Colorado Medicaid
Community Mental Health Services Program

FY 2009–2010 Site Review Report

for

Behavioral HealthCare, Inc.

May 2010

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 2009–2010 Compliance Monitoring Activities

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations, contractual requirements, and each state's quality strategy. The Colorado 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 sixth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2009–2010 site review process, the Department requested a review of seven areas of performance. For its review of **Behavioral HealthCare, Inc.** (**BHI**), HSAG developed a review strategy consisting of seven standards that it had not reviewed within the previous two fiscal years. The areas chosen for review were Standard I—Emergency and Poststabilization Services (a subset of Standard I—Coverage and Authorization of Services); Standard IV—Member Rights and Protections; Standard VI—The Grievance System (Grievances Only); Standard VII—Provider Participation and Program Integrity; Standard VIII—Credentialing and Recredentialing; Standard IX—Subcontracts and Delegation; and Standard X—Quality Assessment and Performance Improvement. Compliance with federal regulations was evaluated through review of the seven standards. This report documents results of the FY 2009–2010 site review activities for the review period—July 1, 2009, through February 16, 2010 (the date of the on-site review). Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Appendices A and B contain details of the findings.

Methodology

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

The seven standards chosen for the FY 2009–2010 site reviews represent a portion of the requirements based on Medicaid managed care requirements. The remainder of Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination of Care, Standard V—Member Information, and the remainder of Standard VI—the Grievance System, will be reviewed in subsequent years.

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

Objective of the Site Review

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

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

Summary of Results

Based on the results from the Compliance Monitoring Tool and conclusions drawn from the review activities, HSAG assigned each element within the standards in the Compliance Monitoring Tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any individual element within the Compliance Monitoring Tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations to enhance some elements, regardless of the score. While HSAG provided recommendations for enhancement of BHO processes based on these identified opportunities for improvement, for requirements that may have been scored *Met*, these recommendations do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **BHI** for each of the standards. Details of the findings for each standard are in Appendix A.

Table 1-1—Summary of Scores for the Standards

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Emergency and Poststabilization Services	9	9	9	0	0	0	100%
IV	Member Rights and Protections	6	6	6	0	0	0	100%

Table 1-1—Summary of Scores for the Standards								
Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
VI	The Grievance System (Grievances Only)	13	13	11	2	0	0	85%
VII	Provider Participation and Program Integrity	8	8	7	1	0	0	88%
VIII	Credentialing and Recredentialing	39	39	39	0	0	0	100%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
X	Quality Assessment and Performance Improvement	12	12	12	0	0	0	100%
	Totals	**93**	**93**	**90**	**3**	**0**	**0**	**97%**

2. Summary of Performance Strengths and Required Actions

for Behavioral HealthCare, Inc.

Overall Summary of Performance

BHI received compliance scores of 100 percent for five of the seven standards reviewed (i.e., Standard I—Emergency and Poststabilization Services, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement). These scores represent areas of clear strength for **BHI**. Standard VI—The Grievance System, and Standard VII—Provider Participation and Program Integrity, received scores of 85 percent and 88 percent, respectively, representing opportunities for continued improvement of **BHI**'s performance. The overall compliance score of 97 percent demonstrates **BHI**'s strong understanding and implementation of the BBA regulations.

Standard I—Emergency and Poststabilization Services

Summary of Findings and Opportunities for Improvement

BHI delegated select utilization management (UM) functions, including making referral and triage decisions for members receiving emergency and poststabilization services, to its three community mental health centers (CMHCs). **BHI** had policies and procedures related to the provision of emergency services that included prudent layperson language, clearly stated that prior authorization was not required for emergency care, and met all other BBA requirements. **BHI** also communicated information regarding how to access emergency mental health services in its Member and Family Handbook, including the ability to access emergency care through out-of-network providers as needed.

Summary of Strengths

BHI had an effective mechanism in place to track the reason for a denial of an emergency room claim and consulted with the medical director in cases in which the decision to approve or deny a claim was in question. **BHI** reviewed all claims for emergency services to ensure that claims were not denied inappropriately.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

BHI had numerous written policies that addressed the issue of member rights and protections, including a policy that provided staff guidance regarding the role of the Office of Member and Family Affairs (OMFA). **BHI** included information regarding member rights in its Member and Family Handbook and required providers to post copies of the rights at clinic sites. **BHI** also tracked grievances and appeals data to help identify any trends related to rights violations. While **BHI** had documents in place that included a list of all rights required by the BBA, the list of rights included in the Provider Service Agreement did not address the requirement for access and quality of services (in the Code of Federal Regulations [CFR] at 42 CFR 438.206 and 42 CFR 438.210). HSAG recommends that **BHI** consider reviewing and revising Attachment C of the Provider Service Agreement to align the document with the list of member rights included in the **BHI** Member/Client Rights policy.

Summary of Strengths

BHI widely communicated information regarding member rights to both members and providers through policy, in-person trainings, the **BHI** Provider Manual, and written materials provided to members at the point of enrollment. In addition, **BHI** had an active OMFA and had advocates stationed at its partner CMHCs to answer questions and assist members if they encountered problems with needed services.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard VI—The Grievance System (Grievances Only)

BHI received an overall score of 85 percent compliance with grievance standards. The **BHI** grievance policies and procedures clearly defined the BHO's process by which a member or his or her designated representative may file grievances orally and in writing, the procedures for processing grievances within the required time frames, and the written acknowledgment of receipt to members who file a grievance. The member and provider materials demonstrated that **BHI** communicated to its members and providers information about the grievance process, required time frames for filing grievances, methods by which members may file grievances, and members' rights as they pertain to grievances and State fair hearings.

The grievance file review provided evidence that: **BHI** provided written acknowledgment of a grievance to the member within two working days of receipt of the grievance for 9 of the 10 files reviewed; **BHI** staff members who processed grievances were not involved in any previous level of review and that staff involved with grievances had the appropriate clinical expertise to make decisions on grievances that involved clinical issues; **BHI** provided written disposition of a grievance to the member within 15 working days from the date the grievance was received in 9 of the 10 files reviewed; and the notice of resolution contained the results of the disposition process in 8 of the 10 files reviewed.

Summary of Strengths

The **BHI** policies and member and provider materials were written clearly and described the grievance process well. The file review provided evidence that staff members who processed grievances clearly documented each step of the resolution process and that the process involved appropriate clinical staff, as needed, for grievances that involved clinical issues.

Summary of Required Actions

BHI should ensure that all grievances are acknowledged within 2 working days of receipt of the grievance. Additionally, **BHI** should ensure that all grievances are resolved within 15 working days and all resolution letters contain the results of the disposition process.

Standard VII—Provider Participation and Program Integrity

Summary of Findings and Opportunities for Improvement

BHI received an overall score of 88 percent compliance with provider participation and program integrity standards. The **BHI** provider contract contained the provision that providers must ensure that member rights are taken into account when furnishing services to members. The provider contract and the Provider Manual described all of the member rights that must be protected, including the right of members to participate in their treatment and the right to refuse treatment. The provider contract and manual did not contain the provision that **BHI** would not prohibit or restrict health care professionals acting within the lawful scope of their practice from advising or advocating on behalf of members regarding treatments that may be self-administered and the risks, benefits, and consequences of treatment or nontreatment.

While the Spanish version of the Member and Family Handbook included the statement that **BHI** did not object to providing services based on moral or religious grounds, this statement was not included in the English version. HSAG believes the English version of the Member and Family Handbook would be strengthened by including a similar statement.

The Corporate Compliance Plan and policies clearly described **BHI**'s plan for guarding against fraud and abuse and maintaining a standard of conduct that articulated **BHI**'s commitment to comply with federal and State standards.

Summary of Strengths

The corporate compliance policies were written clearly and described the process for individuals to report potential fraud and abuse issues. The on-site audit provided evidence that compliance drop-boxes were located throughout the facility for staff to anonymously report potential issues of fraud or abuse.

Summary of Required Actions

BHI should develop a method for informing providers that it does not prohibit or restrict health care professionals acting within the lawful scope of their practice from advising or advocating on behalf of members regarding treatments that may be self-administered and the risks, benefits, and consequences of treatment or nontreatment.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

BHI received an overall score of 100 percent compliance with credentialing and recredentialing standards. The Provider Credentialing and Recredentialing policy detailed **BHI**'s processes for credentialing and recredentialing. As described in the policy, **BHI** delegated selected credentialing activities to Colorado Access, which included collecting credentialing applications and information from providers, verifying information with primary sources, and ensuring that credentialing files are complete prior to sending them to the **BHI** Risk and Resource Committee (R&R Committee) for review and approval or denial of credentialing and inclusion in the network. Colorado Access maintained an electronic credentialing file in its electronic database, Apogee. **BHI** maintained paper files of each credentialing and recredentialing file. The credentialing files reviewed and the R&R Committee minutes provided evidence that the process for credentialing and recredentialing described in the policies was followed by **BHI** staff.

The **BHI** and Colorado Access credentialing and recredentialing policies and procedures contained the necessary provisions for a comprehensive credentialing and recredentialing program. The descriptions of the R&R Committee explained the roles and responsibilities of each of the committees to make recommendations for approving or denying credentialing or recredentialing of providers based on comprehensive primary source verification of information provided by practitioners at the time of application.

The BHO's credentialing and recredentialing policies described the process for evaluating and selecting providers to participate in the network and notifying providers of credentialing decisions within the required time frames. The credentialing and recredentialing process included the use of an application completed by the practitioner, attestation from the practitioner, primary source verification, and R&R Committee decisions to approve credentialing or recredentialing of practitioners who met the required credentialing or recredentialing criteria.

The BHO's credentialing and recredentialing policies listed provider rights as they pertained to the credentialing and recredentialing process. The Provider Manual provided evidence that providers were notified of their rights as they pertained to credentialing or recredentialing.

While the BHO's policies contained the required elements, they did not clearly address the process described by staff. For example, although the policies contained the provision that **BHI** completed credentialing files and provided notification to the provider within seven days based on receiving the R&R Committee's decision to credential or deny credentialing, the language was associated with ongoing monitoring of sanctions. **BHI** staff stated that providers received an acceptance or denial letter within seven days of credentialing decisions and that the language in the policy describing this process was organized under the wrong header. The **BHI** policy would be strengthened by providing more accurate descriptions of the process and reorganizing the policy so that the description is placed with the appropriate heading.

Summary of Strengths

BHI used the Credentialing Guidelines, which was a standardized agenda for the R&R Committee. The guidelines were used to prompt discussion for each credentialing or recredentialing file. Staff stated that the Credentialing Guidelines helped guide the discussion for R&R Committee members to ensure that the discussions were consistent for all practitioners. The R&R Committee minutes provided evidence that the Credentialing Guidelines were used by the R&R Committee and that the committee's discussions were consistent for each credentialing and recredentialing file reviewed.

The on-site review of credentialing and recredentialing files provided evidence that **BHI** maintained well-organized files for each practitioner. The R&R Committee minutes clearly described the discussion of how the committee reached its decision for credentialing and recredentialing.

Summary of Required Actions

There were no required actions for this standard.

Standard IX—Subcontracts and Delegation

Summary of Findings and Opportunities for Improvement

BHI delegated select activities related to access to services, referral and triage, utilization management, member services, and quality improvement to its three CMHCs. Beginning in FY 2009–2010, **BHI** entered into a delegation agreement with Colorado Access to credential the BHO's individual practitioners. **BHI** conducted a predelegation assessment of Colorado Access' ability to perform services under the delegation agreement and had written agreements in place with each of its delegates. The delegation agreements described the scope of work, reporting requirements, and the use of corrective action plans and other remedies to address any problems with delegate performance.

Summary of Strengths

BHI's meeting minutes, findings from annual monitoring activities, and reports submitted by its delegates demonstrated that the BHO closely monitored performance on the part of the CMHCs and Colorado Access. **BHI** also provided evidence that delegate performance, including follow-up to corrective action plans, was addressed at various committee meetings throughout the organization.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

BHI had a Quality Improvement Program Description and Quality Improvement Plan in place that identified Quality Assessment and Performance Improvement (QAPI) program goals, defined the program structure, and included a description of the various performance measures, focus studies, and other quality initiatives in progress. The BHO conducted required performance improvement projects (PIPs) and collected and reported data for numerous performance measures and utilization metrics to the Department. **BHI** evaluated the impact and effectiveness of its QAPI program on an ongoing basis through its Program Evaluations and Outcomes Committee and Standards of Practice Committee and published an annual quality report that detailed goals and activities for the upcoming year.

