Colorado Medicaid
Community Mental Health Services Program

# FY 2010–2011 Site Review Report

*for*

# Behavioral HealthCare, Inc.

February 2011

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

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 300 • Phoenix, AZ 85016
Phone 602.264.6382 • Fax 602.241.0757

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## Overview of FY 2010–2011 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 the State's quality strategy. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for the Colorado behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the seventh year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2010–2011 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the three performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard III—Coordination and Continuity of Care.

The BHO's administrative records were also reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 20 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid denials that occurred between January 1, 2010, and September 15, 2010. For the record review, the BHO received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. For cases in which the reviewer was unable to determine compliance due to lack of documentation, a score of *Unknown* was used. Compliance with federal regulations was evaluated through review of the three standards and administrative denial records. The BHO received an overall percentage of compliance score for the standards and a separate overall percentage of compliance score for the record review.

This report documents results of the FY 2010–2011 site review activities for the review period—January 1, 2010, through the date of the on-site review November 15 and 16, 2010. Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Section 3 describes the extent to which the BHO was successful in completing corrective actions required as a result of the 2009–2010 site review activities. Appendices A and B contain details of the findings. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action process the BHO will be required to complete and the required template for doing so.

## Methodology

In developing the data collection tools and in reviewing the three standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key BHO personnel to determine compliance. 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 findings from review of the three standards follow in Appendix A. Details of the findings from the on-site denials record review follow in Appendix B.

The three standards chosen for the FY 2010–2011 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

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 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 three areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the BHO into compliance with federal health care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, health care furnished by the BHO, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of the BHO's services related to the areas 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 requirement 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 requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for enhancement for some requirements, regardless of the score. Recommendations for enhancement for requirements scored as *Met* did not represent noncompliance with contract requirements or BBA regulations.

Table 1-1 presents the score for **Behavioral HealthCare, Inc.** (**BHI**) for each of the standards. Details of the findings for each standard follow 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 | Coverage and Authorization of Services | 33 | 33 | 30 | 3 | 0 | 0 | 91% |
| II | Access and Availability | 12 | 12 | 12 | 0 | 0 | 0 | 100% |
| III | Coordination and Continuity of Care | 6 | 6 | 5 | 1 | 0 | 0 | 83% |
| | **Totals** | **51** | **51** | **47** | **4** | **0** | **0** | **94%** |

**Table 1-2—Summary of Scores for Record Review**

| Description of Record Review | # of Elements | # of Applicable Elements | # *Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|
| Denials Record Review | 120 | 85 | 60 | 25 | 35 | 70.6% |

# 2. Summary of Performance Strengths and Required Actions

*for* **Behavioral HealthCare, Inc.**

## Overall Summary of Performance

For the three standards reviewed by HSAG, **BHI** earned an overall compliance score of 94 percent. **BHI**'s strongest performance was in Standard II—Access and Availability, where it earned compliance score of 100 percent. Although HSAG identified three required actions in Standard I—Coverage and Authorization of Services (91 percent compliant) and one required action in Standard III—Coordination and Continuity of Care (83 percent compliant), **BHI** demonstrated strong performance overall and an understanding of the federal regulations.

# Standard I—Coverage and Authorization of Services

## Summary of Findings and Opportunities for Improvement

**BHI** had several mechanisms in place to ensure that the services furnished by the community mental health centers (CMHCs) and the contracted provider network (CPN) were sufficient. **BHI**'s utilization review (UR) criteria were based on symptomatology and medical necessity. **BHI**'s definition of medical necessity was consistent with the definition used in the Medicaid managed care contract. Its utilization management (UM) program, policies, and training materials were consistent with Medicaid managed care regulations and the Medicaid managed care contract with the State. **BHI**'s UM policies and training materials were widely available to the CMHCs and the CPN. **BHI**'s processes ensured that UR criteria were implemented consistently throughout the organization.

**BHI** used the term "medically necessary" throughout its member handbook; however, this term was not defined in the member handbook. HSAG suggests that **BHI** revise its member handbook to include a definition of "medical necessity."

HSAG's review of 20 **BHI** denial records proved difficult due to the limited amount of documentation included in the denial records. Insufficient documentation in many of the records prevented HSAG from determining if the records met certain requirements. In addition, HSAG found that **BHI** was unnecessarily handling clinical treatment decisions as denials. HSAG understands that **BHI** management staff was aware of these issues prior to HSAG's review. HSAG encourages **BHI** to continue its efforts to improve the amount of documentation included with denial records. Also, HSAG suggests that **BHI** examine its processes to determine if decisions to provide one service over another constitutes an actual denial by the BHO or simply a treatment decision made by the clinician.

## Summary of Strengths

HSAG found **BHI**'s utilization management (UM) department to be dynamic, with active monitoring and processes in place to ensure compliance with federal Medicaid regulations. **BHI**'s processes for delegation oversight were clearly delineated and executed, and the training provided to delegates was robust. **BHI**'s UM program appeared to promote member access to services, as evidenced by member-run services and initial assessments being provided without requiring prior authorization.

## Summary of Required Actions

**BHI**'s Utilization Management Program Description stated that **BHI** UM staff engaged in ongoing consultation with the provider throughout the episode of care; however, did not specifically address consultation with a requesting provider for utilization determinations. Throughout the record review, HSAG was unable to determine if many of the records met the requirement for consulting the requesting provider because the documentation did not include who actually requested the

service. **BHI** must ensure that the appropriate policy includes a mechanism to consult with the requesting provider. **BHI** must also adequately document any and all consultation with the requesting provider, if applicable.

Also during the record review, HSAG encountered one record in which it was not clear that the reason for the denial was based on the UR criteria. **BHI** must clearly demonstrate the reason for denials and that utilization determinations are made based on UR criteria.

HSAG found that the template **BHI** used for notice of actions included an incorrect timeframe for appeal and/or requesting continuation of benefits related to cases which involved the termination, suspension, or reduction of previously authorized services. **BHI** must revise its template to include accurate timeframes.

The UM Program Description and the UM Decision Timelines policy included the required time frames for making standard and expedited authorization decisions. The description and policy also included the time frame of three working days for expedited decisions. The **BHI** action and appeals training PowerPoint presentation stated that the required time frame was three calendar days. The federal requirement is three working days. The Colorado rule does not specify calendar or working days. While three calendar days would exceed the federal requirement of three working days, **BHI**'s documents must be revised to be consistent with each other.

# Standard II—Access and Availability

## Summary of Findings and Opportunities for Improvement

**BHI** had several processes and policies in place to ensure timely access to routine, urgent, and emergency care. These standards were available to Medicaid members in the member handbook, and the policies and procedures were available to all contracted providers. The member handbook also included clear instruction on how and where to access routine, urgent, and emergency services.

**BHI** employed numerous mechanisms to ensure that it maintained and monitored comprehensive services for its members. These mechanisms included review of individualized assessments, treatment plans, complex case reviews, and analysis of performance measure indicators. **BHI** demonstrated a robust provider network and that it took into consideration the geographic location of both its members and providers, potential physical barriers to locations, practice expertise, and the cultural and language expertise of its providers.

**BHI** demonstrated that it performed various audits annually to ensure that all contracted providers adhered to its standards for access and availability.

## Summary of Strengths

**BHI** earned a score of 100 percent compliance for this standard, demonstrating a very strong understanding and robust implementation of both federal Medicaid managed care regulations and State contract requirements. **BHI** employed an impressive number of single-case agreements, indicating responsiveness to membership needs and flexibility in developing the network. **BHI**'s strong provider oversight included processes specific to the CMHCs and the CPN.

**BHI** implemented impressive new initiatives for cultural competency, including a comprehensive assessment of its system that resulted in a strategic plan that describes specific activities to promote cultural competency.

## Summary of Required Actions

There were no required actions for this standard.

# Standard III—Coordination and Continuity of Care

## Summary of Findings and Opportunities for Improvement

**BHI**'s Coordination of Care policy delineated the processes for timely assessment of members and identification of member needs and available resources. **BHI**'s policies and procedures were designed to ensure the protection of information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and **BHI**'s service agreements with other agencies. These agreements required that the agencies also comply with HIPAA regulations. **BHI** ensured that each member received an individualized intake assessment and that its medical record requirements incorporated all required elements for clinical assessment, treatment planning, and documentation.

## Summary of Strengths

**BHI** demonstrated a variety of clinical and operational processes for coordinating care for its members. For example, **BHI** had interagency collaborations with county departments of human services to provide and coordinate covered and wrap-around services without duplication of assessment or treatment efforts. **BHI** also located mental health clinicians in federally qualified health centers (FQHCs) and other physical health treatment practices. In addition, **BHI** placed care managers on-site at its in-network CMHCs to ensure timely access to medical care, coordination of behavioral health and medical services, and disease management for chronic medical conditions.

## Summary of Required Actions

**BHI's** policies addressed communication between BHOs and with providers related to authorization of services and billing. **BHI** did not have policies that addressed the mechanisms for continuity of care through communication between providers or between BHOs regarding services provided. **BHI** must revise existing or develop new policies to address continuity of care for services provided.

# 3. Follow-up on FY 2009–2010 Corrective Action Plan

*for* **Behavioral HealthCare, Inc.**

## Methodology

As a follow-up to the FY 2009–2010 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all requirements for which it received a score of *Partially Met* or *Not Met*. The BHO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with **BHI** until the BHO completed each of the required actions from the FY 2009–2010 compliance monitoring site review.

## Summary of 2009–2010 Required Actions

As a result of the 2009–2010 site review, **BHI** was required to ensure that all grievances were acknowledged within two working days of receipt of the grievance, that all grievances were resolved within 15 working days, and that all grievance resolution letters contained the results of the disposition process.

**BHI** was also required to 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.

## Summary of Corrective Action/Document Review

**BHI** submitted its plan of corrective action to HSAG and the Department in June 2010. After careful review and discussion, HSAG and the Department approved **BHI**'s plan. **BHI** provided documentation demonstrating the successful implementation of its plan. After review of all submitted documentation, HSAG and the Department determined that **BHI** had sufficiently corrected all required actions.

## Summary of Continued Required Actions

**BHI** successfully addressed all FY 2009–2010 required actions. There were no required actions continued from FY 2009–2010.

The completed compliance monitoring tool follows this cover page.

