Colorado Medicaid
Community Mental Health Services Program

FY 2011–2012 Site Review Report

for

Behavioral HealthCare, Inc.

January 2012

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

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Overview of FY 2011–2012 Compliance Monitoring Activities

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct a periodic evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations and contractual requirements. The Department of Health Care Policy and 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 eighth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2011–2012 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The BHO's administrative records were also reviewed to evaluate implementation of Medicaid managed care regulations related to Medicaid member appeals. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid appeals that were filed between January 1, 2011, and September 30, 2011. For the record review, the BHO received a score of *M* (met), *N* (not met), or *NA* (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 *U* (unknown) was used and did not impact the overall record review score. Compliance with federal regulations was evaluated through review of the four standards and appeal records. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2011–2012 site review activities for the review period—January 1, 2011, through the dates of the on-site review, November 3 and 4, 2011. 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 2010–2011 site review activities. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the appeals record review. 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 for FY 2011–2012 and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing documentation related to the four 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.

The four standards chosen for the FY 2011–2012 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, 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 as outlined in the CMS final protocol.

Objective of the Site Review

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

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

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*, *Not Applicable*, or *Not Scored*. HSAG assigned required actions to any individual requirements 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 elements, 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—Compliance Monitoring Tool.

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 or Not Scored*	Score (% of *Met* Elements)
V	Member Information	19	19	16	3	0	0	84%
VI	Grievance System	26	25	19	5	1	1	76%
VII	Provider Participation and Program Integrity	15	15	14	1	0	0	93%
IX	Subcontracts and Delegation	8	8	6	2	0	0	75%
	Totals	**68**	**67**	**55**	**11**	**1**	**1**	**82%**

Table 1-2 presents the scores for **BHI** for the Appeals Record Review. Details of the findings for the record review follow in Appendix B—Appeals Record Review Tool.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Appeals Record Review	37	37	30	7	0	81%

2. Summary of Performance Strengths and Required Actions

for **Behavioral HealthCare, Inc.**

Overall Summary of Performance

For the four standards reviewed by HSAG, **BHI** earned an overall compliance score of 82 percent. **BHI**'s strongest performances were in Standard V—Member Information and Standard VII—Provider Participation and Program Integrity, with compliance scores of 84 percent and 93 percent, respectively. BHI received compliance scores of 76 percent and 75 percent in Standard VI—Grievance System and Standard IX—Subcontracts and Delegation, respectively. Although HSAG identified required actions in each standard, **BHI** demonstrated adequate performance and understanding of federal health care regulations overall.

BHI staff members indicated that **BHI**'s required actions and lack of compliance were related to significant changes in the management team and the resulting transitions. Certain quality improvement processes were suspended or were in the process of revision at the time of the site review. **BHI** staff members reported that **BHI** appears to be positioned well to evaluate and revise systems and processes that are directly related to member outcomes and move forward in a more organized fashion.

Standard V—Member Information

Summary of Findings and Opportunities for Improvement

BHI's Member and Family Handbook (member handbook) provided information in a well-organized manner to assist members in understanding the behavioral health managed care program and how to obtain services through **BHI**. The member handbook included a comprehensive description of covered benefits, including how and where to obtain emergency services. Members and providers were informed about member rights and providers were directed to take those rights into account when providing services. **BHI** had a system in place to track the distribution of member welcome packets. Member materials were available in English and Spanish and **BHI** had a process to translate materials into other languages, upon request. **BHI** also had a system in place for providing oral translation, when needed, at no cost to the member.

Although the member handbook clearly stated that **BHI** has no objection to provision of services based on moral/religious grounds or conscience, HSAG recommends that a similar policy statement appear in **BHI**'s Advance Directives policy.

Summary of Strengths

The member handbook and other materials, such as member newsletters and topic-specific flyers and brochures, were comprehensive and easy to understand, as was the **BHI** Web site content. **BHI** offered community-based wellness programs that provided information on nutrition, relaxation therapies, physical exercise, and community resources. The Wellness Recovery Action Plan (WRAP) brochure described the eight-week program designed to assist members with incorporating wellness tools and strategies into their lives to maintain long-term mental health wellness.

Summary of Required Actions

The member handbook depicted the time frame for filing grievances and appeals and for requesting a State fair hearing as 20 calendar days. Under the continuation of services section the timely filing for appeals when requesting the continuation of previously authorized services was stated as, "Within 10 calendar days from the date on the letter, or before the authorization ends, whichever is less time." **BHI** must revise the information in its Member and Family Handbook regarding time frames for filing grievances, appeals, and requesting a State hearing to comply with the Colorado Rule and **BHI** policies, and reflect the 30-calendar-day time frame for each. **BHI** must also revise the section of its member handbook that explains the continuation of services during an appeal or State fair hearing related to the termination of previously authorized services. The handbook must accurately reflect the required time frame for filing an appeal or requesting a State fair hearing if requesting the continuation of previously authorized services (within 10 days from date of the notice of action or before the effective date of the termination or change in services, whichever is later).

The Member and Family Handbook stated that members may request information at any time on how **BHI** is structured and operates and on **BHI**'s quality improvement program; however, it did not inform members that they may request information on any physician incentive plans. **BHI** must include a statement in the member information materials concerning the availability, upon request, of information concerning physician incentive plans.

Although the provider manual stated that internal staff receives education on advance directives at orientation and annually thereafter, the Advance Directives policy did not include the provision for staff education regarding advance directives and there was no evidence of staff education regarding advance directives having occurred. During the on-site interview, staff members confirmed there were no processes for staff education regarding advance directives. **BHI** must develop a mechanism to address education of staff concerning its policies and procedures on advance directives, and revise the Advance Directives policy accordingly.