Summary of Strengths

BHI had a robust health information system in place to help collect, analyze, and report data in support of its QAPI program. **BHI** demonstrated that it closely monitored both underutilization and overutilization of services within its provider network and took appropriate action when trends in the data were identified. The BHO published an annual quality report that was very well organized, integrated extensive past-period data, and included a work plan for the current fiscal year.

Summary of Required Actions

There were no corrective actions required for this standard.

3. Follow-up on FY 2008–2009 Corrective Action Plan for Behavioral HealthCare, Inc.

Methodology

As a follow-up to the FY 2008–2009 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all components for which the BHO 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 2008–2009 compliance monitoring site review, or until the time of the on-site portion of the BHO's FY 2009–2010 site review.

Summary of 2008–2009 Required Actions

As a result of the FY 2008–2009 compliance review, **BHI** was required to ensure that each notice of action is easy to understand and is sent within the required time frames. **BHI** was required to 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. Furthermore, **BHI** was required to 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.

Summary of Corrective Action/Document Review

BHI submitted a CAP to address all requirements in July 2009. After careful review, HSAG and the Department determined that, if implemented as written, **BHI**'s CAP would adequately address all required actions. HSAG and the Department continued to work with **BHI** through February 2010 and determined that **BHI** had successfully implemented its plan.

Summary of Continued Required Actions

BHI successfully completed all FY 2008–2009 required actions. There were no required actions continued from FY 2008–2009.

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.114(a)	1. The Contractor defines Emergency Medical Condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ◆ Serious impairment to bodily functions ◆ Serious dysfunction of any bodily organ or part	**Documents Submitted/Location Within Documents:** ◆ Access & Availability pp10 – Page 1 provides the definition of Emergency Medical Condition ◆ Emergency & Post-Stabilization Services pp10 – Page 1 provides the definition of Emergency Medical Condition ◆ BHI Member Materials – Pg. 11 provides members with the definition of Emergency Medical Condition	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI delegated certain UM functions, including making referral and triage decisions for members receiving emergency and poststabilization services, to its three CMHCs. BHI's Emergency and Poststabilization Care Services policy included a definition of "emergency medical condition" that was taken verbatim from 42 CFR 438.114(a). A definition for the term was also included in the BHO's Access and Availability of Services policy, in the BHI Member and Family Handbook, and in a section of the Provider Manual that described level-of-care criteria for emergency services.		
	Required Actions: None		

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.114(a)	2. The Contractor defines Emergency Services as follows: ◆ Services furnished by a provider that is qualified to furnish these services under this title ◆ Needed to evaluate or stabilize an emergency medical condition	**Documents Submitted/Location Within Documents:** ◆ Emergency & Post-Stabilization Services pp10 – Page 1 provides the definition of Emergency Services	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's definition of "emergency services" was consistent with language found in 42 CFR 438. The BHO's Emergency and Poststabilization Care Services policy defined emergency services as covered inpatient and outpatient services furnished by a qualified provider that were needed to evaluate or stabilize an emergency medical condition.		
	Required Actions: None		
42CFR438.114(a)	3. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition.	**Documents Submitted/Location Within Documents:** ◆ Emergency & Post-Stabilization Services pp10 – Page 1 provides the definition of Post-Stabilization Care Services ◆ BHI Member Materials – Pg. 13 provides members the definition of Post-Stabilization Care Services	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Emergency and Poststabilization Care Services policy defined "poststabilization care" as covered services related to an emergency medical condition provided after a member is stabilized to maintain the stabilized condition or to improve or resolve the member's condition. A definition of "poststabilization" as well as a listing of all covered emergency services made available through the network was also included in the BHI Member and Family Handbook.		
	Required Actions: None		

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.114(c)(1)	4. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.	**Documents Submitted/Location Within Documents:** ◆ Emergency & Post-Stabilization Services pp10 – Page 2, Section 2, describes the policy and procedures for Emergency Services ◆ BHI Member Materials Pg. 13 Informs members that they can go to any emergency room regardless of whether they're in the BHI network.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Emergency and Poststabilization Care Services policy stated that members had the right to receive emergency services at the nearest provider regardless of whether the provider had a contract with the BHO. The policy also prohibited the denial of payment for emergency services provided to any member with an emergency medical condition as defined in 42 CFR 438. BHI's Member and Family Handbook informed members of their ability to seek care from any hospital emergency room, even in cases in which the provider was out of network. The UM section of the provider manual also advised contracted providers that members may be taken to any hospital emergency room. During the interview, staff members reported that BHI reviewed all emergency room claims to ensure that they were not inappropriately denied.		
	Required Actions: None		

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.114(c)(1)	5. The Contractor may not deny payment for treatment obtained under either of the following circumstances: ◆ A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes ▪ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ▪ Serious impairment to bodily functions ▪ Serious dysfunction of any bodily organ or part ◆ A representative of the Contractor's organization instructed the member to seek emergency services	**Documents Submitted/Location Within Documents:** ◆ Emergency & Post-Stabilization Services pp10 – Pages 2 – 3, Section 2, describes the circumstances under which BHI does not deny payment for Emergency Services	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Emergency and Poststabilization Care Services policy included prudent layperson language and stated that emergency claims would not be denied for any member who presented with an emergency medical condition. The policy also stated that the BHO would not deny payment for treatment received in cases in which a BHI provider or representative directed the member to seek emergency services. At the interview, staff reported that emergency claims were rarely denied and that the most common reasons for denial were the lack of a mental health diagnosis or the untimely filing of a claim. BHI staff also indicated that the BHO's medical director was available for consultation regarding any questions related to the handling of emergency room claims.		
	Required Actions: None		

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.114(d)(1)	6. The Contractor does not: ◆ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services	**Documents Submitted/Location Within Documents:** ◆ Emergency & Post-Stabilization Services pp10 – Pages 2 – 3, Section 2, describes BHI's policy and procedures regarding any Emergency Medical Condition restrictions ◆ BHI Provider Contract – Page 3, Section 2.1, describes BHI's obligations regarding prior authorizations, including Emergency Services ◆ BHI Provider Contract – Page 5, Section 3.4, describes the provider's obligations regarding prior authorizations with the exception of Emergency Services	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Emergency and Poststabilization Care Services policy indicated that the BHO did not limit what constituted an emergency medical condition based on a list of diagnoses or symptoms. The policy also stated that BHI would not refuse to cover claims for emergency services in cases in which the emergency room provider, hospital, or fiscal agent failed to notify the BHO of the member's screening and treatment within 10 calendar days of presentation for emergency services. BHI's Provider Service Agreement also included a provision stating that there were no prior-authorization or notification requirements related to the provision of emergency care.		
	Required Actions: None		

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.114(d)(2)	7. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	**Documents Submitted/Location Within Documents:** ◆ Emergency & Post-Stabilization Services pp10 – Page 3, Section 2, describes BHI's policy and procedures regarding Member liability for Emergency and Post-Stabilization Care Services ◆ BHI Member Materials – Pages 6 & 13, informs Members that Emergency Services are free	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Emergency and Poststabilization Care Services policy stated that any member who had an emergency medical condition would not be held liable for payment of any subsequent screening and treatment required to diagnose the specific condition or to stabilize the member. Information included in a section of the Member and Family Handbook regarding mental health services and benefits also stated that emergency mental health services were free. During the interview, BHI staff stated that providers received a copy of the Member and Family Handbook and that provider contracts included a provision prohibiting charging fees for emergency mental health care to Medicaid members.		
	Required Actions: None		
42CFR438.114(d)(3)	8. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment.	**Documents Submitted/Location Within Documents:** ◆ Emergency & Post-Stabilization Services pp10 – Page 3, Section 2, describes the role of the attending emergency physician or treating provider in determining transfer or discharge of a Member	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Emergency and Poststabilization Care Services policy required that the attending emergency physician or provider actually treating the member determine when the member is sufficiently stabilized for transfer or discharge. The policy also stated that the provider's determination was binding and that BHI was responsible for payment. Information regarding the emergency physician's or other provider's role in determining member readiness for discharge or transfer was also addressed in BHI's Member and Family Handbook.		
	Required Actions: None		

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.10(f)(6)(viii)(B)	9. The Contractor does not require prior authorization for emergency services.	**Documents Submitted/Location Within Documents:** ◆ Emergency & Post-Stabilization Services pp10 – Page 3, Section 2, specifies that prior authorization is not required for Emergency Services ◆ BHI Provider Contract – Page 3, Section 2.1, describes BHI's obligations regarding prior authorizations, including Emergency Services ◆ BHI Provider Contract – Page 5, Section 3.4, describes the provider's obligations regarding prior authorizations with the exception of Emergency Services ◆ BHI Member Handbook – Pages 6, 13, 14 & 15 inform Members that prior authorization is not required for Emergency Services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Emergency and Poststabilization Care Services policy stated that prior authorization was not required for coverage and payment of emergency mental health services. The BHO's Provider Service Agreement included language that directed providers to make medically necessary emergency services available to members without prior authorization. The section of BHI's Member and Family Handbook that addressed how to access emergency mental health services also stated that emergency services did not require preauthorization.		
	Required Actions: None		

Results for Standard I—Emergency and Poststabilization Services							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.100(a)(1)	1. The Contractor has written policies regarding member rights.	**Documents Submitted/Location Within Documents:** ◆ Member Client Rights pp10 ◆ BHI Member Handbook – Pg. 24-25	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI had numerous written policies that addressed member rights. BHI's Member/Client Rights policy included a listing of member rights as well as guidance for staff regarding providing rights information to facility providers through the Provider Manual, BHI Web site, and provider and facility contracts. BHI maintained a Client Access to Protected Health Information policy that described the process for members to request and receive a copy of their medical records. In addition, BHI's Disclosure of Protected Health Information policy required the safeguarding of confidential member information under the Health Insurance Portability and Accountability Act's (HIPAA's) privacy regulations.		
	Required Actions: None		
42CFR 438.100(a)(2)	2. The Contractor ensures that its staff and affiliated providers take member rights into account when furnishing services to members.	**Documents Submitted/Location Within Documents:** ◆ Member Representative Training Module Slide 10 ◆ Member Rights Posting 08-09 ◆ Medicaid Member Rights PowerPoint ◆ BHI Member Handbook Pg 23-24 ◆ BHI Provider Contract – Addendum C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Member/Client Rights policy mandated that a listing of the member rights included in the policy be posted at all clinic sites. BHI also made member and provider educational materials regarding member rights widely available. For example, the BHO provided a 2009 PowerPoint presentation for members that described their rights and provided information regarding how to file a grievance if needed. A listing of member rights was also included in the BHI Member and Family Handbook and in Attachment C of the BHO's Provider Service Agreement. BHI had systems in place to monitor grievances and appeals data to identify any trends in reported concerns related to rights violations. During the interview, staff indicated that no grievances related to member rights had been filed for the period under review.		
	Required Actions: None		

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.100(b)(2) & (3)	3. The Contractor ensures that members have the right to: ◆ Receive information in accordance with information requirements (42CFR438.10) ◆ Be treated with respect and with due consideration for his or her dignity and privacy ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected as specified in 45CFR164.524 and 164.526 ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210)	**Documents Submitted/Location Within Documents:** ◆ Member Client Rights pp10 ◆ Notice of Privacy Rights pp10 ◆ Client Access Protected Health Information pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI included a listing of member rights, including all rights required by 42 CFR 438.100(b)(2)&(3), in the BHO's Member and Family Handbook and in the BHI Member/Client Rights policy. A list of member rights as well as information regarding how to contact the ombudsman for Medicaid managed care was also posted at clinic sites. Contracted providers were educated regarding member rights through in-person and online trainings. Rights information was also included in the Provider Manual and in Attachment C of the BHI Provider Service Agreement. The listing of member rights included in the Provider Service Agreement did		

