	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
13. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.6.5.5 10CCR2505—10, Sec 8.209.4.A.1	**Documentation:** 1. ADM 207 – Effective Communication with LEP & SI/SI Persons a) Page 2, Policy Statement b) Page 3, Procedure I. A-B c) Page 4, paragraph 3, #2 d) 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.	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
ABC policies and procedures addressed the requirement that NOAs be written in language to ensure ease of understanding. Staff members stated that every notice is reviewed for clarity of information prior to being mailed. However, during denial record reviews, HSAG observed that:

- ABC-D had one NOA that included information inappropriate for the member—it instructed the member to "consider billing fee for service." Billing is a provider responsibility, not a member responsibility; therefore, HSAG considered the letter confusing.
- ABC-NE had two cases in which the reason for the denial, as described in the NOA, included terminology that may have been difficult for the member (and family) to understand.

HSAG noted that several additional NOAs included language that could be considered borderline with respect to terminology used in the reason for the denial or information that may not have been appropriate for the member—such as EPSDT information in letters for adult members who are ineligible for EPSDT services.

Required Actions:
ABC-D and ABC-NE must have effective mechanisms to ensure that all information in NOAs to members is appropriate to the members and written in language that ensures ease of understanding.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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 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 request a State fair hearing. • 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). *42 CFR 438.404(b)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.6	Documentation: 1. ADM203 – Member Grievance Process a) Page 2, Policy Statement b) Page 3, procedure I. A. 1-9 2. CCS307 – Utilization Review Determinations Page 9-10: Procedure 1. E. a) Evidence of Coverage b) Page 11, paragraph 1 c) Page 26 - You may have to pay (be held financially responsible) for all charges linked to an inpatient stay that is not authorized by CHP+ HMO. d) Page 113 – Grievance and Appeal, paragraph 1-3 e) Page 113 - What is a Designated Client Representative (DCR) f) Page 116, paragraph 3 g) Page 118 - Expedited ("Rush") Appeals h) Page 118 - How to Request a State Fair Hearing i) Page 119 – paragraph 4 (under address)	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
15. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except: – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and indicates that the member understands that service termination or reduction will occur. o The member has been admitted to an institution in which the member is ineligible for Medicaid services. o The member's address is determined unknown based on returned mail with no forwarding address. o The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. o A change in the level of medical care is prescribed by the member's physician.	Documentation: 1. Notice of Action Letter a) Page 5: 1. B. Bullet #3 nd #4. b) Page 6: 1. C. Bullet #3 c) Page 7: 1. D. Bullet #4. d) Page 7: 1. E. Bullet #2. e) Page 8-9: E. Bullet #2 - #4.	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
o The notice involves an adverse determination with regard to preadmission screening requirements. o The transfer or discharge from a facility will occur in an expedited fashion. • 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 expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services. • For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the time frame, as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.210 (d)* *42 CFR 438.404(c)* *42 CFR 431.211,431.213, and 431.214* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5 10CCR2505—10, Sec 8.209.4.A (3) (a-c)		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: ABC's policies and procedures accurately addressed all time frames for mailing an NOA per the requirement. However, in the denial record reviews, ABC-D had one case in which the NOA was mailed outside the required time frame for expedited authorization decisions and ABC-NE had one case in which the NOA was mailed outside the required time frame for standard authorization decisions.		
Required Actions: ABC-D and ABC-NE must have a mechanism to ensure that NOAs are mailed in the required time frames as outlined in the ABC policies and procedures.		
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. *42 CFR 438.404(c)(4)(i)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5.5.2 10CCR2505—10, Section 8.209.4.A.3.c (i)	**Documentation:** 1. CCS307 Utilization Review Determinations a) Page 5-6: 1. B. b-d. b) Page 6: 1. C.Bullet # 2. c) Page 7-8: 1. E. Bullet #b-f.	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
17. The Contractor provides that compensation to individuals or entities that conduct utilization management (UM) activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Amendment 6, Exhibit A-2—2.5.15.4	Documentation 1. CCS301 – Qualifications for Staff Engaged in Utilization Management Activities	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
18. The Contractor defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson 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. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.20	Documentation: 1. ABC Member Handbook a) Pg 5; 10-11 2. Provider Handbook a) Page 57 & 60: 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 2 – Definition: Emergency Medical Condition	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ 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 needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.21	**Documentation:** 1. CCS309 –Emergency and Post-Stabilization Care a) Page 2. Definitions – Emergency Services, A & B 2. CCS307 – Utilization Review Determinations a) Page 2. Definitions – Emergency Services, 1 & 2 3. Provider Manuel- Page 57 &60 Definition of an Emergency Medical Condition	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ 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. *42 CFR 438.114(c)(1)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.1	**Documentation:** 1. CCS309 –Emergency and Post-Stabilization Care a) Page 3, Procedure III. 2. ABC Member Handbook a) Pg 3, 12, 21 3. Provider Manual a) Page 57, 60	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor informs members that prior authorization is not required for emergency services. *42 CFR 438.10(f)(6)(viii)(B)* Contract: Amendment 6, Exhibit A-2—2.6.11.1.13.4	**Documentation:** 1. CCS309 –Emergency and Post-Stabilization Care a) Page 2. Definition - Prior Authorization b) Page 3. Procedure II. 2. ABC Member Handbook a) Pg 11 3. Provider Manual- Page 60 Emergency and Urgent Care	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
22. The Contractor may not deny payment for treatment obtained under the following circumstances: • A member had an emergency medical condition, as defined in 42 CFR 438.114(a) (see #18 above). • Situations which a prudent layperson who possesses an average knowledge of health and medicine 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. *42 CFR 438.114(c)(ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.1, 2.2.4.3.4.2	**Documentation:** 1. CCS309 –Emergency and Post-Stabilization Care a) Page 2. Definition – Emergency Medical Condition b) A - C 2. ABC Member Handbook a) Pg 4, and 11 3. Provider Manual a) Page 57-60. Definition of Emergency Medical Condition 4. CCS307 – Utilization Review Determinations a) Page 3. Definition: Emergency Medical Condition b) Page 5. Urgent Care Requests. 1. A.	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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. *42 CFR 438.114(d)(1)(i) and (ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.3	**Documentation:** 1. CCS309-Emergency and Post-Stabilization Care 1-4-10 a) Pg 3 IV 2. ABC Member Handbook a) Pg. 4 and 9	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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. • For *practitioner* emergency room claims for members with a primary substance use or mental health disorder diagnosis. (The Contractor is not financially responsible for outpatient emergency room services for members with a primary substance use disorder diagnosis or when the primary diagnosis is medical in nature.) Contract: Amendment 6, Exhibit A-2—2.2.4.3.11, 2.2.4.3.12, 2.2.4.3.13	Documentation: 1. CCS309 –Emergency and Post-Stabilization Care a) Page 3. IV. 2. Provider Manual- Page 57-60 3. CCS307 – Utilization Review Determinations a) Page 2. Definitions – Medical Necessity, 1.	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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. *42 CFR 438.114(d)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.5	Documentation: 1. CCS309 –Emergency and Post-Stabilization Care a) Page 4. VIII. 2. ABC Member Handbook a) Page 3 3. Provider Manual- Page 47	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ 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. *42 CFR 438.114(d)(3)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.6	Documentation: 1. CCS309 –Emergency and Post-Stabilization Care a) Page 3. Procedure V 2. ABC Member Handbook a) Page 11 & 12 3. Provider Manual- Page 60	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ 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 services" as covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.47	Documentation: 1. eCCS309 –Emergency and Post-Stabilization Care 2. ABC Member Handbook - Page 11&12 3. Provider Manual – Page 57	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ 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. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.7	Documentation: 1. ABC Member Handbook -Page 11&12 2. Provider Manual- Pg 57, 94 3. CCS309 – Emergency & Post-Stabilization Care	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
29. The Contractor is financially responsible for post stabilization 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 post stabilization 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 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 post stabilization care services it has not pre-approved ends. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii) and (iii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.8, 2.2.4.3.8.1, 2.2.4.3.8.2, 2.2.4.3.8.3	Documentation: 1. CCS309 –Emergency and Post-Stabilization Care a) Page 3. VI. B. b) Page 3. VI. C. 1, 2, 3 2. ABC Member Handbook - Page 11&12 3. Provider Manual- Page 57	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: ABC's Emergency and Post-Stabilization Care policy addressed this requirement verbatim. The emergency room (ER) claims payment procedures stated that ABC reviews inpatient admissions following an ER visit (post-stabilization services) to ensure that an authorization was obtained for the inpatient admission. If authorization was granted, the claim is paid. If no authorization was granted, the claim is denied. However, it was unclear in written UM procedures and during on-site interviews whether or not claim payment or authorization decisions considered the circumstances outlined in this requirement and as specified in the Emergency and Post-Stabilization Care policy.		
Required Actions: ABC must develop a process to ensure that both the UM procedures and claims payment decisions are linked to the requirements for the Contractor's financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy.		
30. The Contractor's financial responsibility for post stabilization care services it ***has not*** pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care. • A plan physician assumes responsibility for the member's care through transfer. • A plan representative and the treating physician reach an agreement concerning the member's care. • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.9	Documentation: 1. CCS309 –Emergency and Post-Stabilization Care a) Page 4. VII. A – D	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: ABC's Emergency and Post-Stabilization Care policy addressed this requirement verbatim. The ER claims payment procedures stated that ABC reviews inpatient admissions following an ER visit (post-stabilization services) to ensure that an authorization was obtained for the inpatient admission. If		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
authorization was granted, the claim is paid. If no authorization was granted, the claim is denied. However, it was unclear in written procedures and during on-site interviews whether or not the circumstances outlined in this requirement and specified in ABC's Emergency and Post-Stabilization Care policy were integrated into claims payment decisions.		
Required Actions: ABC must develop a process to ensure that the Contractor's financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy, are integrated into claims payment decisions.		
31. The Contractor must limit charges to members for post stabilization 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. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.8.4	Documentation: 1. ABC Member Handbook Page 11&12	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services for ABC-D							
Total	Met	=	27	X	1.00	=	27
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	27

