State of Colorado

Department of Health Care Policy and Financing

Colorado Medicaid
Community Mental Health Services Program

FY 06–07 Site Review Report

for

Behavioral HealthCare, Inc.

April 2007

HSAG Health Services Advisory Group

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This is the third year that Health Services Advisory Group, Inc. (HSAG) has performed site reviews of the Colorado behavioral health organizations (BHOs). Compliance with federal regulations and contract requirements was evaluated in 10 areas (i.e., delegation; provider issues; practice guidelines; member rights and responsibilities; access and availability; utilization management; continuity-of-care system; quality assessment and performance improvement program; grievances, appeals, and fair hearings; and credentialing). Individual records were reviewed in the areas of grievances, denials, coordination of care for children transitioning from inpatient to outpatient services, and documentation of services to evaluate implementation of select requirements related to the standards. Details of the site review methodology are contained in Appendix D of this report.

This report documents results of the fiscal year (FY) 06–07 site review for **Behavioral HealthCare, Inc.** (**BHI**) related to compliance with requirements in the 10 standard areas and the elements of the record reviews evaluated as part of the site review.

2. Summary of Follow-Up on Prior Year Review

for Behavioral HealthCare, Inc.

As a follow-up to the FY 05–06 site review report, **BHI** was required to submit a corrective action plan (CAP) to the Colorado Department of Health Care Policy & Financing (the Department) addressing all elements for which **BHI** received a score of *Partially Met* or *Not Met*. The plan included interventions to achieve compliance and the timeline. The Department reviewed the CAP and associated documentation, requesting revisions where necessary. **BHI** completed all corrective actions for FY 05–06.

The findings for the FY 06–07 site review were determined from a desk review of the documents submitted by **BHI** to HSAG prior to the on-site portion of the review, interviews with key **BHI** staff members, and a review of records conducted during the site review.

For the review of the 10 standards, the individual elements (i.e., contract requirements) reviewed for each standard were assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable (N/A)*. A summary score was then determined by calculating the percentage of applicable elements found compliant (i.e., *Met*).

Table 3–1 presents the number of elements for each of the 10 standards, the number of applicable elements for each standard, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *N/A*), the overall compliance score for each standard, and the overall compliance score for the review of standards. Details of the review of the 10 standards can be found in Appendix A.

Table 3–1—Summary of Scores for the Standards

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I	Delegation	13	12	11	1	0	1	92%
II	Provider Issues	26	25	23	2	0	1	92%
III	Practice Guidelines	5	2	2	0	0	3	100%
IV	Member Rights and Responsibilities	18	18	18	0	0	0	100%
V	Access and Availability	20	20	19	1	0	0	95%
VI	Utilization Management	8	8	8	0	0	0	100%
VII	Continuity-of-Care System	15	15	15	0	0	0	100%
VIII	Quality Assessment and Performance Improvement Program	12	12	12	0	0	0	100%
IX	Grievances, Appeals, and Fair Hearings	11	11	10	1	0	0	91%
X	Credentialing	32	32	30	2	0	0	94%
	Totals	160	155	148	7	0	5	95%

For the review of records for documentation of services, denials, and grievances, elements in each record reviewed were assigned a score of Yes (compliant), No (not compliant), or Not Applicable (N/A). For each of the scored record reviews, a summary score was then determined by calculating the percentage of applicable elements found compliant.

Table 3–2 presents the number of records reviewed, the number of applicable elements, and the number of compliant elements. It also provides an overall compliance score for each record review as well as a combined record review compliance score. Details of each record review can be found in Appendix B. The coordination-of-care record review was not scored. A narrative summary of each record review can be found in Section 4.

Table 3–2—Summary of Scores for the Review of Records

Associated Standard #	Description of Record Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
II	Documentation of Services	**10**	**20**	**19**	**95%**
VI	Denials	**10**	**30**	**29**	**97%**
VII	Coordination of Care—Children Transitioning From Inpatient to Outpatient Services	**10**	**Not Scored**	**Not Scored**	**Not Scored**
IX	Grievances	**10**	**41**	**40**	**98%**
	Totals	**40**	**91**	**88**	**97%**

Table 3–3 presents the overall scores (percentage of compliance) for the review of the standards, for the review of records, and for the review of the standards and records combined.

Table 3–3—Overall Compliance Scores

Review of the Standards—Percentage Compliant	**95%**
Review of Records—Percentage Compliant	**97%**
Overall Percentage Compliant	**96%**

This section of the report describes **BHI**'s strengths and required actions related to each of the standards and types of records reviewed. Details of the scores related to the review of the standards can be found in Appendix A and details of the scores related to the review of records can be found in Appendix B.

Standard I—Delegation

Strengths

BHI had delegation agreements with each of its delegates and an effective system for monitoring delegation activities, requiring corrective action when necessary, and following up on required corrective action. Written delegation agreements contained all of the required language.

Required Actions

BHI must have a process for notifying the Department in writing of its decision to terminate any existing delegation subcontract applicable to the performance of services under the contract. The process must include a notice to the Department 60 calendar days prior to the termination unless termination of the subcontract is based on quality or performance issues.

Standard II—Provider Issues

Strengths

BHI had an effective tracking mechanism to ensure that it had an agreement with each provider. **BHI** had clear policies and procedures for monitoring providers and several mechanisms for monitoring and ensuring corporate compliance.

Review of Documentation of Services

A sample of 10 consumer records was reviewed to assess **BHI**'s compliance with contract requirements related to documentation of services for encounters submitted. **BHI** was compliant with 19 of 20 applicable elements reviewed, for a record review score of 95 percent. All 10 records contained documentation of the service provided for the day the encounter was submitted. Nine of 10 records contained documentation that described the service for which the encounter was submitted. For one record, the provider used an incorrect encounter code.

Required Actions

BHI must ensure that providers submit accurate encounter codes that represent the services provided.

While **BHI** had evidence of written agreements with each of its mental health center providers within the **BHI** service area, these agreements were signed in 1995 and have not been updated or amended since that time. As a result, the specified activities and reporting responsibilities assigned to these provider organizations were outdated. **BHI** must update or amend agreements with its community mental health center (CMHC) providers to specify current activities and reporting responsibilities assigned to the CMHCs.

Standard III—Practice Guidelines

Strengths

BHI had an active Standards of Practice Committee that reviewed and adopted clinical practice guidelines, medication algorithms, toolkit information, and clinician training materials for the treatment of various mental health conditions. **BHI**'s practice related to the research, adoption and dissemination of practice guidelines was consistent with policy and ensured that the guidelines were based on valid and reliable clinical evidence, considered the needs of members, and were adopted in consultation with health care professionals with expertise in treating mental health disorders. **BHI** also demonstrated that it actively reviewed and updated practice guidelines based on changes in the literature and/or the development of new technologies. **BHI** made information regarding practice guidelines available to consumers, family members, and providers.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard IV—Member Rights and Responsibilities

Strengths

BHI had policies, procedures, and practices in place to provide consumer rights information to consumers, staff, and providers, and to ensure that those rights were taken into account when providing services.

The BHO had an active, functioning Office of Consumer and Family Affairs and demonstrated consumer involvement and empowerment in many of its programs and initiatives.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard V—Access and Availability

Strengths

BHI had processes in place to ensure an adequate network and timely access to services and supports. Data were collected and analyzed regarding the sufficiency of the network in meeting the needs of consumers. Data were analyzed based on geographic access and provider type. The BHO demonstrated that consumers had a choice of providers as evidenced by the presence of several single-case agreements.

While timely medication management appointments were a challenge, the BHO had developed initiatives, including a performance improvement project, to analyze and address barriers and was making progress in this regard.

The BHO's commitment to the use of alternative services and to services that supported empowerment and the recovery model was outstanding. The language, documentation, practices, and culture of the organization modeled this philosophy, and numerous examples of initiatives and programs that were consumer-driven provided evidence of **BHI**'s commitment.

Required Actions

Because the Access and Availability policy documented two different standards for timely access to routine appointments (both 7 and 14 days were listed), **BHI** must revise its policy to clarify that the standard is 7 days.

Standard VI—Utilization Management

Strengths

BHI had an active Utilization Management (UM) Program in place. The BHO used numerous UM measures, monitoring tools, and studies to assess consumer access to covered services, to ensure the consistent application of medical necessity criteria, and to help detect under- and overutilization of services.

BHI delegated several UM functions to InNET and to its delegate CMHCs. To help ensure consistency in practice, the BHO provided ongoing training to InNET and the CMHCs regarding level-of-care criteria and the appropriate handling of actions and appeals related to utilization review denials. **BHI** monitored compliance with activities delegated to InNET and the CMHCs through annual audits.

Review of Denial Records

Ten enrollee denial records were reviewed to assess **BHI**'s compliance with contract requirements related to the presence and content of required documentation and the timeliness of resolution and documentation. **BHI** was compliant with 29 of 30 applicable elements reviewed for an overall score of 97 percent. **BHI** was fully compliant in the following areas: 1) the notice included the reason for denial, and 2) the decision was made by a qualified clinician. A Notice of Action for one case reviewed was not sent in a timely manner to the consumer and provider following a utilization review (UR) denial as required in Exhibit G of the BHO's contract with the Department.

Required Actions

BHI must ensure that a Notice of Action is sent in a timely manner to the consumer and provider following a UR denial decision.

Standard VII—Continuity-of-Care System

Strengths

BHI had numerous policies, procedures, and forms that addressed various issues related to continuity of care. The BHO provided multiple examples of collaborative projects with medical providers, including several initiatives that involved the colocation of mental health services in primary care physician (PCP) and pediatrician offices and in federally qualified health centers. The BHO also provided school-based services in more than 30 elementary, middle, and high schools and offered mental health care to consumers in juvenile and adult correctional facilities.

Review of Coordination of Care—Children Transitioning from Inpatient to Outpatient Services

Ten records were reviewed for evidence of care coordination and outpatient follow-up for children following discharge from an inpatient facility. In all records there was a progress note from the inpatient facility that described contact with the family, the Department of Human Services (DHS), or the planned outpatient facility, as applicable. Five records indicated that the children were discharged to outpatient services provided by **BHI** or its subcontractors. In each of these cases, the first follow-up appointment occurred within one week. Two records contained documentation of a follow-up appointment within two days, and one case contained documentation of the first appointment having occurred on the same day as discharge. Of the five children that were discharged without services provided by the BHO, two were not Medicaid-eligible at the time of discharge, one child was discharged to DHS, one was discharged to family in another state, and one was discharged with arrangements made at two different mental health centers, but with documentation of lack of follow through by the family.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard VIII—Quality Assessment and Performance Improvement (QAPI) Program

Strengths

BHI demonstrated that it had a comprehensive QAPI program in place. The program was supported by a health information system capable of collecting, analyzing and reporting data. In addition, the BHO demonstrated that it routinely analyzed and integrated data from multiple sources as part of the quality improvement process.

BHI delegated several quality improvement program functions to its three CMHCs. Delegated functions included conducting peer case file review, monitoring consumer satisfaction, and reporting to the BHO on any below-benchmark performance for measures included on the Quality Performance Report Card. **BHI** monitored CMHC performance for these delegated activities through annual audits

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard IX—Grievances, Appeals, and Fair Hearings

Strengths

BHI had policies, procedures, and practices in place for processing requests for grievances, appeals, and fair hearings according to State and federal requirements. Documentation (paper) and tracking systems (electronic) in use by the BHO were noteworthy for their orderliness and completeness, and allowed the BHO to examine case-specific as well as systemwide data for trends. The BHO statement that it used the number of grievances filed as a barometer of consumers' comfort with and access to the complaint process was an indicator of **BHI**'s commitment to consumers' ability to exercise their right to complain without fear of retaliation.

Review of Grievance Records

Ten grievance files were reviewed. Nine of the 10 files had timely written acknowledgments sent to the consumer. All 10 of the files had timely written resolution letters documented, were processed by qualified staff, and had resolutions that were responsive to the grievance issue.

Required Actions

The BHO must ensure that all consumers receive a written acknowledgment of the BHO's receipt of a grievance within two working days of the complaint.

Because **BHI** operationally defines and handles formal grievances and complaints differently, the BHO must ensure that all expressions of dissatisfaction are handled in accordance with Medicaid and State regulations and that data from each are included in tracking and trending so that opportunities to improve care and services can be identified.

Standard X—Credentialing

Strengths

BHI had clear policies and procedures, as well as documentation mechanisms, for the credentialing and recredentialing of practitioners and the assessment of organizational providers. The credentialing and recredentialing policies included the majority of the requirements. There was evidence that **BHI** followed the credentialing and recredentialing policies and procedures.

Required Actions

The Credentialing and Recredentialing policy was unclear regarding notification of practitioners who were declined participation in the network and regarding on-site quality assessment of organizational providers. **BHI** must revise the policy to describe the process for ensuring that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision. **BHI** must also revise its Credentialing and Recredentialing policy to clarify **BHI**'s processes for performing on-site quality reviews for nonaccredited organizational providers, and processes for substituting a regulatory body review that meets the requirements. If **BHI** chooses to use a review by a regulatory body to meet this requirement, it must ensure that the criteria used during that review meets the standards in the **BHI** policy as required by National Committee for Quality Assurance (NCQA).

BHI is required to submit to the Department a CAP for all elements within the standards scored as Partially Met or Not Met and for all elements within the record reviews scored as No. The CAP must be submitted within 30 days of receipt of the final version of this report. For each element that requires corrective action, the BHO must identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. After the Department has approved the CAP, **BHI** will be required to submit documents identified as evidence of compliance.

Table 5-1 describes activities required for the CAP process.

Table 5-1—Corrective Action Plan Process	
Step 1:	**Corrective action plans are submitted.**
	Each BHO will submit a CAP to the Department within 30 calendar days of receipt of the final external quality review site review report. CAPs will be submitted via HSAG's file transfer protocol (FTP) site and the BHO will e-mail notification to the Department and HSAG. For each of the elements within the standards receiving a score of *Partially Met* or *Not Met*, and for each element within the record reviews receiving a *No*, the CAP must address the planned intervention(s) to achieve compliance and the timeline(s) for the intervention(s).
Step 2:	**Plans are reviewed and approved.**
	HSAG and the Department will review the CAPs. The Department will notify each BHO as to the adequacy of its plan. If the Department determines that a CAP is adequate to bring the BHO into full compliance with the applicable contract requirements, the Department will notify the BHO in writing that the plan is approved. If the Department determines that a CAP is not adequate to bring the BHO into full compliance with one or more contract requirements, the Department will require the BHO to submit a revised CAP. Following the review of the revised plan, the Department will notify the BHO in writing of its decision to approve the plan or to require further revisions.
Step 3:	**Progress reports may be required.**
	Based on the nature and seriousness of the noncompliance, the Department may require the BHO to submit regular reports to the Department detailing progress made on one or more elements in the CAP.
Step 4:	**Corrective actions are implemented.**
	Each BHO is expected to implement all corrective actions and achieve full compliance with the applicable contract requirements within 60 calendar days of the Department's written notification of having approved the BHO's CAP. The Department may extend the time frame for implementation of one or more of the corrective actions if requested by a BHO in writing and with cause.