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	not address the requirements for access and quality of services (42 CFR 438.206 and 42 CFR 438.210). It is recommended that BHI consider reviewing and revising Attachment C of the Provider Service Agreement to align the document with the list of member rights included in the BHO's Member/Client Rights policy.		
	Required Actions: None		
42CFR438.100(c)	4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor treats the member.	**Documents Submitted/Location Within Documents:** ◆ Member Client Rights pp10 ◆ BHI Member Handbook – Pgs. 24-25 inform members of their rights	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Member/Client Rights policy stated that members were free to exercise their rights and that the exercise of those rights would not adversely affect the way they were treated by the BHO, providers, or the State. The BHI Member and Family Handbook also addressed the right of members to exercise their rights without fear of retaliation and included information regarding how to contact OMFA for assistance as needed. At the interview, the director of OMFA stated that BHI hired clinician advocates who were stationed at the CMHCs to answer questions and assist members if they encountered problems with needed services.		
	Required Actions: None		
42CFR438.100(d)	5. Contractor complies with any other federal and State laws (such as Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and Titles II and III of the Americans with Disabilities Act and other laws regarding privacy and confidentiality).	**Documents Submitted/Location Within Documents:** ◆ Compliance with Applicable Laws pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Compliance With Applicable Laws policy required that the BHO comply with all relevant federal and State laws, including those required in 42 CFR 438.100(d). The BHO's Disclosure of Protected Health Information policy addressed the protection of member privacy and confidentiality under HIPAA privacy regulations. In addition, a provision mandating that subcontractors comply with federal and State statutes related to the operation of their programs was included in the BHI Provider Service Agreement.		
	Required Actions: None		

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.224	6. The Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable.	**Documents Submitted/Location Within Documents:** ◆ Disclosure of Protected Health Information PP10 ◆ BHI Provider Contract Page 10 ◆ BHI HIPAA TEST ◆ BHI HIPAA Training ◆ Business Associate Contract Procedures pp10 ◆ Privacy Regulation Training pp10 ◆ The Notice of Privacy Rights pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Disclosure of Protected Health Information policy addressed the issue of safeguarding confidential member information, including the handling of requests for protected health information (PHI). The BHO's Provider Service Agreement also included a requirement that providers adhere to HIPAA and any other applicable laws and regulations related to the disclosure of individually identifiable information. BHI provided a copy of a PowerPoint presentation regarding HIPAA that was delivered to staff upon hire. The presentation included a review of key terms related to HIPAA, information regarding how to access PHI, and instructions regarding accounting for disclosures. BHI also provided a post-test given to staff following the HIPAA training to ensure their understanding of key concepts regarding the handling of confidential member information.		
	Required Actions: None		

Results for Standard IV—Member Rights and Protections							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	6	**Total Score**		=	6
			Total Score ÷ Total Applicable			=	100%

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.402(a) Volume 8 8.209.1	1. The Contractor has a system in place that includes a grievance process.	**Documents Submitted/Location Within Documents:** ◆ Grievance Procedure pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Grievance Procedure policy described the BHO's grievance process, which included the BHO's procedures for receiving, acknowledging, processing, resolving, and providing written disposition of member grievances. The grievance record review provided evidence that staff followed the procedures described in the policies for processing grievances.		
	Required Actions: None		
42CFR438.400(b) Volume 8 8.209.2	2. The Contract defines Grievance as an oral or written expression of dissatisfaction about any matter other than an Action, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or an employee, or failure to respect the member's rights.	**Documents Submitted/Location Within Documents:** ◆ Grievance Procedure pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Grievance Procedure policy detailed the BHO's definition of a grievance: "A grievance refers to an oral or written expression of dissatisfaction about any matter other than an action (as defined in HCPF 8.209.2). This may include but is not limited to quality of care or services provided, aspects of interpersonal relationships such as rudeness, or failure to respect a client's rights."		
	Required Actions: None		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.402(b)(1) Volume 8 8.209.1	3. The Contractor has provisions for who may file grievances: ◆ A member may file a grievance (or his or her authorized representative), ◆ A provider may file a grievance on behalf of a member (Colorado permits the provider to act as the member's authorized representative)	**Documents Submitted/Location Within Documents:** ◆ Grievance Procedure pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Grievance Procedure policy detailed the BHO's provisions for who may file a grievance, which included a member, a member's designated representative, or a provider filing (with the member's written consent) on the member's behalf.		
	Required Actions: None		
42CFR438.402(b)(3) Volume 8 8.209.5.D	4. The Contractor accepts grievances orally or in writing.	**Documents Submitted/Location Within Documents:** ◆ Grievance Procedure pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Grievance Procedure policy detailed BHI's provision for accepting member grievances filed in writing or orally by the member or his or her designated representative. BHI staff stated that most grievances were filed by telephone.		
	Required Actions: None		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.402(b)(2) Volume 8 8.209.5.A	5. The member has 20 calendar days from the date of the incident to file a grievance.	**Documents Submitted/Location Within Documents:** ◆ Grievance Procedure pp10 ◆ Member Client Rights pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Grievance Procedure policy contained the provision that members must file a grievance either orally or in writing within 20 calendar days from the date of the incident. The Member Client Rights document provided evidence that this provision was communicated to members.		
	Required Actions: None		
42CFR438.406(a) Volume 8 8.209.4.C	6. In handling grievances, 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.	**Documents Submitted/Location Within Documents:** ◆ Grievance Procedure pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Grievance Procedure policy detailed the types of assistance offered to members in filing a grievance, such as completing forms and taking other procedural steps and providing interpreter services and toll-free numbers that have adequate teletype/telecommunications device for the deaf (TTY/TDD) and interpreter capability.		
	Required Actions: None		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.406(a) Volume 8 8.209.5.B	7. The Contractor acknowledges each grievance in writing within two working days of receipt.	**Documents Submitted/Location Within Documents:** ◆ Grievance Acknowledgement Template	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Grievance Procedure policy contained the provision that BHI acknowledged each grievance in writing within two working days of receipt. Of the 10 grievance files reviewed, 9 files provided evidence that BHI acknowledged grievances within two days of receipt of the grievance.		
	Required Actions: BHI should ensure that all grievances are acknowledged within two working days of receipt of the grievance.		
42CFR438.406(a) Volume 8 8.209.5.C	8. The Contractor ensures that the individuals who make decisions on grievances are individuals who: ◆ Were not involved in any previous level of review or decision-making ◆ If deciding a grievance regarding the denial of expedited resolution of an appeal, or a grievance that involves clinical issues, has the appropriate clinical expertise in treating the member's condition or disease.	**Documents Submitted/Location Within Documents:** ◆ Grievance Procedure pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Grievance Procedure policy detailed BHI's provision for processing grievances, which included the assurance that individuals who made decisions on grievances were not involved in any previous level of review or decision making and had the appropriate level of expertise in treating the member's condition if the grievance involved a clinical issue. Of the 10 grievance files reviewed, all 10 files contained evidence that the individuals processing and making decisions on grievances were not involved in any previous level of review or decision making. Of the 10 grievance files reviewed, only 5 of the grievances involved a clinical issue. All 5 of these grievance files provided evidence that the individuals making decisions on the grievances had the appropriate clinical expertise in treating the member's condition.		
	Required Actions: None		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.408(b)&(d) Volume 8 8.209.5.D &F	9. The Contractor must dispose of each grievance and provide notice of the disposition in writing, as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the Contractor receives the grievance. The notice includes: ◆ The results of the disposition/resolution process ◆ The date it was completed	**Documents Submitted/Location Within Documents:** ◆ Grievance Procedure pp10 ◆ Grievance resolution letter template	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Grievance Procedure policy contained the provision that BHI would resolve each grievance and provide written notice to the member within 15 working days from the day that BHI received the grievance. The BHI Grievance Resolution Letter template provided an example of the notice of disposition sent to members. Of the 10 grievance files reviewed, 9 files provided evidence that the grievances were resolved within 15 working days, 8 files provided evidence that the written resolution letter contained the results of the disposition process, and 10 of the files provided evidence that the resolution letters contained the date the grievance was completed. For the one grievance file that was not resolved within 15 working days, a request to extend the time frame for resolution of the grievance was not provided by the BHO.		
	Required Actions: BHI must ensure that all grievances are resolved within 15 working days and that all resolution letters contain the results of the disposition process.		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.408(c) Volume 8 80209.5.E	10. The Contractor may extend the timeframes for resolution of grievances by up to 14 calendar days if: ◆ The member requests the extension, or ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest	**Documents Submitted/Location Within Documents:** ◆ Grievance Procedure pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Grievance Procedure policy contained the provisions that BHI may extend the timeline for disposition by up to 14 calendar days if the member requests an extension. The policy also stated that if BHI required more time to collect information, and the additional time would be in the member's best interest, BHI may extend the time frame and must provide written notice to the member that includes the reason for the delay. Of the 10 files reviewed, there were no requests filed by either a member or the BHO to extend the time frame to resolve a grievance.		
	Required Actions: None		
42CFR438.408(c)(2) Volume 8 80209.5.E	11. If the Contractor extends the timeframes, it must—for any extension not requested by the member—give the member written notice of the reason for the delay.	**Documents Submitted/Location Within Documents:** ◆ Grievance Procedure pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Grievance Procedure policy contained the provisions that BHI may extend the timeline for disposition by up to 14 calendar days if the member requests an extension. The policy also stated that if BHI required more time to collect information, and the additional time would be in the member's best interest, BHI may extend the time frame and must provide written notice to the member that includes the reason for the delay. Of the 10 files reviewed, there were no requests filed by either a member or the BHO to extend the time frame to resolve a grievance.		
	Required Actions: None		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.414 Volume 8 8.209.3.B	12. 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 timeframes 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 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 ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service	**Documents Submitted/Location Within Documents:** ◆ Member Representative Posting ◆ Provider Handbook ◆ BHI Provider Contract – Attachment C ◆ BHI's website provides information regarding the grievance process, state fair hearing, and appeals. http://www.bhicares.org/providers.htm	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Findings: The BHI Provider Contract, Attachment C, contained the provision that providers may obtain member rights information by accessing the BHI Web site or through the Provider Manual. The BHI Provider Manual and the BHI Web site provided evidence that providers were informed of the following: the member's right to file grievances; the toll-free numbers to file a grievance orally; 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 a State fair hearing; the availability of assistance filing a grievance, an appeal, or requesting a State fair hearing; and the fact that, when requested by a member, benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. The Provider Manual and BHI Web site also listed all of the avenues by which members may file a grievance and included the toll-free telephone numbers available to members to file a grievance orally with the BHO. The Provider Manual contained the provision that if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of the services while the appeal is pending if the final decision is adverse to the member. The Provider Manual contained the provision that providers may serve as a member's designated representative and file an appeal on the member's behalf with the written permission of the member. The BHI Web site also contained a link to the BHI Member and Family Handbook for providers to access. The Provider Manual incorporated the Member and Family Handbook. The BHI Member and Family Handbook also contained all of the aforementioned provisions.		
	Required Actions: None		
42CFR438.416 Volume 8 8.209.3.C	13. The Contractor maintains records of all grievances, and submits quarterly reports to the Department.	**Documents Submitted/Location Within Documents:** ◆ FY10 Q1 BHI Grievance Appeal Report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FY 2010 Quarter 1 BHI Grievance Appeal Report provided evidence that BHI maintained records of grievances and submitted quarterly reports to the Department that described the number of grievances received, the people filing the grievances, the types of grievances received, whether or not grievances involved a clinical issue, the outcome of grievance investigations, and a written analysis of the grievances received and any possible trends in grievances identified.		
	Required Actions: None		

Results for Standard VI—The Grievance System							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	13	**Total Score**		=	11
				Total Score ÷ Total Applicable		=	85%

