Colorado Medicaid
Community Mental Health Services Program

FY 2008–2009 Site Review Report

for

Behavioral HealthCare, Inc.

June 2009

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

HSAG HEALTH SERVICES ADVISORY GROUP

1600 East Northern Avenue, Suite 100 • Phoenix, AZ 85020
Phone 602.264.6382 • Fax 602.241.0757

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Overview of FY 2008–2009 Compliance Monitoring Activities

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

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

In developing the data collection tools and in reviewing the four components, HSAG used the BHOs' contract requirements and regulations specified by the BBA with revisions that were issued on June 14, 2002, and effective on August 13, 2002. The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)* (see Appendix F).

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

Objective of the Site Review

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

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

Summary of Results

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

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

Table 1-1—Summary of Scores for the Components

Component #	Description of Component	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable or Not Scored*	Score (% of *Met* Elements)
1	Member Information	25	23	23	0	0	2	100%
2	Notices of Action	9	9	7	2	0	0	78%
	Notices of Action Record Review	50	40	35	0	5	10	88%
3	Appeals	23	22	21	1	0	0	95%
	Appeals Record Review	42	42	42	0	0	0	100%
4	Underutilization	4	4	4	0	0	0	100%
	Totals	**153**	**140**	**132**	**3**	**5**	**12**	**94%**

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

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

Methodology

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

Summary of Findings and Opportunities for Improvement

Overall Score: In Compliance

BHI had an effective mechanism for ensuring that the required information was mailed within one month of **BHI**'s notification of enrollment. Mailings occurred monthly after receiving the notification of enrollment. **BHI**'s materials were available in Spanish, large print, and audio format. In addition, staff members reportedly offered to read materials when needed. For oral interpretation services, **BHI** used contracted interpreters, the language line, or bilingual staff members available at some of the community mental health center (CMHC) sites. While the consumer handbook included all of the requirements, there were some areas that represented opportunities for improvement for **BHI**. The consumer handbook informed members that they may choose their provider. **BHI** may also consider specifically informing members of the process for changing providers upon members' request. None of **BHI**'s member materials clearly informed members that providers may file appeals on their behalf (with written consent) or that a provider may become a designated client representative (DCR). **BHI** may consider clarifying materials to clearly state that providers may file appeals or State fair hearings on behalf of members and may be a member's DCR. **BHI** mailed a letter annually that informed members that they may request information about **BHI** and may receive another consumer handbook.

Summary of Strengths

BHI's materials demonstrated a clear member focus and member orientation. **BHI** had multiple methods of helping members and potential members understand the services offered by **BHI**. Many of these methods included personal contact with either **BHI** staff or consumer representatives during outreach programming that occurred within CMHC activities and inpatient hospital settings.

Summary of Required Actions

There were no corrective actions required for this component.

Methodology

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

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

Summary of Findings and Opportunities for Improvement

Overall score: In Partial Compliance

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

The notice-of-action template letters used for all notices sent to members included the requirements and time frames for continuation of benefits during the appeal and State fair hearing processes. As a result, members who were not eligible to receive continuation of services during the appeal or State fair hearing processes received the above information, resulting in letters that may have been confusing for members. **BHI** may consider customizing letters to the member's particular circumstances and removing nonapplicable language to improve their understandability.

Notice-of-Action Record Review Summary

HSAG reviewed 10 notice-of-action records at **BHI**. All 10 notices contained the content required by the BBA. One notice was confusing as to what action was being taken by **BHI**. Six of 10 records met the requirement to mail the notice of action within the required time frame. In two of the records that did not meet the required time frame **BHI** waited to perform the assessment on the member until the member had stabilized. In these cases an extension may have been appropriate

since **BHI** was unable to act on the request within the required time frame. In addition, in these two cases, there may not have been an actual request for the service at the time **BHI** initiated the UM process. **BHI** may want to evaluate its UM processes for determining when a request is received and for using extensions for making authorization decisions when appropriate.

Summary of Strengths

Overall, **BHI**'s notice-of-action letters were very easy to understand and consumer-friendly. When the reason for a denial of service was lack of medical necessity, **BHI**'s notice-of-action letters included quite a bit of nontemplate language that explained to the member what medical necessity was for the requested service and why the member did not meet the medical necessity requirement for the particular service requested. **BHI**'s notice-of-action training was very comprehensive and described the regulations by providing examples and case studies. **BHI**'s documentation system contained clear records of what had occurred with each case. In addition, **BHI** kept the notice-of-action records and the appeal records in the same case-specific file, allowing staff to easily access and follow cases from the beginning.

Summary of Required Actions

Based on the results of the on-site record review, **BHI** must ensure that each notice of action is easy to understand and is sent within the required time frames.

In addition, **BHI** must revise any applicable policies and documents to include the time frame for mailing the notice of action for actions related to a denial in whole or in part of payment for a service.

Methodology

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

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

Summary of Findings and Opportunities for Improvement

Overall Score: In Partial Compliance

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

Appeals Record Review Summary

Six appeal records were reviewed. Each of the records contained evidence of assistance provided to members during the appeal process. For all six cases, **BHI** met the required time frames for acknowledging the appeal and for sending the notice of resolution. Appeal resolution letters contained nontemplate language clearly explaining the reasons for the decision. All records also contained evidence that the individuals who made decisions on the appeals had not been involved in any previous level of review and had the clinical expertise required.

While the resolution letters contained all of the required information, the templates used contained information not applicable to all cases. For example, all resolution letters contained information about continuation of benefits during the State fair hearing process (which would not apply unless the action was related to the termination of previously authorized services), and resolution letters in favor of the member contained State fair hearing rights. **BHI** may consider customizing resolution letters to specific cases and/or developing a template for use when the decision is favorable to the member so that rights are not offered to members who are not eligible for them.

Summary of Strengths

BHI's case-specific appeal records clearly described the communication that occurred between **BHI** and members during the appeal process. **BHI** had an effective system to ensure that the review panel for an appeal was composed of professionals located at a CMHC other than the CMHC that had made the original decision. All appeal panels included professionals with credentials similar to the original decision-maker and a psychiatrist.

Summary of Required Actions

BHI's Appeal of Action policy addressed the continuation of benefits during the appeal and State fair hearing processes; however, the policy defined timely filing as 20 days rather than 10 days, as specified in the Code of Federal Regulations (CFR) at 42 CFR 438.420. **BHI** must revise its applicable policies and related member and provider materials to reflect the accurate time frame for requesting continuation of benefits and filing appeals related to the termination, suspension, or reduction or a previously authorized service.

Methodology

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

Summary of Findings and Opportunities for Improvement

Overall Score: In Compliance

BHI had a variety of routine reports that analyzed and trended utilization data and were designed to identify over- and underutilization. Reports included data on initial outpatient visits, hospital admissions, inpatient length of stay, hospital readmission at 7 and 30 days following discharge, and emergency room utilization. The reports trended data by type of service (both authorized and not authorized) and by providers and compared the CHMCs (as single, organizational providers).