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 1. The Contractor ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.<br><br>*42CFR438.210(a)(3)(i)*<br>*Contract: II.I.1.d* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Pg. 6)<br>Policy Treatment Responsibilities pp10 (Pg. 1, #A.5)<br>Provider Contract__08242010_Final (Pg. 4)<br><br>**Description of Process:**<br>BHI ensures that enrollees consistently receive the appropriate type and amount of all medically necessary covered service that are the most effective and the least restrictive possible in supporting recovery. Services are authorized in sufficient amount, duration or scope to achieve identified treatment objectives. All authorization decisions are based solely on the appropriateness of the care for the member. The BHI UM Program supports member recovery by ensuring consistent access to the most effective and least restrictive medically necessary behavioral health services. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The UM Program Description and the Treatment Responsibilities policy both stated that services are authorized "sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished." The provider contract template required providers to furnish covered services to members in the same manner as provided to any patient. During the on-site interview, BHI staff members described a variety of processes BHI management used to ensure that the services furnished by the CMHCs and the CPN were sufficient in amount, duration, and scope to achieve stated treatment plan goals. The processes included site visits for newly contracted providers and review of assessments and treatment plans prior to authorization. During the on-site interview, BHI staff members also described the addition of qualitative review fields while reviewing member records as part of the required 411 audit. Review of sample assessment and treatment plan forms and a template site visit form confirmed the content of those documents. | | |
| **Required Actions:**<br>None | | |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 2. The Contractor does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the member.<br><br>*42CFR438.210(a)(3)(ii)*<br>*Contract: II.I.1.e* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Pg. 6)<br>Provider Manual (104 of 436)<br><br>**Description of Process:**<br>BHI has established Utilization Management/Medical Necessity Criteria that serve as a basis for all clinical authorization decisions and also serves as an assessment tool that promotes consistent, clinically appropriate decision making and sound and efficient utilization of available resources. They are a synthesis of scientific research, professional literature review, industry standards, best practices and are integrated with the established Medical Necessity Criteria as defined by HCPF. BHI does not arbitrarily deny or reduce the amount, duration or scope of required services solely based on diagnosis, type of illness, or condition of the member.<br><br>Providers are notified of these UM criteria through the provider handbook which details the UM program description and criteria. Providers are informed that additional copies can be obtained through the UM Department or by accessing BHI's website. Providers are informed of any updates to the provider manual<br><br>BHI Utilization Management Criteria are also available to members, family members, advocates and interested others through the BHI website or by calling the BHI UM Department. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The UM Program Description included UR criteria based on symptomatology and medical necessity. The criteria were designed to apply to all Medicaid members requesting the specified service. The same criteria were used whether the service was authorized by utilization management staff at BHI or staff at the CMHCs as part of the delegation arrangement. The UR criteria training PowerPoint presentation described the UR criteria and provided examples of cases and recommended decisions/authorization determinations. During the on-site interview, BHI staff members stated that the PowerPoint presentation was provided to the CMHCs to train any CMHC staff members involved with utilization decisions. | | |
| **Required Actions:**<br>None | | |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 3. If the Contractor places limits on services, it is:<br>◆ On the basis of criteria applied under the State plan (medical necessity).<br>◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.<br>◆ Consistent with the Contractor's published practice guidelines.<br>◆ On the basis of the Department's established utilization requirements or utilization review standards.<br><br>*42CFR438.210(a)(3)(iii)*<br>*Contract: II.I.1.f* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Pgs. 3, 5)<br>Policy Medical Necessity pp10<br>Policy Utilization Management Criteria pp10<br>FY08 BHI UM Criteria.doc<br>Provider Manual (104 of 436)<br>Policy Clinical Practice Guidelines pp10 (Page 3, #5.A)<br>Minimum UM Policies and Procedures – Medicaid Contract Exhibit V<br>BHI Med Nec-UM Criteria Training 032010wkk.ppt<br>BHI-CMHC Delegated Functions Training 032010wkk.ppt<br><br>**Description of Process:**<br>BHI requires that services meet established medical necessity criteria for authorization. This and other mechanisms ensure consistency and appropriateness in clinical decision making across the BHI system. A covered service is deemed medically necessary if it is found to be an equally effective treatment among other treatment options and if the services might be reasonably expected to prevent, reduce, assist, correct the symptoms of an illness or if the service will or is reasonably expected to maintain a member's highest level of independent functioning. Per Medicaid Contract requirements BHI meets minimum UM Policy Standards as outlined in Contract Exhibit V.<br><br>BHI's practice guidelines are consistent with UM /Medical necessity criteria per contract requirements. | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>BHI's UM program policies and training materials included the definition of medical necessity. The UR criteria published on BHI's Web site were consistent with BHI's published clinical practice guidelines. In one denial case in the on-site record review it was not clear that the decision was based on UR criteria. In addition, there were several cases in which notices of action were sent, but were not required, based on the documentation available | | |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| (see Denials Record Review Tool—Appendix B). BHI does not need to send notices of action when decisions are based on clinical issues and the member or provider has not requested a UR decision. | | |
| **Required Actions:**<br>BHI must ensure that all denial decisions are based on UR criteria. | | |
| 4. The Contractor specifies what constitutes "medically necessary services" in a manner that:<br>◆ Is no more restrictive than that used in the State Medicaid program.<br>◆ Addresses the extent to which the Contractor is responsible for covering services related to the following:<br>▪ The prevention, diagnosis, and treatment of health impairments,<br>▪ The ability to achieve age-appropriate growth and development,<br>▪ The ability to attain, maintain, or regain functional capacity.<br><br>*42CFR438.210(a)(4)*<br>*Contract: I.A.23* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Pgs. 3, 5)<br>Policy Medical Necessity pp10<br>Policy Utilization Management Criteria pp10<br>FY08 BHI UM Criteria.doc<br>Policy – BHI DDMI Guidelines<br>Provider Manual (104 of 436)<br>BHI Med Nec-UM Criteria Training 032010wkk.ppt<br>BHI-C3MHC Delegated Functions Training 032010wkk.ppt<br><br>**Description of Process:**<br>BHI reviews service authorization requests on the basis of medical necessity (as defined by the Colorado Medicaid Community Mental Health Services Program) and UM Criteria. Medical necessity is determined through the evaluation of a number of factors, including but not limited to:<br>◆ Member and family/guardian identification of preferences and goals for recovery;<br>◆ Ongoing consultation with the provider throughout the episode of care (EOC) to determine the medical necessity of services as established by changes in the member's condition and treatment needs and identified goals; and<br>◆ Consultation with the member, family, informal supports and/or person with legal custody about his/her treatment history, to identify unique and/or special client needs (e.g., cultural considerations, communications needs and special clinical circumstances that may necessitate a unique approach to treatment). | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| **Findings:**<br>BHI's medical necessity criteria, found in the Medical Necessity Criteria policy, were consistent with the definition of medical necessity in the Medicaid managed care contract. BHI's UM Program Description and Utilization Management Criteria policy described authorization of services deemed to be medically necessary and that are consistent with BHI's UM criteria. CMHC providers were informed of the definition via PowerPoint training. Since "medically necessary" was a term used in the member handbook, BHI may want to consider defining it for members. | | |
| **Required Actions:**<br>None | | |
| 5. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services.<br>*42CFR438.210(b)*<br>*Contract: II.I.1.g* | **Documents Submitted/Location Within Documents:**<br>Policy Admission and Continued Stay Authorizations and Census Tracking pp10<br>Policy Utilization Management Criteria pp10<br>FY08 BHI UM Criteria.doc<br>UM Program Description (Pgs. 5, 6)<br>Provider Letter COA 07282010<br>Verification of Benefits_Initial Auth Form<br><br>**Description of Process:**<br>BHI requires prior authorization for behavioral health services, with the exception of emergency/post-stabilization services, member-run alternative services (i.e., drop-in centers, clubhouse and peer specialist services), and prevention/early intervention services. Prior service authorizations are based on a thorough review of complete and current clinical information. If the documentation is incomplete, BHI UM staff members follow up with a verbal request to the provider for the missing clinical information. Documentation includes a Colorado Client Assessment Record (CCAR), Initial Assessment, Individualized Service Plan and admission form, progress notes, Census Tracking and Authorization (CT&A) form (inpatient/hospital diversion only), psychiatric and medical evaluations, specialty evaluations/consultations, or equivalent information. All prior | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| | service authorization decisions are made in compliance with regulatory and contractually required timelines and documentation standards. | |
| **Findings:**<br>The Admission and Continued Stay Authorizations and Census policy described the procedures for processing authorizations for admissions and for continued stay in inpatient facilities. The 2008 BHI UM criteria included admission criteria, continued stay criteria, and discharge criteria for inpatient, community-based, partial hospital, residential, day treatment, outpatient services, and specialty services. The BHI UM Criteria policy described the use and distribution of the BHI UM criteria. The BHI UM criteria described admission, continued stay, and discharge criteria for outpatient services. The medical necessity UM criteria training PowerPoint presentation informed staff at the CMHCs about criteria and responsibilities for authorizing services. The provider letter described the process for obtaining authorization of outpatient services by the CPN. During the on-site interview, BHI staff members explained that the provider letter was sent to all CPN providers when BHI entered into the delegation agreement with Colorado Access. The purpose of the letter was to clarify changes and describe authorization processes. | | |
| **Required Actions:**<br>None | | |
| 6. The Contractor's written policies and procedures include mechanisms to ensure consistent application of review criteria for authorization decisions.<br><br>*42CFR438.210(b)(2)(i)*<br>*Contract: II.I.1.j and II.I.1.q* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Pgs.1, 3 – 4, 6)<br>Policy Utilization Management Criteria pp10<br>FY08 BHI UM Criteria.doc<br>Policy Medical Necessity pp10 (Pg.1)<br>Policy Subcontractual Relationships and Delegation pp10 (#2.b, #3 – 4, #6)f<br>Delegation Agreements ADMHN, AUMHC, CRC<br>FY09 Delegation Oversight Final Report ADMHN, AUMHC, CRC<br>Inter-rater Reliability Scenarios Adult<br>Inter-rater Reliability Scenarios Youth<br>BHI Med Nec-UM Criteria Training 032010wkk.ppt<br>BHI-CMHC Delegated Functions Training 032010wkk.ppt | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| | **Description of Process:**<br>BHI maintains policies and procedures to ensure BHI Medical Necessity and UM criteria are consistently applied across the network and all levels of care (LOC). Periodic evaluations and reviews of service authorizations and inter-rater reliability studies are conducted by BHI. Sub-contracted providers are monitored through the delegation oversight process.<br><br>Additionally, the BHI UM Department identifies and examines utilization patterns outside of established criteria ranges through examination of performance data and over/under-utilization measures. Any significant variance and/or pattern of variance is reviewed in more detail (e.g., individual case reviews) and re-training is provided as needed. | |
| **Findings:**<br>The UM Program Description stated that UM department staff members examined utilization patterns outside of ranges for established criteria. This occurred through review of grievance and appeal data and participation in hospital reviews, interagency staffing, UM Committee meetings, and complex case reviews. The UM Program Description also indicated that interrater reliability studies were conducted by BHI and its UM delegates (CMHCs). The UM Criteria policy stated that the UR criteria were distributed to all providers via the provider manual. The provider manual included a narrative regarding UM procedures and the UR criteria. The UM medical necessity training PowerPoint presentation and the delegated functions PowerPoint presentation provided evidence of informing applicable staff at the CMHCs of the criteria. The presentations included a description of delegated functions and case studies with recommended dispositions. The Delegation Agreement with each of the CMHCs and the CMHC delegated functions training provided evidence that CMHC management and staff members performing delegated UM tasks were informed of each CMHC's responsibility to provide BHI with evidence of having applied the UR criteria consistently. The Subcontractual Relationships and Delegation policy described BHI's delegation oversight process. The Delegation Oversight Report for each of the CMHCs demonstrated that BHI monitored the CMHCs' performance of UM activities, including the CMHCs' interrater reliability studies. | | |
| **Required Actions:**<br>None | | |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 7. The Contractor's written policies and procedures include a mechanism to consult with the requesting provider when appropriate.<br><br>*42CFR438.210(b)(2)(ii)*<br>*Contract: II.I.1.j* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Page 3)<br><br>**Description of Process:**<br>BHI UM staff engages in ongoing consultation with the provider throughout the episode of care (EOC) to determine the medical necessity of behavioral health services as established by changes in the member's condition and treatment needs. | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The UM Program Description just stated that BHI UM staff consulted with providers throughout the episode of care: however, the description did not specifically address consultation with a requesting provider for utilization determinations. The on-site record review demonstrated that the denials documentation did not contain adequate information to determine if a provider had requested the service or if a consultation would have been appropriate. | | |
| **Required Actions:**<br>BHI must ensure that the appropriate policy includes a mechanism to consult with the requesting provider. BHI must also develop a mechanism to adequately document any consultation with the requesting provider. | | |
| 8. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.<br><br>*42CFR438.210(b)(3)*<br>*Contract: II.I.1.h and Exhibit V.A.4* | **Documents Submitted/Location Within Documents:**<br>Policy Notice of Action pp09 (Page 3, #4)<br>Delegation Agreements ADMHN, AUMHC, CRC (Pg. 3)<br>Doctors who Signed NALs<br>BHI Action and Appeals Training 032010wkk.ppt<br><br>**Description of Process:**<br>All BHI Notices of Action involving the denial, reduction, suspension, termination, or limited authorization of a requested type or level of service are reviewed and signed by a Board-certified licensed psychiatrist. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Notice of Action policy stated that all notices of action involving the denial, reduction, suspension, termination, or limited authorization of a requested type or level of service involving clinical issues such as failure to meet medical necessity criterion will be reviewed and signed by a licensed clinician. The delegation agreement with each CMHC indicated that it was the responsibility of the CMHCs to have a psychiatrist review any action based on medical necessity. The on-site record review demonstrated that each notice of action reviewed was signed by a psychiatrist. | | |
| **Required Actions:**<br>None | | |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).<br><br>*42CFR438.210(c)*<br>*Contract: II.I.1.j* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Page 5)<br>Policy Notice of Action pp09 (Page 3, #4)<br>Policy Appeal Process pp10 (Pages 6 – 7, #12)<br>NAL English<br>NAL Spanish<br>BHI Action and Appeals Training 032010wkk.ppt<br><br>**Description of Process:**<br>Prior service authorization decisions are communicated to members and providers in compliance with Medicaid regulations regarding timelines and notice content. BHI provides timely notification to BHI members and providers regarding any denial, reduction, suspension, termination or limited authorization of a requested type or level of service in accordance with Federal and State regulations. BHI provides notice to the member, guardian or the Designated Client Representative (DCR). BHI notifies the requesting provider verbally of any decision to deny or reduce a service authorization request. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Notice of Action policy described the procedures for sending a member a notice of action for any decisions involving a denial or limited authorization of services. The policy also stated that providers will be notified of the decision verbally and will be provided a copy of the notice of action. The on-site record review provided evidence of written notice to the member. Although the record review did not indicate noncompliance with the stated policies, there was inadequate documentation to determine if providers had requested the service and, therefore, required notice of the determination. BHI may consider revising documentation practices to include increased documentation in administrative denial records. | | |
| **Required Actions:**<br>None | | |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 10. The Contractor's written policies and procedures include the following timeframes for making standard and expedited authorization decisions:<br>◆ For standard authorization decisions—10 calendar days.<br>◆ For expedited authorization decisions—3 days.<br><br>*42CFR438.210(d)*<br>*Contract: Attachment K: 8.209.4.A.3.c and 8.209.4.A.6* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Pgs. 6 – 7)<br>Policy Utilization Management Decision Timelines pp10 (#1 – #2, #4 - #5, #7)<br>Delegation Agreements ADMHN, AUMHC, CRC<br>BHI-CMHC Delegated Functions Training 032010wkk.ppt<br><br>**Description of Process:**<br>Prior service authorization decisions are communicated to BHI members and providers in compliance with Medicaid regulations regarding timelines and notice content. BHI monitors the timeliness of UM decision-making by tracking the date services are initially requested, the date on which the authorization decision is made and whether this timeframe is within authorization response time requirements. BHI takes action to improve performance if authorization response standards are not met. BHI also conducts annual audits of UM timelines for service authorizations and denials. Policies and procedures require adherence to the timeframes for which prior service authorization, concurrent and retrospective UR decisions are made. Standard service authorization decisions are made and communicated to the client and provider within 10 calendar days following the receipt of the request. An expedited UR process is used when BHI determines that the standard authorization timeline could seriously jeopardize the client's life, health or ability to attain, maintain or regain maximum function. These UR decisions are made and communicated to the client and provider as expeditiously as the client's condition requires and no later than three working days after the receipt of the request for service authorization. | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| **Findings:**<br>The UM Program Description and the Utilization Management Decision Timelines policy included the required time frames for making standard and expedited authorization decisions and included the time frame for expedited decisions of three working days. The BHI action and appeals training PowerPoint presentation stated that the required time frame was three calendar days. | | |
| **Required Actions:**<br>The federal requirement is three working days. The Colorado rule does not specify calendar or working days. While three calendar days would exceed the requirement of three working days, BHI's documents must be revised to be consistent with each other. | | |