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.102(a)	1. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient for the following: ◆ The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered ◆ Any information the member needs in order to decide among all relevant treatment options ◆ The risks, benefits, and consequences of treatment or non-treatment ◆ The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions	**Documents Submitted/Location Within Documents:** ◆ BHI Contract Final Pg. 17, Section II.E 1.H – Provider Member Communications ◆ BHI Member/Client Rights Policy ◆ BHI Provider Contract – Attachment C	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Provider Contract, Attachment C, contained the provision that providers must ensure that member rights are taken into account when furnishing services to members. The list of members rights included the right for members to participate in decisions regarding their health care, including the right to refuse treatment except as provided by law and the right to receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand. The Provider Contract and Provider Manual did not provide evidence of the provision that BHI would not prohibit or restrict health care professionals acting within the lawful scope of their practice from advising or advocating on behalf of a member regarding treatments that may be self-administered and the risks, benefits, and consequences of treatment or nontreatment.		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Required Actions: BHI should develop a method for informing providers that it does not prohibit or restrict health care professionals acting within the lawful scope of their practice from advising or advocating on behalf of a member regarding treatments that may be self-administered and the risks, benefits, and consequences of treatment or nontreatment.		
42CFR438.102(b)	2. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: ◆ To the State ◆ To member before and during enrollment ◆ To members within 90 days after adopting the policy with respect to any particular service (consistent with the format provisions in 42CFR438.10) (The Contractor need not furnish information on how and where to access the service.)	**Documents Submitted/Location Within Documents:** ◆ BHI Contract with the Department of Health Care Policy and Financing	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI staff stated that BHI did not object to providing any services based on moral or religious grounds. The Spanish version of the Member and Family Handbook, which was contained in the Provider Manual, included the statement that BHI did not object to providing services based on moral or religious grounds. The English version of the Member and Family Handbook would be strengthened by including a similar statement to inform English-speaking members that BHI did not object to providing services on moral or religious grounds.		
	Required Actions: None		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.12(a)(1) 42CFR438.214(c)	3. The Contractor does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification, and does not discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	**Documents Submitted/Location Within Documents:** ◆ Prohibition of Provider Discrimination pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Prohibition of Provider Discrimination policy and Provider Manual contained the provision that BHI would not discriminate—in terms of participation, reimbursement, or indemnification—against any provider who is acting within the scope of his or her license or certification under applicable State law solely on the basis of that license or certification. The BHI Prohibition of Provider Discrimination policy and Provider Manual also contained the provision that BHI would not discriminate against particular practitioners that serve high-risk populations or specialize in conditions that require costly treatment.		
	Required Actions: None		
42CFR438.12(a)(1)	4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 ◆ Decline to Include in Network Template	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Provider Credentialing and Recredentialing policy contained the BHO's provision for providing the reason, by written notice, to individual or groups of providers if BHI declines to include the providers in its network. The BHI Decline to Include in Network Letter template provided evidence of the type of written communication sent to providers if they were denied credentialing and participation in the network.		
	Required Actions: None		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.106	5. The Contractor provides that Medicaid members are not held liable for: ◆ The Contractor's debts in the event of the Contractor's or subcontractor's insolvency ◆ Covered services provided to the member for which the State does not pay the Contractor ◆ Covered services provided to the member for which the State or the Contractor does not pay the health care provider that provides the services under a contractual, referral, or other arrangement ◆ Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly	**Documents Submitted/Location Within Documents:** ◆ BHI Contract with Department of Health Care Policy and Financing, Pg. 37, "Liability for Payment", Section II.G.11 ◆ BHI Provider Contract, Pg. 7., Section 4.4: "Payment in Full" and Pg. 8, Section 4.8: "No Recourse Against Covered Persons" ◆ Claim Denial-Not a Covered Service ◆ Claim Denial-Not a Covered Diagnosis	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Provider Contract contained the provision that providers must agree to look solely to BHI for payment for all covered services provided to covered persons. The contract also stated that a "Provider hereby agrees that in no event, including but not limited to, non-payment by BHI, BHI insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Person." The BHI Provider Contract also contained the provision that under no circumstance can providers make any charge or claim against a covered person for covered services. The BHI Provider Manual contained the provision that BHI would not assess any charges to members and that providers who attempted to collect payment from members for covered services may be terminated from the network.		
	Required Actions: None		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.214(d)	6. The Contractor does not employ or contract with providers excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act.	**Documents Submitted/Location Within Documents:** ◆ Corporate Compliance and Employee, Contractor Relations pp10 Pgs. 2-3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Provider Credentialing and Recredentialing policy and the BHI Corporate Compliance and Employee, Contractor Relations policy detailed BHI's provision for inquiring into the background of prospective employees, vendors, and providers to determine if an individual had been convicted of a criminal offense related to health care or listed by a federal agency as debarred, excluded, or otherwise ineligible for federal program participation as required by current State and federal laws.		
	Required Actions: None		
42CFR438.608	7. The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse and include: ◆ Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards ◆ The designation of a compliance officer and a compliance committee that are accountable to senior management ◆ Effective training and education for the compliance officer and the Contractor's employees ◆ Effective lines of communication between the compliance officer and the Contractor's employees	**Documents Submitted/Location Within Documents:** ◆ Corporate Compliance Plan Pgs. 4, 14, 15, 16, 17, 18, 20, 21 ◆ Corporate Compliance Policy pp10 ◆ DRA Employee Handbook Pg. 12	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	◆ Enforcement of Standards through well publicized disciplinary guidelines ◆ Provision for internal monitoring and auditing ◆ Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Medicaid managed care contract requirements		
	Findings: The BHI Corporate Compliance and Employee, Contractor Relations policy and the BHI Corporate Compliance Plan provided evidence of the BHI's written procedures and plan for guarding against fraud and abuse and maintaining a standard of conduct that articulated BHI's commitment to comply with all applicable federal and State standards. The BHI Corporate Compliance Plan described the designation of a corporate compliance officer (CCO), who was accountable to the Corporate Compliance Committee (CCC) and reported directly to the BHI chief executive officer (CEO). The BHI Corporate Compliance Plan described the reporting structure of the CCC, which was composed of representatives from the BHI Board of Directors, representatives of BHI departments, representatives of the core subcontracted clinical providers, and the CEO. The BHI Corporate Compliance Plan described the lines of communication among the compliance officer, BHI employees, the CCC, and the CEO. The BHI Corporate Compliance Plan described the disciplinary guidelines employed by the BHO and the internal monitoring and auditing mechanisms used to detect offenses and respond accordingly, including use of corrective actions for incidents that involved Medicaid managed care contracts. The BHI Corporate Compliance Plan also detailed the use of regular educational and training sessions to inform BHI employees and associates about changes in the compliance program or related local, State, and federal rules and regulations that necessitate further education. The BHI Corporate Compliance Plan provided evidence of the type of information used to educate and train BHI associates and included information regarding the standards of conduct, designation of a CCO, lines of communication between the CCO and employees or others associated with BHI, disciplinary guidelines, and BHI's provision for promptly responding to detected offences and corrective action initiatives related to the Medicaid managed care contract. The BHI Corporate Compliance Plan listed all of the ways in which an employee or associate may report corporate compliance issues, which included reporting an issue in person to the CCO, faxing the CCO, calling the Corporate Compliance Hotline anonymously, mailing a written concern, or placing a written, anonymous concern in the locked drop box located outside BHI's offices.		
	Required Actions: None		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.610	8. The Contractor may not knowingly have a director, partner officer, employee, subcontractor, or owner (owning 5 percent or more of the entity) who is debarred, suspended or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549.	**Documents Submitted/Location Within Documents:** ◆ BHI Provider Contact page 3 and Attachment E	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Provider Contract provided evidence that BHI maintained a mechanism to collect ownership information from providers so that BHI could inquire about an individual's background and possible suspension, debarment, or exclusion from participating in procurement or nonprocurement activities under federal regulation. BHI staff stated that BHI had not had a director, partner officer, employee, subcontractor, or owner debarred, suspended, or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulations or Executive Order 12549 in FY 2010. BHI staff stated that BHI reviewed employee information against the Office of Inspector General (OIG) sanction list at the time of employment. BHI staff stated that it reviewed contracted providers' information against the OIG sanction list on a monthly basis, and mental health centers were delegated the responsibility to review OIG sanction information for each of the practitioners in the partner mental health centers on a monthly basis.		
	Required Actions: None		