Table 5-1—Corrective Action Plan Process	
Step 5:	**Substantiating documentation is submitted.**
	When all Department-approved corrective actions have been implemented, the BHO will submit documentation to the Department substantiating the completion of all required corrective actions and compliance with the related contract requirements.
Step 6:	**Documentation substantiating implementation of the plans is reviewed and approved.**
	Following a review of the documentation, the Department will inform the BHO as to whether: (1) the documentation is adequate to demonstrate completion of all required actions and compliance with the related contract requirements, or (2) the BHO must take additional actions and/or submit additional documentation. The Department will inform each BHO in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the BHO into full compliance with all the applicable contract requirements.

Table 5-2 can be used by the BHO to document its planned interventions for any required actions that are listed.

Table 5-2—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard I: Delegation				
7. Termination of Subcontracts The Contractor notifies the Department in writing of its decision to terminate any existing subcontract applicable to the performance of services under the Contract.	BHI must have a process for notifying the Department in writing of its decision to terminate any existing delegation subcontract applicable to the performance of services under the BHO contract with the State. The process must include a notice to the Department 60 calendar days prior to the termination unless termination of the subcontract is based on quality or performance issues.			
Standard II: Provider Issues				
4. Content of Agreement The written agreement: A. Specifies the activities of the provider.	BHI must update or amend agreements with its CMHCs to specify current activities subcontracted to the provider.			
B. Specifies the reporting responsibilities of the provider.	BHI must update or amend agreements with its CMHCs to specify current reporting activities required of the CMHCs.			
13. Record Review: Documentation of Services	BHI must ensure that providers submit accurate encounter codes that represent the services provided.			

Table 5-2—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard V: Access and Availability				
3. Access to Services B. The contractor meets standards for timeliness of service including the following: 3. Routine services are available within seven calendar days.	BHI must revise the Access and Availability policy to clarify that routine services are available within seven days.			
Standard VI: Utilization Management				
7. Record Review: Denials	BHI must ensure that a Notice of Action is sent in a timely manner to the consumer and provider following a UR denial decision.			
Standard IX: Grievances, Appeals, and Fair Hearings				
1. Grievance and Appeal Records The Contractor maintains a record of grievances and appeals.	BHI must ensure that all complaints and expressions of dissatisfaction are considered grievances; are processed to ensure written acknowledgment, timely resolution, and reasonable assistance to the consumer; and are included in the analysis and reporting of grievances.			
7. Record Review: Grievance	BHI must ensure that it provides timely acknowledgment of all grievances.			

Table 5-2—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard X: Credentialing				
3. Content of Policies and Procedures The written policies and procedures specify: I. The process to ensure that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision.	BHI must revise the Credentialing and Recredentialing policy to describe the process to ensure that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision.			
9. Policy Content—Organizational Provider Credentialing The Contractor's written policies and procedures include: C. If there is no accreditation status, the Contractor conducts an on-site quality assessment.	BHI must revise its Credentialing and Recredentialing policy to clarify BHI's processes for performing on-site quality reviews for nonaccredited organizational providers and processes for substituting a regulatory body review that meets the requirements. If BHI chooses to use a review by a regulatory body to meet this requirement, it must ensure that the criteria used during that review meets the standards in the BHI policy as required by NCQA.			

The review of the standards follows this cover page.

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
1. Pre-delegation Assessment	Prior to entering into subcontracts, the Contractor evaluates the proposed subcontractor's ability to perform the activities to be delegated.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The Subcontractual Relationships and Delegation policy included the requirement that predelegation assessment be performed by BHI prior to entering into delegation agreements. BHI management staff reported that there were no delegation subcontracts entered into by BHI during the review period.	
II.C.1	**Required Actions** None	
2. Written Agreements	The Contractor has a written agreement with each subcontractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI delegated primary source verification of independent practitioner credentials to MedAdvantage; claims processing, claims reporting, inpatient care coordination, and reauthorization of inpatient services to InNET; and selected quality improvement, service authorization activities, and the distribution of advance directive information to consumers to the three community mental health centers (CMHCs) in the BHI service area (Community Reach Center, Aurora Mental Health Center, and Arapahoe/Douglas Mental Health Network). BHI had a signed delegation agreement with each organization.	
II.C.2	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement	The written agreement: A. Specifies the activities delegated to the subcontractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each of the delegation agreements specified the activities delegated to the subcontractor.	
	Required Actions None	
	B. Specifies the reporting responsibilities delegated to the subcontractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each of the delegation agreements specified the reporting responsibilities delegated to the subcontractor and the reporting responsibilities of the delegate related to any delegated functions.	
	Required Actions None	
	C. Includes provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each of the delegation agreements included provisions for revoking delegation or imposing other sanctions if the subcontractor's performance became inadequate.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement II.C.2	D. Specifies that the subcontractor shall comply with the standards specified in the contract between the BHO and the Department for any responsibilities delegated to the subcontractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each of the delegation agreements with the CMHCs and the agreement with InNET included language that specified that the delegate agreed to comply with the standards set forth in the contract between the BHO and the Department for responsibilities delegated to the subcontractor. The MedAdvantage agreement included language that required the delegate to comply with the credentialing standards of the National Committee on Quality Assurance (NCQA). This requirement satisfied the credentialing requirements specified in the contract between the BHO and the Department.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
4. Policies and Procedures	The Contractor has written procedures for monitoring the performance of subcontracts: A. On an ongoing basis	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Subcontractual Relationships and Delegation policy described BHI's procedures for monitoring the performance of delegates on an ongoing basis. Ongoing monitoring of InNET included monthly meetings held between InNET and BHI and monthly reports submitted by InNET and reviewed by BHI. Ongoing monitoring of the CMHCs included monthly review and trending of documentation submitted to BHI. BHI monitoring of the credentialing activities performed by MedAdvantage was not required. MedAdvantage was NCQA-certified. BHI maintained a copy of the MedAdvantage NCQA certification letter in the delegation file at BHI.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
4. Policies and Procedures II.C.4	B. Through formal review	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Subcontractual Relationships and Delegation policy described BHI monitoring of delegate performance through formal review. Formal review of InNET included the audit of 411 encounter records by BHI completed during the review period, quarterly audits of hospital records, and review of hospital discharge summaries. Formal review of the CMHCs included annual delegation audits to determine compliance with requirements for each delegated activity. BHI monitoring of the credentialing activities performed by MedAdvantage was not required. MedAdvantage was NCQA-certified. BHI maintained a copy of the MedAdvantage NCQA certification letter in the delegation file at BHI.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
5. Monitoring of Delegates	The Contractor monitors services provided through subcontracts for: A. Quality	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI monitoring of InNET performance included monitoring the quality of delegation activities performed by InNET. BHI monitoring of the CMHCs' performance included monitoring the quality of delegation activities performed by the CMHCs.	
	Required Actions None	
	B. Data reporting	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI monitoring of InNET performance included monitoring data reporting performed by InNET. BHI monitoring of the CMHCs' performance included monitoring data reporting performed by the CMHCs.	
II.C.3	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
6. Corrective Action II.C.5	If the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor take corrective action.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There were corrective action plans submitted by Community Reach Center, Aurora Mental Health Center, Arapahoe/Douglas Mental Health Network, and InNET, as well as evidence of BHI's follow-up to the corrective action plans submitted.	
	Required Actions None	
7. Termination of Subcontracts II.C.9	The Contractor notifies the Department in writing of its decision to terminate any existing subcontract applicable to the performance of services under the Contract.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's current Subcontractual Relationships and Delegation policy did not include a provision addressing notification to the Department of delegation subcontract terminations. The policy previously in effect included the provision, but did not indicate a timeline for notification. BHI management staff reported that this clause was inadvertently removed from the policy during update and that BHI's practice regarding this requirement had not changed. BHI management staff reported that no delegation subcontracts were terminated during the review period.	
	Required Actions BHI must have a process for notifying the Department in writing of its decision to terminate any existing delegation subcontract applicable to the performance of services under the BHO contract with the State. The process must include a notice to the Department 60 calendar days prior to the termination unless termination of the subcontract is based on quality or performance issues.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
8. Access to Records II.C.8	All subcontracts provide for access to all records by the Secretary of the U.S. Department of Health and Human Services, for 3 years following disposition of property or equipment. **Findings** Each of the delegation subcontracts (agreements) provided for access by the secretary of the U.S. Department of Health and Human Services either in the body of the subcontract or in an amendment. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Results for Standard I					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
11	1	0	1	12	92%

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
1. Provider Discrimination	A. The Contractor does not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Prohibition of Provider Discrimination policy contained the required nondiscrimination clause. BHI management staff described application of the credentialing process equally regardless of the scope of the provider's practice or type of license. BHI management staff provided an example of the Risk and Resource (R&R) Committee review and reconsideration of an organizational provider initially denied network participation, and subsequently accepted to the network based on the unique practice the provider offered.	
	Required Actions None	
	B. If the Contractor declines to include individual or groups of providers in its network, it gives the affected providers written notice of the reason for its decision.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Prohibition of Provider Discrimination policy indicated that individuals or groups of providers were given written notice of the reason if they were declined participation in the network. An example of a letter denying participation in the network was reviewed on-site and provided the reason for declining participation in the network.	
	Required Actions None	
II.H.4.a		

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity	A. The Contractor has a mandatory compliance plan and administrative and management arrangements or procedures that are designed to guard against fraud and abuse, and that include: 1. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state requirements.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Corporate Compliance Plan included policies, procedures, and standards of conduct that articulated a commitment to comply with all applicable federal and State requirements, and to guard against fraud and abuse.	
	Required Actions None	
	2. Designation of a compliance officer and compliance committee that is accountable to senior management.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Corporate Compliance Plan described the designation of a corporate compliance officer, known at BHI as the program integrity officer (PIO), and the PIO's role on the Corporate Compliance Committee. The Corporate Compliance Committee was composed of representatives from the Board of Directors and senior management staff of BHI. Corporate Compliance Committee meeting minutes were reviewed on-site and demonstrated implementation of the Corporate Compliance Plan, as written.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity	3. Training and education for the compliance officer and the Contractor's employees.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Corporate Compliance Plan described the content of training for BHI's employees. BHI management staff reported that the requirement was for annual refresher training for corporate compliance. BHI required employees to sign acknowledgment forms to demonstrate that training had occurred.	
	Required Actions None	
	4. Provisions for internal monitoring and auditing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Corporate Compliance Plan described monitoring and auditing procedures to detect fraud and abuse and determine compliance. A review of audits performed by BHI demonstrated implementation of procedures described in the Corporate Compliance Plan	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity II.G.5.c.1-7 II.H.5.d	5. Provisions for prompt response to detected offenses and for development of corrective action initiatives.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Corporate Compliance Plan described the provisions for prompt responses to possible compliance offenses and included investigation and development of corrective action plans when deemed necessary by the corporate compliance officer and the Corporate Compliance Committee. A review of the Corporate Compliance Committee meeting minutes demonstrated implementation of the processes described in the Corporate Compliance Plan.	
	Required Actions None	
	B. The Contractor reports possible instances of Medicaid fraud to the Department within ten (10) business days of receipt of information. The Referrals include specific background information, the name of the Provider and a description of how the Contractor became knowledgeable about the occurrence.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Corporate Compliance Plan described the policy of reporting possible instances of fraud to the Department within 10 business days of the receipt of the information and described the content of the report to the Department, which included the required information. BHI staff, during the interview, indicated that there had been not possible instances of fraud.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
3. Provider Agreements	The Contractor has a written agreement with each provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Template agreements reviewed were for child placement agencies, outpatient facilities, outpatient group practices, inpatient facilities, individual providers and single case agreements. Examples of signed contracts were reviewed on-site for selected individual practitoners and organizational providers. Credentialing files contained a credentialing checklist, which included a field to track and ensure that each provider had signed an agreement.	
II.H.10.a.2	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
4. Content of Agreement	The written agreement: A. Specifies the activities of the provider	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each of the agreement templates specified the activities of the provider. Credentialing files were reviewed and demonstrated that the signed agreements were consistent with the agreement templates, except for the signed agreements between BHI and the three CMHCs within BHI's service area (Community Reach Center, Aurora Mental Health Center, and Arapahoe/Douglas Mental Health Network). The CMHC agreements had an effective date of 1995. BHI management staff reported that there had been no updated agreement or amendment executed between BHI and the three CMHCs in question. The 1995 agreements contained an annual renewal provision. Article III of the CMHC contracts discussed the provision of covered services and referred to Attachment B of the CMHC/BHI agreement. Attachment B referred specifically to Paragraph 3.3 of the 1995 contract between BHI and the State of Colorado. Other activities specified in the agreement between BHI and the CMHCs that had changed since the agreement was signed were specific activities related to authorization of services and the management of provider contracts between the CMHCs and independent providers. While recent delegation agreements (2005) were signed with the CMHCs and provided an updated relationship between the CMHCs and BHI regarding service authorization, the differences in provider network management activities and specification of covered services were not accurately addressed in any agreement between the CMHCs and BHI.	
	Required Actions BHI must update or amend agreements with its CMHCs to specify current activities subcontracted to the provider.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
4. Content of Agreement	B. Specifies the reporting responsibilities of the provider.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Articles II and III of each template agreement included reporting responsibilities of the provider. Specific reporting of data related to covered persons admitted to the CMHCs was not present in the 1995 agreements.	
	Required Actions BHI must update or amend agreements with its CMHCs to specify current reporting activities required of the CMHCs.	
	C. Includes provisions for revoking the agreement or imposing other sanctions if the provider's performance is inadequate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article VII of the agreement templates, including the 1995 agreements, included provisions for revoking the agreement if the provider's performance was inadequate.	
	Required Actions None	
II.H.10.a.2		