Total Score ÷ Total Applicable	=	87%

Results for Standard I—Coverage and Authorization of Services for ABC-NE							
Total	Met	=	26	X	1.00	=	26
	Partially Met	=	5	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	26

Total Score ÷ Total Applicable	=	84%

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 and monitors a network of providers sufficient to provide access to all covered behavioral health and substance use disorder services. *42 CFR 438.206(b)(1)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.1, 2.5.9	**Documentation:** 1. FY16 Network Adequacy Reports Q2-4 a) Entire report 2. FY 16 Access to Care Reports Q1-4 b) Entire report 3. PNS202 Selection and Retention of Providers c) Pg 3&4 II.C pg .	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ 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 healthcare needs of specific Medicaid populations represented in the Contractor's service area. • The numbers, types, and specialties of providers required to furnish the contracted Medicaid services. • The number of network providers accepting/not accepting new Medicaid members. • The geographic location of providers in relationship to where Medicaid members live, considering	**Documentation:** 1. FY16 Network Adequacy Reports Q2-4 a) Entire report 2. FY 16 Access to Care Reports Q1-4 b) Entire report c) Pg 2&3 example of access to care reporting. 3. PNS202 Selection and Retention of Providers d) II.C pg 3&4.	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
distance, travel time, and means of transportation used by members. – Members have access to a provider within 30 miles or 30 minutes' travel time, whichever is larger, to the extent such services are available. • Physical access to locations for members with disabilities. *42 CFR 438.206(b)(1)(i) through (v)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.9.1; 2.5.9.2; 2.5.8.1.4		
3. The Contractor provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain one outside the network, at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Amendment 6, Exhibit A-2—2.5.8.2	**Documentation:** 1. ABC Member Handbook a) pg 15 1st paragraph 2. CCS302-Medical Criteria for Utilization Review a) pg 3-explains how Medical Criteria will be used for reviews including second opinions. 3. CCS307-Utilization Review Determinations a) pg6-explains the utilization review process to included second opinions. 4. Provider Manual	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. 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 for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Amendment 6, Exhibit A-2—2.5.9.5	**Documentation:** 1. CCS310-Access to Primary and Specialty Care a) pg 4 & 5 2. ABC Member Handbook a) 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).	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. 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. *42 CFR 438.206(b)(5)* Contract: Amendment 6, Exhibit A-2—none	**Documentation:** 1) CCS310-Access to Primary and Specialty Care a) pg 5, III.J	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
6. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.9	**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 a) Page 2, Policy Statemenet b) Page 4, Procedure I. B. c) Page 4, Procedure I. D. 1. a – c	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid fee-for-service if the provider serves only Medicaid members. • Minimum hours of provider operation shall include service coverage from 8 a.m. to 5 p.m. Mountain Time, Monday through Friday. • Extended hours of operation and service coverage shall be provided at least 2 days per week at clinic treatment sites, which may include additional morning, evening, or weekend hours. • Emergency coverage 24 hours a day, 7 days a week. *42 CFR 438.206(c)(1)(ii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.2, 2.5.8.1.3	**Documentation:** 1. Provider manual Page 18-19	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. 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 1 hour of contact in urban and suburban areas. – In person within 2 hours of contact in rural and frontier areas. • Urgently needed services are provided within 24 hours of 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.) • Routine outpatient appointments following intake/initial assessment shall occur at least 3 times within 45 days. • Outpatient follow-up appointments shall occur within 7 business days after discharge from an inpatient psychiatric hospitalization or residential facility.	**Documentation:** 1. Provider Manual (pg 8-9, 17-19) 2. New Provider Training (slide 32) 3. FY16 Access to Care Reports Q1-4 4. FY16 ABC-Denver Annual Quality Report (pg 9-11, 30-31) 5. FY16 ABC-NE Annual Quality Report (pg 9-10, 28-29) Providers are notified of Access to Care Standards via the Provider Manual and through new provider orientation. ABC ensures that standards are being met through various mechanisms, including Access to Care reporting (more information in following standard).	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Ongoing mental health and substance use disorder services shall be scheduled and continually provided for within 2 weeks from an initial assessment or intake appointment. (Ongoing services include but are not limited to assignment to a therapist and individual/group outpatient therapy.) *42 CFR 438.206(c)(1)(i)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.1—2.5.8.1.11.6		
9. 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. *42 CFR 438.206(c)(1)(iv) through (vi)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.8	**Documentation:** 1. Quality Assessment and Performance Improvement Program Description (pg 6) 2. ABC FY16Annual Quality Reports a) ECHO Survey (ABC-D pg 17-18; ABC-NE pg 15-16) b) Grievance monitoring (ABC-D pg 19-20. ABC-NE pg 17) c) Clinical denials and appeals (ABC-D pg 22-24, ABC-NE pg 20-22) d) Penetration rates (ABC-D pg 7-8, ABC-NE pg 7-8) e) Telephone Monitoring (ABC-D pg 11, ABC-NE pg 10) f) Provider appointment availability (ABC-D pg 9-10, ABC-NE pg 9) g) Network Adequacy Analysis (ABC-D pg 12-15, ABC-NE pg 11-13) 3. Access to Care Provider Letter The QAPI Program Description describes each of the mechanisms utilized in evaluating compliance with access to care standards. The results of each monitoring mechanism (and compliance	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	standards for each mechanism) is presented in detail in the Annual Quality Reports for both the Denver and Northeast regions. Because ABC providers have maintained high rates of compliance with access to care standards, formal corrective action plans have not been necessary the past two years. ABC has taken the opportunity to continue to educate providers about the access to care standards, as evidenced by the "Access to Care provider letter" noted above. ABC is working on a more robust, formalized process by which providers can receive results of their access to care monitoring activities – expected implementation in January 2017.	
10. 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 and diverse cultural and ethnic backgrounds. (Includes a written cultural competency plan, policies, and training) *42 CFR 438.206(c)(2)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.12.1—2.5.12.3	**Documentation:** 1. Colorado Access Provider Manual pg7-8, 2. Coaccess.com top of homepage-choice of language 3. ABC304- Member Choice of Behavioral Health Providers p2 II.E 4. ABC Member Handbook, welcome page, pg 12-13 **5.** PNS202 Selection and Retention of Providers pg 2 I.B 6. ADM206-Culturally Sensitive Services for Diverse Populations pg1-3 7. ABC Access to Care Focus Group Flyer in Spanish 8. ABC Flyer 102013	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability for ABC-D							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	10	**Total Score**		=	10