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	8	**Total Score**		=	7

Total Score ÷ Total Applicable	=	88%

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA—CR1	1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 2&4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy described BHI's credentialing and recredentialing processes. As described in the policy, BHI delegated selected credentialing activities to Colorado Access: collecting credentialing applications and information from providers, verifying information with primary sources, and ensuring that credentialing files are complete prior to sending to them to the R&R Committee. The R&R Committee was responsible for reviewing each file and approving or denying inclusion in the network. Colorado Access maintained an electronic credentialing file in its electronic database, Apogee. BHI maintained paper files of each credentialing and recredentialing file. The credentialing files reviewed and the R&R Committee minutes provided evidence that the process for credentialing and recredentialing described in the policies was followed by BHI staff.		
	Required Actions: None		
NCQA CR1— Element A Element B NCQA CR9— Element A NCQA CR10— Element A Element B Element C 42CFR438.214(a)	2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include psychiatrists, psychologists, clinical social workers, psychiatric nurse specialist, and or licensed professional counselors.	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 2) ◆ BHI Provider List Website 121809	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
NCQA CR1— Element A and B NCQA CR9 CR10-Element A and C	**Findings:** The Provider Credentialing and Recredentialing policy described each of the types of practitioners subject to BHI's credentialing processes. Practitioners credentialed and recredentialed by BHI included medical doctors, doctors of osteopathy, psychologists, psychiatrists, social workers, nurses, and counseling professionals (including family therapists and licensed professional counselors).		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	The BHI Web site contained a list of providers who contracted with BHI. The list contained the location of the provider, the provider type, the appropriate licensure of the provider, the non-English languages spoken by the provider, and the ages served. The list provided evidence of the types of providers contracted in the BHI network.		
	Required Actions: None		
	2.B. The verification sources used	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 8)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Provider Credentialing and Recredentialing policy described the acceptable primary sources used for verifying licensure, education and training, U.S. Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certification, board certification, and malpractice coverage. Sources included the National Practitioners Data Bank (NPDB) and OIG reports.		
	Required Actions: None		
	2.C. The criteria for credentialing and recredentialing	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 2, 12)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The BHI Provider Credentialing and Recredentialing policy described the criteria for network participation and for credentialing and recredentialing each provider type. The policy described the process for credentialing each provider prior to contracting and recredentialing each provider at least every 36 months.		
	Required Actions: None		
	2.D. The process for making credentialing and recredentialing decisions	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 pg. 7) ◆ Credentialing Form ◆ Credentialing Guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Findings: The Provider Credentialing and Recredentialing policy described BHI's credentialing and recredentialing process by which providers submit credentialing or recredentialing applications to Colorado Access, which was responsible for primary source verification. Once the information presented on the application was verified through primary source verification, Colorado Access' credentialing program coordinator reviewed the file for completeness and submitted the file to BHI to be presented to the R&R Committee. The R&R Committee maintained the decision-making authority to approve or deny credentialing or recredentialing based on the information presented in the credentialing or recredentialing file. The Credentialing Checklist provided evidence of the summary sheet used by the R&R Committee or medical director as a summary of what was contained in the credentialing or recredentialing file. BHI staff explained the use of the Credentialing Guidelines, which was a standardized agenda for the R&R Committee to prompt discussion for each credentialing or recredentialing file. Staff stated that the Credentialing Guidelines helped guide the discussion for the R&R Committee members and also ensured that each topic presented in the guidelines was discussed for each file, which ensured that the discussions were consistent for all practitioners. The R&R Committee minutes provided evidence that the R&R Committee used the Credentialing Guidelines and that the committee's discussions were consistent for each credentialing and recredentialing file reviewed.		
	Required Actions: None		
	2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg 5)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that credentialing files for practitioners in the BHI provider network were managed by Colorado Access (BHI's delegate for selected credentialing activities). The policy also described the minimum content for the practitioner credentialing files. The Provider Credentialing and Recredentialing policy described BHI's credentialing and recredentialing process by which providers submitted credentialing or recredentialing applications to Colorado Access, which was responsible for primary source verification. Once the information presented on the application was verified through primary source verification, Colorado Access' credentialing program coordinator reviewed the file for completeness and submitted the file to BHI to be presented to the R&R Committee. The R&R Committee maintained the decision-making authority to approve or deny credentialing or recredentialing based on the information presented in the credentialing or recredentialing file. The BHI medical director maintained the authority to		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	sign off on all credentialing decisions made by the committee. Minutes from the November 4, 2009, R&R Committee meeting provided evidence that the R&R Committee reviewed and made decisions to approve credentialing for several providers. The minutes also provided evidence of the medical director's participation on the committee. BHI staff stated that Colorado Access maintained the electronic version of each credentialing and recredentialing file, and BHI maintained paper copies of the files once primary source verification information was received from Colorado Access.		
	Required Actions: None		
	2.F. The process for delegating credentialing or recredentialing (if applicable)	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 20) ◆ COA Credentialing Delegation Agreement FY2010 ◆ Med-advantage Delegation Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that BHI delegated individual provider credentialing activities to Colorado Access. The credentialing activities delegated to Colorado Access included application mailing and follow-up, application processing, and primary source verification. Colorado Access described the use of the online Council for Affordable Quality Healthcare (CAQH) credentialing application to collect provider information for the purposes of credentialing. Colorado Access and BHI staff stated that the CAQH application was an online tool that was free for providers to use to streamline administrative processes such as processing credentialing applications. Colorado Access staff stated that Colorado Access maintained a subscription with CAQH to retrieve credentialing applications and associated information used for verifying provider credentials and obtaining updated provider information. To use the CAQH application, providers must reverify information every 90 days, which helped Colorado Access staff ensure that provider information was kept current.		
	Required Actions: None		
	2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing	**Documents Submitted/Location Within Documents:** ◆ Non-discrimination and Confidentiality Attestation ◆ Provider Credentialing and Recredentialing pp10 (pg. 4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes)	◆ Culturally Appropriate & Compliant Services pp10 ◆ Cultural Competence Goals & Objectives (pg. 4)	
	Findings: The Provider Credentialing and Recredentialing policy stated that BHI does not make credentialing and recredentialing decisions based solely on ethnic/national identity, gender, age, sexual orientation, type of practice, or types of patients the practitioner may specialize in treating. The policy also stated that BHI will not discriminate—in terms of participation, reimbursement, or indemnification—against any health care professional who is acting within the scope of his or her license or certification under State law solely on the basis of that license or certification. In addition, the policy described how the R&R Committee reviews applications against BHI's criteria for provider qualifications and network need and described the process for committee members to sign a nondiscrimination acknowledgment form. BHI provided an example of the Nondiscrimination and Confidentiality Attestation form used by the R&R Committee. The Culturally Appropriate and Competent Services policy and the Cultural Competency Goals and Objectives described BHI's efforts to recruit and contract with a culturally diverse and competent provider network. Review of R&R Committee meeting minutes demonstrated a heterogeneous committee and a peer review and decision-making process consistent with what the policy described.		
	Required Actions: None		
	2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor	**Documents Submitted/Location Within Documents:** ◆ Colorado Credentialing Application (pg. 23) ◆ Provider Credentialing and Recredentialing pp10 (pg. 6-8) ◆ Provider Manual (pg. 74)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that if an application contains information that varies substantially from the information acquired during the credentialing process, the practitioner is given the opportunity to correct the information and/or explain the discrepancy. Providers were notified in the credentialing application that they would be notified if information received during the credentialing process varied from the information provided by the applicant and that the applicant has the right to correct any erroneous information. The process for collecting provider information used in primary source verification was the delegated responsibility of Colorado Access. The Colorado Access Practitioner Rights policy described the process by which providers were notified if any information found on the application was discrepant from that obtained by primary source		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	verification. The policy stated that the credentialing program coordinator would notify the practitioner via written notification, which included: the nature of the inconsistency, the format for submitting corrections, the time frame in which the practitioner was to respond, and the person to whom the practitioner must submit the correction. The policy also stated that the practitioner must respond within 10 business days, and if the practitioner fails to respond within 10 business days, the file would be forwarded to the chief medical officer or associate medical director and/or the R&R Committee for review. If the practitioner responds, the response is noted in the practitioner's credentialing file and any supporting documentation is included with the credentialing information for consideration in the credentialing decision-making process. Staff stated that if the practitioner does not respond, the R&R Committee may terminate the practitioner's application for credentialing or recredentialing. R&R Committee meeting minutes from October 15, 2009, provided evidence that the committee decided to suspend the application of a provider who did not fully complete the credentialing application. It was documented that BHI staff made numerous attempts to receive the information from the provider, but the provider never responded to BHI's inquiries. Therefore, the committee made the decision to suspend the provider's application.		
	Required Actions: None		
	2.I. The process for ensuring that practitioners are notified of the credentialing/recredentialing decision within 60 calendar days of the committee's decision	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 5, 12)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that for recredentialing decisions, the provider will receive an acceptance or denial letter within seven days (based on the decision from the R&R Committee). The policy also stated that facilities would be notified of the decision to approve or deny credentialing within seven days of the R&R Committee's decision. While the policy addressed completed credentialing files and notification to the provider within seven days of receiving the R&R Committee's decision to credential or deny credentialing to the provider, the language was associated with ongoing monitoring of sanctions. BHI staff stated that providers received an acceptance or denial letter within seven days of credentialing decisions and that the language in the policy describing this process was organized under the wrong header. The BHI policy would be strengthened by providing more accurate descriptions of the process and reorganizing the policy so that the description is placed with the appropriate heading.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/recredentialing program	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 6)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that the medical director is a member of the R&R Committee and approves all credentialing decisions. The policy also stated that the medical director may approve clean files that meet BHI's credentialing and recredentialing criteria. Review of R&R Committee meeting minutes for October 7, 2009; November 4, 2009; and November 19, 2009, provided evidence of the medical director's attendance at the R&R Committee meetings. The on-site review of all remaining minutes provided evidence of the medical director's participation in the R&R Committee meetings.		
	Required Actions: None		
	2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/recredentialing process, except as otherwise provided by law	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 6) ◆ Provider Manual (pg. 78) ◆ Non-discrimination and Confidentiality Attestation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy described the processes and procedures used for ensuring the confidentiality of information obtained during the credentialing and recredentialing processes. Processes included signed confidentiality attestations from staff with access to credentialing and recredentialing materials, management of paper files, destruction of copied materials, and password protection security of electronic files. BHI provided a sample of the Nondiscrimination and Confidentiality Attestation form.		
	Required Actions: None		
	2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty	**Documents Submitted/Location Within Documents:** ◆ Provider Update Form ◆ COA Delegation Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Findings: The Provider Credentialing and Recredentialing policy described BHI's and Colorado Access' (BHI's delegate for selected credentialing processes) process for ensuring that listings in the provider directory (and other pertinent member materials) are consistent with the information obtained during the credentialing process. The process included use of the credentialing database for development of the provider directory and annual audits for accuracy of the provider directory information. BHI staff stated that BHI updated the provider directory at least quarterly based on information obtained by Colorado Access during credentialing and recredentialing activities.		
	Required Actions: None		
	2.M. The right of practitioners to review information submitted to support their credentialing/recredentialing application	**Documents Submitted/Location Within Documents:** ◆ BHI Provider Manual (pg. 78) ◆ Provider Credentialing and Recredentialing pp10 (pg. 6) ◆ Colorado Credentialing Application (pg. 23)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy included the provision that practitioner applicants maintain the right to review information submitted in support of their credentialing/recredentialing application. Providers were informed of this right in the credentialing application and in the Provider Manual.		
	Required Actions: None		
	2.N. The right of practitioners to correct erroneous information	**Documents Submitted/Location Within Documents:** ◆ BHI Provider Manual (pg. 78) ◆ Provider Credentialing and Recredentialing pp10 (pg. 7)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy included the provision that practitioners have the right to correct any erroneous information obtained during the credentialing/recredentialing process. Providers were notified of this right in the credentialing application and in the Provider Manual.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	2.O. The right of practitioners, upon request, to receive the status of their application	**Documents Submitted/Location Within Documents:** ◆ BHI Provider Manual (pg. 78) ◆ Colorado Credentialing Application (pg. 23) ◆ Provider Credentialing and Recredentialing pp10 (pg. 7)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy included the practitioner's right to receive the status of his or her credentialing application upon request. Providers were notified of this right in the credentialing application and in the Provider Manual.		
	Required Actions: None		
	2.P. The right of the applicant to receive notification of their rights under the credentialing program	**Documents Submitted/Location Within Documents:** ◆ BHI Provider Manual (pg. 78) ◆ Provider Credentialing and Recredentialing pp10 (pg. 7)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that providers were notified of their rights via the Provider Manual and the credentialing application. The credentialing application and the Provider Manual included each of the applicant rights.		
	Required Actions: None		
	2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions ◆ Collecting and reviewing sanctions or limitations on licensure	**Documents Submitted/Location Within Documents:** ◆ 2009-10-07 Adult RR Minutes HBH, 2009-11-19 Kids RR Minutes HBH, and 2009-11-04 Adult RR Minutes HBH show BHI's credentialing committee review of quality of care concerns with Highlands Behavioral Health. ◆ Provider Credentialing and Recredentialing pp10 (pg. 5)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	◆ Collecting and reviewing complaints ◆ Collecting and reviewing information from identified adverse events ◆ Implementing appropriate interventions when it identified instances of poor quality, when appropriate		
	Findings: The Provider Credentialing and Recredentialing policy included BHI's procedures for ongoing monitoring of providers for sanctions. The procedures included monthly review of Medicare/Medicaid sanctions, review for State sanctions or limitations on licensure, and review of grievances and adverse events by the Quality Improvement Department and the R&R Committee. The policy indicated that BHI initiated CAPs and monitored the CAPs for compliance. The Quality of Care Concerns policy described BHI's procedures for initiating and tracking CAPs. Review of R&R Committee meeting minutes demonstrated committee review of grievances and quality-of-care concerns when making credentialing and recredentialing decisions. BHI staff stated that BHI conducted a monthly scan of the OIG database to verify that providers had not had any OIG incidents on record. The R&R Committee meeting minutes provided evidence that the results of OIG scans and potential quality-of-care concerns were presented to the R&R Committee. Colorado Access staff stated that Colorado Access' credentialing system, Apogee, also conducted a monthly scan of OIG information for all credentialed providers. If a provider name was present on the OIG sanction list, Colorado Access staff members stated that they would forward the information to BHI to assist with the investigation and forward the information to the R&R Committee.		
	Required Actions: None		
	2.R. The range of actions available to the Contractor if the provider does not meet the Contractor's standards of quality	**Documents Submitted/Location Within Documents:** ◆ Clinical Quality of Care Concerns pp10 ◆ Provider Credentialing and Recredentialing pp10 (pg. 13, 14)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that corrective actions for noncompliance with policies and procedures, conduct resulting in poor quality of care for members, or violation of ethical standards may include suspension, a written warning, a letter of reprimand, probation, required consultation, or termination of the provider agreement. The Quality of Care Concerns policy included specific procedures related to reviewing quality-of-care concerns and monitoring CAPs. BHI staff stated that in the event of quality-of-care concerns, BHI first issued a corrective action to the provider, then levied sanctions or		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	terminated participation if the issue could not be resolved through corrective action. The R&R Committee minutes provided evidence that the committee pended recredentialing of a provider who did not respond to a quality-of-care concern. The committee decided that if the provider did not respond to the committee's inquiry, the committee would terminate the provider's participation in the program.		
	Required Actions: None		
	2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 14)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that all physicians and licensed clinicians were subject to reporting of adverse actions to the applicable State licensing board, the Department, and NPDB. BHI staff members stated that they have reported quality-of-care concerns to the Colorado Department of Public Health and the State's quality improvement organization in one instance that involved Medicare.		
	Required Actions: None		
	2.T. A well defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 14) ◆ Provider Manual (pg. 74)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy included procedures for a change in practitioner status. The procedures included informing providers of the appeal process and allowing the provider to present evidence to the BHI Provider Advisory Council in person or by telephone. Providers were notified of the appeal process via the BHI Provider Manual. The Provider Credentialing and Recredentialing policy contained the provision that providers had 30 days from the date of notification to file an appeal if the provider's contract conditions were modified. Staff stated that a provider may appeal the decision to modify his or her participation in the program based on the recredentialing process. If a decision to modify a provider's participation is upheld, staff stated that the provider may appeal to the Department, but no other appeals may be filed with BHI.		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Required Actions: None		
	2.U. How the Contractor makes the appeal process known to practitioners	**Documents Submitted/Location Within Documents:** ◆ Provider Termination Letter ◆ Decline to Include in Network Letter ◆ Provider Manual (pg. 74)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that the termination letter informs providers of the appeal process. BHI provided a template of a termination letter, which included information about how to initiate an appeal of the decision.		
	Required Actions: None		
NCQA CR2—Element A	3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners.	**Documents Submitted/Location Within Documents:** ◆ R & R minutes with credentialing ◆ Adult Risk and Resource Committee Member List	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that BHI designated the BHI R&R Committee as the committee responsible for credentialing and recredentialing decisions. Review of the R&R Committee meeting minutes demonstrated that the committee was composed of leadership from each of BHI's network CMHCs. The minutes also documented credentialing discussions and decisions.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR2—Element B	4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds ◆ Medical director or equally qualified individual review and approval of clean files	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 6, 7) ◆ Credentialing Committee Provider Approval	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Review of the R&R Committee meeting minutes demonstrated committee review of all clinicians. BHI staff stated that the R&R Committee reviewed all credentialing and recredentialing files. The R&R Committee meeting minutes provided evidence of the use of the Credentialing Guidelines, which was a standardized agenda for the R&R Committee to prompt discussion for each credentialing or recredentialing file. The Credentialing Guidelines were used to guide discussion for R&R Committee members and ensure that credentialing and recredentialing discussions were consistent for all practitioners. The R&R Committee meeting minutes provided evidence that the R&R Committee used the Credentialing Guidelines and that the R&R Committee reviewed all credentialing and recredentialing files, regardless of whether they met or did not meet credentialing criteria.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR3— Element A Element B	5. The Contractor conducts timely verification (using primary sources) of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification includes: ◆ A current, valid license to practice ◆ A valid DEA or CDS certificate ◆ Education and training, including board certification, if applicably ◆ Work history ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Recredentialing pp10 (pg. 5, 8)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that the verification time limits included the provision that information verified is not more than 180 days old at the time of the credentialing decision. The policy also stated that primary source verification included verification of all of the required information. Colorado Access staff stated that it used its electronic credentialing system, Apogee, to track the status and timelines for verification. An on-site demonstration of Apogee provided evidence that Colorado Access staff members were able to track the status and timelines for verification of information through Apogee.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR4—Element A NCQA CR7—Element C	6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation ◆ Lack of present illegal drug use ◆ History of loss of license and felony convictions ◆ History of loss or limitation of privileges or disciplinary activity ◆ Current malpractice insurance coverage (minimums= physician—.5mil/1.5mil; facility—.5mil/3mil) ◆ The correctness and completeness of the application	**Documents Submitted/Location Within Documents:** ◆ Colorado Credentialing Application (pg. 17, 20, 21, 25, 26)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that BHI required all practitioners to complete the Colorado Health Care Professional Credentials Application. The application included each of the required attestations. The on-site review of files provided evidence that each file contained an application for credentialing and a signed attestation.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR5—Element A	7. The Contractor receives information on practitioner sanction before making a credentialing decision, including ◆ State sanctions, restrictions on licensure or limitations on scope of practice ◆ Medicare and Medicaid sanctions	**Documents Submitted/Location Within Documents:** ◆ Sample Provider Licensure and OIG	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that primary verification consisted of verification of appropriate licensure using the applicable state licensing boards. The policy also stated that the OIG list of excluded entities and individuals was used to screen providers for exclusion from participation in federal health care programs. A review of several credentialing files provided evidence that BHI conducted site visits of each office prior to initial credentialing. The files also provided evidence that BHI staff conducted a review to identify state sanctions, restrictions, or limitations on licensure, and Medicare and Medicaid sanctions.		
	Required Actions: None		
NCQA CR6—Element A	8. The Contractor has a process to ensure that the offices of all practitioners meets its office-site standards. The organization sets standards for ◆ Office site criteria ▪ Physical accessibility ▪ Physical appearance ▪ Adequacy of waiting and examining room space ▪ Availability of appointments ◆ Medical/treatment record criteria ▪ Secure/confidential filing system ▪ Legible file markers ▪ Records are easily located	**Documents Submitted/Location Within Documents:** ◆ BHI Site Review Tool	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy included BHI's criteria for evaluating the quality of individual providers' office sites. The criteria for office sites included physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments, and medical/treatment record-keeping criteria. The BHI EPN Office Site Visit Form		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	included a space for the evaluator to document results of the evaluation for each of the criteria. Specifically, medical record-keeping practices included evaluation of a secure/confidential filing system, whether records are kept in an individual folder by name or ID number with legible file markers, and that the records are easily located. The credentialing files reviewed on-site contained completed site visit reviews, which provided evidence that BHI staff conducted a site visit for each respective office site.		
	Required Actions: None		
NCQA CR6— Element B	9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints ◆ Instituting actions to improve offices that do not meet thresholds ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds ◆ Monitoring member complaints for all practitioner sites at least every six months ◆ Documenting follow-up visits for offices that had subsequent deficiencies	**Documents Submitted/Location Within Documents:** ◆ Grievance Policy pp10 (pg. 4) ◆ Credentialing and Re-credentialing Policy pp10 (pg. 11)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that BHI would conduct a site visit if BHI received a member complaint about the provider and/or their location. The policy stated that providers were required to meet at least 80 percent compliance with the following standards: physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments, and adequacy of treatment record-keeping. For providers that do not meet the established 80 percent threshold, the policy stated that BHI would conduct a follow-up site visit within 90 days. If the provider failed to meet the established criteria during the second site visit, the policy stated that BHI may suspend the provider's participation in the network. The R&R Committee meeting minutes reviewed on-site provided evidence that the R&R Committee continually reviewed quality-of-care concerns and results from site visits conducted by BHI staff. The R&R Committee meeting minutes from November 4, 2009, provided an example of a description of a provider who was suspended from participation due to quality-of-care concerns.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR7— Element A Element B Element D NCQA CR8	10. The organization formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information includes: ◆ A current, valid license to practice ◆ A valid DEA or CDS certificate ◆ Board certification ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner ◆ State sanctions, restrictions on licensure, or limitations on scope of practice ◆ Medicare and Medicaid sanctions	**Documents Submitted/Location Within Documents:** ◆ Credentialing and Recredentialing Policy pp10 (pg. 19)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that individual providers were recredentialed every three years. The policy also contained the provision for primary source verification of each of the required elements for recredentialing. The recredentialing files reviewed on-site provided evidence that the required elements for recredentialing were collected and verified through primary source verification. For practitioner offices that were not accredited, BHI conducted a site review, and the files provided evidence that a site review was conducted. For practitioner offices that were accredited by an accrediting organization such as The Joint Commission or the Council on Accreditation, BHI maintained a copy of the accreditation certificate in the practitioner office credentialing file.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR11—Element A	11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with state and federal regulatory bodies.	**Documents Submitted/Location Within Documents:** ◆ Credentialing and Recredentialing Policy pp10 (pg. 14-20)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy included the procedures for assessment of organizational providers with which BHI contracts. The procedures included the process for obtaining applicable state licenses, certifications, and evidence of eligibility for participation in federal health care programs as evidenced by the OIG database query. BHI staff stated that it scanned the OIG database monthly to verify that each provider was in good standing with state and federal bodies. Colorado Access staff stated that Colorado Access' credentialing application, Apogee, conducted a Web crawl, which automatically scans the OIG database monthly. The on-site demonstration of Apogee provided evidence that staff received regular updates on the status of OIG database scans.		
	Required Actions: None		
	11.B. The Contractor confirms whether the provider has been reviewed and approved by an accrediting body.	**Documents Submitted/Location Within Documents:** ◆ Centennial Peaks JCAHO Accreditation ◆ Organization Application	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy included the process for obtaining a copy of any applicable accreditation certificates when contracting with and assessing organizational providers. The Centennial Peaks JCAHO Accreditation certificate provided evidence that BHI obtained the accreditation status of the Centennial Peaks facility. On-site review of credentialing and recredentialing files provided evidence that BHI received updated copies of accreditation certificates.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	11.C. If there is no accreditation status, the Contractor conducts an on-site quality assessment.	**Documents Submitted/Location Within Documents:** ◆ Site Visit Example	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that nonaccredited facilities were subject to an on-site assessment by BHI. The completed Homebase Treatment and Contracting Services site review report provided evidence of BHI's site review of an unaccredited facility as part of its credentialing process. An on-site review of credentialing files provided evidence that BHI conducted site visits of practitioner offices that were not accredited.		
	Required Actions: None		
	11.D. At least every three years, the Contractor confirms that the organizational provider continues to be in good standing with state and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider is not reviewed and approved by an accrediting body.	**Documents Submitted/Location Within Documents:** ◆ Sample Site Visit ◆ Credentialing and Recredentialing Policy pp10 (pg. 18, 20)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy contained the procedures for reassessment of organizational providers every three years, which included verifying that providers are in good standing with state and federal regulatory agencies, whether they are accredited, and, if not, conducting an on-site visit. The completed Homebase Treatment and Contracting Services site review report provided evidence of BHI's site review of an unaccredited facility as part of its credentialing process. An on-site review of credentialing files provided evidence that BHI conducted site visits of practitioner offices that were not accredited.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	11.E. The selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts.	**Documents Submitted/Location Within Documents:** ◆ Credentialing and Recredentialing Policy pp10 (pg. 2, 16, 17)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy included the content and criteria for site visits for nonaccredited facilities. The criteria included review of appointment availability, credentialing/recredentialing policies and practices, clinical operations, safety policies and practices, office/site appearance, treatment record-keeping practices, confidentiality procedures, and medication safety practices. The sample organizational provider site review form included spaces for the BHI staff member to evaluate each of the above elements.		
	Required Actions: None		
NCQA CR11—Element A	12. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.	**Documents Submitted/Location Within Documents:** ◆ Organizational Site Visit Tool ◆ Credentialing and Recredentialing Policy pp10 (pg. 16)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that the site visit for nonaccredited facilities included a review of credentialing and recredentialing policies and procedures and a review of three personnel files to verify credentialing processes. The policy also stated that the policy/procedure review specifically evaluated policies related to the review for Medicare/Medicaid sanctions. The example of the organizational provider site visit form included review of credentialing and recredentialing policies and procedures and review of credentialing files for required content, including review for Medicare/Medicaid sanctions. The completed Homebase Treatment and Contracting Services site review report provided evidence of BHI's site review of an unaccredited facility as part of its credentialing process, which included a review of the facility's credentialing and recredentialing processes, policies, and procedures. An on-site review of credentialing files provided evidence that BHI conducted site visits of practitioner offices. All of the files included a completed site visit checklist, which included a review of the facility's credentialing and recredentialing process.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR11—Element B	13. The Contractor's organizational provider assessment policies and process includes at least: ◆ Inpatient facilities ◆ Residential facilities ◆ Ambulatory facilities	**Documents Submitted/Location Within Documents:** ◆ Organizational Site Visit Tool	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Credentialing and Recredentialing policy stated that BHI's organizational providers may include CMHCs, child placement agencies, group practices, hospitals, home health organizations, nursing homes, residential facilities, and rehabilitation facilities. BHI's list of providers included each of the above provider types.		
	Required Actions: None		
NCQA CR11—Element D	14. The Contractor has documentation that organizational providers have been assessed.	**Documents Submitted/Location Within Documents:** ◆ Organizational Credentialing Checklist ◆ Site Review Tool Example	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: An on-site review of credentialing files provided evidence that BHI conducted site visits of practitioner offices and maintained files with supporting documentation that organizational providers were assessed. Each file reviewed contained a completed organizational provider checklist and site review form.		
	Required Actions: None		
NCQA CR12—Element A—H	15. If the Contractor delegates any credentialing activities, the Contractor: ◆ Has a written delegation document with the delegate ◆ Retains the right to approve, suspend, and terminate individual practitioners, providers, and sites. This right is reflected in the delegation agreement	**Documents Submitted/Location Within Documents:** ◆ COA Credentialing Delegation Agreement ◆ BHI FY09-10 Quarterly Contract Performance Summary Q1 111309	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	◆ Audits credentialing files annually against NCQA standards ◆ Performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations ◆ Evaluates regular reports ◆ The organization identifies and follows up on opportunities for improvement, if applicable		
	Findings: The executed BHI/Colorado Access delegation agreement included the provision that BHI retained the right to review individual practitioners or providers and to exclude from participation or terminate the participation of any individual practitioner or provider from the BHI network. The delegation agreement stated that periodically, but not less than annually, BHI will conduct a review or audit of the delegate's policies, procedures, and records pertaining to the delegated functions. If the delegate is NCQA certified, BHI will review any requirements outside of NCQA standards annually, and non-NCQA-certified delegates will received a full annual review against NCQA standards. The delegation agreement also stated that BHI shall monitor the performance of the delegate by reviewing reports of credentialing activities monthly; and, if applicable, the delegate will submit an action plan to BHI, which will perform follow-up activities as required. The Quarter 1 FY 2009–10 Contract Performance Summary provided evidence of BHI's review of regular reporting submitted by Colorado Access related to the delegated activities.		
	Required Actions: None		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	39	X	1.00	=	39
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	39	**Total Score**		=	39