| 11. The Contractor's written policies and procedures include the following timeframes for possible extension of timeframes for authorization decisions:<br>◆ Standard authorization decisions—up to 14 calendar days.<br>◆ Expedited authorization decisions—up to 14 calendar days.<br><br>*42CFR438.210(d)*<br>Contract: None | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Pgs. 6 – 7)<br>Policy Utilization Management Decision Timelines pp10 (#3, #6)<br>Delegation Agreements ADMHN, AUMHC, CRC<br><br>**Description of Process:**<br>Prior service authorization decisions are communicated to BHI members and providers in compliance with Medicaid regulations regarding timelines and notice content. Service authorization decisions may be extended up to 14 calendar days if the client or provider requests an extension. BHI may request additional information to justify that the requested extension is in the client's best interest. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Utilization Management Decision Timelines policy and the BHI action and appeals training PowerPoint presentation included the required time frames for extending standard and expedited authorization decisions. | | |
| **Required Actions:**<br>None | | |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 12. The Contractor maintains a comprehensive utilization management (UM) program to monitor the access to, use, consumption, levels and intensity of care, outcomes of, and appropriate utilization of covered services.<br><br>*Contract: II.I.1.a* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Pg. 1)<br><br>**Description of Process:**<br>BHI maintains a comprehensive and effective UM Program to monitor access to the outcomes, appropriate utilization, level and intensity of covered behavioral health services.<br><br>BHI's UM functions operate in a way so as to maximize the ability to provide flexible, individualized, timely treatment while working within all regulatory and contractual requirements. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>BHI's UM program included a program description, criteria for authorization decisions, policies, and procedures that described multiple methods of monitoring utilization of services, as well as analysis of penetration rates as an additional method of monitoring for underutilization. The UM program, as evidenced by UM Committee meeting minutes, included an interdisciplinary committee that reviewed UM criteria and utilization reports on a regular basis. Key staff for BHI's UM program included the UM director, UR manager, UR coordinator, and involvement by the chief medical officer. BHI staff reported that a position of claims coordinator was recently added the UM team. The program description outlined how UM decisions are made, what UM activities are delegated, and how oversight of delegated activities is accomplished. BHI staff members and CMHC staff were informed of UM processes via training PowerPoint presentations. CPN providers were informed of UM processes via the provider manual, which was available on the BHI Web site. Hard copies of the provider manual were also available. | | |
| **Required Actions:**<br>None | | |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 13. The Contractor evaluates the medical necessity, appropriateness, efficacy, and efficiency of health care services, referrals, procedures, and settings.<br><br>*Contract: II.I.1.a* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Pg. 1)<br>Policy Utilization Management Criteria pp10<br>FY08 BHI UM Criteria.doc<br>Policy Medical Necessity pp10<br>BHI Med Nec-UM Criteria Training 032010wkk.ppt<br>BHI-CMHC Delegated Functions Training 032010wkk.ppt<br><br>**Description of Process:**<br>BHI utilization review comprises a set of formal techniques designed to monitor and evaluate the clinical necessity, appropriateness, efficacy and efficiency of health care services, referrals, procedures and levels of care. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The BHI UM Benchmark Report included an evaluation of the selected UM indicators. The FY 2010 Quality Improvement Program Evaluation included analysis of performance measure outcomes such as utilization rates, penetration rates, recidivism, follow-up after inpatient hospitalization, and continuity of care. The program evaluation also included results from BHI's coordination of care performance improvement project (PIP). During the on-site interview, BHI staff members explained that UM staff review assessments and treatment plans as a requirement of authorization. Staff also described the complex case review process used for particular cases to evaluate the appropriateness of care and explore alternatives. | | |
| **Required Actions:**<br>None | | |
| 14. The Contractor's UM program is under the direction of an appropriately qualified clinician and includes policies and procedures that have been reviewed by the Department.<br><br>*Contract:II.I.1.a* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Pg. 2)<br>Kidd CV 2009<br><br>**Description of Process:**<br>BHI's UM program is under the direction of an appropriately qualified clinician. BHI's UM program policies and procedures have been reviewed and approved by HCPF. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>BHI's UM director held a bachelor of science degree in psychology and a master's degree in counseling, and was a licensed professional counselor. The director's professional experience included clinical and management experience, as well as approximately 13 years experience in utilization | | |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| management. In addition, the chief medical officer was available to the UM department for consultation, as needed. During the on-site interview BHI staff members confirmed that BHI's UM policies and procedures have been reviewed by the Department of Health Care Policy & Financing. | | |
| **Required Actions:**<br>None | | |
| 15. The Construction of the UM program does not impede Member's timely access of services.<br><br>*Contract: II.I.1.b* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Pg. 1)<br><br>**Description of Process:**<br>BHI's UM program is designed not to impede/hinder members' timely access to services. BHI has attempted to implement a "no wrong door" approach to service access by creating multiple ways for members to seek services. These methods include accessing care directly through BHI's UM Department, through the Access Departments at BHI mental health centers, through coordination of care mechanisms in place in integrated care settings in pediatric and primary care practices, FQHCs, DHS and Community Center Board settings, BHI's member outreach efforts consumer run programs and services, etc. Members may also contact the BHI Department of Member and Family Affairs for assistance in finding a behavioral health provider or general systems navigation. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>Based on the UM Program Description and information obtained during the on-site interview, services available without prior authorization included consumer-run services such as the clubhouse and drop-in centers. All urgent and emergency services also did not require authorization. During the on-site interview, BHI staff explained that while outpatient services required authorization, the initial assessment was done without prior authorization, as the assessment and treatment plan were required for authorization of the services. BHI's UM staff was available during normal business hours. BHI contracted with Protocall for after-hours triage, telephone intervention, or referral to the on-call CMHC staff for face-to-face evaluation after hours, if necessary. The Access to Care report demonstrated that BHI monitored access to services to ensure timely access. | | |
| **Required Actions:**<br>None | | |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 16. The Contractor ensures that the UM program incorporates mechanisms to continuously update guidelines, policies and procedures used in making determinations based on evaluation of new medical technologies and new application of established technologies, including medical procedures, drugs, and devices.<br><br>*Contract: II.I.1.k* | **Documents Submitted/Location Within Documents:**<br>Policy Clinical Technology Review pp10<br>PEO SOP Minute<br>BHI Practice Guideline-Atypical Antipsychotics - Monitoring for Metabolic Side Effects FY10<br><br>**Description of Process:**<br>BHI evaluates the inclusion of new technologies and devices and new applications of existing technologies into its benefit package. This may include new clinical and/or pharmaceutical treatment approaches or procedures. New technology review is based on a thorough review of current professional literature, relevant research, clinical outcome studies, and other available data and information.<br><br>BHI's Standards of Practice (SOP) committee includes clinicians, administrators and psychiatrists who are very involved in clinically significant issues (e.g., monitoring metabolic side effects of atypical anti-psychotic medications) and develop research guided practice guidelines to address them. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Clinical Technology Review policy described the process for review and consideration of new treatments, devices, or technology in service provision. The Program Evaluation/Outcomes Design Committee meeting minutes, March 9, 2010, demonstrated discussion by the committee regarding new or atypical service. UM Committee meeting minutes demonstrated that the committee reviewed and discussed current authorization processes and considered changes in those processes. During the on-site interview, BHI staff members explained that, due to the loss of the chief medical officer, the last review and approval of the UM criteria was in 2008. Staff reported that BHI has had an interim director since December 1, 2009, and that UM criteria will be reviewed once a permanent chief medical officer has been identified. | | |
| **Required Actions:**<br>None | | |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 17. The Contractor maintains mechanisms to evaluate the effects of the UM program.<br>*Contract:II.I.1.l* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Page 4)<br>Report Card FY10 Q2<br>ED Summary w Diagnosis Codes 8.6-8.19.doc<br>Final BHO PM For 2008 2009 (Date March 2 2010).xls<br><br>**Description of Process:**<br>Key quantitative measures of over- and under-utilization include penetration rates by age, ethnicity, Medicaid eligibility category and geographic area; inpatient recidivism by age group at seven, 30 and 90 days; inpatient length of stay by age group, hospital and geographic area, and inpatient admissions and days per 1,000 members by age group, hospital and geography. The aggregate data that is analyzed for over- and under utilization includes quarterly performance data on key indicators of BHI enrollment, penetration rates, client satisfaction, resolution of client grievances and appeals, peer review of treatment records, outcome measures, and utilization of crisis, inpatient, emergency department and outpatient services.<br><br>Performance data is analyzed and trended to identify normal and special cause variation such as outliers, and provide detailed comparative data against local and national benchmarks. Previous and overall BHI performance data is used in this analysis and problem identification. Aggregate provider performance is evaluated by client age group, ethnicity and Medicaid eligibility category. Report cards provide management and staff with the ability to quickly analyze information at the program level. BHI benchmark data allows for comparison of BHI performance to other Behavioral Health Organizations (BHOs) across age groups, level of care, ethnicity and other domains. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| | The BHI UM Department identifies and examines utilization patterns outside of established criteria ranges through analysis of individual and aggregate grievances and appeal data; peer review of Quality of Care Concerns (QOCC) related to UM, such as receiving service authorizations outside of required timelines; participation by the BHI UM Director or UM Supervisor in hospital review meetings, interagency staffing and complex case reviews; and UM Department participation at meetings of the Risk and Resource committees, Provider Advisory Council and UM Committee.<br><br>In each of these venues, details regarding individual clinical cases are discussed, allowing case-by-case identification of access issues, barriers to discharge from higher levels of care, over- and under- utilization of services, provider-specific UM issues and gaps in the BHI service continuum. This process can uncover barriers to appropriate service utilization that may not be reflected in aggregate data and provides case examples that may be useful in explaining identified trends. Collected data is reviewed and analyzed by the UM Committee and reported to the BHI Provider Advisory Council. The UM committee develops corrective action plans for areas of concern identified in the UM Program. The UM Committee is responsible for oversight of any corrective action plans (CAPs) that are implemented. | |
| **Findings:**<br>The FY 2010 Quality Improvement Program Evaluation and the FY 2010 BHI UM Benchmark Report provided analysis and evaluation of BHI's UM program. UM Committee meeting minutes demonstrated that management staff discussed and considered process changes to improve the efficacy of the UM program. | | |
| **Required Actions:**<br>None | | |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 18. The Contractor has UM review standards that are the same for network providers as they are for out-of-network or unaffiliated providers.<br><br>*Contract:II.I.1.n* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Page 4)<br>Policy Utilization Management Criteria pp10 (#2 – #3)<br>FY08 BHI UM Criteria.doc<br>BHI Med Nec-UM Criteria Training 032010wkk.ppt<br>BHI-CMHC Delegated Functions Training 032010wkk.ppt<br><br>**Description of Process:**<br>BHI UR standards are applied consistently to all UR determinations, regardless of whether the requesting provider is in network, out-of-network, or unaffiliated with BHI. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>During the on-site interview, BHI staff members confirmed that the UM criteria used by BHI UM staff were the same criteria used by the CMHC staff when making utilization determinations. The provider manual and BHI's Web site contained one set of UM criteria. Staff confirmed that the provider manual distributed to the CMHCs was the same provider manual found on the Web site for the CPN. | | |
| **Required Actions:**<br>None | | |
| 19. The Contractor's written policies and procedures provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.<br><br>42CFR438.210(e)<br>*Contract: II.D.6.a.1 and II.I.1.c* | **Documents Submitted/Location Within Documents:**<br>UM Program Description (Page 6)<br>Corporate Compliance Plan 2007-05-09<br>Provider Contract__08242010_Final (Pg. 6, article 4-compensation, Pg. 19 attestation in contract)<br><br>**Description of Process:**<br>BHI does not offer incentives of any kind for individuals or entities conducting UM functions to limit, discontinue, or deny medically necessary services to any member. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The UM Program Description included the provision that BHI did not offer incentives of any kind for individuals or entities to limit, discontinue, or deny medically necessary services to any member. Providers were informed via the UM Program Description, which was reproduced in the provider manual. The provider contract template included a provision that informed providers that rates for services were set so that they would not directly or | | |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| indirectly reduce or limit services provided to any Medicaid member. The BHI Corporate Compliance Plan informed BHI staff and providers that BHI did not provide incentives to CMHCs (core providers) or subcontracted providers to reduce or limit services to Medicaid beneficiaries. During the on-site interview, BHI staff members reported that the Corporate Compliance Plan was distributed to the CMHCs and to CPN providers at the time of initial contracting. | | |
| **Required Actions:**<br>None | | |
| 20. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:<br>◆ 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,<br>◆ Serious impairment to bodily functions,<br>◆ Serious dysfunction of any bodily organ or part.<br><br>*42CFR438.114(a)*<br>*Contract: I.A.10* | **Documents Submitted/Location Within Documents:**<br>Policy Access and Availability pp10 (Page 1)<br>Policy Sub-contractual Relationships and Delegation pp10 (Page 1) Member Handbook English/Spanish<br><br>**Description of Process:**<br>BHI's definition of Emergency Medical Condition is consistent with the language found in 10 CCR 2505-10 § 8.212.5.C, 42 CFR 422.113 (b) (1) (i), and 42 CFR 438.114 (a).<br><br>Access & Availability pp10 – Page 1 provides the definition of Emergency Medical Condition<br>◆ Emergency & Post-Stabilization Services pp10 – Page 1 provides the definition of Emergency Medical Condition<br>◆ BHI Member Materials – Pg. 11 provides members with the definition of Emergency Medical Condition<br><br>BHI's definition of Emergency Medical Condition is consistent with the language found in 10 CCR 2505-10 § 8.212.5.C, 42 CFR 422.113 (b) (1) (i), and 42 CFR 438.114 (a). | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>BHI's Emergency and Poststabilization Services policy and the Access and Availability policy included the federal definition of emergency medical condition. The member handbook included a definition that was consistent with the federal definition of emergency medical condition. Providers were informed via the member handbook, which was reproduced in the provider manual. | | |
| **Required Actions:**<br>None | | |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 21. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition.<br><br>*42CFR438.114(a)*<br>*Contract: I.A.11* | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 1)<br>Member Handbook English/Spanish<br>BHI-CMHC Delegated Functions Training 032010wkk.ppt<br><br>**Description of Process:**<br>BHI's definition of Emergency Services is consistent with the language found in 10 CCR 2505-10 § 8.212.5.D, 42 CFR 422.113 (b) (1) (ii), and 42 CFR 438.114 (a). (A, B) | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Emergency and Poststabilization Services policy included the federal definition of emergency services. The member handbook described the variety of emergency services provided by BHI (crisis evaluation, acute treatment unit services, inpatient services, and poststabilization services). Providers were informed via the member handbook, which was reproduced in the provider manual. | | |
| **Required Actions:**<br>None | | |
| 22. The Contractor defines Poststabilization Care Services 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.<br><br>*42CFR438.114(a)*<br>*Contract:I.A.29* | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 1)<br>Member Handbook English/Spanish<br><br>**Description of Process:**<br>BHI's definition of Post-Stabilization Care Services is consistent with the language found in 42 CFR 422.113 (c) (i) and 42 CFR 438.114 (a). The Emergency Services clinician evaluates consumer's progress through clinical interview which includes risk assessment and mental status examinations to ensure no suicidal or homicidal ideation, plan or intent exist and that consumer does not meet criteria for grave disability. Emergency Services clinicians consult with the Emergency Room attending physician and nurse regarding clinical impressions and recommendations based on their assessment. If consumer meets criteria for psychiatric hospitalization then clinician will enact a | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| | mental health hold, if one is not already in place, and again consult with the attending physician and/or nurse. Clinician then begins process of securing hospital placement. If consumer does not meet criteria for enacting or maintaining a mental health hold, then clinician will again consult both the Emergency Department physician and the on-call psychiatrist with the respective center and provide consumer with referrals to area providers for follow up and ongoing assessment and services. | |
| **Findings:**<br>The Emergency and Poststabilization Services policy included the federal definition of poststabilization services. The member handbook included a definition that was consistent with the federal definition of poststabilization services. Providers were informed via the member handbook, which was reproduced in the provider manual. | | |
| **Required Actions:**<br>None | | |
| 23. The Contractor makes emergency services available to members without preauthorization.<br><br>*42CFR438.10(f)(6)(viii)(B)*<br>*Contract:II.I.1.p.1* | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 3, #2)<br>Member Handbook English/Spanish<br>Provider Contract__08242010_Final (Page 3, Section 2.1 and 3.4)<br><br>**Description of Process:**<br>BHI's contracts with hospitals and other emergency services providers clearly state that prior service authorization is not required for coverage and payment of Emergency Services. The BHI Member Handbook informs members that a prior service authorization is not required for Emergency Services.<br><br>◆ Emergency & Post-Stabilization Services pp10 – Page 3, Section 2, specifies that prior authorization is not required for Emergency Services | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| | ◆ BHI Provider Contract – Page 3, Section 2.1, describes BHI's obligations regarding prior authorizations, including Emergency Services<br>◆ BHI Provider Contract – Page 5, Section 3.4, describes the provider's obligations regarding prior authorizations with the exception of Emergency Services<br>◆ BHI Member Handbook – Pages 6, 13, 14 & 15 inform Members that prior authorization is not required for Emergency Services.<br><br>BHI's contracts with hospitals and other providers clearly state that prior service authorization is not required for coverage and payment of Emergency Services.<br>The BHI Member Handbook informs Members that a prior service authorization is not required for Emergency Services. | |
| **Findings:**<br>BHI's Emergency and Poststabilization 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. Members were informed via the member handbook that prior authorization was not required for emergency services. In the member handbook, members were informed of how to access emergency mental health services, crisis evaluations, and urgent services. Members were informed that they may go to the nearest emergency room without prior authorization. | | |
| **Required Actions:**<br>None | | |