Total Score ÷ Total Applicable	=	100%

Results for Standard II—Access and Availability for ABC-NE							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	10	**Total Score**		=	10

Total Score ÷ Total Applicable	=	100%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The Contractor must comply with the following requirements based on 42 CFR 441.50 to 441.62 effective October 1, 2015, and Code of Colorado Regulations 10 CCR 2505-10 8.280 effective April 30, 2016. References Contract: Amendment 6, Exhibit A-2—2.5.13.5 The Contractor shall comply with all federal (441.50 to 441.62) and state (10 CCR 2505-10 8.280) EPSDT regulations. Contract: Amendment 6, Exhibit A-2—2.2.1 The Contractor shall provide or arrange for the provision of all medically necessary covered services and diagnoses and procedures, including *services* identified under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, 42 CFR Sections 441.50 to 441.62. (Includes informing, screening, diagnosis, treatment, discretionary services, referral/care coordination, and transportation and scheduling assistance.) Additional Resources State Medicaid Manual/Section 5 offers further detailed instructions and guidance regarding the various components of the EPSDT Program.		
1. The Contractor must have written policies and procedures for providing EPSDT services to members age 20 and under. • The definition of EPSDT services includes informing, screening (assessment), diagnosis, treatment, discretionary services (e.g. medically necessary wrap-around services), referral and care coordination, and transportation and scheduling assistance. 10 CCR 2505-10 8.280.2 and 8.280.8A	**Documentation:** 1. Care Coordination-CCS305 (page 2) 2. CCS Desktop Procedure – Adverse Determinations and EPSDT – pending approval by Compliance Dept. 3. Provider Manual, pages 91-93, “EPSDT Services” 4. CM Desktop Procedure EPSDT Referrals 5. Member Handbook (ABCDen_MemBK_Draft)- Currently waiting for HCPF approval Additional information will be included in 2017 EPSDT Strategic Plan, to be submitted to HCPF/HSAG December 15, 2016 as a result of 2015 EPSDT-CAP.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: ABC submitted existing and proposed policy and procedure information that addressed processes for integrating medical necessity criteria for EPSDT services into UM decisions, coordination among UM care managers and Colorado Access care coordinators for any services denied for members 20 and under, and providing care coordinators to assist EPSDT-eligible members with access to needed services. ABC had no defined policies related to informing members of EPSDT services, ensuring screening services are performed, performing mental health diagnostic or treatment services related to EPSDT, providing referrals and care coordination for EPSDT services other than services denied by the BHO, or providing transportation and scheduling assistance for EPSDT services. ABC has developed an EPSDT Strategic Plan for continued development of ABC's EPSDT program components, which includes "improvement of internal Colorado functions" related to EPSDT. The strategic plan does not specify development of additional written policies and procedures related to EPSDT service requirements. During on-site discussions, HSAG suggested that Colorado Access consider defining an umbrella EPSDT service policy to address all EPSDT requirements, with procedures for implementing the policy defined within individual applicable departments.		
Recommendations: HSAG recommends that ABC revise existing or develop new policies and procedures to address all required components of EPSDT service requirements.		
2. The Contractor must notify members age 20 and under of the benefits and options for children and adolescents under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and is responsible for ensuring that children and their families are able to access the services appropriately. The Contractor must— • Provide a combination of written and oral methods to inform all eligible members (or their families) about the EPSDT program within 60 days of enrollment and annually thereafter. – Member communications must effectively inform those individuals who are blind or deaf or who cannot read or understand the English language.	**Documentation:** 1. Provider Manual p. 91-93 "EPSDT Services" 2. CCS Desktop Procedure 3. CM Desktop Procedure EPSDT Referral 4. EPSDT Fact Sheet 5. No Wrong Door Community Centered Boards Fact Sheet 6. No Wrong Door Single Entry Point Fact Sheet 7. ABC Denial Notice of Action 8. Member Handbook (ABCDen_MemBK_Draft)- Currently waiting for HCPF approval Additional information will be included in 2017 EPSDT Strategic Plan, to be submitted to HCPF/HSAG December 15, 2016 as a result of 2015 EPSDT-CAP.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Using clear and nontechnical language, provide information about the following— – The benefits of preventive healthcare. – The services available under the EPSDT program and where and how to obtain those services; (includes physical, mental, oral and substance abuse, as well as services that may have limits or services not covered in the state plan). – That the services under the EPSDT program are provided without cost to members 20 and under. – That necessary transportation and scheduling assistance for EPSDT services is available to members upon request, and the process to make a request. *42 CFR 441.56 (a)(1)—(4)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.9.1; 2.5.9.2; 2.5.8.1.4		