Summary of Strengths

In addition to routine data pulls to identify over- and underutilization, **BHI** had additional creative methods for identifying and addressing over- and underutilization. **BHI** provided evidence of having conducted a three-year study to determine if a correlation existed between shorter hospital lengths of stay and hospital recidivism. **BHI** also had examined encounter data to identify outlier practice patterns of providers. Hospital Review Committee meeting minutes reflected analysis and discussion regarding evidence of follow-up after discharge from hospitalization. In addition, **BHI** had developed a study to be implemented in 2009. The study was designed to analyze the gap between the number of initial Colorado Client Assessment Records (CCARs) and data on subsequent encounters for those members who had initial CCARs.

Summary of Required Actions

There were no corrective actions required for this component.

6. Follow-up on FY 2007–2008 Corrective Action Plan for Behavioral HealthCare, Inc.

Methodology

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

Summary of FY 2007–2008 Required Actions

BHI scored 100 percent on the FY 2007–2008 site review and did not have any required actions.

Summary of Findings

BHI scored 100 percent on the FY 2007–2008 site review and did not have any required actions.

Summary of Required Actions

There were no required actions continued from FY 2007–2008.

The completed compliance monitoring tool follows this cover page.

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(3) Contract: II.G.d.g & II.G.d.h	1. The Contractor provides all members the required information (see below) within a reasonable time after the BHO receives notice of enrollment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: BHI's Enrollee Information policy stated that BHI will mail required information to all new enrollees within a reasonable amount of time after it receives notice of the recipient's enrollment. BHI's enrollment mailing included the member handbook and the network provider list. BHI provided an example of an invoice from the contractor for the monthly mailing of new enrollment packets.	
	Required Actions: None	
Contract: II.G.d.b	2. The Contractor has a mechanism to help members and potential members understand the requirements and benefits of the plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: BHI staff reported that the BHI member handbook was used by BHI to educate members and potential members about benefits offered under the plan. The handbook was distributed to members at the time of enrollment via the enrollment mailing. An annual letter (mailed during the review period in December 2007) reminded members of how to obtain information about benefits available under the Medicaid plan. BHI staff reported that the annual letter was English on one side and Spanish on the other. Other activities described by BHI staff that were designed to help members and potential members included: ◆ Open houses held at the CMHCs at various dates and times throughout the year. During these open houses, BHI distributed information about available services and consumer rights. Clinicians were available at the open houses to conduct mental health screenings and provide information about the mental health center. The open houses were advertised in a flier included with the annual letter sent in December 2007. ◆ Education from peer outreach specialists on the range of services available. These peer outreach specialists worked with consumers and staff at the CMHCs, drop-in centers, nursing facilities, alternative care facilities, and the Fort Logan inpatient unit. ◆ Delivery of gifts to children hospitalized over the holiday season by BHI's youth program. The gifts were accompanied by personalized letters handwritten by members of the youth group wishing the recipient wellness and hope, and extending an invitation to become involved in various drop-in center or CMHC groups and activities.	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.10(b)(1)&(3) 42CFR438.10(d) Contract: II.G.d.a; II.G.d.c; & II.G.d.d	3. The Contractor provides all enrollment notices, informational materials (handbooks, newsletters, directories), and instructional materials (health education, grievance system notices) in a manner and format that may be easily understood: ◆ In the prevalent non-English language. ◆ In alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The front page of the BHI member handbook included a statement in Spanish instructing members to call BHI if they need a Spanish version of the handbook. The first page of the member handbook also offered the use of a teletype/telecommunications (TTY/TTD) device for people who are deaf or hard of hearing and audio and large-print versions of the handbook, along with instructions on how to obtain these alternative formats. BHI had used the Flesch-Kincaid scale to determine that BHI's member materials were written at a sixth-grade reading level.	
	Required Actions: None	
42CFR438.10(c)(4)&(5) Contract: II.G.d.c; II.G.d.e; & II.G.d.f	4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The Culturally Appropriate and Competent Services policy addressed interpreter services. The Enrollee/Consumer Rights policy and the Enrollee Information policy both stated that interpretation is available free of charge. The member handbook section titled, "What do I need to know if English is not my primary language?" stated that interpretation help is available for any language, free of charge, and provided a telephone number to call to obtain these services. The Protocol for Accessing Interpreter Service policy stated that BHI's contractors inform Medicaid members that interpretation services are available and how to access them. This policy also stated that contractors make interpretation services available free of charge. BHI staff reported that the CMHCs submit reports periodically describing the requests for and use of interpreter services. BHI staff reported that the use of interpreter services is monitored through the annual delegation oversight process. External providers contracted with BHI were informed of their responsibilities regarding interpreters via the provider manual and the BHI Web site.	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.10(c)(5) Contract: II.G.d.f	5. The Contractor notifies members that written information is available for prevalent non-English languages and how to access the materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: BHI made all of its written member materials available in Spanish. Materials provided as examples included the member handbook, the annual letter, the coordination-of-care consumer survey, an Office of Consumer and Family Affairs (OCFA) brochure, and an ombudsman flier. BHI's Culturally Appropriate and Competent Services policy, the Enrollee/Consumer Rights policy, the Enrollee Information policy, and the Written Enrollee Materials—Prevalent Languages & Alternative Formats policy each stated that all written member materials would be made available in Spanish.	
	Required Actions: None	
42CFR438.10(d)(2) Contract: II.G.d.f	6. The Contractor notifies members that written information is available in alternative formats and how to access the materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The front page of the member handbook offered members the option to use the TTY/TTD or request a spoken version or a large-print copy of the member handbook. The member handbook also offered "any written materials…in a different format" and listed two telephone numbers (one local and one toll-free) members can call for help or to request other formats.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(2) Contract: II.G.d.k	7. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information (42CFR438.10), upon request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: BHI's annual letter reminded members of their right to obtain the required information and provided instructions on how to obtain it. The annual letter for the review period was sent in December 2007.	
	Required Actions: None	
42CFR438.10(f)(4) Contract: II.G.d.i	8. The Contractor gives written notice of any significant change in information to members at least 30 days before the intended effective date of the change.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook stated that BHI will notify members in writing at least 30 days in advance of any change in a member's health care or benefits. The Enrollee Information policy required that enrollees be notified of any significant change at least 30 days before the intended effective date. BHI changed locations in April 2008 and provided a bilingual postcard that had been mailed to its members, notifying them of the new location. BHI mailed the postcards 30 days before the move.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(5) Contract: II.G.d.j	9. The Contractor makes a good-faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who is receiving or has received in the last six months his or her primary mental health care from, or was seen on a regular basis by, the terminated provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook stated that BHI would give members written notice within 15 days if a member's provider or care site is changing. The member handbook also stated that the letter would include instructions on how to choose a new provider and how to get help. BHI provided an example of a letter notifying a guardian that the provider the child was seeing was no longer with BHI. The letter included a contact number and offered assistance with finding a new provider. BHI's provider manual informed providers of their responsibility to notify the director of provider relations of any change in information, including location, hours, client demographics, or availability for referrals.	
	Required Actions: None	
42CFR438.10(f) Contract: II.G.d.g.	10. Member information materials include: ◆ Names, locations, and telephone numbers of, and non-English languages spoken by, current contracted providers, including identification of providers who are not accepting new patients. ◆ Any restrictions on freedom of choice among network providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: BHI stated that it maintained its list of providers so that it only included providers who are accepting new patients. BHI distributed provider directories with every member handbook and maintained a current list of providers on its Web site. The directory included the location, licensure, languages spoken, ages served, and telephone number for each provider. BHI stated that it does not restrict freedom of choice among network providers. The member handbook informed members of their right to choose a provider. BHI may consider including in the member handbook the procedure to request a change in provider.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f) Contract: II.G.d.g	11. Member information materials include: ◆ Member rights as specified in 42CFR438.100. ◆ Additional member rights that include the right to: ▪ Have an independent advocate. ▪ Request that a specific provider be considered for inclusion in the network. ▪ Receive a second opinion. ▪ Receive culturally appropriate and competent services from participating providers. ▪ Receive interpreter services for members with communication difficulties or for non-English-speaking members. ▪ Prompt notification of termination or changes in services or providers. ▪ Express an opinion about the Contractor's services to regulatory agencies, legislative bodies, or the media without the Contractor causing any adverse effects upon the provision of covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: BHI used its member handbook and consumer rights posters to notify members of their rights. BHI reminded members of these rights in its annual letter.	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	12. Member information regarding the grievance, appeal, and fair hearing procedures have been approved by the Department and include: ◆ The right to file grievances. ◆ The right to file appeals. ◆ The right to a State fair hearing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: BHI's member handbook included information about a member's right to file grievances and appeals and the right to request a State fair hearing. BHI reminded its members of these rights in its annual letter. BHI provided evidence that the Department had approved member materials.