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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 24. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.<br><br>*42CFR438.114(c)(1)(i)*<br>*Contract:II.D.6.a.1* | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 2, # 2)<br>Member Handbook English/Spanish<br><br>**Description of Process:**<br>BHI's policy and procedures, as well as member materials, ensure payment of medically necessary Emergency Services, regardless of whether the rendering provider has a contract with BHI. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>BHI's Emergency and Poststabilization 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 the Code of Federal Regulations (CFR) at 42 CFR 438. BHI's member handbook informed members of their ability to seek care from any hospital emergency room, even in cases in which the hospital was out of network. During the interview, staff members reported that in the past, BHI's process was to review all emergency room claims. At the time of the site review, however, staff members reported that the process had changed to reviewing only emergency room claims denied by the system to ensure that the claims were not inappropriately denied. There were no emergency room denials in the sample pulled for the on-site record review. | | |
| **Required Actions:**<br>None | | |

| Standard I—Coverage and Authorization of Services | | |
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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 25. The Contractor may not deny payment for treatment obtained under either of the following circumstances:<br>◆ A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes:<br>▪ 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,<br>▪ Serious impairment to bodily functions,<br>▪ Serious dysfunction of any bodily organ or part,<br>◆ A representative of the Contractor's organization instructed the member to seek emergency services.<br><br>*42CFR438.114(c)(1)(ii)*<br>*Contract:II.D.6.a.2* | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 2, # 2)<br>Member Handbook English/Spanish<br><br>**Description of Process:**<br>BHI's policies and procedures prohibit the denial of payment for treatment obtained by the member under the specific circumstances defined in 42 CFR 438.114 (c) (1) (ii). | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>BHI's Emergency and Poststabilization Services policy 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. The policy also included the federal language that BHI may not deny payment in cases that did not result in an emergency, as emergency is defined in the BBA. Staff reported that during the review period, all emergency claims were reviewed. At the time of the site review, however, BHI was reviewing only those emergency claims that were not automatically adjudicated. | | |
| **Required Actions:**<br>None | | |

| Standard I—Coverage and Authorization of Services | | |
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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 26. The Contractor does not:<br>◆ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms.<br>◆ 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.<br><br>*42CFR438.114(d)(1)*<br>*Contract:II.D.6.c* | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 2, #2)<br>Provider Contract__08242010_Final (Page 3, Sections 2.1 and 3.4)<br><br>**Description of Process:**<br>BHI's policy and procedures prohibit the restriction of Emergency Medical Conditions on the basis of a list of diagnoses or symptoms. BHI's contracts with hospitals and other providers clearly state that a prior service authorization request (i.e., notification) is not required for coverage and payment of emergency services. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The BHI Emergency and Poststabilization Services policy indicated that the BHO did not limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. The policy also included the provision that BHI does not deny payment for emergency services based on timely notice of the service. | | |
| **Required Actions:**<br>None | | |

| Standard I—Coverage and Authorization of Services | | |
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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 27. 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.<br><br>*42CFR438.114(d)(2)*<br>*Contract:II.D.6.c* | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 2, #1.B)<br>Member Handbook English/Spanish<br><br>**Description of Process:**<br>BHI's policies and procedures ensure that members are not billed for Emergency and/or Post-Stabilization Care Services, pursuant to 42 CFR 438.114 (d) (2). BHI's Member Handbook informs members that Emergency Services are free of charge to them. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>BHI's Emergency and Poststabilization 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 the member handbook regarding mental health services and benefits stated that emergency mental health services were free even if the provider was not a BHI provider. | | |
| **Required Actions:**<br>None | | |
| 28. 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.<br><br>42CFR438.114(d)(3)<br>Contract:II.D.6.d | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 2, #1.B)<br><br>**Description of Process:**<br>BHI defers to the attending emergency physician or treating provider in determining when the member is stabilized for transfer or discharge, pursuant to 42 CFR 438.114 (d) (3). The process of emergency evaluation of a Medicaid member is a collaboration between the member, emergency services clinician, ER attending physician, family and other collateral contacts involved in emergency response. This process includes a thorough review of the member's condition, safety needs, preferences of the member and/or family, availability of community based resources that can | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| | safely and effectively meet the member's immediate needs for treatment and stabilization, and medical necessity criteria for level of care. Ultimately, the decision about post-stabilization care is the responsibility of the emergency room physician and provider, but is conducted with a thoughtful review of all available, relevant information from involved informants. | |
| **Findings:**<br>BHI's Emergency and Poststabilization Services policy included the provision that the attending emergency physician or practitioner determines when the member is sufficiently stabilized for transfer or discharge. | | |
| **Required Actions:**<br>None | | |
| 29. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are pre-approved by a plan provider or other organization representative.<br><br>*42CFR438.114(e)*<br>*42CFR422.113(c)(2(i)*<br>*Contract:II.D.6.e* | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 3, #2.B)<br><br>**Description of Process:**<br>BHI is responsible for payment of post-stabilization services when BHI or its representative has authorized such services. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Emergency and Poststabilization Services policy included the provision that BHI was responsible for poststabilization care services when BHI authorized such services. During the on-site interview, BHI staff confirmed that utilization staff members worked with hospital providers to ensure appropriate poststabilization services and payment. | | |
| **Required Actions:**<br>None | | |

| Standard I—Coverage and Authorization of Services | | |
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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 30. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within 1 hour of a request to the organization for pre-approval of further post-stabilization care services.<br><br>*42CFR438.114(e)*<br>*42CFR422.113(c)(2)(ii)*<br>*Contract: II.D.6.a* | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 3, #2.B)<br><br>**Description of Process:**<br>BHI is responsible for payment of post-stabilization services when the hospital reached BHI, but did not get instructions within one hour of the request. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Emergency and Poststabilization Services policy included the provision that BHI was responsible for poststabilization care services when BHI did not provided instructions to the hospital within one hour of the request for continued poststabilization services. | | |
| **Required Actions:**<br>None | | |
| 31. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if:<br>◆ The organization does not respond to a request for pre-approval within 1 hour,<br>◆ The organization cannot be contacted,<br>◆ The organization representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 3, #2.B)<br><br>**Description of Process:**<br>BHI is responsible for payment of post-stabilization services when the hospital was unable to reach BHI; the hospital reached BHI, but did not get instructions within one hour of the request; or the BHI representative and the treating physician cannot reach an agreement concerning the member's care and a BHI physician is not available for consultation.<br><br>The Emergency Services clinician evaluates consumer's progress through clinical interview which includes risk assessment and mental status examinations to ensure no suicidal or homicidal | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| provider may continue with care of the patient until a plan provider is reached or one of the criteria in requirement number 33 is met.<br><br>*42CFR438.114(e)*<br>*42CFR422.113(c)(2)(iii)*<br>*Contract:II.D.6.f* | ideation, plan or intent exist and that consumer does not meet criteria for grave disability. Emergency Services clinicians consult with the Emergency Room attending physician and nurse regarding clinical impressions and recommendations based on their assessment. If consumer meets criteria for psychiatric hospitalization then the emergency services clinician will enact a mental health hold, if one is not already in place, and again consult with the attending physician and/or nurse. Clinician then begins process of securing hospital placement or 27-10 appropriate hospital diversion. If consumer does not meet criteria for enacting or maintaining a mental health hold, then clinician will again consult both the Emergency Department physician and the on-call psychiatrist with the respective center and provide consumer with referrals to area providers for follow up and ongoing assessment and services. | |
| **Findings:**<br>The Emergency and Poststabilization Services policy included the provision that BHI was responsible for poststabilization services when the hospital was unable to reach BHI; the hospital reached BHI, but did not get instructions within one hour of the request; or the BHI representative and the treating physician could not reach an agreement concerning the enrollee's care and a BHI physician was not available for consultation. | | |
| **Required Actions:**<br>None | | |

| Standard I—Coverage and Authorization of Services | | |
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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 32. The Contractor must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the contractor.<br>*42CFR438.114(e)*<br>*42CFR422.113(c)(2)(iv)*<br>*Contract:II.D.6.g* | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 2, #1.B)<br><br>**Description of Process:**<br>BHI does not charge members for post-stabilization care services. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The member handbook clearly stated that all mental health care was free and that emergency mental health care was free, even if the member used an out-of-network provider. | | |
| **Required Actions:**<br>None | | |
| 33. The Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when:<br>◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care,<br>◆ A plan physician assumes responsibility for the member's care through transfer,<br>◆ A plan representative and the treating physician reach an agreement concerning the member's care,<br>◆ The member is discharged.<br>*42CFR438.114(e)*<br>*42CFR422.113(c)(3)*<br>*Contract:II.D.6.h* | **Documents Submitted/Location Within Documents:**<br>Policy Emergency and Post Stabilization Services pp10 (Page 3, #2.B)<br><br>**Description of Process:**<br>BHI responsibility for post-stabilization care services it has not pre-approved ends when a BHI plan physician with privileges at the treating hospital assumes responsibility for the member's care, a BHI plan physician assumes responsibility for the member's care through transfer; a BHI representative and the treating physician reach an agreement concerning the member's care; or the member is discharged. These decisions are reached in collaboration between the member, ER attending physician, emergency services clinician and others involved in the emergency response. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The policy included the appropriate provision. During the on-site interview, staff members confirmed that poststabilization in the emergency room or hospitalization have not resulted in payment disputes and that BHI covered and paid for poststabilization services under these circumstances. | | |
| **Required Actions:**<br>None | | |

| Results for Standard I—Coverage and Authorization of Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 30 | X | 1.00 | = | 30 |
| | Partially Met | = | 3 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | 0 |
| **Total Applicable** | | = | 33 | **Total Score** | | = | 30 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | 91% |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 1. The Contractor ensures that all covered services are available and accessible to members.<br><br>*42CFR438.206(a)*<br>*Contract:II.E* | **Documents Submitted/Location Within Documents:**<br>Policy Access and Availability pp10<br>Policy Member Information pp10<br>Member Handbook English<br>Report Access to Care FY10 Q2<br><br>**Description of Process:**<br>Access and availability of medically necessary covered services are determined according to the level of care that is needed for routine, urgent or emergent situations.<br><br>BHI gathers and analyzes access to care data from network providers on a quarterly basis. BHI requires implementation of corrective action plans for core providers who fail to meet access benchmarks.<br><br>Member handbook detailing BHI services and member rights are mailed annually all Medicaid members and within one month of enrollment for all new Medicaid members. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Access and Availability policy described the timely access standards for routine, urgent, and emergency care. The Network Adequacy policy described the standards for geographic access to providers (30 minutes travel time or 30 miles). The member handbook informed members of how to access routine, urgent, and emergency services. The handbook also included the standards for timely access to care, the telephone numbers for BHI (to access either the CMHCs or the CPN), and the telephone numbers to contact each of the three CMHCs directly. The member handbook referred members to the provider directory (included in welcome packet) to choose a provider, which included both CMHC sites and CPN providers. Each CMHC had multiple sites to access care. The quarterly and annual Access to Care reports demonstrated that BHI evaluated the availability and accessibility of services on a regular basis. | | |
| **Required Actions:**<br>None | | |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 2. The Contractor maintains and monitors a comprehensive provider network capable of serving the behavioral health needs of all members in the program.<br><br>*42CFR438.206(b)(1)*<br>Contract:II.E.1.c.1 | **Documents Submitted/Location Within Documents:**<br>Policy Network Adequacy pp10<br>Provider List<br><br>**Description of Process:**<br>BHI has an established network of highly qualified behavioral health professionals that provide the full array of state plan services. Inpatient psychiatric care is provided by 10 private and public hospitals; of those 8 serve adults and older adults, 6 serve children and adolescents. Community-based services for both adults and youth include residential care, individual, group and family therapy, psychiatric services and medication management, emergency services and case management. Specialized services for children and families include home and school based treatment. BHI's network includes providers from a broad range of cultural and ethnic backgrounds, clinical specialties and experience working with members with complex co-occurring medical, substance abuse and developmental disability diagnoses. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

**Findings:**
The Network Adequacy policy described the types of providers available within the CMHCs and in the CPN and included prescribers, licensed and unlicensed mental health practitioners, and organizational providers. The fourth quarter FY 2010 Network Practitioner Report listed the number of individual CMHC practitioners that BHI has contracted with by type in each county within and outside the BHI service area. The fourth quarter FY 2010 Organizational Providers Report listed the organizational providers (including hospitals, CMHCs, FQHCs, and others) within and outside BHI's service area. The Outlier Report contained the number of members who travel in excess of 30 miles to access a provider. During the on-site interview, BHI staff members explained that these members totaled less than 2 percent of BHI's membership and were members living outside BHI's service area. The Network Adequacy Report FY 2009–2010 stated that BHI's current provider network is capable of meeting the needs of more than 122,000 members. During the on-site interview, BHI staff members clarified that 122,000 was the number of eligible members at the time of the report and that BHI could serve the portion of members who usually present for services based on typical utilization patterns. The Network Adequacy Report FY 2009–2010 listed BHI's provider types and indicated that BHI contracted with 34 organizational providers within its service area and a total of 72 organizational providers throughout the State, including hospitals and all 17 CMHCs. In addition, BHI staff reported that BHI has 108 single-case agreements.