Findings:
ABC drafted an update to the ABC member handbook to provide information about the benefits and services of the EPSDT program; however, at the time of review ABC had not yet published these changes. The ABC denial NOA also referred members aged 20 and under to the BHO care coordinators for assistance with obtaining access to services not covered by the BHO. The EPSDT Strategic Plan addressed plans to develop onboarding education for new members which will include information on accessing EPSDT services, to coordinate with Healthy Communities on outreach and education for newly enrolled Health First Colorado members, and to work with ABC's Member Advisory Council to identify additional opportunities to share EPSDT information with members. ABC had developed EPSDT information to be included in the January 2017 member newsletter. Staff members stated that ABC was considering care coordinator procedures for communicating with members regarding EPSDT services as another possible mechanism. During

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
on-site discussions, HSAG encouraged ABC to consider enhancing responsibilities and mechanisms for EPSDT communications with members at the provider point of service and include ongoing and periodic—not merely at time of enrollment—mechanisms for communicating information about EPSDT services to members.		
Recommendations: HSAG recommends that ABC implement effective mechanisms to inform members aged 20 and under (or their families) about services available under the EPSDT program, and where and how to obtain those services.		
3. The Contractor must reasonably ensure the provision of all applicable components of periodic health screens (assessments) to EPSDT beneficiaries who are receiving BHO services or referred to a BHO provider. *42 CFR 441.56 (b), 441.59 (b)* 10 CCR 2505-10 8.280.8.C; 8.280.4.A.3 (d) and (h), and 8.280.4.A (4) Contract: Amendment 6, Exhibit A-2—2.5.13.2.1	**Documentation:** 1. Provider Manual p. 91-93 "EPSDT Services" 2. CM Desktop Procedure EPSDT Referrals 3. CCS Desktop Procedure	Information Only
Findings: The provider manual stated, "providers are expected to contact the PCP for results of EPSDT exams." The manual described that providers should determine if the EPSDT screening has been conducted by the PCP, can obtain and review results of the screening, and/or should refer the member to a PCP to perform a screening if needed. The manual did not define the specific components of EPSDT periodic health screens. ABC had no defined policies or detailed procedures to reinforce or implement this process with providers and had not conducted provider training specific to this expectation. During the on-site interview, staff stated that ABC was updating the medical record audit tool to monitor for documentation related to EPSDT requirements; however, it did not appear that the elements of the audit tool would monitor documentation in the medical record to ensure compliance with the provider expectations outlined in the provider manual. In addition, ABC would apply these elements of the medical record audit tool to only a subset (members age 20 and under) of the 50 total records reviewed annually across the BHO. During on-site interviews, HSAG suggested that ABC consider a focused EPSDT medical record audit—conducted and self-reported by the provider—that would enable a more comprehensive assessment and reinforcement of provider responsibilities related to assisting members with obtaining EPSDT periodic health screens. During the on-site interview, staff also acknowledged that care coordinators could potentially facilitate referrals to PCPs if requested to do so by the BHO provider.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Recommendations: HSAG recommends that ABC develop or enhance policies and procedures and provider communications to clarify mechanisms that will reasonably ensure the provision of all components of EPSDT periodic health screens to EPSDT beneficiaries.		
4. Results of screenings (assessments) and examinations for members receiving BHO services shall be recorded in the child's medical record. Documentation shall include, at a minimum, identified problem and negative findings and further diagnostic studies and/or treatments needed and the date ordered. 10 CCR 8.280.4.A (5)	Documentation: 1. Quality will audit this item during the Medical Record Audits. Medical Record Audit tool will be available during the onsite review.	Information Only
Findings: ABC had no policies and procedures that addressed the requirement for documenting EPSDT results in the child's medical record. ABC provided no evidence that providers had been informed of the requirement for documenting results and required components of EPSDT screenings in the member's medical record. The medical record audit tool that ABC was developing included limited monitoring of information related to EPSDT screenings, such as performance of developmental screening by the BHO provider and any documentation of follow-up referrals. The tool did not appear to monitor for documentation of screening results obtained from PCPs.		
Recommendations: HSAG recommends that ABC clarify expectations related to documenting in the child's medical record results of EPSDT screenings and examinations.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. The Contractor must ensure the delivery of EPSDT Contractor-covered services. 10 CCR 2505-10 8.280.8.A	**Documentation:** 1. Provider Manual p. 91-93 "EPSDT Services" 2. CM Desktop Procedure EPSDT Referrals 3. CCS Desktop Procedure	Information Only
Findings: The EPSDT section of the provider manual stated, "any service necessary to treat healthcare needs identified through an EPSDT screening must be provided." The manual stated that providers should communicate any behavioral health assessment and treatments with the member's PCP and did identify mechanisms for doing so. However, the language in the provider manual did not suggest the types of BHO-covered services that may apply to EPSDT-eligible members or specifically require that BHO providers deliver those services. During on-site interviews, staff clarified that ABC conducts UM authorization for only higher levels of care—not outpatient services. However, UM policies and procedures did not address the application of EPSDT medical necessity criteria to authorizations for services for members 20 and under; nor was there evidence to suggest that that UM reviewers would be aware whether or not a specific requested service is related to EPSDT. ABC had developed a desktop procedure for Adverse Determinations and EPSDT that included the EPSDT "medical necessity" definition, but the procedure had not yet been implemented. ABC conducted no staff training to alert UM staff to examples of EPSDT contractor-covered services or how to implement EPSDT-specific procedures for authorization decisions. Therefore, ABC did not appear to have adequate procedures to operationalize processes to ensure delivery of BHO covered services to EPSDT-eligible members.		
Recommendations: HSAG recommends that ABC enhance and implement policies and procedures and provider and staff communications to adequately operationalize processes to ensure delivery of EPSDT BHO-covered services.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
6. The Contractor must ensure that BHO providers provide diagnostic services in addition to treatment of all mental illnesses or conditions (includes substance abuse) discovered by any screening and diagnostic procedure—even if the services are not covered in the plan. *42 CFR 441.56 (c)* 10 CCR 2505-10 8.280.4.A (3) (e); 8.280.4.C (3) Contract: Amendment 6, Exhibit A-2—2.5.13.2.5	**Documentation:** 1. Care Coordination-CCS305, page 5, C3 and page 6, C11 2. CCS Desktop Procedure – Adverse Determinations and EPSDT – pending approval by Compliance Dept. 3. Member Notice of Action Letter 4. CM Desktop Procedure EPSDT Referrals	Information Only
Findings: ABC developed policies and procedures applicable to coordinating services "not covered by the plan" for members 20 and under. Procedures outlined the process for UM staff to coordinate with care coordination staff to assist members with access to any services denied by the BHO but potentially available through fee-for-service programs. However, ABC had not fully implemented the EPSDT-specific UM and care coordination procedures; and staff stated that ABC had not yet provided training to UM and care coordination staff. The EPSDT Strategic Plan indicated that staff training would be completed in the second quarter of calendar year 2017. The most current version of the member NOA letter included the statement, "If the member is under age 21 and the requested service was denied because it is not a covered benefit, you will be contacted by a Care Manager for assistance with additional resources." During on-site record reviews, HSAG noted that one case had no documentation of the BHO care coordinator having contacted the member to provide assistance, per this statement. As noted in findings related to Element 5 preceding, the provider manual encouraged behavioral health providers to contact the PCP to obtain information on screenings performed but did not explicitly address the requirement that BHO providers provide diagnostic services in addition to treatment of all mental illnesses or conditions (including substance abuse) discovered by any screening and diagnostic procedure. ABC also had not trained providers regarding this requirement.		