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(g) Contract: II.G.d.g	13. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The requirements and time frames for filing grievances and appeals. ◆ The method for obtaining a State fair hearing. ◆ The rules that govern representation at a State fair hearing.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: BHI's member handbook included the requirements and time frames for filing grievances and appeals. BHI included the method for obtaining a State fair hearing and the rules that govern representation at a State fair hearing in its member handbook and in its notice-of-action letters. While the time frame for filing an appeal related to the denial or limited authorization of a requested service was correct, BHI may consider including the time frame for filing an appeal related to the termination, reduction, or suspension of a previously authorized service. (In this case, timely filing is defined by 42 CFR 438.420(a) as the later of the following: within 10 days of the date of the notice of action or before the date of the intended action.)	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	14. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The BHI member handbook stated that members could obtain assistance with filing appeals and requesting State fair hearings. The handbook also offered local and toll-free telephone numbers for the BHI director of consumer and family affairs, as well as local, toll-free, and TTY/TTD telephone numbers for the Medicaid ombudsman. The member handbook also included the toll-free TTY/TTD phone number for BHI.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(g) Contract: II.G.d.g	15. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State fair hearing is filed within the timeframes specified for filing ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The BHI member handbook stated that members can ask for benefits to continue and mentioned that a member may be required to pay the cost of services. The template letter used by BHI for notices of action and appeal resolution included the circumstances under which a member could request continuation of services, as well as the circumstances under which a member may be responsible for the cost of services provided during the appeal process. BHI may consider including this information in letters to members to whom the continuation of benefits would apply (in the case of termination, suspension, or reduction of a previously authorized service).	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	16. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: BHI's member handbook specifically stated that a member's provider may request an expedited appeal. It also stated that members may have an "approved representative" at a State fair hearing. The notice-of-action template letter stated that members could represent themselves or ask someone to represent them at a State fair hearing. None of the documents reviewed clearly stated that a provider may file an appeal on behalf of a member (with the members' consent), or that a provider may be a designated client representative (DCR). BHI may consider clearly stating in materials that providers may file appeals or requests for State fair hearings on behalf of members, and that providers may be a member's DCR.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(6) Contract: II.G.d.g	17. Information provided to members includes: ◆ The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. ◆ Procedures for obtaining benefits, including authorization requirements. ◆ The extent to which and how members may obtain benefits from out-of-network providers. ◆ How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract, including any cost-sharing and how transportation is provided.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The BHI member handbook included information regarding the amount, duration, and scope of benefits offered by BHI. The handbook also included procedures for obtaining benefits, including services from out-of-network providers, and where to access benefits available under the State plan but not covered by BHI.	
	Required Actions: None	
42CFR438.10(f)(6) Contract: II.G.d.g	18. Information provided to members includes: ◆ The extent to which and how after-hours and emergency coverage are provided, including: ▪ What constitutes an emergency medical condition, emergency services, and poststabilization services with reference to the definitions in 42 CFR 438.114(a). ▪ The fact that prior authorization is not required for emergency services. ▪ The process and procedures for obtaining emergency and poststabilization services, including the use of the 911 telephone system or its local equivalent. ▪ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services. ▪ The fact that the member has the right to use any hospital or other setting for emergency care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The definitions of emergency medical condition and poststabilization services included in the member handbook were consistent with BBA and State requirements. The member handbook gave members three options to seek emergency medical care, including calling 911. The member handbook included names, locations, and telephone numbers for local emergency rooms, and stated that members could seek emergency care at any emergency room—not just those included on the list. The member handbook also stated that no prior approval was needed for emergency care.	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.10 Contract: II.G.d.g	19. Information provided to members includes policies on referral for specialty care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: BHI's member handbook stated that BHI will monitor a member's care, and if a specialist is needed, BHI will refer the member to the right one.	
	Required Actions: None	
42CFR438.10 42CFR438.6(I)(2) 42CFR422.128 Contract: II.G.d.g	20. Member information regarding advance directives for adult members includes: ◆ The member's right to formulate advance directives. ◆ The member's rights under the State law to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment. ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State agency. ◆ The Contractor's policies regarding implementation of advance directives, which must include: ▪ A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. ▪ The difference between institution-wide conscientious objections and those raised by individual physicians. ▪ Identification of the State legal authority permitting such objection. ▪ Description of the range of medical conditions or procedures affected by the conscientious objection. ▪ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. ▪ Provisions for providing advance directive information to the incapacitated member once he or	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	she is no longer incapacitated. ▪ Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. ▪ The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive. ▪ Provisions for ensuring compliance with State laws regarding advance directives. ▪ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. ▪ Provisions for the education of staff concerning its policies and procedures on advance directives. ▪ Provisions for community education regarding advance directives that includes: • What constitutes an advance directive. • Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. • A description of applicable state law concerning advance directives.	
	Findings: The member handbook included information regarding a member's right to formulate advance directives, the right to refuse medical or surgical treatment, and who to call if the member feels his or her advance directive is not being followed. BHI submitted a sample medical history questionnaire on which members are asked if they have an advance directive. The Advance Directives policy included the process for documenting the advance directive in a prominent part of the member's record, stated that care may not be conditioned on whether the member has an advance directive, and addressed education of staff members. BHI staff described monitoring for compliance with documentation in the medical record regarding advance directives. The policy included a provision that members will be notified of any change in State law regarding advance directives within 90 days following the change. BHI's Web site and the provider manual included information about advance directives.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
Contract: II.G.d.h	21. Information provided to members includes: ◆ The fact that no fees may be assessed for covered mental health services provided to enrolled members. ◆ Notice that the member has been enrolled in the Community Mental Health Services Program operated by the Contractor, and that enrollment is mandatory. ◆ The Contractor's hours of operation. ◆ That assistance is available through the Medicaid Managed Care Ombudsman Program and how to access ombudsman services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook included a section titled, "Do I have to pay for my care?" in which BHI stated that covered mental health services are free. BHI used the member handbook to explain that Medicaid members who live in the BHI area are automatically enrolled in BHI by the State. BHI's hours of operation were included in the member handbook. BHI used ombudsman postings at provider sites to educate members about the services offered by the ombudsman and how to access those services. BHI's OCFA brochure included ombudsman information, as did its member handbook and grievance and appeal resolution letters. BHI staff reported that consumer and family representatives monitored provider sites for the prominent display of both the ombudsman posters and the member rights posters.	
	Required Actions: None	
Contract: II.G.d.h	22. Information provided to members includes: ◆ Appointment standards for routine, urgent, and emergency situations. ◆ Procedures for requesting a second opinion. ◆ Procedures for requesting accommodations for special needs, including written materials in alternative formats. ◆ Procedures for arranging transportation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The appointment standards for routine, urgent, and emergency situations were included in the member handbook, as were procedures for requesting a second opinion and accommodations for special needs and transportation.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10 Contract: II.G.d.h	23. Information provided to members includes: ◆ Information on how members will be notified of any changes in services or service delivery sites. ◆ Procedures for requesting information about the Contractor's Quality Improvement Program. ◆ Information on any member and/or family advisory boards the Contractor may have in place.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook stated that members would be told in writing at least 30 days ahead of any important changes in services. The handbook included a telephone number that members could call to request information about the quality improvement program, and a telephone number to call for information about the consumer advisory board. During the review period BHI also had fliers at provider sites inviting members to join the consumer advisory board.	
	Required Actions: None	
42CFR438.10 Contract: II.G.d.g	24. Additional information that is available upon request: ◆ Physician incentive plans	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: BHI's member handbook stated that members may request information about any doctor incentive plans that BHI has in place and included a telephone number to use to request the information. BHI's corporate compliance plan clearly stated that BHI does not provide any incentives to physician providers.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10 Contract: II.G.d.g	25. Information that must be made available annually and upon request: ◆ Information on the structure and operation of the Contractor ◆ The Contractor's service area ◆ The benefits covered under the contract ◆ The fact that no fees may be assessed for covered mental health services provided to enrolled members ◆ To the extent available, quality and performance indicators, including enrollee satisfaction	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: BHI used an annual letter to inform members that they may request a copy of the member handbook at any time. The member handbook included all of the required information.	
	Required Actions: None	