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
5. Liability for Payment	The Contractor provides that its Medicaid members are not held liable for: A. The Contractor's debts in the event of the Contractor's insolvency.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article IV of each agreement, including the 1995 agreements, provided that Medicaid members were not held liable in the case of BHI's insolvency.	
	Required Actions None	
	B. Covered services provided to the member for whom the Department does not pay the Contractor, or the Department or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article IV of each agreement, including the 1995 agreements, provided that Medicaid members were not held liable in the case of BHI's breach of the contractual agreement.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
5. Liability for Payment II.H.11.a	C. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article IV of each agreement, including the 1995 agreements, provided that the subcontractor may not bill, charge, collect deposits from, or seek compensation from covered persons.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	The Contractor monitors covered services provided under provider agreements for: A. Quality	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Utilization Management Program and Quality Improvement Program descriptions described the processes used for monitoring covered services for quality. A review of the Risk and Resource Committee meeting minutes and the BHI Quality Performance Report Cards demonstrated implementation of the policies and program descriptions.	
	Required Actions None	
	B. Appropriateness	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Utilization Management Program and Quality Improvement Program descriptions described the processes used for monitoring covered services for appropriateness. A review of the Risk and Resource Committee meeting minutes, and the BHI Quality Performance Report Cards demonstrated monitoring of providers for appropriateness of services provided.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	C. Member outcomes	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Utilization Management Program and the Quality Improvement Program descriptions described the processes used for monitoring covered services for member outcomes. A review of the Risk and Resource Committee meeting minutes, the BHI Quality Performance Report Cards, and the Bipolar Education and Skills Training (BEST) program outcome reports indicated the use of a variety of indicators to monitor member outcomes.	
	Required Actions None	
	D. Requirements for medical records	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Monitoring for adherence to requirements for medical records was accomplished through a review by the corporate compliance officer for subcontracted providers, and the peer review process for CMHC providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	E. Requirements for data reporting	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A review of the Risk and Resource Committee meeting minutes and the BHI Quality Performance Report Cards, as well as the peer review checklists, demonstrated that BHI monitored providers for adherence to requirements for encounter and CCAR data reporting.	
II.H.10.a.3	**Required Actions** None	
7. Policies and Procedures	The Contractor has written procedures for monitoring the performance of providers on an ongoing basis.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Access and Availability policy, the Credentialing and Recredentialing policy, and the Quality Improvement Program Description described the procedures for monitoring performance of providers on an ongoing basis. A review of the Risk and Resource Committee meeting minutes, database documentation of document review for subcontracted practitioners, and completed delegation oversight audits for CMHCs demonstrated implementation of the procedures described.	
II.H.10.a.4	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
8. Termination of Provider Agreements II.H.10.d	The Contractor notifies the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area and provides the notice at least ninety (90) days prior to termination of the services unless the termination is based on quality or performance issues.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Network Adequacy policy included the provision that BHI would notify the Department in writing of its decision to terminate any existing provider agreements, as required. BHI management staff reported that, although provider contracts had been terminated during the review period, none had been defined as causing the delivery of services in a given area to be inadequate.	
	Required Actions None	
9. Prohibited Affiliations II.H.6.a	The Contractor does not knowingly have a relationship of the type described below with the following: An individual or an affiliate of an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy described the procedures BHI used to ensure that BHI did not have relationships with individuals or organizations excluded from federal health care programs. A review of individual and organizational provider credentiling files demonstrated that BHI followed the credentialing and recredentialing procedures regarding this requirement.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
10. Marketing	The Contractor adheres to all contract requirements related to marketing.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings BHI management staff reported that during the review period, BHI did not engage in marketing activities, as marketing is defined in the BHO contract with the Department.	
II.H.8	**Required Actions** None	
11. Department Approved Member Handbook	The BHO's Member Handbook was submitted to and approved by the Department prior to distribution.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI provided a copy of an e-mail from the Department approving the October 30, 2006, version of the BHI Member Handbook. BHI management staff reported that BHI was currently using the handbook that was approved by the Department in April 2006. At the time of the site review, the October 30, 2006, version had been sent to the printer.	
II.H.8.a	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
12. Statistically Valid Sampling II.J.6.c.3.c	The BHO reviews compliance with criteria for submission of encounter claims data each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI reviewed a statistically valid sample of encounter records (411) for compliance with contract criteria. The report BHI submitted indicated that BHI reviewed for accuracy and completeness of data, for the presence of documentation in the medical record, and the presence of both paid and denied claims. BHI's report also indicated that the sample included data from each of the in-network mental health centers, as well as other subcontracted providers and represented the array of services provided by BHI.	
	Required Actions None	
13. Record Review: Documentation of Services	Presence, timeliness, and accuracy of documentation to support encounter claims.	
	Findings A sample of 10 consumer service records was reviewed to assess BHI's compliance with contract requirements related to documentation of services for encounters submitted. BHI was compliant with 19 of 20 of the total applicable elements reviewed for a record review score of 95%. All ten records contained documentation of the service provided for the day the encounter was submitted. Nine of ten records contained documentation that described the service for which the encounter was submitted. For one record the provider had used an incorrect encounter code.	
	Required Actions BHI must ensure that providers submit accurate encounter codes that represent the services provided.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		

Results for Standard II					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
23	2	0	1	25	92%

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	Any practice guidelines adopted by the Contractor will: A. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the field.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings Meeting minutes from BHI's Standards of Practice Committee documented that although several new practice guidelines were considered for implementation (i.e., Vagal Nerve and Trans Cranial Magnetic Stimulation guidelines and Eye Movement Desensitization and Reprocessing guidelines), no new practice guidelines were adopted by the BHO this review period. During the interview, staff confirmed that BHI had not implemented new practice guidelines over the past year.	
	Required Actions None	
	B. Consider the needs of the members.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings Meeting minutes from BHI's Standards of Practice Committee documented that although several new practice guidelines were considered for implementation (i.e., Vagal Nerve and Trans Cranial Magnetic Stimulation guidelines and Eye Movement Desensitization and Reprocessing guidelines), no new practice guidelines were adopted by the BHO this review period. During the interview, staff confirmed that BHI had not implemented new practice guidelines over the past year.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	C. Be adopted in consultation with contracting health care professionals.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings Meeting minutes from BHI's Standards of Practice Committee documented that although several new practice guidelines were considered for implementation (i.e., Vagal Nerve and Trans Cranial Magnetic Stimulation guidelines and Eye Movement Desensitization and Reprocessing guidelines), no new practice guidelines were adopted by the BHO this review period. During the interview, staff confirmed that BHI had not implemented new practice guidelines over the past year.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	D. Be reviewed and updated periodically as appropriate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Clinical Practice Guideline policy stated that guidelines were reviewed and revised periodically as appropriate. During the interview, BHI staff clarified that the BHO's practice was to review guidelines at least every two years and that changes in technology may trigger the need for an earlier review. Staff stated that in past review periods, the BHO adopted numerous practice guidelines and medication algorithms, including guidelines for the treatment of ADHD, bipolar spectrum disorders, eating disorders, schizophrenia, major depression and dissociative disorder. The BHI Clinical Guideline Summary provided an overview of practice guidelines adopted by the BHO, including the date that each practice guideline was initially adopted and the date(s) guidelines were reviewed, modified as appropriate, and readopted by the Standards of Practice Committee. Meeting minutes from the Standards of Practice Committee dated February 21, 2006, and November 21, 2006, documented the discussion and approval to readopt practice guidelines and medication algorithms, including the following: risk assessment guideline, dissociative guideline, APA eating disorder guideline, ADHD medication algorithm, and bipolar disorder psychosocial treatment guidelines. The committee was composed of physicians and other mental health professionals employed at BHI and its delegate community mental health centers (CMHCs). Staff reported that ongoing feedback regarding practice guidelines was solicited from consumers and family members through think tanks and focus groups.	
II.I.2.a.1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
2. Dissemination II.I.2.a.2	The Contractor disseminates practice guidelines to all affected providers and, upon request, to members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Clinical Practice Guideline policy stated that the BHO dissiminated practice guidelines to affected providers and to consumers upon request. Clinical practice guidelines, medication algorithms, and toolkit information was available to consumers, family members and providers on the BHI Web site. Copies of practice guidelines adopted by the BHO were also included as Addendum A of the provider manual. The BHO produced a Clinician's Guidebook to Bipolar Spectrum Disorders and provided several brochures regarding the Bipolar Education and Skills Training (BEST) Program. In the interview, BHI staff stated that information regarding practice guidelines had been included in consumer newsletters and that consumers may receive copies of practice guidelines upon request.	
	Required Actions None	

Results for Standard III					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
2	0	0	3	2	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	The Contractor has written policies and procedures for treating members in a manner that is consistent with the member's right to: A. Receive information about his/her rights.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had policies and procedures that addressed the consumer's right to receive information about rights and included the procedures for BHI, its providers, and staff to communicate the consumer rights information to the consumer. The policies, Enrollee/Consumer Rights and Enrollee Information, listed the rights and stated that all new enrollees would be notified of their rights in writing in the first month following BHI's notification of their enrollment. The policies also required posting of the rights at major service sites (CMHCs) and on the BHI Web site. Providers were notified of consumer rights information via the provider manual, the BHI Web site, and provider contracts. All providers were required to provide a copy of the rights information (in the consumer handbook) at the time of the consumer's intake assessment. Consumers also received an annual letter reminding them that they could request a copy of the handbook and any other information about the BHO. BHI provided evidence of random site visits and the tool used by consumer representatives to monitor for posting of rights information at each location.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	B. Be treated with respect and with due consideration for his/her dignity and privacy.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policies, Enrollee/Consumer Rights and Enrollee Information, addressed the consumer's right to be treated with respect and due consideration for the consumer's dignity and privacy. In addition, the notice of privacy rights policy contained procedures for protection of consumer health information. BHI staff provided evidence of a secret shopper procedure that was conducted to assess the degree to which providers responded to phone inquiries from consumers with respect, responsiveness, and accommodation for their disabilities and special needs.	
	Required Actions None	
	C. Participate in decisions regarding his/her health care, including the right to refuse treatment except as provided by law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policies, Enrollee/Consumer Rights and Enrollee Information, addressed the consumer's right to participate in decisions about health care and the right to refuse treatment as allowed by law. BHI conducted consumer focus groups to ensure that consumers perceived that they were included and empowered to participate in treatment decisions.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	D. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policies, Enrollee/Consumer Rights and Enrollee Information, addressed the consumer's right to receive information regarding treatment options and alternatives and stated that the information would be presented in an understandable manner.	
	Required Actions None	
	E. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policies, Enrollee/Consumer Rights and Enrollee Information, addressed the consumer's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	F. Request and receive a copy of his/her medical records and to request that they be amended or corrected.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policies, Enrollee/Consumer Rights, Enrollee Information, Consumer Access to Protected Health Information, and Amendment of Protected Health Information, addressed the consumer's right to request, receive, or amend medical records.	
	Required Actions None	
	G. Be furnished health care services in accordance with 42 C.F.R. Sections 438.206 through 438.210.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policies, Enrollee/Consumer Rights and Enrollee Information, addressed the requirement for consumers to be furnished health care services in accordance with 42 Code of Federal Regulations (CFR), Sections 438.206 through 438.210. Several additional policies addressed the relevant areas of availability of services, assurance of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights II.G.3	H. Be free to exercise his/her rights without it affecting the way the Contractor and its providers treat the member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policies, Enrollee/Consumer Rights and Enrollee Information, addressed the consumer's right to freely exercise his or her rights without affecting the way the BHO or providers treat the consumer. BHI staff described a focus group and other initiatives aimed at improving consumers' comfort when expressing concerns. The initiatives began after BHI learned that consumers in residential care were worried that their housing would be at risk if they complained.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	A. The Contractor ensures that its staff and affiliated providers take these rights into account when furnishing services to members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI documented evidence of a number of forums and processes used to ensure that staff and providers take rights into account when furnishing services to consumers. Communication to staff and providers occurred through online training about consumer rights. Focus groups and meetings with consumers (e.g., Consumer Advisory Board (CAB) meetings, Rainbow Center meetings, train the trainer) were used to discuss and educate consumers about rights issues. There was evidence that BHI used information obtained in the grievance process about rights complaints to improve care and services.	
	Required Actions None	
	B. The BHO has a process to ensure the member's right to an independent advocate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Enrollee/Consumer Handbook contained information about the consumer's right to an independent advocate. BHI staff and consumer representatives monitored provider sites for posting of the consumer rights information. BHI staff indicated that when an independent advocate was requested, the Cross-Disability Coalition and Mental Health Association were contacted for assistance.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	C. The BHO has processes to follow-up on all member complaints about a staff person or provider and to ensure that the staff/providers do not retaliate against the member for expressing a concern.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI had processes to follow up on member complaints, which included conducting interviews and formal meetings during the grievance/complaint resolution process, as well as using secret shopper techniques to monitor staff and provider responses. The BHI staff stated that there had not been instances of consumer complaints of retaliation. Staff were able to articulate the investigation process that would be used. Processes were also in place to communicate to staff, providers, and consumers that retaliation for voicing a concern would not be tolerated.	
	Required Actions None	
	D. The BHO furnishes to each of its Members information about the assistance available through the Medicaid Managed Care Ombudsman Program and how to access Ombudsman Program Services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's enrollee/consumer handbook contained information about accessing assistance from the Medicaid managed care ombudsman. The phone number for the ombudsman program was also distributed to consumers during grievance processing (in the grievance resolution letter) and in the Medicaid consumer rights training. BHI staff furnished evidence that consumer representatives monitored provider sites for posting of the consumer rights and ombudsman flyers.	
	Required Actions None	
II.G.3-4		

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
3. Member Responsibilities	The Contractor has written requirements for member participation and responsibilities in receiving covered services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Enrollee/Consumer Handbook contained a listing of member requirements for participation and responsibilities in receiving services. This information was also presented during Consumer Advisory Board meetings, as reflected in the minutes.	
II.G.2	**Required Actions** None	
4. Consumer and Family Affairs	The Contractor has an Office of Consumer and Family Affairs to work with members and families.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI had an Office of Consumer and Family Affairs (OCFA) that included a director, assistant director, consumer representatives at each of the CMHCs, and other support staff. An organizational chart was provided and information about assistance was available from OCFA and was included in the Enrollee/Consumer Handbook. There was evidence that the OCFA functioned to support consumer and family rights and empowerment.	
II.G.5	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
5. Advance Directives	A. The Contractor has written policies and procedures for Advance Directives.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Advance Directives policy included procedures that described how BHI respected and implemented advance directives rights under State law. The policy described how advance directive information was distributed to consumers, how it was documented in the medical record, that the provision of care was not conditioned on whether or not the consumer had an advance directive, and how BHI would inform its staff and providers about policies and procedures on advance directives and their responsibilities. BHI delegated responsibility for provision of advance directives information to the CMHCs and monitored this and provider/staff training through its delegation oversight process.	
	Required Actions None	
	B. The Contractor provides all adult members with written information on Advance Directives policies, which includes: 1. A description of the applicable state law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policy on advance directives stated that BHI would provide all adult enrollees with written information on advance directives at the time of initial enrollment and annually thereafter. This information included a description of the applicable State law. The advance directives information was contained in the BHI consumer handbook. BHI provided oversight of the CMHCs' policies, procedures, and implementation of the advance directives procedures.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
5. Advance Directives	2. The member's rights under the law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policy on advance directives stated that BHI would provide all adult enrollees with written information on advance directives at the time of initial enrollment and annually thereafter. This information included a description of the consumer's rights under the law. The advance directives information was contained in the BHI consumer handbook.	
	Required Actions None	
	3. The fact that complaints concerning non-compliance with the Advance Directive requirements may be filed with the State Department of Public Health and Environment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policy on advance directives stated that BHI would provide all adult enrollees with written information on advance directives at the time of initial enrollment and annually thereafter. This information included the fact that complaints concerning noncompliance with the advance directive requirements could be filed with the State Department of Public Health and Environment. The advance directives information was contained in the BHI consumer handbook and included the phone number to call with complaints.	
	Required Actions None	
II.H.7		