Total Score ÷ Total Applicable	=	100%

Standard IX—Subcontracts and Delegation			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.230(a)(1) Contract: II.H.1	1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor.	**Documents Submitted/Location Within Documents:** ◆ BHI's Subcontractual Relationships and Delegation pp10 policy describes BHI's responsibility in overseeing and being accountable for responsibilities delegated to its subcontractors.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI delegated select activities related to access to services, referral and triage, UM, member services, and quality improvement to its three CMHCs. Beginning in FY 2009–2010, BHI entered into a delegation agreement with Colorado Access to credential the BHO's individual practitioners. BHI's Subcontractual Relationships and Delegation policy described the delegation process, including the responsibilities of both parties, and stated that the BHO was ultimately accountable for the performance of its delegates.		
	Required Actions: None		
42CFR438.230(b)(1) Contract: II.H.1	2. Before any delegation, the Contractor evaluates a prospective subcontractor's ability to perform the activities to be delegated.	**Documents Submitted/Location Within Documents:** ◆ Credentialing Discussion 060309 – 1 (Attachment A) ◆ Credentialing Accuracy Monitoring Oct08 - Mar09	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: This review period, BHI entered into a new delegation agreement with Colorado Access to perform provider credentialing activities. In June 2009 the BHO conducted a predelegation assessment of Colorado Access' ability to meet obligations under the delegation. The evaluation included a review of policies and procedures and an analysis of Colorado Access' historical accuracy and timeliness in maintaining credentialing and recredentialing files. BHI also hosted a meeting June 3, 2009, to discuss the scope of work under the agreement.		
	Required Actions: None		