Results for Member Information							
Total	Met	=	23	X	1.00	=	23
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	2	X	N/A	=	N/A
Total Applicable		=	23	**Total Score**		=	23

Total Score ÷ Total Applicable	=	100%

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.400(b) Contract: Exhibit G—8.209.2	1. The Contractor defines action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Notice of Action policy included a definition of action that was consistent with the BBA. The Action Training PowerPoint presentation included the same definition and provided discussion and case examples. Training rosters provided for each CMHC verified that training was conducted at new-hire orientation and annually.	
	Required Actions: None	
42CFR438.404(a) Contract: Exhibit G—8.209.4.A.1	2. Notices of action must meet the language and format requirements of 42CFR438.10 and ensure ease of understanding.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The notice-of-action template letter and the sample notice of action included with the desk review materials were easy to understand. One notice of action in the on-site record review was not easy to understand regarding what action was being taken.	
	Required Actions: BHI must ensure that each notice of action is easy to understand as required by 42 CFR 438.10.	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.404(b) Contract: Exhibit G—8.209.4.A.2	3. Notices of action must contain: ◆ The action the Contractor has taken or intends to take. ◆ The reasons for the action. ◆ The member's (and provider's on behalf of the member) right to file an appeal and how to do so. ◆ The member's right to request a State fair hearing and how to do so. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that. ◆ The circumstances under which the member may have to pay for the costs of services if continued benefits are requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The template and sample notices of action provided by BHI included all of the requirements. The on-site review of notice-of-action records demonstrated that BHI sent notices of action that that included all of the requirements. BHI may consider only including information pertinent to the member. For example, notices to members who would not qualify to continue services contained information about continuation of services.	
	Required Actions: None	
42CFR438.404(c) Contract: Exhibit G—8.209.4.A.3	4. The notice of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized, Medicaid-covered services, at least 10 days before the date of action (unless extenuating circumstances exist—found in Exhibit G) ◆ For denial of payment, at the time of any action affecting the claim ◆ For standard service authorization decisions that deny or limit service, within 10 calendar days ◆ For service authorization decisions not reached within 10 calendar days, on the date the time frames expire ◆ For expedited service authorization decisions, within three days	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Management (UM) Decision Timelines policy included time frames for mailing notices of action, but did not include the time frame for sending a notice of action regarding the denial, in whole or in part, of payment for a service provided. In addition, the on-site record review demonstrated that not all notices were sent within the required time frames.	
	Required Actions: BHI must revise the applicable policy to include all time frames for mailing the notice of action. BHI must also ensure that all notices of action are sent within the required time frames.	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.404(c) Contract: Exhibit G—8.209.4.A.4	5. If the Contractor extends the time frame for authorization decisions (see Standard I) it provides the member: ◆ Written notice of the reason for the decision to extend the time frame. ◆ The right to file a grievance if the member disagrees with the decision. ◆ Issuance of its decision (and carries out the decision) as expeditiously as the member's health condition requires and no later than the date the extension expires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Management (UM) Decision Timelines policy included the process for extending the time frame for expedited or standard authorization decisions. The policy, however, indicated that the member would be notified of his or her right to file an appeal if he or she disagreed with the BHO's decision to extend the authorization decision time frame. BHI may consider clarifying that the member has grievance rights rather than appeal rights in this case. BHI may also consider reviewing any other pertinent materials to ensure consistency (training materials, template letters, etc.).	
	Required Actions: None	
42CFR438.210(a)(3)(ii) Contract: II.J.a..d.2	6. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Management Program Description described use of BHI's UM criteria and medical necessity criteria for making UM decisions. The criteria were defined in the Utilization Management Program Description. The Utilization Management Program Description included the results of interrater reliability testing. The on-site record review demonstrated that decisions to deny or limit services were not based solely on diagnosis or condition (i.e., developmental disability). Instead, decisions were due to lack of covered diagnosis, a request for noncovered services, or lack of medical necessity. BHI staff reported that the executive director had received no direct calls related to denials of services to developmentally disabled individuals and that any complaints regarding that issue would be processed using the grievance system processes.	
	Required Actions: None	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.210(a)(3)(iii) Contract: II.J.a.d.3	7. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Management Program Description described the UM and medical necessity criteria used. The BHI Utilization Management Criteria policy stated that the UM criteria serves as an assessment tool for making authorization decisions and described how the criteria were used and distributed. The Utilization Management Program Description addressed the use of aggregate UM data trending and analysis to ensure that services provided can achieve the purpose for which they were provided.	
	Required Actions: None	
42CFR438.210(b)(3) Contract: II.J.a.f	8. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The BHI Utilization Management Criteria policy stated that any decision to deny, limit authorization, terminate, reduce, or suspend services must be reviewed and signed by a psychiatrist. The Utilization Management Program Description included a detailed procedure and indicated which physician would review and sign the notice of action based on the type of service requested. The on-site review of notice-of-action records demonstrated that BHI had an effective mechanism to ensure that decisions to deny or terminate service or limit authorization were made by physicians who had appropriate clinical expertise in treating the member's condition or disease.	
	Required Actions: None	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.210(c) Contract: II.J.a.h	9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. (Notice to the provider does not need to be in writing.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Notice of Action policy stated that notices are sent to the member and verbal notice is given to the provider. The on-site review of notice-of-action records demonstrated that members were sent notices of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. UM records in the record review sample contained documentation that providers were notified of authorization decisions via telephone.	
	Required Actions: None	