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		

Results for Standard IV					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
18	0	0	0	18	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
1. On-site Nursing Facilities II.F.2-3	The Contractor: - Provides medically necessary mental health services on-site in nursing facilities for members who are residents of nursing facilities and who cannot reasonably travel to a service delivery site for their services. - Considers the ability of the resident to travel when determining the service delivery site (i.e., BHO site or nursing facility).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policy, Nursing Home Services, required that BHI or its providers provide mental health services to nursing home residents or transport the consumer to a service site if the consumer could travel and if transportation was available. BHI provided documented evidence of nursing facility residents who were transported to the mental health centers or other providers for services. BHI also provided documentation of mental health services provided to consumers in the nursing facility residence.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
2. Dual Medicare/Medicaid Eligible	A. The Contractor makes an effort to identify and include providers in the Contractor's network that are capable of billing Medicare for dual Medicare and Medicaid eligible members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policy, Coordination of Medicaid and Medicare Benefits, documented the procedures for identifying and including providers capable of billing Medicare for dual-eligible consumers. The three contracted CMHCs were all Medicare certified and were the largest provider of services to BHI's dual-eligible consumers. BHI provided tracking reports of services provided to dual-eligibles for whom Medicare was the primary payer. The BHO also provided a listing of all Medicare providers within its network and their Medicare ID number. The organizational provider application used by BHI required the provider to indicate its certification for Medicaid and Medicare participation.	
	Required Actions None	
	B. If qualified Medicare providers cannot be identified, the Contractor provides the medically necessary mental health services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policy, Coordination of Medicaid and Medicare Benefits, documented BHI's procedures for assisting consumers in finding qualified Medicare providers and, if one could not be identified, BHI or its providers would ensure access to all covered, medically necessary services.	
	Required Actions None	
II.F.4		

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	A. The Contractor monitors providers to determine compliance with standards for timely access.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policy, Access and Availability, contained the requirements and standards for all BHI providers regarding timely access to services. BHI's procedure included a provision for conducting quarterly phone audits of its independent providers to monitor appointment availability and providers' knowledge of standards for routine access. Evidence was provided of the results of the first quarterly audit conducted in September 2006. Because the audit results demonstrated high rates of compliance and knowledge, BHI stated it will revisit the policy decision on audit frequency and may opt for less frequent audit procedures. BHI's community mental health centers provided quarterly data reporting on their performance on timely access to services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	B. The Contractor meets standards for timeliness of service including the following: 1. Emergency services are available - By phone within 15 minutes of the initial contact. - In person within one hour of contact in urban and suburban areas. - In person within two hours of contact in rural and frontier areas.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI staff articulated the process for consumers to obtain emergency services (through the CMHCs and hospitals) and stated that independent providers were required to ensure that consumers knew how to access emergency services when the independent provider was not available. BHO staff stated that the licensing requirements for independent practitioners included a requirement for phone answering devices to direct or refer the caller when there is an emergency. Consumer handbook information directed consumers to use 911, a hospital emergency room, or one of the CMHCs for mental health emergencies. The BHI provider manual also required providers to know and abide by emergency access standards. Data were tracked, monitored, and reported for access to emergency services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	2. Urgent care is available within 24 hours.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI staff articulated the process for consumers to obtain urgent services (through the CMHCs and hospitals) and stated that independent providers were required to ensure that consumers knew how to access urgent services when the independent provider was not available to direct them. BHI staff stated that the licensing requirements for independent practitioners also included a requirement for phone answering devices to direct or refer the caller when there is an emergency. Consumer handbook information directed consumers to use 911, a hospital emergency room, or one of the CMHCs for mental health emergencies. The BHI provider manual required providers to know and abide by urgent care access standards. Data were tracked, monitored, and reported for access to urgent care services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	3. Routine services are available within seven calendar days.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI staff reported that the provision of routine services within the timeliness standard was monitored and reported quarterly for both independent providers and the CMHCs. The CMHCs reported their data to BHI, and as part of the oversight of its CMHC contractors, BHI monitored the access data through its quality report card process. For independent practitioners, timely access to routine appointments was initially monitored in September 2006, and a policy on access and availability described that this monitoring activity would occur quarterly. During the interview, staff described the high rates of compliance found during the initial phone audit, and that they may revisit the time frame within which additional independent provider monitoring of routine access will occur going forward. The percentage of routine services provided in the independent practitioner network was relatively low and concern was expressed that quarterly monitoring may be perceived as a burden for these providers. While access-to-care standards were communicated accurately in the provider manual, the BHO's Access and Availability policy and procedure listed two standards for routine appointments: within 7 days and within 14 days. The BHOs had previously been required by the Department to monitor both routine access time frames; however, the contract standard has been 7 days.	
	Required Actions The BHO must revise the Access and Availability policy to clarify that routine services are available within seven days.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	C. The Contractor takes corrective action if there is a failure to comply with standards for timely access.	
	Findings This element was not reviewed or scored.	
	Required Actions	
	D. The authorization process takes into consideration other factors, such as the need for services and supports to assist a Member to gain new skills or regain lost skills that support or maintain functioning and promote recovery.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHI Utilization Management Program Description contained procedures and considerations for determining medical necessity for authorization of services. Included in the criteria was consideration of any special clinical circumstances that might necessitate a unique approach to treatment as well as consideration of a consumer's preferences and needs for recovery. During the interview, there was evidence of BHI's philosophy and culture in support of consumer empowerment and recovery. Training of providers and staff on the use of community, peer, and clinical supports also promoted this awareness and practice across its providers. BHI had employed a mood disorder screening tool to assist providers in assessing consumers' needs related to support and recovery, as the BHO did not find that the Colorado Client Assessment Record was useful as a screening assessment tool, but rather as a periodic assessment tool useful for indicating improvement over time.	
	Required Actions None	
II.F.1.a.7 II.F.1.a.4.a-e II.F.1.a.8 Exhibit C.III.C		

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	In establishing and maintaining the provider network, the Contractor considers: A. Including both Essential Community Providers and other providers.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The network adequacy policy addressed the requirement to include both essential community providers (ECPs) and other providers. There was documented evidence in the quarterly network adequacy report that ECPs and other providers were represented in BHI's network. Additionally, BHI provided evidence of its contracts with numerous federally qualified health centers and with a number of new providers in single-case agreements as a result of consumer requests.	
	Required Actions None	
	B. The anticipated Medicaid enrollment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The network adequacy policy addressed the use of information about the anticipated Medicaid enrollment. The quarterly network adequacy report included data describing the Medicaid enrollment by county. The utilization management (UM) report card also trended eligibility and user information (penetration rates) over time to project future enrollment.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	C. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the enrolled population.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The network adequacy policy addressed the use of information about the expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the enrolled population. The UM report card analyzed and trended penetration rates by age group, ethnicity, and eligibility category to anticipate future network needs and utilization of services. Utilization by type of service was also analyzed and trended.	
	Required Actions None	
	D. The numbers and types (training/experience) of providers required to furnish the contracted Medicaid services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The network adequacy policy addressed the numbers and types of providers required to furnish the contracted Medicaid services. The quarterly network adequacy report documented the number and types of providers in the network and included graphic and narrative analysis of the adequacy of the network.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	E. The numbers of network providers who are not accepting new Medicaid patients.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The network adequacy policy addressed the numbers of network providers who were not accepting new Medicaid patients. The quarterly network adequacy report provided information about any contracted providers who were not accepting new patients during the quarter, which was a small number.	
II.F.1.c	**Required Actions** None	
5. Out-of-Network Providers	If the Contractor is unable to provide covered services to a particular member, the Contractor provides the covered services out of network at no cost to the member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Out of Network Provider/Single Case Agreements policy included specific procedures for providing covered services out of network at no cost to the member when BHI was unable to provide the service within the network. The quarterly network adequacy report provided evidence of several single-case agreements in place and listed the out-of-network providers used by BHI. During the interview, BHO staff described the ease with which a new contracted provider could join the network at a consumer's request and how quickly a new service provider could be identified and recruited when a network need arose.	
II.F.1.d	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
6. Geographic Access II.F.1.e II.1.a.5	A. The Contractor has arrangements to ensure proximity of participating providers to the residences of members so as not to result in unreasonable barriers to access and to promote continuity of care taking into account the usual means of transportation ordinarily used by members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The network adequacy policy addressed the requirement to ensure the proximity of participating providers to the residences of members. BHI had a mechanism to assess the proximity of its providers to members and furnished a report developed in December 2006 showing that 86 percent of the CMHCs' service sites were within two blocks of a bus stop. BHO staff members described that since the majority of services were provided by CMHCs, this was an important indicator to them, and that if they had included all providers in this assessment, the results would have been higher.	
	Required Actions None	
	B. The Contractor ensures that providers are located throughout the Contractor's service area, within 30 miles or 30 minutes travel time, to the extent such services are available.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI used Maptitude software to assess the distance in time and miles between its members and its network. Ninety percent of members were found to be within 20 miles of a provider and 100 percent within 30 miles. This evaluation was reported in the quarterly network adequacy report.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
7. Selection of Providers II.F.1.f	The Contractor allows each member to choose, to the extent possible and appropriate, his or her health professional.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The consumer handbook, given to consumers at the time of enrollment, includes a notice of consumer rights and information about consumer's choice of providers. The Consumer Request for External Provider policy contained the procedures for responding to requests for an independent provider outside the current network. There was evidence in the network adequacy report that BHI had included new providers via single-case agreements, as requested by consumers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
8. Recovery Model Exhibit C.II	The Contractor will demonstrate commitment to the recovery model.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Throughout the interviews, BHI described and demonstrated its deep commitment to the recovery model. There was evidence of practice and philosophy aimed at improving consumers' participation and decision-making, and consumers were represented in almost all facets of the BHO's organization and delivery system. Consumers played active roles on committees and boards, as evidenced in meeting minutes. More than 50 percent of employees of the BHO were consumers or former consumers of services. The BHO regularly sponsored consumers' attendance at the leadership academy. The BHO developed a peer specialist certification program for consumers with college credit and provided job placement upon completion. The BHO also has training programs by and for consumers that supported recovery beliefs, empowerment, and choice. A key feature of the BEST program was to help consumers with bipolar illness describe their patterns of illness and direct their care accordingly.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
9. Medication Management Exhibit C.IV.I	The BHO provides or arranges for the monitoring of medications prescribed, and consultation provided to Members by a physician as necessary.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI provided a report documenting medication management services provided to 5,473 members in 2006. BHI had a performance improvement project that focused on improving access to initial medication evaluations and, as a result, has increased the number of prescribers in its network. BHI was aware that its need for prescribers which was described as greater for the child/adolescent consumer population, paralleled national trends in the availability of child psychiatrists. The BHO staff described several initiatives it had undertaken to increase the availability of medication management services, including the use of nurse practitioner prescribers and routinely reserving daily appointment slots for more urgent medication assessments.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
10. Alternative Services Exhibit K.III.A-I	The BHO has sufficient capacity to provide alternative services as described in Exhibit K of the Contract with the Department (effective 3/31/06). These services are available to serve the specified number of Members, and at the specified locations. **Findings** BHI provided a report of its alternative services provided by type of service and capacity as described in its contract with the Department. The report included quarterly and annualized data demonstrating BHI's provision of these services and the degree to which it approximated the availability described in its contract. The BHO staff described its innovative use of swipe cards for consumers to log their attendance at drop-in centers and other nonencountered services and supports. This procedure assisted the BHO in capturing, quantifying, and analyzing valuable attendance data that were previously logged on paper attendance sheets. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Results for Standard V					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
19	1	0	0	20	95%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program	A. The Contractor has a Utilization Management (UM) Program to monitor the access to and appropriate utilization of covered services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI provided numerous documents that demonstrated that the BHO had an active Utilization Management (UM) Program in place to monitor access to and appropriate utilization of covered services. BHI's Utilization Management Program Description and polices related to UM described the guiding principles of the program, the program structure, delegated UM functions, the utilization review process, UM monitoring, and data reporting, trending and analysis activities. The BHO also provided a 2005-2006 Utilization Management Program Evaluation, the level-of-care criteria used by the BHO and its delegate providers, and examples of various UM reports used to monitor service utilization. During the interview, staff stated that the BHO delegated responsibility for various UM activities to its CMHCs and to InNET, Inc. BHI staff reported that to help ensure consistency in practice, the BHO provided training for the CMHCs and InNET regarding level of care criteria and the appropriate handling of actions and appeals related to Utilization Review (UR) denials. BHI monitored compliance with UM requirements for activities delegated to the CMHCs and InNET through annual audits, and ongoing monitoring processes.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program	B. The UM program includes written policies and procedures.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI had a comprehensive set of policies and procedures related to various utilization management processes. Policies included but were not limited to the following: Medical Necessity, Admission and Continued Stay Authorization and Census Tracking, BHI Utilization Management Criteria, Utilization Management Decision Timelines, and Notice of Action.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program II.J.1	C. The Contractor has a mechanism in effect to ensure consistent application of the review criteria for authorization decisions and, as applicable, consultation with the requesting provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHI Utilization Management Program Description stated that the BHO used the following activities to ensure consistency in authorization decision-making: 1) periodic auditing of authorizations to ensure the consistent application of medical necessity criteria, 2) dissemination of and training on BHI utilization management and medical necessity criteria, and 3) interrater reliability auditing to ensure consistency in authorization processes. During the interview, staff reported that the interrater reliability study conducted by BHI evaluated the appropriateness of a sample of UR decisions made by utilization review staff employed by the CMHCs, InNET and the BHO, and that study findings indicated improved performance from the previous year. BHI's Psychiatric Consultations, Second Opinions policy stated that consultations, including discussions regarding utilization review decisions, were made available upon request by the consumer, clinician, or psychiatrist.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
2. Over-/Under-Utilization II.I.2.e	The Contractor has in effect mechanisms to detect both under-utilization and over-utilization of services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHI director of utilization management stated that decisions regarding the types and frequency of reports produced by the BHO to help detect under- and overutilization of services were made in consultation with staff from the quality improvement area and with input from the Risk and Resource Committee and Provider Advisory Council as appropriate. BHI provided examples of several reports used by the BHO to monitor for both under- and overutilization of services. The reports included data regarding the number of emergency department visits per 1,000 members, grievance and appeal data, and examples of Utilization Management Report Cards produced by the BHO each quarter. The Utilization Management Report Cards included graphs and an analysis of data for various utilization measures. including: penetration rates by age group, inpatient days by age group, bipolar inpatient days, UR denials and appeals, and the number of evaluation and routine appointments requested, trended by CMHC.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
3. Evaluation of UM Program II.J.I.e	The Contractor has mechanisms to evaluate the effects of the UM program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI used quarterly UM Report Cards and an annual UM Program evaluation to assess the effects of its UM Program. The 2005-2006 Utilization Management Program Evaluation included findings for a variety of utilization-related measures and activities, including a description of the BHO's oversight and monitoring activities of delegated utilization management functions, grievance data, access-to-care data, and information related to several utilization management monitors (e.g., penetration rate, readmissions within 30 days, hospital admits per 1,000). The annual evaluation also described follow-up action taken for each measure, if any, and identified future plans for utilization management activities for the following fiscal year. At the time of the interview, staff reported that information from UM Report Cards and from the 2005-2006 Utilization Management Program Evaluation was shared with members of the UM Committee and with leadership staff from InNET and the BHO's delegate CMHCs.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
4. Clinical Expertise II.J.1.g	The Contractor ensures that any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope, that is less than requested, is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Notice of Action policy required that all Notices of Action involving the denial, reduction, suspension, termination, or limited authorization of a requested type or level of service that involved clinical issues be reviewed and signed by a licensed physician. Findings from the denial record review indicated that the BHO's practice was consistent with policy and that 100 percent of the UR denials included in the sample had been reviewed and signed by a licensed physician. BHI's delegation agreements with its delegate CMHCs included a requirement that a psychiatrist review any action based on medical necessity. Compliance with this requirement was monitored by the BHO through audit activity using the BHI Delegation Oversight Tool.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
5. Co-occurring MI/DD II.E.1	The Contractor has written criteria for determining whether the need for mental health services for a member with co-occurring mental illness and developmental disabilities is a result of the individual's mental illness, or a result of the individual's developmental disability, or developmental delay (if the member is under age 5).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Site Review Document Request Form stated that BHI continued to participate with the Department and other BHOs in the refinement of the BHO Practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in Children, Youth, and Adults with Developmental Disabilities (DD). The BHO also provided meeting minutes from a November 7, 2006, BHI DD/MI task force meeting. The focus of the task force was to strategize how to best operationalize the current guidelines for BHI network providers.	
	Required Actions None	
6. Compensation for Conducting UM Activities II.F.1.g	The Contractor does not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHI Utilization Management Program Description stated that compensation provided to InNet and to the BHO's delegate CMHCs was not structured to provide incentives for the denial, limitation, or discontinuation of medically necessary services to consumers. Article IV of the BHO provider contract included a provision stating that payments under the agreement had not been established with an aim to reduce or limit services provided to Medicaid consumers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
7. Record Review—Denials	Presence and timeliness of required documentation and decisions by qualified clinician.	
	Findings A sample of 10 enrollee denial records was reviewed to assess BHI's compliance with contract requirements related to the presence and content of required documentation, and the timeliness of resolution and documentation. BHI was compliant with 29 of 30 of the total applicable elements reviewed for an overall score of 97 percent. BHI was fully compliant in the following areas: 1) the notice included the reason for the denial, and 2) the decision was made by a qualified clinician. A Notice of Action for one case reviewed was not sent in a timely manner to the consumer and provider following a UR denial as required in Exhibit G of the BHO's contract with the Department.	
	Required Actions BHI must ensure that a Notice of Action is sent in a timely manner to the consumer and provider following a UR denial decision.	