**Required Actions:**
None

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 3. In establishing and maintaining the network, the Contractor considers:<br>◆ The anticipated Medicaid enrollment,<br>◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area.<br>◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services,<br>◆ The numbers of network providers who are not accepting new Medicaid patients,<br>◆ The geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities,<br>◆ The potential physical barriers to accessing provider's locations,<br>◆ The cultural and language expertise of providers,<br>◆ Provider to member ratios for behavioral health care services.<br><br>*42CFR438.206(b)(1)(i) through (v)*<br>Contract:II.E.1.c.1 | **Documents Submitted/Location Within Documents:**<br>Policy Network Adequacy pp10<br>Report BHI NW Adequacy Report Q4 FY 2009-2010 Final.xls<br>Policy Client Request for Contracted Provider pp10<br><br>**Description of Process:**<br>BHI methodically and regularly evaluates network adequacy and adjusts for needs. Data comes from many sources, including:<br>◆ Trend analysis of Single Case Agreements<br>◆ Assessment of access times to ensure providers are able to remain well within standards<br>◆ Client input through the grievance and appeal process, focus groups, member and client committees and client comments to providers<br>◆ Provider feedback<br>◆ Quarterly analysis of demographic data and trends<br>◆ Regular tracking of special population needs<br><br>The input is monitored continuously by the Director of Provider Relations and the executive management team at BHI. Additionally, BHI's core mental health centers are required as part of their contract with BHI to expand capacity whenever necessary to assure adequate access for any BHI member. BHI created a Penetration Rate Work Group that includes key staff from the core mental health centers. The purpose of this work group is to analyze and monitor current penetration rates, increased enrollment and develop plans for continued outreach to populations that may be underserved. The findings and initiatives of this work group are brought to the Cultural Competency Committee, Utilization Management Committee and Provider Advisory Council for additional discussions and collaborations with our core mental health centers. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| **Findings:**<br>The Network Adequacy Report FY 2009–2010 described the processes for evaluating the adequacy of the network and addressed each of the above requirements. The Network Adequacy Report FY 2009–2010 reported the number and types of organizational providers and individual practitioners, the number of providers not accepting new patients, and the number of providers with language expertise other than English. The report included maps illustrating the geographic concentration of both providers and Medicaid-eligible members in BHI's service area. During the on-site interview, BHI staff members described executive staff discussions regarding the growing number of monolingual Spanish-speaking Medicaid members in BHI's service area and strategies for designing the network as well as hiring BHI management and support staff to respond to the needs of these members. | | |
| **Required Actions:**<br>None | | |
| 4. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.<br><br>*42CFR438.206(b)(3)*<br>*Contract: II.E.1.a.12* | **Documents Submitted/Location Within Documents:**<br>Policy Psychiatric Consultations, Second Opinions pp10<br>Policy Member Client Rights pp10<br>Member Handbook English<br><br>**Description of Process:**<br>BHI informs members of their rights to second opinions. BHI's policy states BHI's intent in incorporating second opinions into the consumer's treatment planning. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Psychiatric Consultations, Second Opinions policy described the processes for arranging second opinions (at no cost to the member) from internal CMHCs, external CMHCs, the CPN, and providers outside the BHI provider network. The Member/Client Rights policy included the right to receive a second opinion in the list of member rights. The list of member rights in the member handbook included the right to receive a second opinion. The member handbook also explained what a second opinion is, when a member might want to request a second opinion, and how to request a second opinion. During the on-site interview, BHI staff members stated that second opinions were often recommended by BHI management staff as a result of complex case reviews. | | |
| **Required Actions:**<br>None | | |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 5. If the Contractor is unable to provide necessary services to a member in-network, the Contractor must adequately and timely cover the services out of network for the member, for as long as the Contractor is unable to provide them.<br><br>*42CFR438.206(b)(4)*<br>Contract:II.E.1.c.3 and II.E.1.d.1 | **Documents Submitted/Location Within Documents:**<br>Policy Out of Network Provider-Single Case Agreements pp10.doc<br><br>**Description of Process:**<br>BHI is able to offer a Single Case Agreement to out of network providers to provide services to members who are unable to utilize an in-network provider for various reasons. Single Case Agreements are offered to providers in instances where a) medically necessary services cannot be provided by BHI's provider network or b) a client identifies a qualified provider of choice that is not a part of the BHI network. BHI currently has 108 single case agreements.<br><br>1. For all Single Case Agreements, BHI will verify the provider has a license in good standing. BHI uses the online access to Division of Registrations to verify license.<br>2. BHI checks the Sanctions list on line at the H.H.S. Office of the Inspector General website to insure the provider is not a sanctioned provider.<br>3. Once BHI determines the practitioner has a license in good standing, and is not currently sanctioned as a Medicaid provider, BHI sends an application form and Colorado Bureau of Investigation (CBI) request for background check.<br>4. Upon receipt of "clean" CBI background check, the provider is sent a Single Case Agreement Contract.<br>5. The Single Case Agreement may be amended to include other clients.<br>6. If the provider meets an ongoing network need, they are offered full credentialing and contract.<br>7. All providers under a Single Case Agreement are expected to comply with BHI policies regarding prior authorization, timely filing of claims, corporate compliance requirements and client rights. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| | 8. In the case that a Single Case Agreement is made as the result of the BHI inability to provide a medically necessary services through its provider network, BHI will cover services through an out of network provider for as long as they cannot be provided through the network.<br>9. Out-of-network providers under Single Case Agreements are expected to coordinate directly with BHI for authorization and payment. | |
| **Findings:**<br>The Out of Network Provider/Single Case Agreements policy described the procedures for arranging a single-case agreement in response to a member request for a particular provider or if services were not available in the network. The member handbook directed members to call to ask how to obtain services from out-of-network providers. During the on-site interview, BHI staff members stated that BHI currently has 108 single-case agreements. Staff explained that typically, single-case agreements are made for members new to Medicaid who request to continue services with a current provider. | | |
| **Required Actions:**<br>None | | |
| 6. The Contractor requires out-of-network providers to coordinate with the Contractor with respect to payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network.<br>*42CFR438.206(b)(5)*<br>*Contract: II.E.1.d.2* | **Documents Submitted/Location Within Documents:**<br>Policy Out of Network Provider-Single Case Agreements pp10.doc<br>SingleCaseAgreement__08242010_final.doc (pg. 6-8)<br>**Description of Process:**<br>All providers under a Single Case Agreement are expected to comply with BHI policies regarding prior authorization, timely filing of claims, corporate compliance requirements and client rights. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Out of Network Provider/Single Case Agreements policy stated that out-of-network providers with single-case agreements are expected to coordinate directly with BHI for authorization and payment. The Single Case Agreement template described the provider's responsibilities with respect to billing and that members may not be held liable for any covered services rendered under the contract. During the on-site interview, BHI staff members stated that provider relations staff members worked with providers who had single-case agreements and that typically, these providers did not have compliance problems related to billing procedures. BHI staff members said this was because the providers were usually accustomed to working in a managed care environment. | | |
| **Required Actions:**<br>None | | |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 7. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services:<br>◆ Emergency services are available:<br>• By phone, including TTY accessibility, within 15 minutes of the initial contact,<br>• In-person within one hour of contact in urban and suburban areas,<br>• In-person within two hours of contact in rural and frontier areas.<br>◆ Urgent care is available within twenty four hours from the initial identification of need<br>◆ Routine services are available upon initial request within 7 business days.<br>◆ Outpatient follow-up appointments within seven business days of an inpatient psychiatric hospitalization or residential facility.<br>◆ Providers are located throughout the Contractor's service area, within thirty miles or thirty minutes travel time, to the extent such services are available.<br><br>*42CFR438.206(c)(1)(i)*<br>Contract:II.E.1.a.6 through II.E.1.a.8 | **Documents Submitted/Location Within Documents:**<br>Report Access to Care FY10 Q2<br>Policy Access and Availability pp10<br>Delegation Agreement ADMHN, AUMHC, CRC (Pg. 1)<br>BHI Organizational Site Visit Tool.doc (pg. 2)<br>BHI EPN Site Visit Evaluation Form 1106.doc<br>Provider Manual (Pg. 137 of 436)<br>Verification of benefits_Initial Auth<br>Final BHO PM for 2008/2009 (Date March 2 2010).xls<br>Report NW Adequacy Quarterly Q4 FY2009-2010<br><br>**Description of Process:**<br>All providers are expected to comply with BHI policies and procedures including access and availability standards. BHI's access and availability requirements are listed in the provider manual. BHI also reviews access standards with providers during initial and re-credentialing site visits.<br><br>BHI quarterly Access to Care Reports help to ensure that access guidelines are met.<br><br>Outpatient follow-up post hospitalization is monitored annually through contractually required performance measure indicators.<br><br>BHI's Network Adequacy Report includes an analysis of provider locations in relation to distribution of members across the service area. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The provider manual described provider responsibilities regarding timely access standards. The Network Adequacy Report FY 2009–2010 included a Maptitude analysis of the locations of Medicaid members and providers. During the on-site interview, staff explained that all initial appointments and assessments were handled through the CMHCs. If a member requested a CPN provider, the CMHC made the referral. Staff reported that the CMHCs | | |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| tracked adherence to appointment timeliness standards. BHI staff stated that when new providers were added to the network, BHI provider relations staff conducted an initial site visit. The initial site visit included an assessment of appointment availability, as reported by the provider. Staff members also stated that BHI has monitored compliance with appointment timeliness by having provider relations staff periodically perform a secret shopper study, during which BHI members were hired to call CPN providers and determine how long it would take to obtain an appointment. | | |
| **Required Actions:**<br>None | | |
| 8. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members.<br><br>*42CFR438.206(c)(1)(ii)*<br>Contract:II.E.1.a.4 | **Documents Submitted/Location Within Documents:**<br>Access and Availability pp10.doc<br>Provider Survey Information Update 081908.doc (pg. 1)<br>CMHC Hours of Operation<br>Provider Manual (Pg. 69 of 436)<br><br>**Description of Process:**<br>BHI providers are expected to offer hours of operation comparable to hours offered to commercial and FFS Medicaid members.<br><br>The Provider Survey Information Update form is sent to all providers at initial credentialing and re-credentialing to gather hours of operation information. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Access and Availability policy included the provision that BHI providers maintain hours of operation that are comparable to those offered to Medicaid fee-for-service, Medicare, or commercial plan members. The provider contract included a clause requiring providers to maintain hours of operation that are comparable to those offered to Medicaid fee-for-service, Medicare, or commercial plan enrollees. The Web sites for each of BHI's three in-network CMHCs advertised the hours of operation and did not distinguish between or mention payer sources. During the on-site interview, BHI staff members reported that office-hour information was collected for CPN providers during the credentialing and recredentialing processes. | | |
| **Required Actions:**<br>None | | |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 9. The Contractor makes Services available 24 hours a day, 7 days a week, when medically necessary.<br><br>*42CFR438.206(c)(1)(iii)*<br>Contract:II.E.1.a.5 | **Documents Submitted/Location Within Documents:**<br>Policy Access and Availability pp10.doc (Pg. 2, Section 3a)<br>Protocall contract<br>Member Handbook English/Spanish (Pg. 8)<br><br>**Description of Process:**<br>BHI emergency services are available 24 hours a day, seven days a week, 365 days a year. BHI has 54 licensed behavioral health professionals designated to provide emergency services. All BHI providers offer 24-hour emergency access to members via telephone consultation and/or face-to-face evaluation. BHI contracts with Protocall to provide after-hours telephone triage and emergency assessment services.<br><br>Members are informed of access to 24 hour care through the member handbook. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Access and Availability policy described access to BHI's providers 24 hours per day via the emergency room. The policy also described access to an evaluation by CMHC emergency on-call clinicians by calling BHI's 24-hour number or the 24-hour number for any of BHI's in-network CMHCs. The provider manual informed providers of their responsibility to have 24-hour answering machine capability to direct members to call the BHI emergency line or go to the nearest emergency facility in life-threatening emergencies. The Standard Services Agreement between Protocall and BHI described Protocall's responsibility to provide crisis intervention and telephone assessment services to BHI members 24 hours per day, seven days per week. The member handbook informed members of how to obtain emergency services 24 hours per day. | | |
| **Required Actions:**<br>None | | |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 10. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, and has mechanisms to monitor providers regularly to determine compliance and to take corrective action if there is failure to comply.<br><br>*42CFR438.206(c)(1)(iv) through ( vi)*<br>*Contract :II.E.1.a. 9 through II.E.1.a. 11* | **Documents Submitted/Location Within Documents:**<br>Policy Access and Availability pp10.doc<br>Policy Sub-contractual Relationships and Delegation pp10<br>Report Access to Care FY10 Q2<br>Report Telephone Log FY10 Q4<br>Report Card FY10 Q2<br>MHCA Results<br><br>**Description of Process:**<br>BHI uses several reports to ensure that consumers have timely access to services. BHI's report card process helps monitor providers and gives an opportunity for corrective action plans.<br><br>Every year BHI uses a validated client satisfaction instrument that allows comparison to 80 behavioral health systems across 18 states. This survey helps get consumer perspectives on access to services | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Access and Availability policy stated that BHI performs annual audits of independent providers. During the on-site interview, BHI staff described the process for secret shopper audits to determine compliance with timely appointment standards. In addition, staff reported that since all initial appointments were scheduled through the CMHCs, the CMHC data included all initial access appointments. Staff reported that as a result of the last secret shopper audit, there were some CPN providers who required additional training regarding the timely access standard. | | |
| **Required Actions:**<br>None | | |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 11. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by:<br>◆ Addressing the language and cultural expertise of providers in the network plan,<br>◆ Ensuring members' right to receive culturally appropriate and competent services from participating providers,<br>◆ Assessing member demographics, cultural, and racial affiliations, language and reading proficiency,<br>◆ Evaluating members' cultural and linguistic needs,<br>◆ Utilizing information gathered [regarding cultural and linguistic needs] in the service plan.<br><br>*42CFR438.206(c)(2)*<br>*Contract: II.E.1.c.1.v; II.F.4.j.3.iv; F.7.d.1; F.7.e.2; and F.9.a* | **Documents Submitted/Location Within Documents:**<br>Policy Culturally Appropriate and Competent Services<br>Policy Protocol for Accessing Interpreter Service pp10<br>Cultural Competency Strategic Plan 2010 and Accomplishments<br>Cultural Competency Survey<br>Cultural Competency Committee Description 7-09<br>Member Handbook Spanish<br>Member Handbook Large Print<br>Provider Survey Information Update 081908<br><br>**Description of Process:**<br>BHI strives to be a behavioral health leader in innovating and promoting the culture of recovery and fostering supportive attitudes and practices within the communities we serve. BHI's policies, procedures and the cultural competency strategic plan detail and describe this organizational commitment.<br><br>Member handbooks are available in Spanish and Large print. BHI will ensure translation of member information in any language or Braille as requested by a member.<br><br>Our service network provides professionals who have competencies in serving diverse communities. These providers are competent at dealing with divergent norms, beliefs, expectations, strengths and resources of each individual, and how these important factors for recovery and personal success are related to cultural background and identity. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Culturally Appropriate and Competent Services policy described several methods for ensuring culturally appropriate services. Methods included hiring or contracting with a diverse panel of providers, providing training regarding the cultural needs of clients, and evaluating client satisfaction by ethnic/cultural groups. The policy also described providing written materials in other languages, as requested by the member, and providing interpreter | | |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| services whenever mental health services were not provided in the client's native or preferred language. The Cultural Competency Strategic Plan described specific systemwide goals and objectives related to cultural competency based on a systemwide cultural competency survey. The Network Adequacy Report FY 2009–2010 listed providers who collectively spoke 25 different languages, in addition to English. BHI provided a copy of the Spanish and large-print versions of the member handbook. The member handbook informed members of their right to receive culturally appropriate services and that they may request a provider who speaks another language or has a certain cultural background. During the on-site interview, BHI staff reported that written materials were routinely available in English and Spanish and could be provided in any other language upon request. | | |
| **Required Actions:**<br>None | | |
| 12. The Contactor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor:<br>◆ Offers an appropriate range of preventative, primary care, and specialty services that is adequate for the anticipated number of members for the services area,<br>◆ Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area,<br>◆ Certifies that the network meets the requirements set forth in 438.206 and 438.207.<br><br>*42CFR438.207(b)*<br>Contract:II.E1.b.1 | **Documents Submitted/Location Within Documents:**<br>Report Certification_NWA_BHI_Q4FY10<br>Report NW Adequacy Annual FY09_10<br>Report NW Adequacy Quarterly Q4 FY 2009-2010 Final<br><br>**Description of Process:**<br>BHI submits quarterly and annual network adequacy reports. The details in this report include number, mix and geographic distribution of providers. The network adequacy reports also detail member outliers, which is defined as members with access to a network provider greater than 30 miles. Currently, less than 1% of BHI's total Medicaid membership of over 127,000 Medicaid eligible members continues to reside outside the Metro East service area. The 4th quarter's analysis of Medicaid member outliers and provider locations shows that these members are within an average of 46.2 miles of a contracted provider, which includes the locations of all mental health center treatment sites across the state. These numbers have not changed significantly throughout the fiscal year. BHI continues to work with Colorado Access in combining our respective contracted provider networks to provide greater geographic accessibility to our Medicaid membership. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| **Findings:**<br>BHI submitted annual and quarterly network adequacy reports, as well as evidence that BHI's chief executive officer certified the data. During the on-site interview, BHI staff members confirmed that both annual and quarterly network adequacy reports were submitted to the Department for approval. | | |
| **Required Actions:**<br>None | | |