Results for Notices of Action							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	0	X	N/A	=	N/A
Total Applicable		=	9	**Total Score**		=	7

Total Score ÷ Total Applicable	=	78%

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.402(a) Contract: Exhibit G—8.209.1	1. The Contractor has a system in place that includes an appeal process and access to the State fair hearing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The member handbook described the appeal and State fair hearing processes. The Appeal of Action policy described BHI's processes for allowing members access to the BHI appeal process and the State fair hearing process. On-site review of appeal records demonstrated compliance with this requirement.	
	Required Actions: None	
42CFR438.400(b) Contract: Exhibit G—8.209.2	2. The Contractor defines an appeal as a request for review of an action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of Action policy included the BBA-compliant definition of an appeal. The member handbook included an easy-to-understand definition of appeal that was consistent with the BBA. The provider manual included a definition of appeal that was consistent with the BBA.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.402(b)(1) Contract: Exhibit G—8.209.1	3. The Contractor has provisions for who may file: ◆ A member may file a PIHP-level appeal and may request a State fair hearing. ◆ A provider, acting on behalf of a member and with the member's written consent, may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member. (The State permits the provider to act as the member's authorized representative.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of Action policy described the process for members or DCRs to file appeals. The definition of DCR in the policy included health care professionals. Neither the member handbook nor the provider manual included complete information regarding DCRs (including providers filing appeals or requests for State fair hearings). BHI may consider revising member and provider materials to completely address who may file appeals and requests for State fair hearings.	
	Required Actions: None	
42CFR438.402(b)(3) Contract: Exhibit G—8.209.4.F	4. The member may file an appeal either orally or in writing and must follow an oral request with a written request (unless the request is for expedited resolution).	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The Appeal of Action policy stated that appeals may be filed orally or in writing, but did not address the requirement that oral requests be followed by a written request. The member handbook and notice-of-action letter informed members that they may file orally or in writing. BHI's notice-of-action template included check boxes that members may complete and return to BHI. The choices were to indicate agreement, disagreement, or the desire to appeal. During the on-site interview, BHI staff reported that this was a new practice and had not yet met with success. The BBA requires oral requests for an appeal to be followed by a written request. The Department will send a clarification to the BHOs regarding this requirement.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.402(b)(2) Contract: Exhibit G—8.209.4.B	5. An appeal may be filed 20 calendar days from the date of the notice of action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of Action policy stated that appeals may be filed within 20 days of the notice of action. The member handbook and the notice-of-action letter informed members of this. Providers were informed in the provider manual.	
	Required Actions: None	
42CFR438.402(b)(3) Contract: Exhibit G—8.209.4.N	6. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing 20 days from the date of the notice of action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The member handbook notified members of the time frames for filing an appeal and for requesting a State fair hearing. The notice-of-action letter informed members specifically that they need not file any other appeal before requesting a State fair hearing.	
	Required Actions: None	
42CFR438.406(a) Contract: Exhibit G—8.209.4.C	7. In handling appeals, the Contractor must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of Action policy stated that BHI provides assistance with filing appeals or requesting a State fair hearing. The notice-of-action letter offered members assistance in filing appeals or requesting a State fair hearing. The member handbook offered assistance with filing grievances or appeals and requesting a State fair hearing. There was evidence in the appeal records that assistance was provided to members during the appeal process.	
	Required Actions: None	

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

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.406(b) Contract: Exhibit G—8.209.4.G—I	10. The Contractor's appeal process must provide: ◆ That oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution. ◆ The member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents considered during the appeals process. ◆ That either of the following individuals are included as parties to the appeal: ▪ The member and his or her representative ▪ The legal representative of a deceased member's estate	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Members were notified in the notice-of-action letter and the appeal acknowledgment letter of their (and their representative's) right to present evidence and review any pertinent case files. The Appeal of Action policy described the process for notifying members of this right. The on-site review of records contained documentation that members reviewed files and presented evidence both in writing and in person. Appeal records also demonstrated that the oral filing date was used as the filing date for the appeals.	
	Required Actions: None	
42CFR438.408(b)&(d) Contract: Exhibit G—8.209.4.J	11. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires: ◆ For standard resolution of appeals, 10 working days from the day the Contractor receives the appeal ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Both time frames for resolution of appeals were addressed in the Appeal of Action policy. Members were informed in the member handbook of the resolution time frames. The on-site review of appeal records demonstrated that each of the appeals reviewed was resolved with notice provided within the required time frame.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.408(c) Contract: Exhibit G—8.209.4.K & 8.209.5.E	12. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if either: ◆ The member requests the extension. ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of Action policy included the process for extending time frames for resolution (applied to both expedited and standard cases). Members were informed in the member handbook of the extension time frames. The on-site review of records indicated that the resolution time frame was extended in one case.	
	Required Actions: None	
42CFR438.408(b)(3) Contract: Exhibit G—8.209.4.K & 8.209.5.E	13. If the Contractor extends the time frames, it must—for any extension not requested by the member—give the member written notice of the reason for the delay.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The record review demonstrated that when BHI extended the time frame for resolution of an appeal the member was notified in writing of the reason for the extension.	
	Required Actions: None	
42CFR438.408(d) Contract: Exhibit G—8.209.4.L	14. For notice of an expedited resolution of an appeal, the Contractor must also make reasonable efforts to provide oral notice of resolution.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of Action policy stated that oral notice was provided to the member in addition to the written notice for all appeals. The record review demonstrated that BHI followed this process as stated in the policy. All members were notified of appeal results orally (via telephone) and in writing. There were no expedited appeals in the sample of records reviewed.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.408(e) Contract: Exhibit G—8.209.4.M	15. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: ▪ The right to request a State fair hearing and how to do so. ▪ The right to request that benefits continue while the hearing is pending and how to make the request. ▪ That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The template resolution letter included all of the requirements. The on-site record review demonstrated that the resolution letters sent to the members included all of the requirements. Resolution letters that address a decision in the member's favor included State fair hearing information. BHI may consider removing State fair hearing information from resolution letters with a decision in the member's favor.	
	Required Actions: None	
42CFR438.410 Contract: Exhibit G—8.209.4.P—R	16. The Contractor has an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes the following: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: ▪ Transfer the appeal to the time frame for standard resolution. ▪ Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two calendar days.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of Action policy included all of the provisions. The notice-of-action letter and the member handbook informed members about the expedited review process. During the on-site review, BHI staff reported that BHI would honor and not deny any request for an expedited review of an appeal, but that BHI receives very few requests for expedited appeals. There were no expedited appeals in the records reviewed on-site.	