Recommendations: HSAG recommends that ABC implement its proposed procedures and provide appropriate staff and providers with training to operationalize the intent to provide or coordinate diagnostic and treatment services needed as a result of EPSDT screenings or diagnostic services.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. If the provider is not licensed or equipped to render necessary treatment or further diagnosis, the provider shall refer the individual to an appropriate practitioner or facility or to the Outreach and Case Management Office (Healthy Communities) for assistance in finding a provider. 10 CCR 2505-10 8.280.4.C.2 Contract: Amendment 6, Exhibit A-2—2.5.13.1.1	**Documentation:** 1. Care Coordination-CCS305, page 5, C3 and page 6, C11 2. CCS Desktop Procedure – Adverse Determinations and EPSDT – pending approval by Compliance Dept. 3. Member Notice of Action Letter 4. CM Desktop Procedure EPSDT Referrals	Information Only
Findings: ABC has internal procedures for assisting members and providers with referrals to other providers of EPSDT services, especially when the required service is not covered by the plan. The Care Coordination policy also outlined the provision of care coordination related to a broad array of EPSDT-eligible services, including assisting with provider referrals, obtaining medical care, and coordinating with Healthy Communities. However, neither the provider manual nor other provider communications stated that the provider is responsible to refer the member to an appropriate practitioner or to Healthy Communities, nor did provider communications direct the provider to contact the BHO care coordinators for assistance. Therefore, it was not clear how the provider or the BHO would consistently refer the member to an appropriate practitioner or Healthy Communities when the "provider is not licensed or equipped to render necessary treatment or further diagnosis."		
Recommendations: HSAG recommends that ABC more clearly outline this requirement to providers and/or establish a link between providers and BHO care coordination processes to ensure that members are referred to appropriate providers when the current provider is not licensed or equipped to render necessary treatment or further diagnosis.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor defines "Medical Necessity for EPSDT Services" as: • A service that is found to be equally effective treatment among other less conservative or more costly treatment options; • Meets one of the following criteria: – The service is expected to prevent or diagnose the onset of an illness, condition, or disability. – The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. – The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability. – The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living. • May be a course of treatment that includes observation or no treatment at all. – The Contractor's UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements: o The service is medically necessary.	**Documentation:** 1. CCS Desktop Procedure – Adverse Determinations and EPSDT – pending approval by Compliance Dept. 2. CM Desktop Procedure EPSDT Referrals 3. EPSDT Fact Sheet 4. No Wrong Door Community Centered Boards Fact Sheet 5. No Wrong Door Single Entry Point Fact Sheet	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
o The service is in accordance with generally accepted standards of medical practice. o The service is clinically appropriate in terms of type, frequency, extent, and duration. o The service provides a safe environment or situation for the child. o The service is not for the convenience of the caregiver. o The service is not experimental and is generally accepted by the medical community for the purpose stated. *42 CFR 441.57* 10 CCR 2505-10 8.280.1, 8.280.4.D and E		
Findings: The proposed Adverse Determinations and EPSDT procedure included the EPSDT definition of "medical necessity" but did not include the criteria for approval of EPSDT requested services outlined in the requirement. In addition, ABC should note that the definition of medical necessity outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—includes the EPSDT-specific criteria per 8.280.4.E. HSAG strongly recommends that ABC incorporate the definition of medical necessity as outlined in the Findings section of Standard I, element 4 of this tool. The Adverse Determinations and EPSDT procedure was pending approval and had not yet been implemented. UM policies and procedures did not include the EPSDT definition of "medical necessity" or the criteria for approval of EPSDT services outlined in the requirement. ABC had not trained UM staff regarding the specific criteria to be applied to authorization of EPSDT-related procedures. During on-site interviews, staff members could not articulate how EPSDT medical necessity and authorization criteria are applied within existing UM authorization processes. Therefore, it was not apparent that ABC had integrated EPSDT authorization criteria into its UM processes.		
Recommendations: HSAG recommends that ABC establish mechanisms to apply EPSDT "medical necessity" definitions and criteria in its service authorization processes for members age 20 and under.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor must provide referral assistance to members receiving BHO services for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening (assessment) and diagnosis. • The Contractor must coordinate with other programs that may provide EPSDT-related services: State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Health Care Program for Children with Special Needs), other public health, mental health, and education programs and related programs such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC). – Includes Child Find, Early Intervention Colorado, and the Accountable Care Collaborative. • Contractors are encouraged to refer children and their families to the Healthy Communities program in their area for community services and medical referrals, transportation information, appointment assistance, and administrative case management. – Contractors are encouraged to contact Healthy Communities for assistance in locating families who may have excessively missed appointments. • The Contractor must have a process to ensure that medically necessary services not covered by the	**Documentation:** 1. Care Coordination-CCS305, pages 5-6 2. CCS Desktop Procedure – Adverse Determinations and EPSDT – pending approval by Compliance Dept. 3. Member Notice of Action Letter 4. CM Desktop Procedure EPSDT Referrals Additional information will be included in 2017 EPSDT Strategic Plan, to be submitted to HCPF/HSAG December 15, 2016 as a result of 2015 EPSDT-CAP.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Contractor are referred to the Office of Clinical Services for action. *42 CFR 441.61 and 441.62* 10 CCR 2505-10 8.280.8.D (5) Contract: Amendment 6, Exhibit A-2—2.5.13.1		
10. The Contractor must share PHI with the Department's EPSDT outreach and case management agencies (Healthy Communities) as allowable under HIPAA for treatment, payment and operations purposes, without requiring any special releases or other permission from the member. • The Contractor shall have either written consent from a member or a qualified service organization (QSO) agreement with a substance abuse organization to share member information regarding substance abuse disorder treatment with the Department's EPSDT outreach and case management agencies (Healthy Communities). Contract: Amendment 6, Exhibit A-2—2.5.13.3, 2.5.13.4	**Documentation:** 1. Provider Manual, pages 91-93, "EPSDT Services" Additional information will be included in 2017 EPSDT Strategic Plan, to be submitted to HCPF/HSAG December 15, 2016 as a result of 2015 EPSDT-CAP.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11. The Contractor facilitates provision of components of periodic health screens (assessments) for members receiving BHO services through systematic communication with network providers regarding the Department's EPSDT requirements. 10 CCR 2505-10 8.280.8.D (3) and (4)	**Documentation:** 1. Provider Manual, pages 91-93, "EPSDT Services" Additional information will be included in 2017 EPSDT Strategic Plan, to be submitted to HCPF/HSAG December 15, 2016 as a result of 2015 EPSDT-CAP.	Information Only
Findings: The provider manual included an EPSDT-specific section that generally describes EPSDT services but does not define the components of periodic health screens. The manual "encouraged" providers to communicate with PCPs or refer members to a PCP as needed, but did not clearly define all provider expectations related to EPSDT requirements. The EPSDT Strategic Plan indicated that ABC would develop and deploy provider training modules in quarters 2 and 3 of calendar year 2017, including an EPSDT webinar to be available on the Colorado Access website and incorporating EPSDT as a component of provider orientation training. During on-site discussions, HSAG clarified that "systematic" communication with providers required that the BHO address mechanisms for ongoing and periodic communication with providers rather than one-time or infrequently accessed information sources—i.e., the provider manual or provider orientation training. ABC had not implemented sufficient systematic communication with network providers regarding the Department's EPSDT requirements.		
Recommendations: HSAG recommends that ABC enhance and implement communications with its network providers regarding the EPSDT program and requirements to ensure that providers understand EPSDT services for members—periodic health screens—as well as communicate clear expectations to providers and inform providers about BHO or external resources available to assist providers with implementing EPSDT requirements.		