| Results for Standard II—Access and Availability | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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% |

| Standard III— Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 1. The Contractor has written policies and procedures to ensure timely coordination of the provision of covered services to its members and to ensure service accessibility attention to individual needs and continuity of care to promote maintenance of health and maximize independent living.<br><br>*Contract: II.E.1.g.1* | **Documents Submitted/Location Within Documents:**<br>Policy Access and Availability pp10 (Pgs. 1,2)<br>Policy Coordination of Care pp10 (Pg. 2, Sections 8 and 9)<br><br>**Description of Process:**<br>BHI's policy on Access and Availability as well as the policy on Coordination of Care outline procedures to ensure timely service accessibility and coordination. BHI ensures that services promote recovery, health maintenance, and maximize independent living. | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Coordination of Care policy addressed the processes for timely assessment of members and identification of member needs and available resources. The policy also addressed treatment planning, identification of other agencies and provider types needed, identification of supportive services required to access treatment, and coordination between medical and behavioral health providers. The Access and Availability policy addressed processes for member access to care and processes for providing emergency services. The Client Notification of Termination of Providers policy addressed notifying members of provider termination and how to select a new provider. The Procedure on BHO to BHO Treatment policy addressed coordination between BHOs regarding authorization and billing. There were no policies that addressed the mechanisms for continuity of care regarding communication between providers or between BHOs with respect to the services provided. | | |
| **Required Actions:**<br>BHI must revise or develop policies to address continuity of care with respect to services provided. | | |
| 2. Policies and procedures address:<br>◆ The coordination of services furnished to the member by the Contractor with the services the member receives from any other MCO or PIHP.<br>◆ The coordination and provision of services in conjunction with other behavioral health care providers, physical health care providers, long term care providers, waiver service providers, pharmacists, county and state agencies, and other organizations that may be providing wrap around services.<br><br>*42CFR438.208(b)(2)*<br>*Contract: II.E.1.g.1 and II.E.1.g.2* | **Documents Submitted/Location Within Documents:**<br>Policy Coordination of Care pp10<br>MHC-BHO Policy<br>Douglas County 1451 MOU<br>MCS MOU<br>COA BHI ASO Agreement (Pg. 2 of Addendum A)<br>COA Quarterly Contract Performance Summary Q4 (Pg. 7)<br>Colorado Access Care Management.pdf<br>Colorado BHO Proposal.doc (PPD Training Collaborative) | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard III— Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| | **Description of Process:**<br>BHI's Policy on Coordination of Care addresses the need to ensure comprehensive and collaborative treatment activities with other medical and behavioral health service provider, local agencies, advocacy groups, other insurance carriers, and other individuals or organizations that are involved in a client's treatment and recovery process.<br><br>BHI has an understanding with out of network CMHCS to authorize and pay for services provided.<br><br>BHI participates in multiple clinical and operation forums with other community agencies for the purpose of Coordination and Continuity of Care.<br>◆ County Departments of Human Services (DHS)<br>a. 1451 interagency collaborations: BHI participates in 1451 collaborations in Adams and Arapahoe Counties. These plans bring community agencies together to address psychosocial, educational and behavioral health needs of high risk youth served through DHS. 1451 initiatives include reducing truancy and educational neglect, services to youth and families with developmental disabilities and/or mental illness, responding to needs of children and families experiencing domestic violence, and advocacy for youth in the juvenile corrections system.<br>b. Co-location of mental health clinicians in DHS settings: Community Reach Center has embedded mental health clinicians in DHS settings to facilitate timely access for children and families in need of mental health services.<br>◆ Coordination with Developmental Disability agencies: BHI has developed mechanisms for coordination with Community Center Boards (CCBs), the agencies responsible for serving | |

| Standard III— Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| | consumers with developmental disabilities. BHI partners with Developmental Pathways in developing interagency training, forums for complex case review of shared clients, interagency clinical consultation, and expanding community based services for mutual clients. Community Reach Center has a mental health clinician co-located within North Metro Community Services, the CCB serving Adams County. This co-location ensures timely access to needed mental health care, clinical consultation and care coordination.<br>◆ Grants: BHI has obtained grants to support coordination of care efforts in the following areas: Wellness and Smoking Cessation (in collaboration with University of Colorado Health Sciences Center), psycho-education for consumers with Bipolar disorder (National Institute of Mental Health grant), and treatment and clinician training to serve women at risk for or experiencing post partum depression (in collaboration with Children's and University Hospitals).<br>◆ Emergency triage and response: BHI is actively involved in the development of behavioral health phone triage services through Metro Crisis Services (MCS). MCS is an interagency collaboration that includes mental health centers, BHOs, law enforcement, advocacy groups and elected officials for the seven county metro Denver area.<br>◆ Care Management: BHI contracts with Colorado Access to provide care management services to high risk, high need mental health consumers. Care managers are embedded in each of the three BHI centers and work to ensure timely access to needed medical care, coordination of behavioral health and medical services, and disease management for chronic medical conditions. | |

| Standard III— Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| **Findings:**<br>The MCO-BHO policy (developed by a collaboration between Colorado's five BHOs) indicated that each BHO agreed to provide members from other BHOs access equal to the access provided to in-network members. The 1451 Memorandum of Understanding (MOU) represented an agreement between agencies that served children with special health care needs (including BHI) to provide and coordinate covered and wrap-around services without duplication of assessment or treatment efforts. The Colorado Access/BHI Administrative Services Organization (ASO) Agreement provided evidence of the delegation agreement for case management of BHI members by Colorado Access. The Coordination of Care policy addressed the processes for coordination of services with other agencies and coordination between medical and behavioral health providers. | | |
| **Required Actions:**<br>None | | |
| 3. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities.<br><br>*42CFR438.208(b)(3)*<br>Contract: None | **Documents Submitted/Location Within Documents:**<br>DDMI Training<br>Policy DDMI Guidelines pp10<br>Coordination of Care - Clinician Training<br>Coordination of Care - Prescriber Training<br>PCP Notification of Care Letter Template<br>BHI ACF, MI Waiver, FQHC Lists (Available at site visit)<br>Clinica_020309 Signed Copy.pdf<br>CRICC challenges and metrics.ppt<br><br>**Description of Process:**<br>BHI providers work with members with special health care needs who are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. BHI ensures regular trainings for providers and encourages coordination of care with allied agencies to prevent duplication of services.<br>◆ MH Providers send letters to consumers' PCPs to exchange contact and treatment information to facilitate coordination of care. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard III— Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| | ◆ Each BHI CMHC has a "Health Coordinator" located within the centers to provide coordination of care for consumers with a high need for both medical and psychiatric care.<br>◆ BHI maintains lists of BHI consumers in ACF, NH, on MI waivers, or in FQHCs to coordinate care. Integration of care is facilitated by BHI's longstanding collaborative relationships with medical care offices including primary care physicians and Federally Qualified Health Centers (FQHCs); substance abuse agencies, schools; advocacy agencies; county departments of human services; alternative care facilities and nursing homes.<br>◆ BHI collaborates with Colorado Access in the Colorado Regional Integrated Care Collaborative (CRICC) to provide coordinated medical and behavioral health care to high-need Medicaid members in Adams and Arapahoe Counties. | |

**Findings:**
The developmental disability/mental illness PowerPoint presented the requirements and guidelines for assessment and treatment of members who were developmentally disabled and presenting with a co-occurring mental health diagnoses. The coordination of care clinician training and coordination of care prescriber training PowerPoint presentations provided information to assist clinicians in identifying members with behavioral health/physical health co-morbidities. During the on-site interview, BHI staff members stated that the PCP notification letter was used to notify the member's PCP of the member's treatment plan information at the time of intake. The Clinica/BHI Agreement represented a subcontractor (organizational provider) agreement between BHI and Clinica, an FQHC. The agreement specified that Clinica staff members provided behavioral health services on-site at Clinica locations. The Colorado Regional Integrated Care Collaborative (CRICC) PowerPoint presentation provided an overview of the CRICC program, which provides physical services to many BHI members. During the on-site interview, BHI staff members explained that the health coordinators on-site at the CMHCs were Colorado Access care managers (per the delegation agreement between Colorado Access and BHI). The health coordinators were on-site to facilitate communication between physical health and behavioral health providers.