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

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.416 Contract: Exhibit G—8.209.3.C	18. The Contractor maintains records of all appeals and submits quarterly reports to the Department.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The quarterly reports provided demonstrated compliance as did the on-site review of appeal logs and case-specific appeal records.	
	Required Actions: None	
42CFR438.420(b) Contract: Exhibit G—8.209.2 & 8.209.4.S	19. The Contractor continues the member benefits if: ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice of action ▪ The intended effective date of the proposed action ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of Action policy addressed the continuation of benefits and the conditions under which benefits could continue; however, the policy simply stated "if the member files timely." The only reference to a time frame for filing appeals was the 20-day time frame for filing appeals related to the denial or limited authorization of a requested service.	
	Required Actions: BHI must revise its applicable policies and related member and provider materials to reflect the accurate time frame for requesting continuation of benefits and filing appeals related to the termination, suspension, or reduction of a previously authorized service.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.420(c) Contract: Exhibit G—8.209.4.T	20. If the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal ◆ Ten days pass after the Contractor mails the notice providing the resolution of the appeal against the member, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached ◆ A State fair hearing officer issues a hearing decision adverse to the member ◆ The time period or service limits of a previously authorized service has been met	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of Action policy included the provision. BHI may consider adding language to notices and member and/or provider materials to inform members of the duration of benefits if they are continued during the appeal or State fair hearing processes.	
	Required Actions: None	
42CFR438.420(d) Contract: Exhibit G—8.209.4.U	21. If the final resolution of the appeal is adverse to the member—that is, it upholds the Contractor's action—the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this rule.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: This provision was included in the Appeal of Action policy.	
	Required Actions: None	
42CFR438.424 Contract: Exhibit G—8.209.4.V	22. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: This provision was included in the Appeal of Action policy.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.424 Contract: Exhibit G—8.209.4.W	23. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: This provision was included in the Appeal of Action policy.	
	Required Actions: None	

Results for Appeals							
Total	Met	=	21	X	1.00	=	21
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	1	X	N/A	=	N/A
Total Applicable		=	22	**Total Score**		=	21

Total Score ÷ Total Applicable	=	95%

Component 4 —Underutilization: Partial Review of Standard X—Quality Assessment and Performance Improvement		
References	**Requirement**	**Score**
42CFR438.240(b)(3) Contract: II.I.e	1. The Contractor's QAPI program includes mechanisms to detect both underutilization and overutilization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM report cards trended and analyzed data for initial outpatient visits, inpatient admissions, average inpatient lengths of stay, readmissions within 7 and 30 days, and emergency room (ER) utilization. The UM report cards contained analysis regarding the correlation between shorter inpatient lengths of stay and recidivism. The results of examining three years of data indicated no significant correlation.	
	Required Actions: None	
UM Criteria – Section IV	2. The Contractor has policies and procedures outlining the activities undertaken to specifically identify and address underutilization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Encounter data summaries were analyzed to evaluate for outlier patterns. Hospital review committee meeting minutes demonstrated discussion regarding follow-up activities with members after hospitalization. The UM department developed specific ER utilization reports to analyze the types of services being received in the ER and to develop methods to address overutilization of ER services and possible underutilization of outpatient services. During the on-site interview, BHI staff described a project initiated for FY 2009. The project, CCAR Encounter Gap Analysis, will be designed to use CCAR and encounter data to identify members who had an admit CCAR and no encounters for treatment. Interventions resulting from this project could include contacting the provider or investigating underutilization issues as appropriate. BHI also had a new policy titled Procedures for Outreach to Clients who Unexpectedly Miss Appointments. The policy included risk-assessment categories and outreach procedures based on a member's assessed risk category.	
	Required Actions: None	

Component 4 —Underutilization: Partial Review of Standard X—Quality Assessment and Performance Improvement		
References	**Requirement**	**Score**
UM Criteria – Section IV	3. The Contractor's policies and procedures include the mechanism for routine trending and analysis of data by levels of care and by provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Risk and Resource Committee meeting minutes demonstrated that analysis was performed by level of care (inpatient, outpatient, ER), type of service (clubhouse, residential, case management, vocational, recovery), and place of service (CMHC, group home, nursing facility, office, school). BHI staff reported that utilization data from independently contracted providers are used during the recredentialing process, and that CMHCs were compared as organizational providers when analyzing data for trends.	
	Required Actions: None	
UM Criteria – Section IV	4. Trending includes services prior authorized and not prior authorized.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM report card included trending of authorized services (e.g., inpatient, residential, case management, and outpatient services by contracted provider) and services that are not prior authorized (e.g., emergency, recovery, clubhouse, vocational, and outpatient services by CMHC).	
	Required Actions: None	

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

Total Score ÷ Total Applicable	=	100%

Appendix B. Notice of Action Record Review Tool for Behavioral HealthCare, Inc.

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

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Behavioral Health Organization (BHO) Actions Record Review Tool *for* Behavioral HealthCare, Inc.