Results for Standard VI					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
8	0	0	0	8	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
1. Written Policies and Procedures II.F.1.h.1	The Contractor has written policies and procedures that ensure coordination of the provision of covered services to its members, and that address expectations for timely coordination of care.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI provided policies and procedures that described required coordination-of-care activities and addressed the BHO's expectations regarding timeliness of coordination of care. BHI's Coordination of Care policy described the central role of the care coordinator in communicating and collaborating in a timely manner with medical and behavioral health service providers, representatives from the educational system, and others to ensure that consumers' needs are met. The BHI Treatment Responsibilities policy outlined the BHO's responsibilities to coordinate with other service providers and assist consumers in accessing covered services in accordance with their treatment plans.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	The written policies and procedures address: A. Service accessibility	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The following BHI coordination-of-care policies and procedures provided for review included information regarding service accessibility: Access and Availability; Emergency and Post-Stabilization Services; Psychiatric Consultations, Second Opinions; Network Adequacy; and Out of Network Provider/Single Case Agreements.	
	Required Actions None	
	B. Attention to individual needs	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The following BHI coordination-of-care policies and procedures provided for review addressed attention to individual needs: Coordination of Care, Out of Network Provider/Single Case Agreements, and BHI Treatment Responsibilities. The Coordination of Care policy contained information regarding the components of care coordination, including individualized treatment planning.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	C. Continuity of care	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The following BHI coordination-of-care policies and procedures provided for review addressed the issue of continuity of care: Coordination of Care and BHI Treatment Responsibilities. The Coordination of Care policy described the responsibility of the care coordinator to work in close collaboration with medical and behavioral health providers, community agencies, advocates, and others involved in the consumer's treatment.	
	Required Actions None	
	D. Maintenance of health	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Agreement to Secure Primary Care Physician and EPSDT policy included a provision that information regarding the mental health diagnosis and treatment plan be forwarded to the primary care physician (PCP) with consumer consent. The BHO also provided a copy of the form used to transmit mental health treatment information to the PCP. The BHI Coordination of Care policy described the responsibility of the care coordinator to work in close collaboration with other providers, community agencies, advocates, and others involved in the consumer's treatment.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	E. Independent living	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Coordination of Care policy stated that, whenever possible, the care coordinator was to provide assistance and support to consumers returning to or remaining in a community setting. The policy clarified that for youth, a community setting may include a home-like family setting or community-based school, as appropriate. The policy stated that for an adult consumer a community setting may include a noninstitutional community residential setting; vocational opportunities consistent with the consumer's interests, skills and abilities; and appropriate social activities and resources. During the interview, BHI staff stated that the BHO considered the consumer's clinical history, the consumer's preference and recommendations of treatment professionals in making decisions regarding the most appropriate placement setting.	
	Required Actions None	
	F. Coordination with other medical and behavioral health plans	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Coordination of Care policy required that the BHO actively involve medical providers, behavioral health providers, and representatives from other community stakeholder agencies, as appropriate, in the clinical assessment and treatment planning process for consumers. The policy also described the key role of the care manager in coordinating with medical and behavioral health service providers to arrange for needed services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies II.F.1.h.1	G. Confidentiality and privacy consistent with 45 CFR parts 160 and 164 (HIPAA)	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The following BHI coordination-of-care policies and procedures provided for review addressed confidentiality and privacy issues: Disclosure of Protected Health Information and Notice of Privacy Rights. The Disclosure of Protected Health Information policy provided staff guidance regarding the disclosure of protected health information consistent with 45 CFR, Parts 160 and 164 Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Notice of Privacy Rights policy described the process for informing consumers regarding the use and disclosure of protected information by the BHO.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
3. Care Coordination	A. The Contractor provides for care coordination, which addresses the member's need for integration of mental health and other services. This includes identifying, providing, arranging for and/or coordinating with other agencies to ensure that the member receives the health care and supportive services that allow the member to remain in her/his community.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Coordination of Care policy and procedure included information regarding: 1) the identification of other providers, agencies and systems involved in the consumer's care as part of the clinical assessment process; and 2) the role of the care coordinator in initiating referrals to other providers and community agencies and in ensuring effective collaboration and communication. During the interview, BHI staff described various collaborative projects that had been implemented by the BHO and its contracted providers, including the colocation of mental health services in PCP offices, federally qualified health centers, schools, adult and juvenile correctional facilities, and child welfare offices.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
3. Care Coordination II.F.1.h Exhibit C.III.B	B. The BHO, in consultation with the service provider, Member, family, and/or person with legal custody, shall determine the medical and/or clinical necessity of the covered service. **Findings** The BHI Utilization Management Program Description included a requirement that medical necessity be determined in consultation with the consumer, family, and/or person with legal custody. BHI's Treatment Record Content policy stated that, whenever possible, the consumer or parent/guardian must be actively involved in the development of the consumer's individualized treatment plan. During the interview, staff reported that the BHO required providers to obtain the signature of consumers and/or their legal guardian on treatment plans as evidence of their active involvement in the treatment planning process. The BHO provided copies of Peer Review Checklists used by their delegate CMHCs to monitor compliance with this requirement. Staff indicated that CMHCs that failed to meet minimum performance thresholds for this indicator were placed on a corrective action plan (CAP). **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
4. Coordination with Medical Care Services	A. The Contractor assists members in obtaining necessary medical treatment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Coordination of Care policy stated that the care coordinator was responsible for assisting the consumer in accessing needed medical health care services. Information included on the FY 06-07 Site Review Document Request Form indicated that the consumer's care coordinator was also responsible for initiating a referral to a health plan physician for any consumer who does not have an assigned PCP, and for arranging transportation to medical appointments as necessary. The BHO provided a copy of a medical history questionnaire used at admission by the CMHCs to help assess the consumer's medical status and identify any outstanding medical issues. At the interview, BHI staff reported participation in several medical integration projects, including colocating mental health professionals at federally qualified health centers and in PCP and pediatrician offices.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
4. Coordination with Medical Care Services	B. If a member is unable to arrange for supportive services to obtain medical care due to his/her mental illness, these supportive services will be arranged for by the Contractor or another person who has an existing relationship with the member whenever possible.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO's Coordination of Care policy included a requirement that the care coordinator assist in arranging for any necessary supportive services required by the consumer to obtain needed medical care. The BHO provided examples of supportive services to address easy access to needed medical care, including the use of consumer reminder calls, providing transportation to appointments as needed, and the use of colocation models that integrate physical and mental health service delivery.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
4. Coordination with Medical Care Services II.F.1.h	C. The Contractor coordinates with the member's medical health providers to facilitate the delivery of health care services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI provided numerous documents that addressed the BHO's process and activities related to coordination with primary medical providers. The BHO's Coordination of Care policy identified that the care coordinator was responsible for assisting consumers in arranging for medical care services as needed. A flyer and example letter to a PCP described the Medical Home Project, an initiative that allowed for easy access to mental health services and made continuing medical education on child psychiatric disorders and psychiatric consultation services available to participating pediatricians. The FY 06-07 Site Review Document Request Form stated that several programs to integrate mental health and physical health care services were in place, including a program that colocated mental health professionals from the Aurora Mental Health Center at medical clinics operated by the Metro Community Provider Network in Aurora. In response to the FY 05-06 site review, BHI implemented the PCP Notification policy and developed the PCP Letter/EPSDT Screening Form used to share information between providers and PCPs. The BHO also required its delegate CMHCs to monitor coordination of care with the PCPs through case file reviews. BHI staff indicated that two of its delegate CMHCs had been under a corrective action plan (CAP) this review period as a result of subpar case file review findings related to coordination with medical health providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
5. School-Based Services Exhibit C.IV.I	Mental health services are provided to school-aged children and adolescents on site in their schools, with the cooperation of the schools.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A BHI program description indicated that school-based services were provided in 30 elementary, middle, and high schools located in the east metro service area. Services provided included individual, group, and family counseling as well as consultation services to school staff as needed. BHI staff reported that approximately 50 clinicians provided school-based services throughout the review period and that the services resulted in positive outcomes for students involved in the program. Outcomes included improved functioning on the Child and Adolescent Functional Assessment Scale (CAFAS) as well as improved academic performance and behavior. During the interview, BHI staff indicated that schools wishing to participate in the program contacted either the BHO or CMHCs to request services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
6. EPSDT II.E.1	The Contractor provides services identified under the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO used the PCP Letter/EPSDT Screening Form to share behavioral health treatment information with the PCP and request copies of completed EPSDT screenings. The BHI Treatment Responsibilities policy included information to clarify that services provided to children under the EPSDT program were not subject to inpatient and outpatient benefit limitations. In the interview, BHI staff stated that the InCare database flagged any hospitalized consumer approaching inpatient benefit limitations to assist the BHO in proactively managing these cases. The BHO provided an example of an Outpatient Benefit Limitation Monitoring Report and Inpatient Benefit Limitation Report. These reports were used by the Department and the BHO to track utilization for consumers approaching inpatient and outpatient benefit limitations and to track expenditures for consumers having exceeded benefit limits.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
7. Record Review—Coordination of Care: Inpatient to Outpatient Transition (children). Exhibit C.I	There is evidence of coordination of care provided for children transitioning from an inpatient facility to outpatient services. **Findings** Ten records were reviewed for evidence of care coordination and outpatient follow-up for children following discharge from an inpatient facility. In all records there was a progress note from the inpatient facility that described contact with the family, the Department of Human Services (DHS) or the planned outpatient facility, as applicable. Five records indicated that the children were discharged to outpatient services provided by BHI or its subcontractors. In each of these cases the first follow-up appointment occurred within one week. Two records contained documentation of a follow-up appointment within 2 days, and one case contained documentation of the first appointment having occurred on the same day as discharge. Of the five children who were discharged without services provided by the BHO, two children were not Medicaid eligible at the time of discharge, one child was discharged to DHS, one was discharged to family in another state, and one was discharged with arrangements made at two different mental health centers, but with documentation of lack of follow-through by the family. **Required Actions**	