Appendix B. Record Review Tool

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Access Behavioral Care—Denver

Review Period:	January 1, 2016–November 30, 2016
Date of Review:	January 9, 2017
Reviewer:	Kathy Bartilotta
Participating Plan Staff Member:	Christine Gillespie

Requirements	File 1	File 2	File 3	File 4	File 5
Member	JG	JH	AM	CB	SC
Date of initial request	11/08/16	Omitted	10/24/16	08/09/16	07/12/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR		NR	NR	NR
Standard (S), Expedited (E), or Retrospective (R)	S		S	E	E
Date notice of action sent	11/16/16		10/26/16	08/15/16	07/14/16
Notice sent to provider and member? (C or NC)	C		C	C	C
Number of days for decision/notice	8		2	7	2
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	NC	C
Was authorization decision timeline extended? (Y or N)	Y		N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	C		NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	C		NA	NA	NA
Notice of Action includes required content? (C or NC)	C		C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C		C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	N/A		C	NA	NA
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, NC, or N/A)	C		NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C		C	C	C
Was correspondence with the member easy to understand? (C or NC)	C		C	NC	C
Total Applicable Elements	**9**		**7**	**6**	**6**
Total Compliant Elements	**9**		**7**	**4**	**6**
Score (Number Compliant / Number Applicable) = %	**100%**		**100%**	**67%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Requirements	File 6	File 7	File 8	File 9	File 10
Member	KR	AA-V	GL	JG	RW
Date of initial request	06/10/16	05/25/16	03/22/16	01/28/16	02/02/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
Standard (S), Expedited (E), or Retrospective (R)	S	E	E	S	S
Date notice of action sent	06/13/16	05/25/16	03/22/16	01/28/16	02/03/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	3	1	1	1	1
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	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	C
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, NC, or N/A)	NA	C	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	**6**	**7**	**6**	**6**	**7**
Total Compliant Elements	**6**	**7**	**6**	**6**	**7**
Score (Number Compliant / Number Applicable) = %	**100%**	**100%**	**100%**	**100%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Access Behavioral Care—Denver

Requirements	OS1	OS2	OS3	OS4	OS5
Member	AV				
Date of initial request	09/14/16				
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR				
Standard (S), Expedited (E), or Retrospective (R)	E				
Date notice of action sent	09/15/16				
Notice sent to provider and member? (C or NC)	C				
Number of days for decision/notice	1				
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				
Was authorization decision timeline extended? (Y or N)	N				
If extended, extension notification sent to member? (C, NC, or NA)	NA				
If extended, extension notification includes required content? (C, NC, or NA)	NA				
Notice of Action includes required content? (C or NC)	C				
Authorization decision made by qualified clinician? (C, NC, or NA)	C				
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA				
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, NC, or N/A)	NA				
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C				
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 **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Total Record Review Score	Total Applicable Elements: 66	Total Compliant Elements: 64	Total Score: 97%

Notes:

File 1 (JG): Member was 16 years old. Cigna was primary payer and had denied continued authorization of services, so provider requested BHO service authorization. ABC extended the time frame to allow for collection of additional information from provider and Cigna. The member had a legal guardian; but letters to the member were addressed to the member's parent, not the guardian. The member did not meet InterQual criteria, but ABC's medical director denied due to *not a covered diagnosis* (autism and developmental disorders). The denial letter suggested that the member contact BHO care managers and/or the Office of Clinical Services.

File 2 (JH): Record omitted because it was a denial of a provider's request for a single case agreement (SCA). Denial of an SCA is not an adverse determination/action that requires a notice of action.

File 3 (AM): Member was 16 years old. Documentation showed that UM staff obtained additional information from the provider prior to the review determination. ABC denied the service based on lack of medical necessity. Letter referred member to the BHO care manager and/or the Office of Clinical Services.

File 4 (CB): The 60-year-old member was admitted on August 7 with a 72-hour police hold based on a suicide attempt. ABC received the request for authorization of inpatient stay August 9. The member was discharged on August 10. Notes indicated the member was depressed and experiencing alcohol withdrawal. ABC denied due to "not a covered diagnosis/benefit"—alcohol withdrawal. Inpatient substance use disorder (SUD) is not a covered benefit. ABC did not mail the notice of action within the required expedited time frame, although the member had already been discharged. The notice of action included confusing information and instructed the member to "consider billing fee-for-service."