Review Period:	July 1, 2007–June 30, 2008
Date of Review:	March 11, 2009
Reviewer:	Rachel Henrichs and Barbara McConnell
Participating BHO Staff Member:	Susan James-Padilla

1	2	3	4	5	6	7	8	9	10	11
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for all Notices		
File #	Member ID	Date of Initial Request	Date Notice Sent	Number of Days for Decision	Notice Sent Within Time Frame	Date Notice Sent	Notice Sent Within Time Frame	Reasons are Easily Understood	Decision Made by Qualified Clinician	Notice Includes all Required Content
1	XXXXX	NA	NA	NA	M ☐ N ☐ N/A ☒	7/18/07	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The first notice of action, dated July 12, 2007, notified the member that residential treatment would end, effective August 1. The reason for this action was the member's disruptive and threatening behavior. A second notice of action was sent July 18, 2007, telling the member that termination of his residential treatment was effective immediately. The reason for the change of date was that the member's threatening and disruptive behavior (to consumers and staff) had worsened. The first letter was sent within the required time frame. The second letter, notifying the member of immediate termination, was justified under the rules of the BBA. Both notices included all of the required content (42CFR438.404[c][1]; 42CFR431.213; 42CFR483.12[a][2][iii]); however, the first notice of action should have allowed only 13 days to file an appeal (rather than 20).									
2	XXXXX	8/7/07	8/15/07	8	M ☒ N ☐ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The request for day treatment was denied based on lack of medical necessity. The notice of action offered alternative treatment options. The letter was signed by a psychiatrist, was mailed within the required time frame, and included all of the required content.										
3	XXXXX	8/16/07	8/20/07	4	M ☒ N ☐ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: (HB 1116) The request for residential treatment was denied based on lack of medical necessity. The letter included detailed reasons for the denial. The decision-maker (an MD) believed the member could be best served through alternative treatment options, which were listed in the letter. The letter included the option for the member to indicate on the letter whether or not she agreed with the decision, and if she wished to appeal the decision. The letter included all other required content.										
4	XXXXX	10/5/07	10/8/07	3	M ☒ N ☐ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The member's therapist denied the member's request for vocational orientation because the member had not met the requirements for the program, as outlined by the therapist. The decision was made by a qualified clinician, notice was sent within the required time frame, and all required content was included.										
5	XXXXX	11/28/07	11/30/07	2	M ☒ N ☐ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: (HB 1116) The decision to deny residential services was made by a medical doctor. The letter included detailed reasoning for the denial and an explanation as to why the member did not meet medical necessity.										
6	XXXXX	11/29/07	12/13/07	14	M ☐ N ☒ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☐ N ☒	M ☒ N ☐	M ☒ N ☐
Comments: This notice of action was not a denial of service, but was sent because BHI did not meet the required time frame for making the authorization decision. BHI staff reported that the services had been provided. The notice-of-action letter indicated that services requested were approved beginning on the date of the request, so there was no service interruption. BHI staff clarified that the services were authorized retroactive to the request date when it was discovered that the authorization decision had not been made										

Appendix B. Colorado Behavioral Health Organization (BHO) Actions Record Review Tool *for* Behavioral HealthCare, Inc.

1	2	3	4	5	6	7	8	9	10	11
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for all Notices		
File #	Member ID	Date of Initial Request	Date Notice Sent	Number of Days for Decision	Notice Sent Within Time Frame	Date Notice Sent	Notice Sent Within Time Frame	Reasons are Easily Understood	Decision Made by Qualified Clinician	Notice Includes all Required Content
within the required time frame, and since the provider had treated the member, services were not disrupted. The letter was unclear in describing the situation. The notice of action included continuation-of-benefit language and appeal and State fair hearing rights; however, these rights were not applicable to this type of action.										
7	XXXXX	11/26/07	12/16/07	20	M ☐ N ☒ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The decision to deny day treatment services was made by a medical doctor and was based on lack of medical necessity. At the time of the request, the member was an inpatient at a hospital. Because the member's condition was unstable, assessment and decision was postponed until discharge was eminent. No extension letter was sent.										
8	XXXXX	1/11/08	1/23/08	12	M ☐ N ☒ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: (HB 1116) The letter stated that the request for residential treatment was made January 11, 2008. At the time of the request, the member was an inpatient at a hospital. Because the member's condition was unstable, the member was not assessed for residential treatment until January 17, 2008. No extension letter was sent. The notice of action denying residential services was dated January 23, 2008. The reason for the denial was clearly stated, all of the required content was included, and the decision was made by a medical doctor.										
9	XXXXX	12/26/07	1/18/08	23	M ☐ N ☒ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The request for day treatment services was denied by a medical doctor. The program in question was a co-located program co-run by one of BHI's CMHCs and the school district. For BHI to provide the mental health portion of the program, the child must have been eligible for the educational portion of the program. The notice of action stated that the school district felt it could provide education in the public school system and, therefore, would not support the request for day treatment through that particular program. The CMHC (as an agent of BHI) denied services based on lack of participation from the school district. The notice of action did provide the member with suggestions for alternative mental health services and the name and phone number of a contact person at the CMHC. The notice was not mailed within the required time frame.										
10	XXXXX	2/25/08	2/28/08	3	M ☒ N ☐ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The request for residential placement services was denied by a medical doctor based on lack of medical necessity. The letter offered a detailed explanation as to why the member did not meet medical necessity and offered a list of alternative services. The letter included all of the required content.										
# Applicable Elements					9		1	10	10	10
# Compliant Elements					5		1	9	10	10
Percent Compliant										

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

Total Applicable Elements:	**40**
Total # Compliant Elements:	**35**
Total Percent Compliant:	**88%**

Appendix C. Appeals Record Review Tool for Behavioral HealthCare, Inc.

The completed appeals record review worksheet follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix C. Colorado Behavioral Health Organization (BHO) Appeals Record Review Tool *for* Behavioral HealthCare, Inc.

Review Period:	July 1, 2007–June 30, 2008
Date of Review:	March 11, 2009
Reviewer:	Barbara McConnell
Participating BHO Staff Member:	Susan James-Padilla

1	2	3	4	5	6	7	8	9	10	11	12	13	14
File #	**Member ID**	**Date Appeal Received**	**Evidence of Reasonable Assistance**	**Date of Acknow-ledgment Letter**	**Acknow-ledgment Within 2 Working Days**	**Decision-maker—Previous Level**	**Decision-maker—Clinical Expertise**	**Expedited**	**Time Frame Extended**	**Date Resolution Letter Sent**	**Resolved in Time Frame**	**Resolution Notice Includes Required Content**	**Resolution Notice Easily Understood**
1	XXXXX	7/13/07	M☒ N☐ U☐	7/16/07	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	7/20/07	M☒ N☐	M☒ N☐	M☒ N☐
Comments: The action was a denial of residential treatment services. The appeal decision overturned the original decision. The resolution letter (favorable to the member) included State fair hearing rights and information regarding continuation of benefits. The letter was very easy to understand and included nontemplate language.													
2	XXXXX	1/9/08	M☒ N☐ U☐	1/10/08	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	1/14/08	M☒ N☐	M☒ N☐	M☒ N☐
Comments: The action was the denial of day treatment services. The appeal decision upheld the original decision as the child did not meet the criteria for the requested level of care. The resolution letter included State fair hearing rights (as required) and information about continuation of benefits (which was not applicable as this was a new request). The letter was very easy to understand and included nontemplate language.													
3	XXXXX	5/21/08	M☒ N☐ U☐	5/22/08	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	5/27/08	M☒ N☐	M☒ N☐	M☒ N☐
Comments: The action was a denial of respite services. The appeal decision overturned the original denial. The resolution letter included State fair hearing rights and information regarding continuation of benefits, which were not applicable to the member because the resolution was in the member's favor. The letter was very easy to understand and included nontemplate language.													
4	XXXXX	5/27/08	M☒ N☐ U☐	5/28/08	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	6/3/08	M☒ N☐	M☒ N☐	M☒ N☐
Comments: The action was a denial of individual therapy due to lack of follow through with appointments. The appeal decision overturned the original decision. The resolution letter included State fair hearing rights and information regarding continuation of benefits, which were not applicable to the member because the resolution was in the member's favor. The letter was very easy to understand and included nontemplate language.													
5	XXXXX	6/10/08	M☒ N☐ U☐	6/10/08	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	6/12/08	M☒ N☐	M☒ N☐	M☒ N☐
Comments: The action was a denial of residential treatment services. The appeal decision overturned the original decision. The resolution letter included State fair hearing rights and information regarding continuation of benefits, which were not applicable to the member because the resolution was in the member's favor. The letter was very easy to understand and included nontemplate language.													