Results for Standard VII					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
15	0	0	0	15	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
1. Internal Quality Assessment and Performance Improvement Program	The Contractor has an internal Quality Assessment and Performance Improvement (QAPI) Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHI Quality Improvement Program Description stated that the focus of the Quality Assessment and Performance Improvement (QAPI) Program was to develop, implement, coordinate, and monitor clinical and service quality indicators. The program description included information regarding governance structure, program goals, and the BHO's process for internal reporting of quality improvement activities and findings using a Quality Performance Report Card. Information regarding numerous quality improvement activities and indicators were addressed in the program description, including: practice guidelines, clinical documentation standards, accessibility indicators, consumer surveys, clinical outcome data, and oversight by the BHO of delegated functions. BHI staff indicated that topics related to quality improvement were addressed by various BHO committees, including the Standards of Practice Committee, Risk and Resource Committee, and the Program Evaluation/Outcomes Design Committee. A review of committee meeting minutes indicated that QAPI information was also shared with the BHO's Board of Directors and with the Provider Advisory Council, a committee composed of leadership staff from the BHO and its delegate CMHCs. Information included in the FY 06-07 Desk Review Form indicated that the BHO delegated several quality improvement program functions to its three CMHCs. Functions delegated to the CMHCs included conducting peer case file review, monitoring consumer satisfaction, and reporting to BHI on any below-benchmark performance for measures included on the Quality Performance Report Card.	
II.I.1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program	The scope of the QAPI program includes, but is not limited to: A. A quality assessment and performance improvement plan that: 1. Delineates current and future quality assessment and performance improvement activities.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHI Quality Improvement Plan for FY 06-07 described current and future QAPI activities. The plan included strategies for addressing numerous performance improvement activities including conducting performance improvement projects (PIPs), developing and implementing practice guidelines and evidence-based practices, assessing consumer satisfaction, and conducting oversight activities of the quality improvement functions delegated to the CMHCs. The plan included a brief descriptor of each planned activity, goals, actions, the responsible department, and the target date for completion.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program	2. Integrates findings and opportunities for improvement identified in studies, performance outcome measurements, member satisfaction surveys, and other monitoring and quality activities.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Information in the FY 06-07 Desk Review Form cited the BHO's extensive work over the past five years to improve care for consumers diagnosed with bipolar spectrum disorders as an example of integrating findings across data sources and implementing multiple strategies to achieve positive clinical outcomes. Activities implemented by the BHO included practice guideline development, consumer and family education through the BEST Program, and ongoing trending and analysis of several process and outcome measures for consumers participating in the program. The Quality Improvement Annual Evaluation and Program Impact Analysis October 2006 indicated a reduction in inpatient bed day utilization and improved clinical outcomes based on BASIS 32 scores for BEST Program participants. The BHO also collected member satisfaction survey information from consumers and families receiving services through the BEST Program.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program II.I.2	B. Processes for addressing quality of care concerns.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI provided several documents that demonstrated the BHO had a process in place to address quality-of-care concerns. The BHI Quality of Care Concerns (QOCC) policy included information regarding provider reporting requirements, the QOCC investigation process, and a description of the database used to track and trend QOCC information. The BHO also provided a copy of the form used to report potential QOCCs and a flowchart of the QOCC resolution process. During the interview, staff reported that any substantiated claims uncovered through QOCC investigations were considered as part of the provider recredentialing process.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	A. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Quality Improvement Annual Evaluation and Program Impact Analysis October 2006 stated that the BHO and its delegate CMHCs conducted several member surveys throughout the review period, including the Mental Health Statistics Improvement Program (MHSIP) survey, the Youth Services Survey for Families (YSSF) and the Mental Health Corporation of America (MHCA) survey. A description of the survey process and summary findings of member satisfaction in various domains, including accessibility and adequacy of services, was included in the BHO's Quality Performance Report Cards and in the Quality Improvement Annual Evaluation and Program Impact Analysis October 2006. The BHO's written delegation agreements with the CMHCs identified that monitoring consumer satisfaction and implementing CAPs was a shared responsibility between the two parties. The BHI Delegation Oversight Tool included an indicator used by the BHO to monitor CMHC compliance with required activities related to consumer satisfaction.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	B. The Contractor's tools to monitor member satisfaction include: 1. Member Surveys	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI provided copies of data collection tools for the MHSIP and MHCA surveys and instructions, and a survey instrument for a Peer Specialist Consumer Satisfaction Survey used to assess the effectiveness of the Peer Specialist Program. Reports that described the member survey process and summary findings related to member satisfaction were included in Quality Performance Report Cards and in the Quality Improvement Annual Evaluation and Program Impact Analysis October 2006.	
	Required Actions None	
	2. Anecdotal Information	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Site Review Document Request Form stated that the BHI Department of Consumer and Family Affairs (DOCFA) collected anecdotal information from consumers and families regarding their satisfaction with services through focus groups held throughout the network. During the interview, staff reported that consumer satisfaction data had been presented to the Consumer Advisory Board (CAB) and that consumers frequently provided feedback regarding their satisfaction with services through BHO peer support specialists. The BHO provided meeting minutes from an October 2, 2006, focus group that included several examples of action taken by the BHO in response to consumer and family member feedback.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	3. Grievance and Appeal data	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Site Review Document Request Form described the grievance database and appeal database used by the BHO to collect and report grievance and appeal information. BHI also provided a copy of the Advocacy Contact Form used to document grievance- and appeal-related information and screen prints of the grievance database and appeal database. Reports of grievance and appeal findings were documented in Quality Performance Report Cards and in the Quality Improvement Annual Evaluation and Impact Analysis October 2006. The annual evaluation also indicated that aggregate data regarding grievances and appeals was reported to the BHO Risk and Resource Committee and to the CAB.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction II.I.2.d	C. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaints is detected, or when a serious complaint is reported.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Information in the FY 06-07 Site Review Document Request Form indicated that BHI analyzed satisfaction survey results by comparing performance across time and comparing the BHO's scores to statewide performance. BHI required that its delegate CMHCs submit CAPs whenever performance on the MHSIP survey dropped below State performance levels. The BHO provided several examples of CAPs submitted by the delegate CMHCs. The CAPs included data regarding provider performance as well as strategies to improve scores for measures falling below the benchmark. During the interview, BHI staff provided several examples of instituting CAPs with providers in response to complaints from consumers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
4. Health Information System	The Contractor has a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to: A. Utilization	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Site Review Document Request Form stated that the BHO contracts with InNET to develop, populate, and maintain an integrated authorization, claims, and encounter data warehouse. Examples of utilization reports extracted from InNET's InCare claims and authorization system and data warehouse were provided for review. Utilization management data was also reported in Utilization Management Report Cards. The report cards included graphs and a narrative analysis of various utilization monitors, including total inpatient admissions, total patient days, average length of stay, average daily census, and readmission rate within 30 days.	
	Required Actions None	
	B. Grievances and Appeals	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI staff indicated that the BHO maintained a grievance database and an appeal database. The FY 06-07 Site Review Document Request Form stated that information from the databases was queried quarterly and reported to the Department and to various quality improvement-related committees within the BHO. Grievance and appeal data, including a narrative written analysis, was included in Utilization Management Report Cards published by the BHO each quarter.	
II.I.h.2	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
5. Program Impact Analysis II.I.2.j.1	The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO produced a Quality Improvement Annual Evaluation and Program Impact Analysis Report to formally evaluate its QAPI Program. The report included a description of numerous quality improvement program initiatives implemented by the BHO, provided data across time for various performance indicators, and described future interventions to further improve system processes and consumer outcomes. The BHO also used information included in quarterly Quality Performance Report Cards and Utilization Management Report Cards to help evaluate QAPI Program performance.	
	Required Actions None	

Results for Standard VIII					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
12	0	0	0	12	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
1. Grievance and Appeal Records Exhibit G: 8.209.3.C	The Contractor maintains a record of grievances and appeals.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI used a grievance database as well as original paper files to maintain records of grievances and appeals. The database allowed the BHO to collect, analyze, and report data for quarterly or more frequent reporting. Complaints were maintained in a separate log for issues/concerns that were resolved for consumers who expressed that they did not want to file a formal grievance. These complaint data were not included in the overall collection, analysis, and reporting of grievance data. Additionally, these complaints were not processed according to the Medicaid grievance standards.	
	Required Actions The BHO must ensure that all complaints and expressions of dissatisfaction are considered grievances; are processed to ensure written acknowledgment, timely resolution, and reasonable assistance to the consumer; and are included in the analysis and reporting of grievances.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
2. Provider Information Exhibit G: 8.209.3.B	The Contractor provides a Department approved description of the grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the Contractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The revised BHI grievance system information for providers was approved by the Department on December 27, 2006. Providers would routinely receive the grievance information from BHI at contracting/initial credentialing, and then again at recredentialing or contract renewal. The BHO was planning to disseminate the newly revised information on its Web site, via e-mail update, and on hard copy for providers maintaining a paper version of the provider manual.	
	Required Actions None	
3. Reasonable Assistance Exhibit G: 8.209.4.C	The Contractor provides members with assistance in completing any forms required by the Contractor, putting oral requests for a state fair hearing into writing, and taking other procedural steps including providing interpretive services and toll-free numbers that have adequate TTY/TTD interpreter capability.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHI Notice of Action policy contained the requirements to assist consumers with completing forms, putting requests for a State fair hearing into writing, and providing interpretive services and toll-free TTY/TTD capabilities. The consumer handbook offered assistance to consumers, stating "if you need help with getting a hearing or putting the appeal in writing call the BHI...." The provider manual also outlined procedures for providers to follow in assisting members with the grievance, appeal, and fair hearing processes.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
4. Individuals Who Make Decisions Exhibit G: 8.209.4	The Contractor ensures that the individuals who make decisions on grievances and appeals are: A. Individuals who were not involved with any previous level of review or decision-making.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policies for processing grievances and appeals of actions required that individuals making decisions on grievances and appeals would not have been involved with any previous level of review or decision-making. The grievance record review provided evidence that individuals making the resolution decisions had not previously been involved. Staff processing grievances were employed by the BHO and some were located at the three contracted CMHCs.	
	Required Actions None	
	B. Individuals who have the appropriate clinical expertise in treating the member's condition or disease if deciding an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance that involves clinical issues, or an appeal that involves clinical issues.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's policies for grievances and appeals of actions required that individuals making clinical decisions in the processing of grievances or appeals have appropriate clinical expertise. The grievance record review provided evidence that the individuals making clinical or quality-of-care grievance resolution decisions were appropriately qualified to do so.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
5. Accepts Grievances and Appeals Exhibit G: 8.209.4	The Contractor accepts grievances and appeals orally or in writing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The grievance and appeal of action policies stated that BHI accepted grievances and appeals both verbally and in writing. The BHI member handbook stated that members could file appeals or grievances through a phone call or in writing and provided phone numbers and addresses to do so. An appeal acknowledgment letter dated August 1, 2006, provided evidence that the BHO accepted appeals made verbally. Additional appeals documented in the database demonstrated that written appeals were accepted. The grievance record review provided evidence of written and verbal grievances being accepted.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process	A. The Contractor provides the member an opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and informs the member of the limited time available in the case of expedited resolution.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Notice of Action Form Letter included information for the consumer about the opportunity to provide evidence in person or in writing and directed the consumer to call BHI for information about the expedited review process. The BHI consumer handbook contained information about the limited time available for processing an expedited appeal.	
	Required Actions None	
	B. The Contractor provides the member and the designated client representative opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents and records considered during the appeal process.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI, in its grievance and appeal of action policies and Notice of Action Form Letter, provided the member information about the right to look at the member's case file before and during the appeal, including any records that the appeal panel had reviewed.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process	C. The Contractor includes as parties to the appeal, the member and, as applicable, the designated client representative or legal representative.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHI policy on appeals included a statement that a consumer's designated representative or legal representative are considered parties to an appeal.	
	Required Actions None	
	D. The Contractor has an expedited review process for appeals when the contractor determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI's Appeal of Action policy included the process and time frames for an appeal and described the circumstances for an expedited review of an appeal.	
	Required Actions None	
	E. The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHI policy, Appeal of Action, included the statement that BHI would ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
Exhibit G: 8.209.4		
7. Record Review—Grievance	Presence and timeliness of required documentation, decisions by qualified clinician, and responsiveness of resolution.	
	Findings Ten records of grievances were reviewed. Nine of the 10 records had a timely written acknowledgment letter sent to the consumer, and all 10 records had evidence of timely resolution, an appropriate level of staff expertise, and documented responsiveness to the grievance issue.	
	Required Actions BHI must ensure that it provides timely acknowledgment of all grievances.	

Results for Standard IX					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
10	1	0	0	11	91%

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
1. Excluded Providers	The Contractor does not employ or contract with providers excluded from participation in federal health care programs under Title XI of the Social Security Act, Sections 1128 and 1128A.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy included the procedures to ensure that BHI did not employ or contract with providers who had been excluded from participation in federal health care programs. A review of credentialing files for practioners demonstrated that the Credentialing and Recredentialing policy was implemented as written with regard to this requirement.	
II.H.3.e	**Required Actions** None	
2. Written Policies and Procedures	The Contractor documents the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs, and who render services or authorize services to members, and who fall within the Contractor's scope of authority and action.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy described the mechanism for documenting the credentialing and recredenitaling processes. A review of selected practitioner credentialing files demonstrated the implementation of the policies as written with regard to this requirement.	
NCQA CR1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	The written policies and procedures specify: A. The types of practitioners to credential and recredential. At a minimum, this includes all physicians and other licensed and/or certified practitioners who have an independent relationship with the BHO and who see enrollees outside the inpatient hospital setting or outside the facility-based settings.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the types of practitioners subject to credentialing and recredentialing by BHI.	
	Required Actions None	
	B. The verification sources used.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the primary verification sources used during the credentialing and recredentialing processes.	
	Required Actions None	
	C. The criteria for credentialing and recredentialing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the criteria for credentialing and recredentialing.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	D. The process for making credentialing and recredentialing decisions.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the process for making credentialing and recredentialing decisions.	
	Required Actions None	
	E. The process for managing credentialing files that meet the organization's established criteria.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the process for managing credentialing files.	
	Required Actions None	
	F. The process to delegate credentialing or recredentialing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the process to delegate credentialing and recredentialing.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	G. The process to ensure that credentialing and recredentialing are conducted in a non-discriminatory manner, i.e., the Contractor does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy and the Prohibition of Provider Discrimination policy specified the process for ensuring that credentialing and recredentialing were conducted in a nondiscriminatory manner.	
	Required Actions None	
	H. The process for notifying a practitioner about any information obtained during the Contractor's credentialing process that varies substantially from the information provided to the organization by the practitioner.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the process for notifying practitioners about any information obtained during the credentialing process that varied substantially from the information provided by the practitioner.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	I. The process to ensure that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision. Note: The organization (BHO) is not required to notify providers of recredentialing approvals.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy described the process to inform providers of the committee's decision if the applicant was approved. The policy did not address notification of applicants not accepted for participation in the network. The Prohibition of Provider Discrimination policy addressed the process for notifying providers who were not accepted into the Network; however, the policy did not address the time frame for notification.	
	Required Actions BHI must revise the Credentailing and Recredentialing policy to describe the process to ensure that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision.	
	J. The Medical Director or other designated physician's direct responsibility and participation in the credentialing program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the medical director's and the associate medical director's responsibility in the credentialing program. A review of Risk and Resource Committee meeting minutes and recredentialing files for the review period demonstrated that medical director participation was as described in the Credentialing and Recredentialing policy.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	K. The process to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the process to ensure the confidentiality of all information obtained in the credentialing process.	
	Required Actions None	
	L. The process for ensuring that listings in provider directories and other materials for enrollees are consistent with credentialing data, including education, training, certification, and specialty.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the process for ensuring that listings in provider directories and other member materials were consistent with information from the credentialing process, and updated quarterly. The provider directory was reviewed during the site review process.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	M. The right of practitioners to review information submitted to support their credentialing application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy included the rights of practitioners, including the right of practitioners to review information submitted to support their credentialing application.	
	Required Actions None	
	N. The right of practitioners to correct erroneous information.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy included the rights of practitioners, including the right of practitioners to correct erroneous information.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	O. The right of practitioners, upon request, to be informed of the status of their credentialing or recredentialing application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy included the rights of practitioners, including the right of practitioners to be informed, upon request, of the status of their credentialing or recredentialing application.	
	Required Actions None	
	P. How the applicant is notified of these rights and of the appeal process.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the method of notifying applicants of their rights, including appeal rights.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	Q. The procedure for ongoing monitoring of sanctions, complaints and adverse events (for high-volume providers).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the procedure for ongoing monitoring of sanctions, complaints, and adverse events. A review of credentialing files demonstrated implementation of the policies as written regarding this requirement.	
	Required Actions None	
	R. The range of actions available to the Contractor if the provider does not meet the Contractor's standards of quality.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the range of actions available if the provider did not meet BHI's standards of quality.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures CR1-Element A and B NCQA CR9 CR10-Element A and C II.H.3.g	S. Procedures for detection and reporting of incidents of questionable practice, in compliance with Colorado statutes and regulations, the Health Care Quality Improvement Act of 1986, and NCQA standards.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified procedures for the detection and reporting of incidents of questionable practice.	
	Required Actions None	
	T. An appeal process for instances in which the BHO chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy specified the appeal process for instances in which BHI chose to alter the provider's participation based on issues of quality of care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
4. Credentialing Committee NCQA CR2	The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing decisions. **Findings** The Provider Credentialing and Recredentialing policy described the role of the Risk and Resource Committee (the designated credentialing committee at BHI). A review of the Risk and Resource Committee meeting minutes demonstrated implementation of the peer review process to make recommendations regarding credentialing decisions. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
5. Provider Application NCQA CR4-Element A	Providers are required to complete an application for inclusion in the Contractor's provider network that addresses: - The provider's health status, and reasons for any inability to perform the essential functions of the position, with or without accommodation - Lack of present illegal drug use - History of loss of license and felony convictions - History of loss or limitation of privileges or disciplinary activity - Current malpractice insurance coverage - The correctness and completeness of the application. **Findings** During the review period, BHI used a MedAdvantage application, then changed to the Colorado Health Care Professionals Credentials Application. Both applications included all of the required content. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
6. High Volume Practitioners NCQA CR6-Element B	The Contractor specifies the method to identify high-volume providers.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings BHI defined high-volume practitioners as providers who had more than 10 active BHI clients in their practice.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
7. Evaluation of High Volume Practitioners NCQA CR6-Element B	For high-volume providers, the Contractor conducts: A. An initial site visit	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A review of credentialing files for high-volume providers demonstrated that BHI conducted initial site visits for high-volume practitioners.	
	Required Actions None	
	B. An initial evaluation of treatment record-keeping practices at each site.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The site visit form completed for high-volume practitioners included an evaluation of treatment record-keeping practices.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
8. Requirements for Credentialing Policies for Organizational Providers NCQA CR11	The Contractor has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy included procedures for the initial and ongoing assessment of organizational providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
9. Policy Content—Organizational Provider Credentialing	The Contractor's written policies and procedures include: A. The Contractor confirms that the organization is in good standing with state and federal regulatory bodies.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy described the process for confirming that an organizational provider was in good standing with State and federal regulatory bodies. A review of organizational provider files on-site demonstrated that BHI confirmed that the organizational providers were in good standing with State and federal regulatory agencies.	
	Required Actions None	
	B. The Contractor determines whether the provider has been reviewed and approved by an accrediting body.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy described the process for determining whether an organizational provider had been reviewed and approved by an accrediting body. A review of organizational provider files demonstrated that BHI obtained a copy of the organizational provider's accreditation letter or certificate, when applicable.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
9. Policy Content—Organizational Provider Credentialing	C. If there is no accreditation status, the Contractor conducts an on-site quality assessment.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Credentialing and Recredentialing policy described the criteria used when conducting on-site quality reviews for organizational providers not accredited; however, the policy was unclear regarding the requirement for an on-site quality assessment for all nonaccredited organizational providers. The policy indicated that the Division of Mental Health (DMH) survey report would routinely be used in lieu of a BHI-conducted site visit. BHI staff members indicated that the policy had been updated to indicate that BHI would conduct site visits when indicated; however, the outdated language remained in the policy inadvertently. This caused the policy to be unclear regarding BHI's processes. The policy included BHI's process to assess organizational providers every three years, as required, and the process to ensure that organizational providers credentialed their practitioners. A review of selected organizational provider files demonstrated that BHI followed its procedures. BHI had accepted the most recent DMH surveys in lieu of performing site visits for each of the CMHCs within BHI's service area. The DMH survey was within the NCQA 24-month look-back period; however, the DMH survey did not include all of the BHI criteria for site visits. For example, a review that the organizational provider credentialed its practitioners was not included in the DMH survey.	
	Required Actions BHI must revise its Credentialing and Recredentialing policy to clarify BHI's processes for performing on-site quality reviews for nonaccredited organizational providers and processes for substituting a regulatory body review that meets the requirements. If BHI chooses to use a review by a regulatory body to meet this requirement, it must ensure that the criteria used during that review meets the standards in the BHI policy as required by NCQA.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
9. Policy Content—Organizational Provider Credentialing NCQA CR11-Element A	D. At least every three years, the Contractor confirms that the organizational provider remains in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy included the provision that BHI conducted the organizational provider assessment process every three years (confirming good standing with State and federal regulatory agencies, determining accreditation status, and conducting an on-site quality review for nonaccredited organizational providers). Organizational provider credentialing files were reviewed on-site and demonstrated that the providers reviewed had been initially assessed by BHI and reassessed within the three-year time frame if applicable.	
	Required Actions None	