Standard IX—Subcontracts and Delegation			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR 12— Element D	3. There is a written agreement with each delegate.	**Documents Submitted/Location Within Documents:** ◆ Delegation Agreement ADMHN ◆ Delegation Agreement AuMHC ◆ Delegation Agreement CRC ◆ BHI_COA Delegation Agreement 2009	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Subcontractual Relationships and Delegation policy required that the BHO use written agreements with all delegates. BHI had written delegation agreements in place with Colorado Access and with each of its three CMHCs. The agreements defined the scope of delegated activities, identified reporting requirements, and described the use of CAPs and other remedies to address any problems with delegate performance.		
	Required Actions: None		
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR12— Element A Element B Element C	4. The written delegation agreement: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate For delegation of Credentialing only, the agreement: ◆ Is mutually agreed upon ◆ Describes the responsibilities of the Contractor and the delegated entity ◆ Describes the delegated activities ◆ Requires at least semiannual reporting to the Contractor ◆ Describes the process by which the Contractor evaluates the delegated entity's performance	**Documents Submitted/Location Within Documents:** ◆ BHI_COA Delegation Agreement 2009 ◆ Delegation Agreement ADMHN-Pg. 8 ◆ 2007amendment facility agreement_Aurora and MHC_DeliverablesCalendar_FY08_Attachment _F identify financial sanctions for MHC failure to submit required data or information to BHI.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontracts and Delegation			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	◆ Describes the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement ◆ Includes a list of allowed uses of PHI ◆ Includes a description of delegate safeguards to protect the information (PHI) from inappropriate uses ◆ Includes a stipulation that the delegate will ensure that subdelegates have similar safeguards ◆ Includes a stipulation that the delegate will provide individuals with access to their PHI ◆ Includes a stipulation that the delegate will inform the Contractor if inappropriate use of the information (PHI) occur ◆ Includes a stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends ◆ Includes a stipulation that the Contractor has the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision-making		
	Findings: BHI's delegation agreements with Colorado Access and with the BHO's three CMHCs specified the activities and reporting requirements delegated to each subcontractor. The delegation agreements also included language regarding imposing sanctions to address any serious or recurring problems with performance. BHI's delegation agreement with Colorado Access to conduct credentialing activities contained a provision regarding the need for the delegate to satisfy all NCQA standards, including those described in NCQA CR12.		
	Required Actions: None		

Standard IX—Subcontracts and Delegation			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.230(b)(3)	5. The Contractor monitors the delegate's performance on an ongoing basis. The Contractor subjects subcontractor/delegate to a formal review according to a periodic schedule established by the State, consistent with industry standards or state MCO laws and regulations.	**Documents Submitted/Location Within Documents:** ◆ FY08 Delegation Oversight Final Report ADMHN and FY08 Delegation Oversight Final Letter ADMHN are provided to the MHCs to complete the delegation oversight feedback loop. ◆ BHI's Subcontractual Relationships and Delegation pp10 (Pg. 3) policy describes the oversight process for delegated functions. ◆ BHI FY09-10 Quarterly Contract Performance Summary Q1 111309-Pg. 8 details Colorado Access performance in processing credentialing and re-credentialing files and serves as a tool for BHI oversight.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Subcontractual Relationships and Delegation policy required that the BHO conduct annual audits of its delegates. BHI monitored Colorado Access' performance on an ongoing basis through weekly meetings and a review of periodic reports submitted by the delegate. For example, BHI provided a copy of the Contract Performance Summary Report for 1st Quarter Fiscal Year 2009–2010 that summarized the number of newly credentialed practitioners and provided data regarding the timeliness of processing credentialing applications. BHI also monitored all activities delegated to the CMHCs using a standardized checklist and produced a delegation oversight report annually.		
	Required Actions: None		

Standard IX—Subcontracts and Delegation			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.230(b)(4)	6. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance the Contractor and the subcontractor take corrective action.	**Documents Submitted/Location Within Documents:** ◆ FY09 Q4 QI Report Card Final BLINDED ◆ FY09 Q4 ADMHN Report Card CAP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Subcontractual Relationships and Delegation policy stated that delegates were required to implement CAPs in cases in which deficiencies in performance were identified. The policy also described the role of the Delegation Oversight Committee in reviewing action plans and follow-up activities related to corrective action. BHI provided a copy of the fourth quarter FY 2009–2010 CAP submitted by the Arapahoe-Douglas Mental Health Network. The CAP included a summary of BHI's findings and a description of action taken by the delegate to address problem performance regarding penetration rates and the provision of timely emergency face-to-face visits. At the interview, staff stated that the BHO had not imposed sanctions or revoked any delegated duties during the period under review.		
	Required Actions: None		

Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	6	**Total Score**		=	6

Total Score ÷ Total Applicable	=	100%

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.240(a)	1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program.	**Documents Submitted/Location Within Documents:** ◆ Quality Improvement Program Description pp10 ◆ 2009-11-12 SOP Minutes ◆ 2010-01-13 PAC Minutes ◆ 2010-01-14 PEO Agenda	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI had an active QAPI program in place. The BHO had a Quality Improvement Program Description, last updated in January 2010, that identified BHI's goals related to performance improvement, defined the program structure, and included a description of the various performance measures, focus studies, and other quality initiatives in progress. BHI also published the Fiscal Year 2009 Annual Quality Report, which summarized prior-period data for measures required by the Department. The BHI Fiscal Year 2010 Quality Improvement Plan included targeted measures and improvement strategies for implementation in the current fiscal year. BHI also convened a Provider Advisory Committee that addressed issues related to performance improvement. Meeting minutes dated July 8, 2009, for example, documented a discussion regarding new access-to-care standards approved by the Department.		
	Required Actions: None		
42CFR438.240(b)	2. The QAPI Program includes the following basic elements: ◆ Performance improvement projects ◆ The submission of performance measurement data	**Documents Submitted/Location Within Documents:** ◆ Atypical Antipsychotic Focus Study 2009-08-17 and CO_BHI_A-rpt_CO2007-8_BHO_PIP-Val_ CoordCare_Study_F1 are BHI's current performance improvement Project and Focus study. ◆ Corrected Spreadsheet 1238 - FY2008-09 Penetration Rates 09Dec30 ◆ Draft BHO PM For 2008 2009	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI conducted PIPs and submitted performance measurement data as required by the Department. The focus of BHI's PIP was on improving coordination of care between Medicaid physical and behavioral health providers for members with schizophrenia, schizo-affective disorder, and bipolar disorder. In addition, the BHO had a focus study in place to assess the degree to which practitioners were monitoring metabolic side effects for members taking atypical antipsychotics. During the interview, staff stated that the BHO		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	also submitted performance data to the Department for numerous quality measures, including access-to-care indicators, data regarding State hospital utilization, and information regarding hospital recidivism.		
	Required Actions: None		
42CFR438.240(b)(3)	3. The Contractor's QAPI program includes mechanisms to detect both underutilization and overutilization of services.	**Documents Submitted/Location Within Documents:** ◆ FY10 Q1 BHI Grievance Appeal Report ◆ Report 35 Session December 2007 ◆ Report 45-Day FY08 Q1 ◆ BHI FY2010 Q1 Alternative Services Report 111309 ◆ Report FQHC FY08 Q1 ◆ Kids Meeting Handout ◆ Quality Improvement Program Description pp10, Pg. 2 ◆ Reference Document - Utilization Management Program Description-Pg. 2 ◆ FY09 Q4 QI Report Card Final BLINDED ◆ FY09 Q4 ADMHN Report Card CAP ◆ FY09 Program Evaluation FINAL	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Both the BHI Quality Improvement Program Description and Utilization Management Program Description identified the detection of underutilization and overutilization of services as a critical activity. The Quality Improvement Program Description also stated that performance measurement findings related to the underutilization or overutilization of services were considered as part of the recredentialing process. BHI provided copies of several utilization reports, including data regarding hospital readmissions within 30 days of discharge, penetration rates, and the number of adjudicated claims for residential care and alternative services. The FY 2009 fourth quarter CAP for the Arapahoe-Douglas Mental Health Network included required actions to address issues related to utilization metrics.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.240(b)(4)	4. The Contractor's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	**Documents Submitted/Location Within Documents:** ◆ Provider Credentialing and Re-credentialing pp10-Pg. 12	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI had numerous mechanisms in place to evaluate the quality and appropriateness of care provided to members with special health care needs. At the interview, staff reported that provider performance was evaluated on an ongoing basis through data regarding accessibility to care, reported concerns or complaints, and member satisfaction using a customer satisfaction survey developed by the Mental Health Corporation of America. In addition, the BHI Provider Credentialing and Recredentialing policy stated that the quality of care provided to enrolled members was formally assessed through a review of data from multiple of sources at the time of recredentialing.		
	Required Actions: None		
42CFR438.240(e)(2)	5. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program.	**Documents Submitted/Location Within Documents:** ◆ FY09 Program Evaluation FINAL-Pg.55 shows trended data ◆ FY09 QI Work Plan	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Program Evaluations and Outcomes Committee and Standards of Practice Committee evaluated the impact and effectiveness of the QAPI program throughout the year. The BHO also produced the Fiscal Year 2009 Annual Quality Report, which formally evaluated the QAPI program. The report described progress made on quality initiatives throughout the fiscal year and included a high-level summary and analysis of performance data and quality studies conducted by BHI. The BHO developed the Fiscal Year 2010 Quality Improvement Plan, which detailed goals and activities for the upcoming year.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.236(b)	6. The Contractor's QAPI program addresses practice guidelines. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field ◆ Considers the needs of the Contractor's members ◆ Are adopted in consultation with contracting health care professionals ◆ Are reviewed and updated periodically as appropriate	**Documents Submitted/Location Within Documents:** ◆ Clinical Practice Guidelines pp10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Standards of Practice Committee was responsible for the oversight, development, implementation, and monitoring of clinical practice guidelines. The BHO's Clinical Practice Guideline policy required that: 1) a thorough review of professional literature be conducted to ensure that practice guidelines were based on valid and reliable clinical evidence or a consensus of behavioral health professionals, 2) practice guidelines consider the needs of enrollees and reflect issues relevant to the BHI membership, 3) the guidelines were adopted in consultation with contracting behavioral health care professionals, and 4) practice protocols are updated periodically as appropriate. BHI adopted several clinical practice guidelines, including protocols for the treatment of eating disorders and bipolar disorders and for the evaluation and treatment of mental illness in children, youth, and adults with developmental disabilities. The BHO also adopted the use of medication algorithms for the treatment of attention deficit hyperactivity disorder (ADHD), bipolar disorder, schizophrenia, and major depression. At the interview, staff stated that the Standards of Practice Committee actively sought feedback from local experts in the field in making decisions regarding the adoption of practice guidelines. Staff indicated that on one occasion, for example, the committee consulted with an expert in equine assisted therapy.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.236(c)	7. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members.	**Documents Submitted/Location Within Documents:** ◆ Clinical Practice Guidelines pp10 policy-Pg. 3 describes the dissemination process ◆ Delegation Agreement ADMHN -Pg 4 describes the MHC responsibility regarding practice guidelines ◆ http://www.bhicares.org/guidelines.htm shows the link on BHI's website where practice guidelines can be accessed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's clinical practice guidelines and bibliographies were posted on the BHO's Web site. The BHI Clinical Practice Guideline policy stated that the guidelines were available to members through either the member's primary clinician/care coordinator or through BHI directly. BHI's delegation agreements with its CMHCs required that the delegate disseminate practice guidelines and new technology information to its practitioners. At the interview, staff indicated that there was a process in place to share information regarding new practice guidelines with members through the BHO's Member Advisory Board (MAB).		
	Required Actions: None		
42CFR438.236(d)	8. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.	**Documents Submitted/Location Within Documents:** ◆ BHI Practice Guideline-Eating Disorder Background Information FY08	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI's Clinical Practice Guideline policy stated that decisions for UM, member education, coverage of services, and other areas to which the guidelines apply were required to be consistent with practice guidelines. The BHI Utilization Management Program Description described the use of periodic audits to ensure that level-of-care criteria were satisfied and that standards of practice were met. Copies of the clinical practice guidelines were also included in the BHI Provider Manual to facilitate their use as part of the peer review process. At the interview, staff stated that members were frequently educated regarding best practices as part of the treatment process. For example, members participating in Bipolar Education and Skills Training (BEST) were frequently educated regarding the psychosocial model for the treatment of bipolar disorder.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.242(a)	9. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data that is used to support administration of the Contractor's Program.	**Documents Submitted/Location Within Documents:** ◆ Adult R and R Meeting Handout is an example of data analysis that informed the development of BHI's Hospital Diversion Program ◆ Hospital Diversion Program Flow Chart ◆ Hospital Diversion Program Medical Necessity Criteria ◆ Hospital Diversion Program Assessment	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI had a robust information system that allowed the BHO to collect, analyze, integrate, and report data in support of the QAPI program. BHI produced the Fiscal Year 2009 Annual Quality Report, which summarized data findings for measures that addressed member satisfaction, service utilization, access to care, coordination of care, and continuity of care. The BHO also provided examples of several reports that included hospital recidivism rates by age and CMHC. The reports were used to inform decisions regarding the development of a hospital diversion program.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.242(a)	10. The Contractor's health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	**Documents Submitted/Location Within Documents:** ◆ FY10 Q1 BHI Grievance Appeal Report is compiled from the Grievance and Appeal databases and analyzed for any trends. ◆ 30-35 Visit Outpatient Benefit Limit Monitoring Report FY10 Q1 shows members that are reaching the 35 day outpatient benefit limit so alternate service planning is done in a timely fashion. ◆ BHI Lives Accrual Worksheet FY2010 tracks the distribution of BHI's lives across eligibility categories and allows BHI to analyze trends in enrollment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI collected, analyzed, and reported data for utilization metrics, including penetration rates, hospital recidivism, and hospital length of stay. The BHO also produced the Fiscal Year 2010 30-35 Visit Outpatient Benefit Monitoring Report to assist in service planning with members reaching their 35-visit benefit limitation. BHI used Microsoft Access and Excel databases to capture information related to grievances and appeals and reported on any trends in the data on a quarterly basis. At the interview, staff reported that BHI had not disenrolled any members during the period under review.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.242(b)	11. The Contractor collects data on member and provider characteristics and on services furnished to members.	**Documents Submitted/Location Within Documents:** ◆ BHI Access to Care Report FINAL FY10 Q1 helps to ensure that access guidelines are met. ◆ BHI Utilization of State Hospital Beds FY10 Q1monitors the number of members in allocated beds. ◆ FY10 Q1 BHI Grievance Appeal Report helps monitor consumer concerns about services received. ◆ Corrected Spreadsheet 1238 - FY2008-09 Penetration Rates 09Dec30 and Draft BHO PM For 2008 2009 are annual performance indicators calculated by both BHI and HCPF that help review several key services. ◆ BHI Benchmark Reports_1Qtr_FY10 is a quarterly report that monitors some of the annual performance indicators on a quarterly basis. ◆ NW Adequacy Report Final Q1 FY10 is a report of current providers and facilities, counties where they serve, geographic distance from BHI members and whether they currently accept members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI collected, analyzed, and reported service utilization data, including emergency department utilization and bed day utilization at the State hospital. The BHO reported data for access-to-care indicators by age and stratified penetration rate data by age and CMHC. Data from the Mental Health Statistics Improvement Program (MHSIP) survey were also reported by race and ethnicity in the Fiscal Year 2009 Annual Quality Report. BHI published a quarterly network adequacy report that included key provider data, including the number of providers by county and the number of providers not accepting new members. During the interview, staff clarified that the BHI health information system had the capability to report data stratified by any number of member demographics, including age, gender, and diagnosis.		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Required Actions: None		
42CFR438.242(b)	12. The Contractor ensures that data received from providers is accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data ◆ Screening the data for completeness, logic, and consistency ◆ Collecting service information in standardized formats to the extent feasible and appropriate.	**Documents Submitted/Location Within Documents:** ◆ BHI_Detailed Summary Stats by Quarter - 837 files.xls: This file shows the quality checks performed by Colorado Access, as described in the second paragraph. ◆ OctoberSummary.xls: This file shows the SPSS summaries that are saved by the Data Analysts for trending, and comparing to future claims files. ◆ SPSS Syntax for Claims Files.docx: This file is a copy for the SPSS syntax that groups, counts, and summarizes the claims data. This syntax also identifies Medicaid IDs that have more than one client, or shared IDs. There is a NOTE at the bottom of the document that explains that 100% of this code is not used, but only the parts that are still applicable. It was copy/pasted into Word, because the actual file is in an SPSS proprietary format that requires SPSS to open.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: BHI had multiple processes in place to ensure that data received from providers were accurate and complete. Claims data were initially submitted by providers to Colorado Access, BHI's administrative services organization. Colorado Access was responsible for assessing the timeliness of data submitted by providers. BHI provided a copy of the Detailed Summary Statistics Report, which illustrated the accuracy of provider claims data, including the number of paid and denied claims by denial reason. Provider claims data were reviewed by data analysts at BHI, and an annual data validation audit was conducted to assess the accuracy and completeness of provider data. BHI mandated that providers meet the Department's claim encounters flat file requirements for submission of data.		
	Required Actions: None		