File 5 (SC): The member was 32 years old. The request from an out-of-state hospital was received 5 days after admission. ABC denied the first 5 days due to "no authorization." ABC reviewed for and denied the continued stay. Member had been admitted because she had called police and reported that she was suicidal. Member had history of alcohol abuse. Denied due to "not a covered diagnosis/benefit" (inpatient treatment for SUD is not a covered benefit).

File 6 (KR): The member was 52 years old. The new request was for a particular therapy previously covered through grant funds. ABC denied the service based on lack of medical necessity—i.e., alternative therapies are available.

File 7 (AA-V): The member was 15 years old. ABC denied the request for long-term residential services following evaluation at mental health center. Had been discharged from approved short-term residential treatment few days earlier. Denied based on lack of medical necessity—i.e., more appropriate alternatives available. The notice of action instructed the member to contact a BHO care manager for additional assistance.

File 8 (GL): The member was 44 years old. ABC denied the request for continued inpatient stay based on lack of medical necessity—patient was ready for discharge but could not find transportation. (ABC previously approved three requests for total of 11 days).

File 9 (JG): The member was 49 years old. ABC denied the request for intensive outpatient therapy for SUD based on lack of medically necessity.

File 10 (RW): The member was 18 years old. The request was for outpatient psychological testing in order to differentiate diagnosis of psychosis. ABC's medical director offered a consultation with the requesting provider but received no response. Denied due to lack of medical necessity.

File OS1 (AV): Selected from oversample to replace File 2. The member was 19 years old. The member was admitted to the acute treatment unit (ATU) 1 day prior to the request for authorization. Documented diagnoses were bipolar disorder and autism (high functioning). ABC denied services based on lack of medical necessity and offered alternatives for outpatient care. The notice of action letter directed the member to contact a BHO care manager and/or the Office of Clinical Services.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Access Behavioral Care—Northeast

Review Period:	January 1, 2016–November 30, 2016
Date of Review:	January 9, 2017
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Carol Wilde

Requirements	File 1	File 2	File 3	File 4	File 5
Member	WS	CE	JoP	JuP	LC
Date of initial request	03/28/16	01/05/16	Omitted	05/09/16	06/03/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR		NR	NR
Standard (S), Expedited (E), or Retrospective (R)	E	S		E	S
Date notice of action sent	03/28/16	01/12/16		05/10/16	06/09/16
Notice sent to provider and member? (C or NC)	C	C		C	C
Number of days for decision/notice	1	7		1	6
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
Was authorization decision timeline extended? (Y or N)	N	N		N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA		NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA		NA	NA
Notice of Action includes required content? (C or NC)	C	C		C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C		C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA		NA	NA
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, NC, or N/A)	NA	NA		NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C		C	C
Was correspondence with the member easy to understand? (C or NC)	NC	NC		C	C
Total Applicable Elements	**6**	**6**		**6**	**6**
Total Compliant Elements	**5**	**5**		**6**	**6**
Score (Number Compliant / Number Applicable) = %	**83%**	**83%**		**100%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Requirements	File 6	File 7	File 8	File 9	File 10
Member	CW	SK	BP	AP	CH
Date of initial request	06/07/16	11/15/16	11/18/16	10/24/16	Omitted
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	
Standard (S), Expedited (E), or Retrospective (R)	S	S	S	E	
Date notice of action sent	06/07/16	11/15/16	11/29/16	—	
Notice sent to provider and member? (C or NC)	C	C	C	NC	
Number of days for decision/notice	1	1	11	1	
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	NC	NA	
Was authorization decision timeline extended? (Y or N)	N	N	N	N	
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	
Notice of Action includes required content? (C or NC)	C	C	C	NA	
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	
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, NC, or N/A)	NA	NA	NA	NA	
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	
Was correspondence with the member easy to understand? (C or NC)	C	C	C	NA	
Total Applicable Elements	**6**	**6**	**6**	**3**	
Total Compliant Elements	**6**	**6**	**5**	**2**	
Score (Number Compliant / Number Applicable) = %	**100%**	**100%**	**83%**	**67%**	

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Access Behavioral Care—Northeast

Requirements	OS 1	OS 2	OS 3	OS 4	OS 5
Member	JM	MB			
Date of initial request	10/19/16	10/18/16			
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR			
Standard (S), Expedited (E), or Retrospective (R)	S	E			
Date notice of action sent	10/20/26	10/18/16			
Notice sent to provider and member? (C or NC)	C	C			
Number of days for decision/notice	1	1			
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			
Was authorization decision timeline extended? (Y or N)	N	N			
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA			
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA			
Notice of Action includes required content? (C or NC)	C	C			
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C			
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA			
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, NC, or N/A)	C	NA			
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C			
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%**			

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Total Record Review Score	Total Applicable Elements: 58	Total Compliant Elements: 54	Total Score: 93%

Notes:

File 1 (WS): Member was 17 years old. This concurrent review for continued inpatient was denied because the level of care was no longer medically necessary. The member was eligible for EPSDT services; however, the letter offered no information about how to obtain assistance with EPSDT-eligible services. The reason for the denial, as described in the notice of action, included terminology that may be difficult for the member (and family) to understand.

File 2 (CE): The member was 12 years old. The request for respite care was denied based on lack of medical necessity. The member was eligible for EPSDT services; however, the letter offered no information about how to obtain assistance with EPSDT-eligible services. The reason for the denial, as described in the notice of action, was confusing and included language that may have been difficult for the member (and family) to understand.

File 3 (JoP): The member's name did not match the ID number. Additionally, ABC had no record of denial for the member (when searched by name) or for the person belonging to the ID number. This record was removed from the sample and replaced with oversample record number OS1.

File 4 (JuP) The member was 10 years old. The concurrent review for continued short-term residential services was denied because the level of care was no longer medically necessary. The member was eligible for EPSDT services; however, the letter offered no information about how to obtain assistance with EPSDT-eligible services.

File 5 (LC): The member was 11 years old. The request for day treatment services was denied based on lack of medical necessity. The letter included information regarding the EPSDT program and told the member to call an ABC care manager for more information.

File 6 (CW): The member was 25 years old. The request for intensive outpatient services for substance use disorder was denied based on lack of medical necessity. The notice of action included options for lower levels of service that may be more appropriate for this member.

File 7 (SK): The member was 36 years old. The concurrent review for continued inpatient was denied because the level of care was no longer medically necessary.

File 8 (BP): The member was 17 years old. The request for psychiatric testing was denied based on lack of medical necessity. The letter suggested that the member may be eligible for EPSDT services and said she would be contacted by an ABC care manager.

File 9 (AP): The member was 14 years old. The concurrent review for continued inpatient was denied because the level of care was no longer medically necessary. ABC gave the provider verbal notification. ABC had no evidence of having provided a written notice of denial to the member. (The additional requirements pertaining to the written NOA were therefore scored NA.)