Results for Standard X					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
30	2	0	0	32	94%

The review of the records follows this cover page.

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Behavioral HealthCare, Inc.

Type of Record Reviewed	**Documentation of Services**		
Review Period	**January 1, 2006 - June 30, 2006**	**Reviewer**	**Barbara McConnell**
Review Date	**January 11, 2007**	**Participating BHO Staff Member**	**Ann Terrill-Torrez**

Table B-1—Documentation of Services

#	Member ID	Provider ID	Date of Encounter	Doc Date Matches Encounter Date	Service Documentation Within 7 Days of Encounter Date	Procedure Code Submitted	Description of Procedure Code	Documentation Describes Procedure Code Submitted
1	*******	4020095	1/17/2006	Y	NA	H2031	Vocational Attendance	Y
Evidence reviewed was a printout from the service documentation database of encounters. BHI staff reported that the clubhouse kept a log of attendance and that log is entered into the electronic system. Individual progress notes were not kept for clubhouse services provided.								
2	*******	4010096	3/22/2006	Y	NA	90882	Case Management	Y
The progress summary described a case management meeting with the nurse at the nursing home where the member lived.								
3	*******	4025094	1/24/2006	Y	NA	90882	Case Mgmt. - Linkage	N
There was documentation of medication administration on January 24, 2006. BHI staff members reported that during the audit of 411 encounter records, they discovered that this provider had been coding medication administration as a case management visit. BHI staff reported that BHI developed a corrective action plan with this provider.								
4	*******	4020095	1/26/2006	Y	NA	90882	Case Management Contact w/Client	Y
The progress summary described telephone contact between the client and the provider.								
5	*******	4010096	1/20/2006	Y	NA	90882	Case Management	Y
The progress note described a case management meeting with nursing home staff where the member lived.								
6	*******	4010096	1/6/2006	Y	NA	90862	Psych Visit/FU	Y
7	*******	4010096	1/11/2006	Y	NA	90882	Case Management	Y
The progress summary described telephone contact with the consumer's mother to discuss progress and set up a meeting.								
8	*******	4020095	1/24/2006	Y	NA	90806	Psychotherapy Visit	Y
9	*******	4010096	3/12/2006	Y	NA	H0018	IT Residential	Y
10	*******	4010096	3/14/2006	Y	NA	H2012	Partial Long/Short	Y
			# Applicable Elements	**10**				**10**
			# Compliant Elements	**10**				**9**
			% Compliant Elements	**100%**				**90%**

TOTALS	
Total # Applicable Elements	**20**
Total # Compliant Elements	**19**
Total % Compliant Elements	**95%**

Table Legend: DOS = Date of Service, Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Behavioral HealthCare, Inc.

Type of Record Reviewed	**Coordination of Care Inpatient to Outpatient Transition (Children)**		
Review Period	**October 1, 2005 - June 30, 2006**	**Reviewer**	**Barbara McConnell**
Review Date		**Participating BHO Staff Member**	**Julie Holtz, Susan James-Padilla, Diane Cannizzaro**

Table B-2—Coordination of Care Inpatient to Outpatient Transition (Children)

#	Member ID	DOB	Primary Dx	D/C Date From Inpatient Facility	Date of First Follow-up	Documentation of Coordination and follow-up following an inpatient stay	In-Pt. Provider	Out-Pt. Provider
1	*******	********	COND DISORDER, CHILDHOOD ONSET TYPE	2/23/2006		Y	Childrens Hospital	N/A No outpatie
There was no request for prior-authorization of the hospitalization. BHI became aware of the hospitalization after the discharge when it received a retrospective request for payment. The hospitalization was subsequently paid for by BHI; however, there was no request for BHI to follow-up or provide services after hospitalization. The patient was discharged to a DHS foster care placement. There was a hospital progress note that described phone contact with Aurora Mental Health Center prior to the final decision that services would not be provided by BHI or its providers.								
2	*******	**********	DEPRESS PSYCHOSIS-SEVERE	3/30/2006		Y	Centennial Peaks Hospital	JCMH or CRC
The hospital progress notes indicated that the Jefferson Center for Mental Health (JCMH) was contacted to arrange for outpatient mental health services and that an aftercare appointment was scheduled for April 4, 2006. There was also a case management note by Community Reach Center (CRC) that a CRC case manager met with the family at the hospital on March 31, 2006, to do a CRC intake meeting. There was no evidence of service provided following discharge (by JCMH or CRC). BHI reported that there was communication between BHOs (BHI and FBH) discussing the family pattern to move between these BHO service areas and not follow through with appointments or provide contact information.								
3	*******	*********	UNSPECIFIED EPISODIC MOOD DISORDER	3/20/2006		Y	Centennial Peaks Hospital	N/A
Hospital progress notes indicated that the Arapahoe County Department of Human Services (Arapahoe DHS) abruptly discharged the child and took him from the hospital. There was no request for authorization for outpatient services from BHI following discharge. The hospital progress notes stated that Arapahoe DHS did not leave information as to where the child would be placed and that the Arapahoe DHS was contacted following the discharge with no response from Arapahoe DHS. There was a mental health center progress note that described a phone call between the CMHC and the hospital to determine the discharge plan and involve DHS in the case.								
4	*******	*********	BIPOLAR AFF, DEPR-UNSPEC	12/1/2006		Y	Childrens Hospital	N/A
Hospital progress notes indicated that this child was discharged to Oklahoma with the family. There was no BHI involvement following the discharge. The hospital progress notes indicated that there was contact with the mother in Oklahoma to arrange transportation and placement with the family and that the child was given a 30-day prescription for medication.								
5	*******	********	OPPOSITIONAL DEFIANT DISORDER	2/10/2006		Y	Denver Health & Hospitals	
BHI staff reported that this was a case of retroactive eligibility. There was no contact with BHI as there was no Medicaid eligibility prior to or at the time of discharge. The hospital progress note indicated that the discharge plan was to discharge to CRC for follow-up, and that the CRC intake clinician was contacted. There was a copy of the discharge instructions provided to the patient that indicated follow-up would be provided by CRC; however, there was no documentation of a follow-up appointment having occurred related to Medicaid ineligibility status.								
6	*******	********	DEPRESSIVE PSYCHOSIS-MOD	4/12/2006	4/18/2006	Y	Centennial Peaks Hospital	Reach
The hospital progress notes indicated that a family meeting was scheduled and took place prior to discharge. The hospital progress notes also indicated that there was an appointment scheduled with CRC April 18, 2006. There was a progress note from CRC that described an individual therapy session dated April 18, 2006.								
7	*******	**********	OTHER SPECIFIED CONDUCT DISORDER	12/13/2005	12/13/2005	Y	CMHI - Ft. Logan	Community Rea
The hospital progress notes described contact with CRC on December 12, 2005. There was a CRC progress note documenting a family therapy session of December 13, 2005.								

Table Legend: Y=Yes, N=No

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Behavioral HealthCare, Inc.

Table B-2—Coordination of Care Inpatient to Outpatient Transition (Children)								
#	Member ID	DOB	Primary Dx	D/C Date From Inpatient Facility	Date of First Follow-up	Documentation of Coordination and follow-up following an inpatient stay	In-Pt. Provider	Out-Pt. Provider
8	*******	********	DEPRESS PSYCHOSIS-SEVERE	1/4/2006	1/6/2006	Y	CMHI - Ft. Logan	CRC
The hospital discharge plan indicated that the discharge plan was to continue outpatient treatment at CRC and that the patient was scheduled for an appointment on January 5, 2006. There was a progress note from CRC documenting an individual therapy session on January 6, 2006.								
9	*******	********	UNSPECIFIED EPISODIC MOOD DISORDER	10/14/2005	10/20/2005	Y	CMHI - Ft. Logan	Aurora Mental H
The hospital progress notes (October 13, 2005) described contact with Aurora Mental Health Center to arrange a day program at Aurora Mental Health Center and schedule a physician appointment (psychiatry) for October 24, 2005. Aurora Mental Health Center progress notes described a reentry therapy session with the patient on October 20, 2005, and a phone contact with the mother on October 21, 2005. Aurora Mental Health Center progress notes also described a medication management appointment on October 24, 2005.								
10	*******	********	UNSPECIFIED EPISODIC MOOD DISORDER	3/13/2006	3/15/2006	Y	CMHI - Ft. Logan	Arapahoe/Dougl
On March 9, 2006, there was an InNet progress note that indicated an appointment had been scheduled for a doctor visit on March 15, 2006, and a family therapy appointment on March 16, 2006. Arapahoe/Douglas Mental Health Network progress notes described a medication management visit on March 15, 2006.								

Table Legend: Y=Yes, N=No

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Behavioral HealthCare, Inc.

Type of Record Reviewed	**Grievances**		
Review Period	**January 1, 2006 - September 30, 2006**	**Reviewer**	**Bonnie Marsh**
Review Date	**January 11, 2007**	**Participating BHO Staff Member**	**Jen Koberstein**

Table B-3—Grievances Record Review

#	Case ID #	Date Grievance Received	Date of Acknowledgement Letter	Acknowledgement Sent Within 2 Working Days	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Resolved and Notice Sent per Requirement	Appropriate Level of Expertise	Resolution Responsive to Member Grievance?
1	*******	5/23/2006	5/24/2006	Y	6/13/2006	14	NA	Y	Y	Y
Mother of consumer requested and received a change of therapist for her child receiving services due to relationship conflicts and the mother not feeling the therapist was experienced in working with reactive attachment disorder (RAD) children. The child was transferred to a new therapist who was a RAD therapist.										
2	*******	8/20/2006	8/21/2006	Y	8/29/2006	7	NA	Y	Y	Y
Consumer's father/guardian wanted his daughter's case to be closed by the mental health center, and received assistance to have the case closed. The consumer began receiving services elsewhere.										
4	*******	3/16/2006	3/16/2006	Y	4/4/2006	13	NA	Y	Y	Y
Consumer did not want to sign an agreement to stop his threatening behavior and opted instead to transfer to another MHC.										
5	*******	6/29/2006	6/29/2006	Y	6/29/2006	1	NA	Y	Y	Y
Parents filed the grievance because they thought they were being blamed by the therapist for the child's problems. Referred to another therapy location.										
6	*******	2/27/2006	3/6/2006	N	3/10/2006	9	NA	Y	Y	Y
Consumer did not want the recommended treatment, only medications. Was offered a second opinion but did not follow up.										
8	*******	1/17/2006	1/18/2006	Y	2/15/2006	22	Y	Y	Y	Y
Guardianship issue needed to be resolved before grievance could be processed on behalf of the consumer (child). Extension letter was sent on January 31, 2006. Issue was a request for a new therapist for the child. Received transfer to new therapist.										
9	*******	2/7/2006	2/8/2006	Y	2/15/2006	6	NA	Y	Y	Y
Consumer unhappy with case manager and needed additional positive life activities. Activities were arranged with consumer, who was satisfied.										
10	*******	3/13/2006	3/13/2006	Y	3/13/2006	1	NA	Y	Y	Y
Consumer requested and received a new therapist.										
11	*******	7/17/2006	7/17/2006	Y	7/28/2006	9	NA	Y	Y	Y
Consumer was worried about being prescribed contraindicated medications. A pharmacy consultation occurred and the consumer was reassured no contraindication existed.										
12	*******	1/24/2006	1/25/2006	Y	1/31/2006	5	NA	Y	Y	Y
Consumer wanted to change psychiatrists. Transfer to a new psychiatrist was facilitated.										

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Behavioral HealthCare, Inc.

Table B-3—Grievances Record Review										
#	Case ID #	Date Grievance Received	Date of Acknowledgement Letter	Acknowledgement Sent Within 2 Working Days	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Resolved and Notice Sent per Requirement	Appropriate Level of Expertise	Resolution Responsive to Member Grievance?
			# Applicable Elements	10			1	10	10	10
			# Compliant Elements	9			1	10	10	10
			% Compliant Elements	90%			100%	100%	100%	100%
TOTALS										
			Total # Applicable Elements	41						
			Total # Compliant Elements	40						
			Total % Compliant Elements	98%						

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Behavioral HealthCare, Inc.