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	12	**Total Score**		=	12

Total Score ÷ Total Applicable	=	100%

Appendix B. Grievance Record Review Tool for Behavioral HealthCare, Inc.

The completed grievance record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Site Review Report
for Behavioral HealthCare, Inc.

Plan Name:	Behavioral HealthCare, Inc.
Review Period:	July 1, 2009–December 15, 2009
Date of Review:	February 16, 2009
Reviewer:	Gretchen Thompson
Participating Plan Staff Member:	Jen Molloy

1	2	3	4	5	6	7	8	9	10	11
File #	Case ID #	Date Grievance Received	Date of Acknowledg-ment Letter	Acknowledg-ment Sent in 2 W-days?*	Date of Written Notice of Disposition	# of Days to Notice	Resolved and Notice Sent in 15 W-days?*	Not Involved in Previous Level of Review	Appropriate Level of Expertise?	Resolution Letter Includes Required Content
1	***	9/3/09	9/4/09	Y ☒ N ☐ N/A ☐	9/29/09	26	Y ☐ N ☒ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
2	***	11/16/09	11/16/09	Y ☒ N ☐ N/A ☐	11/23/09	7	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
3	***	10/19/09	10/19/09	Y ☒ N ☐ N/A ☐	10/27/09	8	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐
Comments: The resolution letter did not contain the resolution.										
4	***	8/18/09	8/18/09	Y ☒ N ☐ N/A ☐	8/25/09	7	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
5	***	9/14/09	9/17/09	Y ☐ N ☒ N/A ☐	9/17/09	3	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☒ N/A ☐
Comments: The acknowledgment letter was outside of the required time frame and the resolution letter did not contain a resolution. This grievance did not involve a clinical issue.										
6	***			Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments: This grievance was filed outside the parameters of the review period.										
7	***	9/30/09	9/30/09	Y ☒ N ☐ N/A ☐	9/30/09	0	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
8	***			Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments: This was not a Medicaid member.										
9	***	10/2/09	10/2/09	Y ☒ N ☐ N/A ☐	10/16/09	13	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
10	***	9/21/09	9/22/09	Y ☒ N ☐ N/A ☐	9/22/09	1	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										

1	2	3	4	5	6	7	8	9	10	11
File #	Case ID #	Date Grievance Received	Date of Acknowledg-ment Letter	Acknowledg-ment Sent in 2 W-days?*	Date of Written Notice of Disposition	# of Days to Notice	Resolved and Notice Sent in 15 W-days?*	Not Involved in Previous Level of Review	Appropriate Level of Expertise?	Resolution Letter Includes Required Content
11	***	9/16/09	9/18/09	Y ☒ N ☐ N/A ☐	9/18/09	2	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
12	***	9/11/09	9/11/09	Y ☒ N ☐ N/A ☐	9/11/09	0	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
13				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
14				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
15				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments: ***Oversample not required.										
# Applicable Elements				10			10	10	5	10
# Compliant Elements				9			9	10	5	8
Percent Compliant				90%			90%	100%	100%	80%

# Applicable Elements	**45**
# Compliant Elements	**41**
Percent Compliant	**91%**

*W-days = Working days

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

Table C-1 lists the participants in the FY 2009–2010 site review of **BHI**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Gretchen Thompson	Executive Director, State & Corporate Services
Tom Cummins	Consultant
BHI Participants	**Title**
Jeff George	Quality Improvement and Research Analyst
Rebecca Hill	Executive Assistant
Julie Holtz	Chief Executive Officer
Lindsay Holtz	Wellness Intern
Wendy Kidd	Director, Utilization Management
Samatha Kommana	Quality Improvement Director
Melissa Kulasekere	Quality Improvement Program Evaluation/Disease Management Specialist
Jenifer Malloy	Director, Office of Member and Family Affairs
Christina Mitsch	Authorization Coordinator, Utilization Management
Jane Moore	Manager, Utilization Management
Rian Navitzki	Chief Financial Officer/Controller
Travis Perez	Manager, Contract Systems (Colorado Access)
Margaret Pleasant	Utilization Management Supervisor
Teresa Summers	Director, Provider Relations
Michelle Tomsche	Program Director for BHI (Colorado Access)
Department Observers	**Title**
Jerry Ware	Quality/Compliance Specialist
Marceil Case (participated telephonically)	Behavioral Health Specialist

Appendix D. Corrective Action Plan Process for FY 2009–2010 for Behavioral HealthCare, Inc.

BHI is required to submit to the Department a corrective action plan (CAP) for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each element that requires correction, the health plan should identify the planned interventions 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 CAP has been approved by the Department. Following Department approval, the BHO must submit documents per the timeline that was approved.

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each BHO will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting. The BHO will submit the CAP using the template that follows. 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, it 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 interventions to HSAG via e-mail or through the FTP site, with an e-mail notification regarding the FTP 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 require that, based on the nature and seriousness of the noncompliance, the BHO submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department will inform the BHO 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 that substantiates the implementation of all Department-approved corrective actions is deemed sufficient to bring the BHO into full compliance with all the applicable contract requirements.

The template for the CAP follows.

Table D-2—FY 2009–2010 Corrective Action Plan *for* BHI					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
VI. The Grievance System 7. The Contractor acknowledges each grievance in writing within two working days of receipt.	Of the 10 grievance files reviewed, only 9 files provided evidence that BHI acknowledged grievances within two days of receipt of the grievance. BHI should ensure that all grievances are acknowledged within two working days of receipt of the grievance.				
VI. The Grievance System 9. The Contractor must dispose of each grievance and provide notice of the disposition in writing, as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the Contractor receives the grievance. The notice includes: ◆ The results of the disposition/ resolution process ◆ The date it was completed	Of the 10 grievance files reviewed, only 9 files provided evidence that the grievances were resolved within 15 working days, and only 8 files provided evidence that the written resolution letter contained the results of the disposition process. BHI must ensure that all grievances are resolved within 15 working days and that all resolution letters contain the results of the disposition process.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* BHI					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
VII. Provider Participation and Program Integrity 1. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient for the following: ◆ The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered ◆ Any information the member needs in order to decide among all	The Provider Contract and Provider Manual did not provide evidence of the provision that BHI would not prohibit or restrict health care professionals acting within the lawful scope of their practice from advising or advocating on behalf of a member regarding treatments that may be self-administered and the risks, benefits, and consequences of treatment or nontreatment. BHI should develop a method for informing providers that it does not prohibit or restrict health care professionals acting within the lawful scope of their practice from advising or advocating on behalf of a member regarding treatments that may be self-administered and the risks, benefits, and consequences of treatment or nontreatment.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* BHI					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
relevant treatment options ◆ The risks, benefits, and consequences of treatment or non-treatment ◆ The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions					

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

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

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences 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 for other review activities. ◆ HSAG staff members provided an orientation on September 22, 2009, for the BHO and the Department to preview the FY 2009–2010 compliance monitoring review process and to allow the BHO 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 members to the review team. ◆ 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**
	◆ Since the BHOs had just completed the RFP/contracting process, with new organization having been formed, HSAG used only the BBA Medicaid managed care regulations to develop HSAG's 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 standards. ◆ Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected 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 it needed and had identified during its desk audit. ◆ HSAG requested and reviewed additional documents it needed and had 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 members to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 2009–2010 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions to be required of the BHO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2009–2010 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.