File 10 (CH): ABC denied the service on August 19, 2016. The requesting provider called on August 22 to request a peer-to-peer consult and, as a result of that discussion, ABC overturned its decision. ABC had not mailed the notice of action; therefore, the service is not considered "denied." This record was removed from the sample and replaced with oversample record number OS2.

File OS1 (JM): The member was 17 years old. The request for short-term residential services was denied based on "not a covered diagnosis" (traumatic brain injury and severe developmental disabilities). The member was EPSDT-eligible, and the notice of action stated that an ABC care manager would contact the member to help determine if the member qualified for additional services.

File OS2 (MB): The member was 27 years old. The concurrent review for continued inpatient was denied because the diagnosis was substance dependence. ABC previously approved and paid for the initial three days of inpatient care.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **ABC**.

Table C-1—HSAG Reviewers and ABC and Department Participants

HSAG Review Team	Title
Barb McConnell, MBA, OTR	Executive Director
Kathy Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
ABC Participants	**Title**
Carol Wilde	Manager, Utilization Management
Kristin Brown	Operations Manager, Behavioral Health
Marty Janssen	Deputy Director, Northeast Colorado Medicaid
Elizabeth Strammiello	Chief Compliance Officer
Dave Rastatter	Director, Northeast Colorado Medicaid
Jenny Nate	Deputy Director, Behavioral Health
Shelby Kiernan	Director, Integrated Care
Christine Gillespie, RN	Manager, Clinical Appeals
Michelle Tomsche	Operations Director, Behavioral Health Director, Behavioral Healthcare, Inc. Line of Business
Rob Bremer	Vice President, Integrated Care
Jillian Carroll	Regional Manager, Northeast Colorado Medicaid
Regina Fetterolf	Director, Care Management
Julie McNamara	Director, System Operations and Vendor Management
Jason Smith	Manager, Care Delivery System Contracting
Rebecca Lynn	Director, Provider Contracting
Aaron Brotherson	Director, Provider
Scott Humphry	Medical Director, Behavioral Health
Nancy Viera	Project Coordinator, Quality Improvement
Lindsay Cowee (telephonic)	Director, Clinical Quality Management
Department Observers	**Title**
Gina Robinson	Program Administrator
Michael Lott-Manier (telephonic)	Contract Manager
Russ Kennedy	Quality Unit

Appendix D. Corrective Action Plan Template for FY 2016–2017

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	Action
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 email or through the file transfer protocol (FTP) site, with an email 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 email 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 email or the FTP site, with an email 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.

Step	Action
Step 6	**Documentation substantiating implementation of the plan 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 healthcare regulations and managed care contract requirements.

The CAP template follows.

Table D-2—FY 2016–2017 Corrective Action Plan for ABC

Standard I—Coverage and Authorization of Services (ABC-NE ONLY)		
Requirement	**Findings**	**Required Action**
9. The Contractor has in place 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). *42 CFR 438.210(c)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.1 10 CCR 2505-10 8.209.4.A	The Utilization Review Determinations policy accurately outlined this requirement; however, one of the ABC-NE denial records reviewed on-site documented no written notice of action (NOA) to the member.	ABC-NE must have a mechanism to ensure that it gives the member written notice of any decision to deny a service authorization request.
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:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
13. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.6.5.5 10CCR2505—10, Sec 8.209.4.A.1	ABC policies and procedures addressed the requirement that NOAs be written in language to ensure ease of understanding. Staff members stated that every notice is reviewed for clarity of information prior to being mailed. However, during denial record reviews, HSAG observed that: • ABC-D had one NOA that included information inappropriate for the member—it instructed the member to "consider billing fee for service." Billing is a provider responsibility, not a member responsibility; therefore, HSAG considered the letter confusing. • ABC-NE had two cases in which the reason for the denial, as described in the NOA, included terminology that may have been difficult for the member (and family) to understand. HSAG noted that several additional NOAs included language that could be considered borderline with respect to terminology used in the reason for the denial or information that may not have been appropriate for the member—such as EPSDT information in letters for adult members who are ineligible for EPSDT services.	ABC-D and ABC-NE must have effective mechanisms to ensure that all information in NOAs to members is appropriate to the members and written in language that ensures ease of understanding.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
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:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. The notices of action must be mailed within the following time frames: • 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 expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services. *42 CFR 438.210 (d)* *42 CFR 438.404(c)* *42 CFR 431.211,431.213, and 431.214* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5 10CCR2505—10, Sec 8.209.4.A (3) (a-c)	ABC's policies and procedures accurately addressed all time frames for mailing an NOA per the requirement. However, in the denial record reviews, ABC-D had one case in which the NOA was mailed outside the required time frame for expedited authorization decisions and ABC-NE had one case in which the NOA was mailed outside the required time frame for standard authorization decisions.	ABC-D and ABC-NE must have a mechanism to ensure that NOAs are mailed in the required time frames as outlined in the ABC policies and procedures.
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:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
29. The Contractor is financially responsible for post stabilization 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 post stabilization 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 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 post stabilization care services it has not pre-approved ends.	ABC's Emergency and Post-Stabilization Care policy addressed this requirement verbatim. The emergency room (ER) claims payment procedures stated that ABC reviews inpatient admissions following an ER visit (post-stabilization services) to ensure that an authorization was obtained for the inpatient admission. If authorization was granted, the claim is paid. If no authorization was granted, the claim is denied. However, it was unclear in written UM procedures and during on-site interviews whether or not claim payment or authorization decisions considered the circumstances outlined in this requirement and as specified in the Emergency and Post-Stabilization Care policy.	ABC must develop a process to ensure that both the UM procedures and claims payment decisions are linked to the requirements for the Contractor's financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
42 CFR 438.114(e) *42 CFR 422.113(c)(ii) and (iii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.8, 2.2.4.3.8.1, 2.2.4.3.8.2, 2.2.4.3.8.3		
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:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
30. The Contractor's financial responsibility for post stabilization care services it ***has not*** pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care. • A plan physician assumes responsibility for the member's care through transfer. • A plan representative and the treating physician reach an agreement concerning the member's care. • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.9	ABC's Emergency and Post-Stabilization Care policy addressed this requirement verbatim. The ER claims payment procedures stated that ABC reviews inpatient admissions following an ER visit (post-stabilization services) to ensure that an authorization was obtained for the inpatient admission. If authorization was granted, the claim is paid. If no authorization was granted, the claim is denied. However, it was unclear in written procedures and during on-site interviews whether or not the circumstances outlined in this requirement and specified in ABC's Emergency and Post-Stabilization Care policy were integrated into claims payment decisions.	ABC must develop a process to ensure that the Contractor's financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy, are integrated into claims payment decisions.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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 email 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 three 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, 2016, and December 31, 2016. 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.

For this step,	HSAG completed the following activities:
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. • 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 2016–2017 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 draft 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.