**Required Actions:**
None

| Standard III— Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| 4. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E (HIPAA), to the extent that they are applicable.<br><br>*42CFR438.208(b)(4)*<br>*Contract: II.E.1.g.1* | **Documents Submitted/Location Within Documents:**<br>Policy Disclosure of Protected Health Information pp10<br>Policy Coordination of Care pp10 (Pg. 2, Section 7)<br>Provider Contract (Pgs. 6,11 about HIPAA compliance)<br>Business Associate Contract<br>HIPAA Training<br>HIPAA Test<br><br>**Description of Process:**<br>Providers and Business associates are contractually required to follow all HIPAA and confidentiality laws. BHI staff and contracted providers participate in mandatory HIPAA training annually.<br><br>BHI's Policy on Disclosure of Protected Health Information and Policy on Coordination of Care ensure that all care coordination services are rendered in such a way as to ensure the client's confidentiality and privacy is protected as required by 45 C.F.R. Parts 160 and 164 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.<br><br>Additional HIPAA policies address: Accounting of disclosure of PHI, Alternate means of communication, Amendment of PHI, Authorizations and other release of information forms received by BHI, Business associate contact procedures, Client access to PHI, Client request for additional restrictions regarding use or disclosure of PHI, Minimum necessary rule regarding disclosure of PHI, Privacy regulation training, Notice of privacy rights, Treatment record content, and Work force access protected PHI. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard III— Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| **Findings:**<br>The Coordination of Care policy stated that the BHO complied with HIPAA regulations. The Disclosure of Protected Health Information policy described the allowed use and disclosure of protected health information (PHI) and use of the Authorization to Release Information form and the Release of Information form at the BHO level. The Provider Services Agreement template included a provision requiring the provider to comply with HIPAA for medical record maintenance. The BHI Business Associate Agreement was a HIPAA-compliant agreement. The HIPAA training PowerPoint presentation and post-test demonstrated the content of training provided to the CMHCs and CPN providers. During the on-site interview, BHI staff members explained that the CPN providers were sent the mandatory training presentations, were asked to sign an acknowledgment of receipt, and were asked to complete the HIPAA post-test. | | |
| **Required Actions:**<br>None | | |
| 5. The Contractor ensures that each member accessing services receives an individual intake and assessment within contractual timeframes for the level of care needed. The individual intake and assessment shall not be performed as part of any group orientation or therapy session.<br>*42CFR438.208(c)(2)* | **Documents Submitted/Location Within Documents:**<br>CMHC Intake Form<br>CMHC Assessment Form<br>CPN Assessment Form<br>Policy Access and Availability pp10 (Pgs. 1,2)<br>Policy Coordination of Care pp10 (Pg. 1, Section 2)<br>Policy Treatment Record Content pp10 (Pg. 1)<br>Provider Manual (Pg. 104 and 435 of the pdf)<br>**Description of Process:**<br>All intakes and assessments for BHI consumers are done individually by licensed mental health professionals. At the time of referral, a screening is done to evaluate if there is a routine, emergent, or urgent need for an evaluation or crisis intervention. Contractual time frames are met according to level of care needed. Members may participate in an initial group orientation to mental health center services for the purpose of reviewing client rights and responsibilities, the importance of attending scheduled appointments, access to emergency services, and coordination/continuity of care processes. These orientation meetings do not constitute formal clinical assessment and intake procedures. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard III— Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| | BHI Mental Health Centers have all implemented electronic medical record systems that incorporate all required elements for clinical assessment, treatment planning, and documentation. | |
| **Findings:**<br>The CMHC Intake Form, the CMHC Assessment Form, and the CPN Assessment Form provided examples of the standard methods required by BHI for individualized assessment and determination of treatment needed. The Access and Availability policy addressed the processes for scheduling and completing emergency assessments. The Access and Availability policy also included the contractual timelines for access to emergency, urgent, and routine services. The Treatment Record Content policy stated the requirements for member records, which included the assessment and the individualized service/treatment plan. The provider manual included the Treatment Record Content policy as an appendix and stated in the UM section of the manual that a completed assessment was required for initial authorization of treatment. The provider manual also included timely access requirements. During the on-site interview, BHI staff members explained that one of the three in-network CMHCs offered (but did not require) a group orientation session in addition to providing the initial individual assessment within the required time frames. | | |
| **Required Actions:**<br>None | | |
| 6. Each member actively seeking services shall have an individualized service plan (treatment plan), developed by the member and/or the designated member representative and the member's provider or treatment team and:<br>◆ Utilizes the information gathered in the member's intake and assessment to build a comprehensive plan of service,<br>◆ Includes measurable goals, strategies to achieve the stated goals and a mechanism for monitoring and revising the service plan as appropriate,<br>◆ Is signed by the member and reviewing professional. If the member chooses not to sign his/her service plan, documentation is provided in the member's medical record stating the member's reason for not signing the plan, | **Documents Submitted/Location Within Documents:**<br>CMHC Treatment Plan<br>CPN Treatment Plan<br>Policy Coordination of Care pp10 (Pg. 1, Section 3)<br>Policy Treatment Record Content pp10 (Pgs. 2,3)<br>Provider Manual (Pg. 104 and 435 of the pdf)<br><br>**Description of Process:**<br>For BHI providers, development of the plan is a collaborative effort among clients, the parents or legal guardians of child and adolescent members, informal caregivers, family members or other important persons selected by the member and/or parents/guardians.<br><br>a. BHI providers' partner with members and their families to build strength based and individualized treatment plans. The | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard III— Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by BHO/Health Plan** | **Score** |
| ◆ Service planning occurs annually or if there is a change in the member's level of functioning.<br><br>*42CFR438.208(c)(3)*<br>Contract: II.F.9 | treatment plans are reflective of the person's needs, wishes and specific issues that have been identified in the assessment process.<br><br>b. BHI policies ensure that providers develop service plans that are clear, specific and include measurable outcomes that reflect a client's recovery goals. Treatment plan templates are created to capture such measureable goals consistently.<br><br>c. Both the client and the reviewing professional sign each treatment plan and any changes to it. If for any reason the member who participated in crafting the Individualized Service Plan does not wish to sign the plan, an addendum is added that explains, in the member's own words, why the member does not wish to sign.<br><br>d. For BHI, service planning takes place at the beginning of treatment, anytime there is a change in the client's level of functioning and care, upon request of the member, but not less than annually. | |
| **Findings:**<br>The sample BHI Outpatient Integrated Service Plan provided an example of a service plan based on the individualized assessment. The service plan included strengths, problem statements, goals, and strategies for goal achievement. The Treatment Record Content policy stated the requirements for member records, which included the individualized service/treatment plan. The provider manual included the Treatment Record Content policy as an appendix and stated in the UM section of the manual that submission of the treatment plan was required for continued authorization. The Provider Credentialing and Recredentialing policy stated that review for treatment plan completion was included in recredentialing criteria. The Credentialing and Recredentialing policy was reproduced in the provider manual. The sample service plan included a space for the member to sign. The Coordination of Care policy stated, and BHI staff members confirmed, that the service plan was modified as needed to address changes in the member's condition. | | |
| **Required Actions:**<br>None | | |

| Results for Standard III—Coordination and Continuity of Care | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 5 | X | 1.00 | = | 5 |
| | Partially Met | = | 1 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | 0 |
| **Total Applicable** | | = | 6 | **Total Score** | | = | 5 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | 83% |

# Appendix B. Denials Record Review Tool for Behavioral HealthCare, Inc.

The completed compliance monitoring tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

# *Appendix B.* Colorado Department of Health Care Policy & Financing
## FY 2010–2011 Denials Record Review Tool
## *for* Behavioral HealthCare, Inc.

| | |
|---|---|
| **Review Period:** | January 1, 2010–September 15, 2010 |
| **Date of Review:** | November 15 and 16, 2010 |
| **Reviewer:** | Barbara McConnell |
| **Participating Plan Staff Member:** | Wendy Kidd |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Complete if Standard/Expedited Authorization Decision | | | | Complete for Termination, Suspension, or Reduction of Previously Authorized Services | | Complete for All Denials | | | |
| File # | Member ID | Date of Initial Request | Date Notice of Action Sent | Number of Days for Decision and Notice | Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request) | Date Notice Sent | Notice Sent w/in Time Frame? (At least 10 days prior to change in service) | Notice Includes Required Content? | Decision Made by Qualified Clinician? | Requesting Physician Consulted? (if applicable) | Reason Valid? |
| 1 | ****** | 1/20/10 | 1/22/10 | 2 | Y ☒ N ☐ N/A ☐ | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ N/A ☐ |
| **Comments:** | | | | | | | | | | | |
| 2 | ****** | 2/1/10 | 2/3/10 | 2 | Y ☒ N ☐ N/A ☐ | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ N/A ☐ |
| **Comments:** | | | | | | | | | | | |
| 3 | ****** | 2/3/10 | 2/4/10 | 1 | Y ☒ N ☐ N/A ☐ | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☐ ☒ Unknown | Y ☐ N ☐ N/A ☒ |
| **Comments:** The denials record did not contain adequate documentation to determine compliance with the requirements. The reviewer was unable to determine who requested the service or if a requesting provider should have been consulted. Through discussion with the UM director, the reviewer determined that the case involved the clinical decision of the therapist to recommend continued outpatient service in conjunction with substance abuse treatment prior to considering day treatment services. As this was a clinical/treatment team decision rather than a managed care utilization determination, a notice of action should not have been triggered. | | | | | | | | | | | |
| 4 | ****** | Unknown | 2/22/10 | Unknown | Y ☐ N ☐ N/A ☐ ☒ Unknown | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☐ ☒ Unknown | Y ☐ N ☒ N/A ☐ |
| **Comments:** The denials record did not contain adequate documentation to determine compliance with the requirements. The reviewer was unable to determine who requested the service or if a requesting provider should have been consulted. The record also did not contain the date the service was requested. The letter was unclear and contained multiple and conflicting reasons for the denial. | | | | | | | | | | | |
| 5 | ****** | N/A | N/A | N/A | Y ☐ N ☐ N/A ☒ | 2/24/10 | Y ☒ N ☐ N/A ☐ | Y ☐ N ☒ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☒ | Y ☐ N ☐ N/A ☒ |
| **Comments:** BHI provided more than 10 days advance notice (sent 2/24/10, indicating that services would end 3/10/10). The denials record did not contain adequate documentation to determine compliance with the requirements. The time frame for requesting an appeal and continuation of benefits incorrectly stated that the member should file within 20 days. For termination of services and continuation of benefits, requests for an appeal with continuation of services should be made within 10 days of the notice of action or before the services end, whichever is later. The notice of action letter indicated that services were being terminated based on noncompliance with the treatment plan. Through discussion with the UM director, the reviewer determined that the issue of noncompliance in this case was a clinical issue rather than a managed care utilization determination, which should have triggered treatment team planning and treatment plan adjustment instead of a notice of action. | | | | | | | | | | | |
| 6 | ****** | N/A | N/A | N/A | Y ☐ N ☐ N/A ☒ | 2/26/10 | Y ☒ N ☐ N/A ☐ | Y ☐ N ☒ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☒ | Y ☐ N ☐ N/A ☒ |
| **Comments:** BHI provided more than 10 days advance notice (sent 2/26/10, indicating that services would end 3/12/10). The denials record did not contain adequate documentation to determine compliance with the requirements. The time frame for requesting an appeal and continuation of benefits incorrectly stated that the member should file within 20 days. For termination of services and continuation of benefits, requests for an appeal with continuation of services should be made within 10 days of the notice of action or before the services end, whichever is later. The notice of action letter indicated that services were being terminated based on noncompliance with the treatment plan. Through discussion with the UM director, the reviewer determined that the issue of noncompliance in this case was a clinical issue rather than a managed care utilization determination, which should have triggered treatment team planning and treatment plan adjustment instead of a notice of action. | | | | | | | | | | | |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Complete if Standard/Expedited Authorization Decision | | | | Complete for Termination, Suspension, or Reduction of Previously Authorized Services | | Complete for All Denials | | | |
| File # | Member ID | Date of Initial Request | Date Notice of Action Sent | Number of Days for Decision and Notice | Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request) | Date Notice Sent | Notice Sent w/in Time Frame? (At least 10 days prior to change in service) | Notice Includes Required Content? | Decision Made by Qualified Clinician? | Requesting Physician Consulted? (if applicable) | Reason Valid? |
| 7 | ****** | 2/22/10 | 2/25/10 | 3 | Y ☒ N ☐ N/A ☐ | N/A | Y ☐ N ☐ N/A ☒ | Y ☐ N ☒ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☐ ☒ Unknown | Y ☒ N ☐ N/A ☐ |
| **Comments:** This case involved a denial of residential treatment for a child or adolescent and, therefore, should have contained HB1116 information in the notice of action, in addition to the Medicaid managed care information. The denials record did not contain adequate documentation to determine compliance with the requirements. The reviewer was unable to determine who requested the service or if a requesting provider should have been consulted. | | | | | | | | | | | |
| 8 | ****** | 3/16/10 | 3/16/10 | 0 | Y ☒ N ☐ N/A ☐ | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☐ Unknown | Y ☒ N ☐ N/A ☐ |
| **Comments:** The denials record did not contain adequate documentation to determine compliance with the requirements. The reviewer was unable to determine who requested the service or if a requesting provider should have been consulted. | | | | | | | | | | | |
| 9 | ****** | 3/16/10 | 3/19/10 | 3 | Y ☒ N ☐ N/A ☐ | N/A | Y ☐ N ☐ N/A ☒ | Y ☐ N ☒ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☐ ☒ Unknown | Y ☒ N ☐ N/A ☐ |
| **Comments:** This case involved a denial of residential treatment for a child or adolescent and, therefore, should have contained HB1116 information in the notice of action, in addition to the Medicaid managed care information. The denials record did not contain adequate documentation to determine compliance with the requirements. The reviewer was unable to determine who requested the service or if a requesting provider should have been consulted. | | | | | | | | | | | |
| 10 | ****** | Unknown | 3/16/10 | Unknown | Y ☐ N ☐ N/A ☐ ☒ Unknown | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☐ ☒ Unknown | Y ☒ N ☐ N/A ☐ |
| **Comments:** The denials record did not contain adequate documentation to determine compliance with the requirements. The reviewer was unable to determine who requested the service or if a requesting provider should have been consulted. The record also did not contain the date the service was requested. | | | | | | | | | | | |
| 11 | ****** | 4/21/10 | 4/30/10 | 9 | Y ☒ N ☐ N/A ☐ | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ N/A ☐ |
| **Comments:** | | | | | | | | | | | |
| 12 | ****** | 5/14/10 | 5/19/10 | 5 | Y ☒ N ☐ N/A ☐ | N/A | Y ☐ N ☐ N/A ☒ | Y ☐ N ☒ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ N/A ☐ |
| **Comments:** This case involved a denial of residential treatment for a child or adolescent and, therefore, should have contained HB1116 information in the notice of action, in addition to the Medicaid managed care information. | | | | | | | | | | | |
| 13 | ****** | N/A | N/A | N/A | Y ☐ N ☐ N/A ☒ | 5/25/10 | Y ☒ N ☐ N/A ☐ | Y ☐ N ☒ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ N/A ☐ |
| **Comments:** BHI provided more than 10 days advance notice (sent 5/25/10, indicating that services would end 6/5/10). The time frame for requesting an appeal and continuation of benefits incorrectly stated that the member should file within 20 days. For termination of services and continuation of benefits, requests for an appeal with continuation of services should be made within 10 days of the notice of action or before the services end, whichever is later. | | | | | | | | | | | |
| 14 | ****** | Unknown | 6/3/10 | Unknown | Y ☐ N ☐ N/A ☐ ☒ Unknown | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☒ | Y ☐ N ☐ N/A ☒ |
| **Comments:** The notice of action letter was worded as a recommendation for residential treatment rather than as a denial of day treatment services, which the family was requesting. The record did not clarify if the family disagreed with the recommendation. This case should have triggered treatment team planning and treatment plan adjustment instead of a notice of action, as the case involved a | | | | | | | | | | | |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Complete if Standard/Expedited Authorization Decision | | | | Complete for Termination, Suspension, or Reduction of Previously Authorized Services | | Complete for All Denials | | | |
| File # | Member ID | Date of Initial Request | Date Notice of Action Sent | Number of Days for Decision and Notice | Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request) | Date Notice Sent | Notice Sent w/in Time Frame? (At least 10 days prior to change in service) | Notice Includes Required Content? | Decision Made by Qualified Clinician? | Requesting Physician Consulted? (if applicable) | Reason Valid? |
| clinical issue rather than a managed care utilization determination. Additional documentation in the denial record could have clarified whether the family took the request to a managed care level. The record also did not contain the date the service was requested. | | | | | | | | | | | |
| 15 | ****** | Unknown | 6/3/10 | Unknown | Y ☐ N ☐ N/A ☐ ☒ Unknown | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☐ ☒ Unknown | Y ☒ N ☐ N/A ☐ |
| **Comments:** The denials record did not contain adequate documentation to determine compliance with the requirements. The reviewer was unable to determine who requested the service or if a requesting provider should have been consulted. The record also did not contain the date the service was requested. | | | | | | | | | | | |
| 16 | ****** | Unknown | 8/6/10 | Unknown | Y ☐ N ☐ N/A ☐ ☒ Unknown | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ N/A ☐ |
| **Comments:** The record did not contain the date the service was requested. | | | | | | | | | | | |
| 17 | ****** | 8/3/10 | 8/12/10 | 9 | Y ☒ N ☐ N/A ☐ | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☒ | Y ☐ N ☐ N/A ☒ |
| **Comments:** The notice of action letter was addressed to a Department of Human Services (DHS) guardian and indicated that the therapist and the provider agreed on the decision to provide day treatment. While it appeared that the therapist was responding to the guardian's request to reiterate the decision in writing, a professional communication in the form of a letter could have sufficed. A notice of action should not have been triggered as this was a treatment team decision rather than a managed care utilization decision. | | | | | | | | | | | |
| 18 | ****** | Unknown | 8/20/10 | Unknown | Y ☐ N ☐ N/A ☐ ☒ Unknown | N/A | Y ☐ N ☐ N/A ☒ | Y ☐ N ☒ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☐ ☒ Unknown | Y ☐ N ☐ N/A ☒ |
| **Comments:** The denials record did not contain adequate documentation to determine compliance with the requirements. The reviewer was unable to determine who requested the service or if a requesting provider should have been consulted. The record also did not contain the date the service was requested. Based on the documentation available, a notice of action should not have been triggered as this was a treatment team decision rather than a managed care utilization decision. | | | | | | | | | | | |
| 19 | ****** | 8/12/10 | 8/19/10 | 7 | Y ☒ N ☐ N/A ☐ | N/A | Y ☒ N ☐ N/A ☐ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☐ ☒ Unknown | Y ☒ N ☐ N/A ☐ |
| **Comments:** The reviewer was unable to determine from the record who requested the service; therefore, the reviewer was unable to determine if there was a requesting provider who should have been consulted. | | | | | | | | | | | |
| 20 | ****** | Unknown | 8/30/10 | Unknown | Y ☐ N ☐ N/A ☐ ☒ Unknown | N/A | Y ☐ N ☐ N/A ☒ | Y ☒ N ☐ | Y ☒ N ☐ | Y ☐ N ☐ N/A ☐ ☒ Unknown | Y ☒ N ☐ N/A ☐ |
| **Comments:** The denials record did not contain adequate documentation to determine compliance with the requirements. The reviewer was unable to determine who requested the service or if a requesting provider should have been consulted. The record also did not contain the date the service was requested. | | | | | | | | | | | |