Type of Record Reviewed	**Denials**		
Review Period	**January 1, 2006 - September 30, 2006**	**Reviewer**	**Tom Cummins**
Review Date	**January 11, 2006**	**Participating BHO Staff Member**	**Susan James-Padilla**

Table B-4—Denials Record Review

#	Member ID	Date of Initial Request	Standard/Expedited Authorization Decision			Termination, Suspension, or Reduction of Previously Authorized Services		Notice Includes Reasons	Decision Made by Qualified Clinician
			Date Notice Sent	# of Days For Decision	Notice Sent per Requirement	Date Notice Sent	Notice Sent per Requirement		
1	*******	7/24/2006	7/28/2006	4	Y			Y	Y
Request for inpatient stay was denied (by a physician). The consumer did not meet medical necessity.									
2	*******	4/14/2006	4/19/2006	5	Y			Y	Y
Request for outpatient services. Question regarding justification of diagnosis. Denied due to lack of medical necessity.									
3	*******	5/16/2006	5/22/2006	6	Y			Y	Y
Request by the parents for residential treatment center (RTC) was denied. The consumer was receiving outpatient care and did not meet medical necessity criteria.									
5	*******	4/14/2006	4/19/2006	5	Y			Y	Y
Request for outpatient services was denied. Insufficient information to determine medical necessity. Assessment relied solely on information provided by foster parent. Assessment information did not justify diagnosis.									
7	*******	1/9/2006	1/17/2006	8	Y			Y	Y
Request for RTC placement. Did not meet medical necessity for residential. Denial by physician.									
8	*******	4/14/2006	4/19/2006	5	Y			Y	Y
Request for outpatient services denied. Insufficient information to determine medical necessity. Assessment relied solely on information provided by foster parent. Assessment information did not justify diagnosis.									
10	*******	9/7/2006	9/7/2006	1	Y			Y	Y
Request for inpatient care. Consumer evaluted for admission and was denied. No evidence imminent danger. Did not meet medical necessity criteria. Physician decision.									
11	*******	3/2/2006	3/14/2006	12	N			Y	Y
Request for RTC by parent. Evaluation conducted at juvenile detention facility. Consumer determined not to meet medical necessity criteria for this level of care. Physician denial.									
12	*******	3/29/2006	4/3/2006	5	Y			Y	Y
Request for adult residential placement denied. Did not meet medical necessity. Physician denial.									
13	*******	1/27/2006	2/2/2006	6	Y			Y	Y
Request for RTC placement. Consumer had been attending day treatment--poor family participation. Denied for residential. Did not meet medical necessity criteria. Denial by physician.									

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Behavioral HealthCare, Inc.

Table B-4—Denials Record Review

#	Member ID	Date of Initial Request	Standard/Expedited Authorization Decision			Termination, Suspension, or Reduction of Previously Authorized Services		Notice Includes Reasons	Decision Made by Qualified Clinician
			Date Notice Sent	# of Days For Decision	Notice Sent per Requirement	Date Notice Sent	Notice Sent per Requirement		
				# Applicable Elements	10			10	10
				# Compliant Elements	9			10	10
				% Compliant Elements	90%			100%	100%
TOTALS									
				Total # Applicable Elements	30				
				Total # Compliant Elements	29				
				Total % Compliant Elements	97%				

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix C. Site Review Participants
for Behavioral HealthCare, Inc.

Review Dates

Dates for HSAG's site review for **BHI**, the period under review, and the contract term are shown in Table C–1 below.

Table C–1—Review Dates	
Dates of On-Site Review	January 11–12, 2007
Period Under Review	January 1, 2006–December 31, 2006
Contract Term	FY 06–07

Participants

Participants in the FY 06–07 site review of **BHI** are listed in Table C–2 below.

Table C–2—HSAG Reviewers and BHO Participants		
HSAG Review Team		**Title**
Team Leader	Barbara McConnell, MBA, OTR	Colorado Project Director
Reviewer	Bonnie Marsh, RN, BSN, MA	Executive Director, EQR Services
Reviewer	Thomas Cummins, LCSW	Consultant
BHI Participants		**Title**
Diane Cannizzaro, LCSW		Utilization Review Manager
Mary Hajner		Quality Improvement Research Coordinator
Julie Holtz, MA		Chief Executive Officer
Susan James-Padilla, LCSW		Director of Utilization Management
Jen Koberstein		Director, Office of Consumer and Family Affairs
Melissa Kulasekere		Program Evaluator/Disease Management Specialist
LeeAnne Merrifield, MSW		Office of Consumer and Family Affairs
Christina Mitsch		Authorization Coordinator
Rian G. Nowitzki		Chief Financial Officer/Controller
Joe Pastor, MD		Medical Director
Nik Savastinuk		Information Systems and Data Specialist
Teresa Summers		Director of Provider Relations
Ann Terrill-Torrez, RN, CNS, CPHQ		Director of Quality Improvement
Department Observers		**Title**
Katie Brookler		Manager, Quality Improvement
Nancy Jacobs		Behavioral Health Benefits Supervisor
Connie Young		Quality Improvement/Behavioral Health Specialist
CMS Observers		**Title**
Cindy Smith		CMS Region 8

Overview

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine the MCOs' and PIHPs' compliance with contract requirements and federal regulations. The Department has elected to complete this requirement by contracting with an external quality review organization (EQRO). HSAG is the EQRO for the Department. The U.S. Department of Health and Human Services' (DHHS') Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQR.

The site review addressed the BHO's compliance with federal regulations and contract requirements in 10 areas: delegation; provider issues; practice guidelines; member rights and responsibilities; access and availability; utilization management; continuity-of-care system; quality assessment and performance improvement program; grievances, appeals, and fair hearings; and credentialing.

Individual records were reviewed to evaluate implementation of contract requirements for grievances, denials, coordination of care for children transitioning from inpatient to outpatient services, and documentation of services provided.

In developing the monitoring tool, HSAG used the BHO's contract requirements and the regulations specified by the BBA, including revisions that were issued June 14, 2002, and effective August 13, 2002. The site review adhered to the February 11, 2003, CMS final protocol: *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Regulations.*

Methodology and Process

Objective of the Site Review

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

- The BHO's compliance with federal regulations and contract requirements.
- The quality and timeliness of, and access to, mental health care furnished by the BHO.
- Interventions to improve quality.
- Activities to sustain and enhance performance processes.

To accomplish these tasks, HSAG assembled a team to:

- Collaborate with the Department to determine the review and scoring methodology, data collection methods, schedule and agenda, and other issues as requested.
- Collect and review data and documents before and during the on-site portion of the review.
- Analyze the data and information collected.
- Prepare a report of findings and required actions for each BHO.

Site Review Activities

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

The following table describes the activities that were performed throughout the site review process.

Table D–1—Site Review Activities Performed

For this step,	HSAG…
Step 1:	**Established the review schedule.**
	Before the site review, HSAG coordinated with the Department and the BHO to set the site review schedule and assign staff to the site review teams.
Step 2:	**Prepared the data collection tools and submitted them to the Department for approval.**
	To ensure that all information was collected, HSAG developed monitoring tools consistent with BBA protocols. To create the monitoring tool standards, HSAG used the requirements as set forth in the contract between the Department and the BHO. HSAG also followed the guidelines specified by the BBA, including revisions that were issued June 14, 2002, and effective August 13, 2002. Additional criteria used in developing the monitoring tools included the NCQA 2006 Standards for the Accreditation of Behavioral Health Organizations and applicable Colorado and federal requirements.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 3:	**Prepared and submitted the Desk Review Form to the Department and the BHO.**
	After review and approval of the monitoring tools by the Department, HSAG forwarded a Desk Review Form to the BHO and requested that the BHO submit specific information and documents to HSAG within 30 days of the request. The Desk Review Form included instructions on how to organize and prepare the documents related to the review of the standards and records.
Step 4:	**Forwarded a BHO Document Request Form to the BHO.**
	HSAG forwarded a BHO Document Request Form to the BHO as an attachment to the Desk Review Form. The BHO Document Request Form contained the same standards and contract requirements as those in the tool used by HSAG to assess the BHO's compliance with contract requirements for each of the 10 standards. The Desk Review Form included instructions for completing the "BHO Information and Associated Documentation" section of this form. This step provided the opportunity for the BHO to identify, for each requirement, the specific BHO documents or other information that provided evidence of compliance, and streamlined the ability of the reviewers to identify all applicable documentation for review.
Step 5:	**Developed a site review agenda and submitted it to the BHO.**
	HSAG developed an agenda to assist BHO staff in planning for participation in the site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective site review, as well as minimizing disruption to the BHO's day-to-day operations. An agenda sets the tone and expectations for the site review so that all participants understand the process and time frames for the review.
Step 6:	**Provided orientation.**
	HSAG staff provided an orientation for the BHO and the Department to preview the site review process and respond to the BHO's and Department's questions. The orientation included identifying the similarities and differences between the FY 05-06 and the FY 06–07 review processes related to the request for information and documentation prior to the on-site portion of the site review, the schedule of review activities, and the process for the review of records.
Step 7:	**Participated in telephone conference calls with the BHO to answer questions and provide any other needed information before the site review.**
	Prior to the site review, HSAG representatives conducted a pre-site review teleconference with the BHO to exchange information, confirm the dates for the site review, and complete other planning activities to ensure that the site review was completed methodically and accurately. HSAG maintained contact with the BHO as needed to answer questions and provide information to key BHO management staff members. This teleconference and subsequent contact gave BHO representatives the opportunity to request clarification and present any questions about the request for documentation for the desk review and the site review processes.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 8:	**Received desk review documents and evaluated information before the on-site review.**
	Reviewers used the documentation received from the BHO to gain insight into the BHO's structure, enrolled population, providers, services, operations, resources, and delegated functions, if applicable, and to begin compiling the information and findings before the on-site portion of the review. During the desk review process, the reviewers: ◆ Documented findings from the review of the materials submitted by the BHO as evidence of compliance with the requirements. ◆ Identified areas and issues requiring further clarification or follow-up during the interviews. ◆ Identified information not found in the desk review documentation to be requested during the on-site portion of the review.
Step 9:	**Received record review listings and posted samples to HSAG's FTP site prepared for each BHO.**
	The Desk Review Form provided the BHO with the purpose, timelines, and instructions for submitting record review lists and for pulling sample records for HSAG's review. HSAG generated four unique record review samples based on data files supplied by the BHO or the Department. These files included the following databases: consumer grievances, consumer denials, consumers who are children and had been discharged from an inpatient facility, and encounters that had been reviewed by the BHO as part of a statically valid sample of encounters. From each of these databases, a random sample of unduplicated records was selected. For each of the record reviews, HSAG selected 10 records for the sample and five additional records for the oversample.
Step 10:	**Conducted the on-site portion of the review.**
	During the site review, BHO staff members were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. Activities completed during the site review included the following: ◆ Conducted interviews with BHO staff. Interviews were used to obtain a complete picture of the BHO's compliance with contract requirements, to explore any issues not fully addressed in the documents, and to increase overall understanding of the BHO's performance. ◆ Reviewed information and documentation. Throughout the desk review and site review processes, reviewers used a standardized monitoring tool to guide the identification of relevant information sources and to document the findings regarding compliance with the 10 standards. This activity included a review of applicable policies and procedures, meeting minutes, quality studies, reports, records, and other documentation. ◆ Received and reviewed records. Reviewers used standardized monitoring tools to review records and to document findings regarding compliance with contract requirements and the BHO's policies and procedures. ◆ Summarized findings at the completion of the site review. As a final step, HSAG reviewers met with BHO staff to provide a high-level summary of the preliminary findings from the site review.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 11:	**Calculated the individual scores and determined the overall compliance score for performance.**
	All of the 10 standards in the monitoring tool were reviewed and the information analyzed to determine the BHO's performance on the individual elements within each standard. For the review of records, each element was reviewed and the BHO's documentation analyzed to determine compliance.
Step 12:	**Prepared a report of findings and required actions.**
	After completing the documentation of findings and scoring for each of the 10 standards and for the reviews of records, HSAG prepared a draft report of the site review findings, scores, and required actions for the BHO. The report was forwarded to the Department and the BHO for their review and comment. After the Department's approval of the draft, a final, individual BHO report was issued to the Department and the BHO.

Evaluation and Scoring Methodology

Standards

The BHO's performance in complying with the elements (i.e., contract requirements) related to each of the 10 standards was evaluated against evidence obtained through a review of the BHO's documents and information provided during interviews with BHO staff. A score was assigned and the review findings and related substantiating evidence were documented in the "Findings" sections of the monitoring tool. The score (*Met, Partially Met*, or *Not Met*) indicated the degree to which the BHO's performance was in compliance with the individual elements in each standard. A score of *Not Applicable* (*N/A*) was used if an individual element did not apply to the BHO. Corrective actions required by the BHO to achieve compliance with the requirements were documented in the "Required Actions" section of the monitoring tool.

Scoring Methodology (Definitions)

The BHO received a score of *Met*, *Partially Met*, *Not Met*, or *N/A* for each element of each standard. This methodology follows the CMS final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*: *A protocol for determining compliance with Medicaid Managed Care Regulations*, February 11, 2003, and is defined below.

Met indicates full compliance, defined as either of the following:

- All documentation listed under a regulatory provision, or component thereof, must be present, or
- BHO staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews, or
- Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

- No documentation is present and staff have little or no knowledge of processes or issues addressed by the regulatory provisions, or
- For provisions with multiple components, key components of a provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for remaining components.

Not Applicable (***N/A***) signifies that the requirement does not apply, because:

- The standard or element was not applicable to the BHO.

To arrive at an overall percentage of compliance score for each standard, the total number of elements receiving a score of *Met* was divided by the total number of applicable elements.

Record Reviews

The evaluation of records to determine compliance with contract requirements was accomplished through the use of a record review tool developed for each of the applicable reviews (grievances, denials, coordination of care, and documentation of services).

Similar to the methodology followed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for determining the sample size required for confidence when evaluating compliance with elements of performance, a sample of 10 records with an oversample of five records was used for record reviews (unless there were 10 or fewer available records, in which case all available records were reviewed). The samples were selected from all applicable BHO records from January 1, 2006, through September 30, 2006 for the review of grievances and denials. For the review of documentation of services, HSAG used a random sample of 10 records with an oversample of five records selected from the 411 records submitted by each BHO for the validation of the BHO's review of a statistically valid sample of encounter data. For the coordination-of-care record review, HSAG used a sample of 10 records with an oversample of five records selected from the Department's encounter data list of children with inpatient stays and discharge dates between October 1, 2005, and June 30, 2006. Each record was reviewed for evidence of BHO compliance with the applicable elements.

For each type of record review except coordination of care, the BHO received a score of *Yes* (compliant), *No* (not compliant) or *N/A* for each of the elements evaluated. Except for the coordination-of-care record review, the BHO received an overall percentage-of-compliance score for each type of record review and for all the scored record reviews combined. The overall record review score was calculated by dividing the total number of elements scored *Yes* by the total number of applicable elements.

Determination of Overall Compliance Percentage Score

The overall compliance percentage score for each BHO was calculated by dividing the total number of elements that were compliant for the standards and the record reviews by the total number of applicable elements.

References

BBA (Balanced Budget Act). Centers for Medicare & Medicaid Services. CMS and Related Laws and Regulations. Available at: http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr438_04.html.

Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPS): A protocol for determining compliance with Medicaid Managed Care Regulations*, Final Protocol, February 11, 2003.

National Committee for Quality Assurance (NCQA) *2006 Standards for the Accreditation of Behavioral Health Organizations (BHOs)*. Washington, DC.