Appendix C. Colorado Behavioral Health Organization (BHO) Appeals Record Review Tool *for* Behavioral HealthCare, Inc.

1	2	3	4	5	6	7	8	9	10	11	12	13	14
File #	Member ID	Date Appeal Received	Evidence of Reasonable Assistance	Date of Acknow-ledgment Letter	Acknow-ledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
6	XXXXX	8/6/2008	M☒ N☐ U☐	8/8/2008	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	8/14/08	M☒ N☐	M☒ N☐	M☒ N☐
Comments: The action was the denial of day treatment at The Children's Hospital Neuropsychiatric Special Care Unit. The reason for the denial was that the child did not have a covered diagnosis and a less restrictive level of care had not been given an adequate amount of time. The appeal review determined that while the child did have a covered diagnosis, the original decision was upheld because the less restrictive level of care had not been given an adequate amount of time. The resolution letter included State fair hearing rights (as required) and information about continuation of benefits (which was not applicable as this was a new request). The letter was very easy to understand and included nontemplate language.													
# Applicable Elements			6		6	6	6				6	6	6
# Compliant Elements			6		6	6	6				6	6	6
Percent Compliant													

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

Total # Applicable Elements	**42**
Total # Compliant Elements	**42**
Total Percent Compliant	**100%**

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

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

Table D-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Rachel Henrichs	Project Coordinator
BHI Participants	**Title**
Diane Cannizzaro	Utilization Management and Corporate Compliance Officer
Jeffrey George	Quality Improvement and Research Analyst
Rebecca Hill	Executive Assistant
Julie Holtz	Chief Executive Officer
Susan James-Padilla	Director of Utilization Management
Jennifer Koberstein	Director of Consumer and Family Affairs
Samatha Kommana	Director of Quality Improvement
Melissa Kulasekere	Quality Improvement Program Evaluator/Disease Management
Christina Mitsch	Authorization Coordinator/Assistant Accountant
Rian G. Nowitzki	Chief Financial Officer/Controller
Joe Phillips	Quality Improvement Data Analyst
Margaret Pleasant	Utilization Management Supervisor
Nik Savastinuk	Information Technology Manager
Teresa Summers	Director of Provider Relations
Alicia Vix	Quality Improvement Support Coordinator
Department Observers	**Title**
Jerry Ware	Quality Compliance Specialist
Marceil Case	Behavioral Health Specialist

Appendix E. Corrective Action Plan Process for FY 2008–2009 for Behavioral HealthCare, Inc.

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

Table E-1—Corrective Action Plan Process

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

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

The template for the CAP follows.

Table E-2—FY 2008–2009 Corrective Action Plan *for* BHI				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
2. Notices of Action 2. Notices of action must meet the language and format requirements of 42CFR438.10 and ensure ease of understanding. **Findings:** One notice of action in the on-site record review was not easy to understand regarding what action was being taken.	BHI must ensure that each notice of action is easy to understand as required by 42 CFR 438.10.			
4. The notice of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized, Medicaid-covered services, at least 10 days before the date of action (unless extenuating circumstances exist—found in Exhibit G) ◆ For denial of payment, at the time of any action affecting the claim ◆ For standard service authorization decisions that deny or limit service, within 10 calendar day	BHI must revise the applicable policy to include all time frames for mailing the notice of action. BHI must also ensure that all notices of action are sent within the required time frames.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* BHI				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
◆ For service authorization decisions not reached within 10 calendar days, on the date the time frames expire ◆ For expedited service authorization decisions, within three days **Findings:** The Utilization Management (UM) Decision Timelines policy did not include the time frame for sending a notice of action regarding the denial, in whole or in part, of payment for a service provided. In addition, the on-site record review demonstrated that not all notices were sent within the required time frames.				
3. Appeals 19. The Contractor continues the member benefits if: ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice of action ▪ The intended effective date of the proposed action	BHI must revise its applicable policies and related member and provider materials to reflect the accurate time frame for requesting continuation of benefits and filing appeals related to the termination, suspension, or reduction of a previously authorized service.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* BHI				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits. **Findings:** The Appeal of Action policy addressed the continuation of benefits by stating "if the member files timely." The only reference to a time frame for filing appeals was the 20-day time frame for filing appeals related to the denial or limited authorization of a requested service.				

Appendix F. Compliance Monitoring Review Activities for Behavioral HealthCare, Inc.

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

Table F-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG…
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff provided an orientation on October 3, 2008, for the BHO and the Department to preview the FY 2008–2009 compliance monitoring review process and to allow the BHOs to ask questions about the process. HSAG reviewed the processes related to the request for information, CMS' protocol for monitoring compliance, the components of the review, and the schedule of review activities. ◆ HSAG assigned staff to the review team. ◆ HSAG provided a presentation to the Department and the BHOs on January 27, 2009, titled "Developing and Implementing Corrective Action Plans." In this presentation, HSAG reviewed the timeline and requirements for the corrective action plan process. ◆ Prior to the review, HSAG representatives responded to questions from the BHO related to the process and federal managed care regulations to ensure that the BHO was prepared for the compliance monitoring review. HSAG maintained contact with the BHO as needed throughout the process and provided information to the BHO's key management staff members about review activities. Through this telephone and/or e-mail contact, HSAG responded to the BHO's questions about the request for documentation for the desk audit and about the on-site review process.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the BHO's contract, dated March 1, 2007, to develop the monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the desk audit request and sent a documentation request form and an on-site agenda. The BHO had 30 days to provide all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the four components. ◆ Documents requested included applicable policies and procedures, minutes of key BHO committee or other group meetings, reports, logs, and other documentation.

Table F-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents needed that HSAG identified during its desk audit. ◆ HSAG requested and reviewed additional documents needed that HSAG identified during the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with BHO staff to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 2008–2009 Site Review Report to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions required of the BHO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2008–2009 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG coordinated with the Department to incorporate the Department's comments. ◆ HSAG distributed a second draft report to the BHO for review and comment. ◆ HSAG coordinated with the Department to incorporate the BHO's comments and finalize the report. ◆ HSAG distributed the final report to the BHO and the Department.