# *Appendix B.* Colorado Department of Health Care Policy & Financing
## FY 2010–2011 Denials Record Review Tool
## *for* Behavioral HealthCare, Inc.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Complete if Standard/Expedited Authorization Decision | | | | Complete for Termination, Suspension, or Reduction of Previously Authorized Services | | Complete for All Denials | | | |
| File # | Member ID | Date of Initial Request | Date Notice of Action Sent | Number of Days for Decision and Notice | Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request) | Date Notice Sent | Notice Sent w/in Time Frame? (At least 10 days prior to change in service) | Notice Includes Required Content? | Decision Made by Qualified Clinician? | Requesting Physician Consulted? (if applicable) | Reason Valid? |
| 21 | | | | | Y ☐ N ☐ N/A ☐ | | Y ☐ N ☐ N/A ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ N/A ☐ | Y ☐ N ☐ N/A ☐ |
| **Comments:** Oversample cases were not required to obtain and review 20 records. | | | | | | | | | | | |
| 22 | | | | | Y ☐ N ☐ N/A ☐ | | Y ☐ N ☐ N/A ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ N/A ☐ | Y ☐ N ☐ N/A ☐ |
| **Comments:** | | | | | | | | | | | |
| 23 | | | | | Y ☐ N ☐ N/A ☐ | | Y ☐ N ☐ N/A ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ N/A ☐ | Y ☐ N ☐ N/A ☐ |
| **Comments:** | | | | | | | | | | | |
| 24 | | | | | Y ☐ N ☐ N/A ☐ | | Y ☐ N ☐ N/A ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ N/A ☐ | Y ☐ N ☐ N/A ☐ |
| **Comments:** | | | | | | | | | | | |
| 25 | | | | | Y ☐ N ☐ N/A ☐ | | Y ☐ N ☐ N/A ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ N/A ☐ | Y ☐ N ☐ N/A ☐ |
| **Comments:** | | | | | | | | | | | |
| # Applicable Elements | | | | | 17 | | 4 | 20 | 20 | 10 | 14 |
| # Compliant Elements | | | | | 10 | | 4 | 13 | 20 | 0 | 13 |
| Percent Compliant | | | | | 58.8% | | 100% | 65% | 100% | 0% | 92.8% |

| | |
|---|---|
| **Total # Applicable Elements** | **85** |
| **Total # Compliant Elements** | **60** |
| **Total Percent Compliant** | **70.6%** |

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

Table C-1 lists the participants in the FY 2010–2011 site review of **BHI**.

| Table C-1—HSAG Reviewers and BHO Participants | |
|---|---|
| **HSAG Review Team** | **Title** |
| Barbara McConnell, MBA, OTR | Project Director |
| **BHI Participants** | **Title** |
| Julie Holtz | Chief Executive Officer |
| Samatha Kommana | Quality Improvement Director |
| Jerome Stiller | Senior Data Analyst |
| Rian G. Nowitzki | Chief Financial Officer/Controller |
| Jeff George | Quality Improvement Analyst |
| Christina Mitsch | Utilization Management Authorization Coordinator |
| Anjanette McConnell | Claims Coordinator |
| Teresa Summers | Director of Provider Relations |
| Lee Anne Merrifield | Interim Director, Office of Member and Family Affairs |
| Wendy K. Kidd | Director of Utilization Management |
| Melissa Kulasekere | Program Evaluator/Disease Management |
| Eunice Weeks | Administrative Support |
| Rebecca Hill | Executive Assistant |
| **Department Observers** | **Title** |
| Marceil Case (participated telephonically) | Behavioral Health Specialist |
| Jerry Ware | Quality/Compliance Specialist |

# Appendix D. Corrective Action Plan Process for FY 2010–2011 for Behavioral HealthCare, Inc.

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

**Table D-1—Corrective Action Plan Process**

| | |
|---|---|
| **Step 1** | **Corrective action plans are submitted** |
| | 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 provided. The Department should be copied on any communication regarding CAPs.<br><br>For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions. |
| **Step 2** | **Prior approval for timelines exceeding 30 days** |
| | If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing. |
| **Step 3** | **Department approval** |
| | Following review of the CAP, the Department will notify the BHO via e-mail whether:<br><br>◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan.<br>◆ 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 implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs. |
| **Step 5** | **Progress reports may be required** |
| | For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements of the CAP. |

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

The template for the CAP follows.

| Table D-2—FY 2010–2011 Corrective Action Plan *for* Behavioral HealthCare, Inc. | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| I. Coverage and Authorization of Services<br>3. If the Contractor places limits on services, it is:<br>◆ On the basis of criteria applied under the State plan (medical necessity).<br>◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.<br>◆ Consistent with the Contractor's published practice guidelines.<br>◆ On the basis of the Department's established utilization requirements or | In one denial case in the on-site record review it was not clear that the decision was based on UR criteria. BHI must ensure that all denial decisions are based on UR criteria. | | | | |

| Table D-2—FY 2010–2011 Corrective Action Plan *for* Behavioral HealthCare, Inc. | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| utilization review standards. | | | | | |
| 7. The Contractor's written policies and procedures include a mechanism to consult with the requesting provider when appropriate. | The UM Program Description stated that BHI UM staff consulted with providers throughout the episode of care: however, the description did not specifically address consultation with a requesting provider for utilization determinations. The on-site record review demonstrated that the denials documentation did not contain adequate information to determine if a provider had requested the service or if a consultation would have been appropriate. BHI must ensure that the appropriate policy includes a mechanism to consult with the requesting provider. BHI must also develop a mechanism to adequately document any consultation with the requesting provider. | | | | |

| Table D-2—FY 2010–2011 Corrective Action Plan *for* Behavioral HealthCare, Inc. | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| 10. The Contractor's written policies and procedures include the following timeframes for making standard and expedited authorization decisions:<br>◆ For standard authorization decisions—10 calendar days.<br>◆ For expedited authorization decisions—3 days. | The UM Program Description and the Utilization Management Decision Timelines policy included the required time frames for making standard and expedited authorization decisions and included the time frame for expedited decisions of three working days. The BHI action and appeals training PowerPoint presentation stated that the required time frame was three calendar days. The federal requirement is three working days. The Colorado rule does not specify calendar or working days. While three calendar days would exceed the requirement of three working days, BHI's documents must be revised to be consistent with each other. | | | | |

| Table D-2—FY 2010–2011 Corrective Action Plan *for* Behavioral HealthCare, Inc. | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| III. Coordination and Continuity of Care<br>1. The Contractor has written policies and procedures to ensure timely coordination of the provision of covered services to its members and to ensure service accessibility attention to individual needs and continuity of care to promote maintenance of health and maximize independent living. | There were no policies that addressed the mechanisms for continuity of care regarding communication between providers or between BHOs with respect to the services provided. BHI must revise or develop policies to address continuity of care with respect to services provided. | | | | |

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

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

**Table 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:<br>◆ HSAG and the Department held teleconferences and a meeting at the Department to determine the content of the review.<br>◆ HSAG coordinated with the Department and the BHO to set the date of the review.<br>◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities.<br>◆ HSAG staff attended Behavioral Health Quality Improvement Committee (BQUIC) meetings and discussed the FY 2010–2011 compliance monitoring review process as needed.<br>◆ HSAG assigned staff to the review team.<br>◆ Prior to the review, HSAG representatives also responded to questions from the BHO via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the BHO was prepared for the compliance monitoring review. |
| **Activity 2:** | **Obtained Background Information From the Department** |
| | ◆ HSAG used the BBA Medicaid managed care regulations and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, desk audit request, on-site agenda, record review tool, and report template.<br>◆ 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 via delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk audit request included instructions for organizing and preparing the documents related to the review of the three standards. Thirty days prior to the review, the BHO provided documentation for the desk audit, as requested.<br>◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk audit form, the compliance monitoring tool with the BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.<br>◆ 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 and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.)<br>◆ HSAG reviewed additional documents requested as a result of the on-site interviews. |
| **Activity 6:** | **Analyzed and Compiled Findings** |
| | ◆ Following the on-site portion of the review, HSAG met with BHO staff to provide an overview of preliminary findings.<br>◆ HSAG used the FY 2010–2011 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities.<br>◆ HSAG analyzed the findings and assigned scores.<br>◆ HSAG determined opportunities for improvement based on the review findings.<br>◆ HSAG determined actions required of the BHO to achieve full compliance with Medicaid managed care regulations and associated contract requirements. |
| **Activity 7:** | **Reported Results to the Department** |
| | ◆ HSAG completed the FY 2010–2011 Site Review Report.<br>◆ HSAG submitted the site review report to the Department for review and comment.<br>◆ HSAG incorporated the Department's comments.<br>◆ HSAG distributed a second draft report to the BHO for review and comment.<br>◆ HSAG incorporated the BHO's comments and finalized the report.<br>◆ HSAG distributed the final report to the BHO and the Department. |