Standard VI—Grievance System

Summary of Findings and Opportunities for Improvement

There was ample evidence that **BHI** had a well-defined process for grievances and appeals. This process included assisting members with access to the State fair hearing process. **BHI**'s member handbook informed members that they may file grievances and appeals orally or in writing, and HSAG found evidence that **BHI** accepts grievances and appeals both orally and in writing. **BHI** maintained a grievance and appeal database, individual appeal records, and reported grievances and appeals to the Department quarterly, as required.

BHI's grievance and appeal processes included a mechanism to extend resolution dates if requested by the member or if **BHI** needed additional information to make the determination. **BHI** also had an expedited appeal process that included the required provisions. **BHI**'s member handbook included information about the process for members to request continuation of previously authorized services during the appeal or State fair hearing. While a certain portion of this language was technically correct, **BHI** may want to consider revising the member handbook language regarding this requirement. The handbook states, "…ten days pass after we mail the original notice to you that we are denying the appeal." HSAG recommends removing the word "original," as it may be confusing and lead the member to believe this refers to the notice of action.

BHI had revised only some of the relevant documents, or the revisions may not have been consistent between documents. HSAG suggests that the **BHI** management team review documents, training materials, provider materials, and member materials for consistency between documents and interaction of processes as depicted throughout the documents.

Summary of Strengths

During the on-site record review, HSAG found good documentation of contact with the member throughout the appeal process. Appeals were resolved and resolution letters sent within the required time frames. Appeal resolution letters were written using easy-to-understand language. One appeal record demonstrated that all written member communication (the notice of action and the notice of resolution) were written and sent to the member in Spanish. **BHI**'s process for deciding appeals using a panel review was a clear strength. Using this process ensured that members had the opportunity to attend the panel and present evidence and that decision makers were not involved in previous levels of review. Panel members consisted of board certified psychiatrists and clinical team members from the two community mental health centers (CMHCs) that had not been involved with the original notice of action.

Grievance database reports and quarterly reports submitted to the Department demonstrated that grievances were also resolved, with notice provided to the member within the required time frames. Grievance resolution letters were also written in easy-to-understand language.

Summary of Required Actions

While **BHI** began implementing the revised rule from the 20-calendar-day time frame to the 30-calendar-day time frame for filing appeals and for requesting the State fair hearing, there was not consistency between documents. The time frames for filing appeals and requesting a State fair hearing, depicted in the notice of action and the appeal resolution letters sent during the review period were inaccurate. **BHI** must review its processes to ensure that members receive accurate information provided during the appeal process regarding the time frame for filing appeals.

Although **BHI**'s documents (including policies, procedures, and the training PowerPoint presentation) clearly described appeal acknowledgement, this process had not occurred during the review period. Training materials related to the grievance system included inaccurate information regarding the format of appeal resolution notices. **BHI** must review and revise training materials and other applicable documents to ensure consistency and accuracy of information given to staff and providers related to the processing and resolution of appeals. **BHI** must evaluate its systems and take steps to ensure that appeal acknowledgement letters are sent within the required time frame and that **BHI**'s policies and procedures regarding the appeals process are followed.

BHI's appeal resolution template letter included an inaccurate time frame for requesting a State fair hearing related to the continuation of previously authorized services. **BHI** must revise templates used for member communication during the review process to accurately state that members may request continuation of services (during the appeal or State fair hearing processes and when applicable) within 10 calendar days of the notice of action, or before the effective date of the intended action.

While **BHI**'s provider manual included the grievance and appeals policies—which had been revised to depict correct filing time frames for grievances, appeals, and for requesting State fair hearings—the manual also contained a copy of the member handbook—which depicted incorrect filing time frames. **BHI** must review distribution patterns for the member handbook and ensure that all documents, including the provider manual and mailings or postings that reproduce the member handbook, contain the correct information.

Standard VII—Provider Participation and Program Integrity

Summary of Findings and Opportunities for Improvement

BHI had a thorough process for evaluating providers through its credentialing and recredentialing program. **BHI**'s credentialing and recredentialing program was consistent with NCQA requirements. **BHI**'s policies and procedures included the required provisions related to nondiscrimination and provider-member communication. **BHI** had a mechanism for monitoring the Office of Inspector General (OIG) list of excluded individuals and entities at initial contracting or employment and for providers on a monthly basis to ensure that **BHI** does not contract with or employ any individual who had been debarred or otherwise excluded from federal program participation.

Although **BHI** provided examples of several methods of monitoring the services furnished to members, there was not a consistent approach to reviewing and responding to the data, such as through Quality Improvement (QI) or Utilization Management (UM) committee review and approval of reports and patient outcomes measures. **BHI** should consider routine measuring and reporting to appropriate oversight committees regarding the results of monitoring for quality and appropriateness of services and patient outcomes, as addressed in **BHI**'s policies and procedures and program descriptions.

Summary of Strengths

BHI's corporate compliance plan was comprehensive and robust and **BHI** provided evidence of following procedures outlined in the corporate compliance plan in a case of suspected fraud. The case demonstrated preliminary investigation to confirm suspicion, immediate notification of the Department regarding suspicion, an exhaustive investigation of medical records against claims, and processing of results internally—including financial recovery, credentialing committee determinations, referral to legal authorities, and placement of members with appropriate alternative providers.

Summary of Required Actions

Although the annual 411 audits evaluated for some medical record requirements for the CMHC providers, there was not a comprehensive review of CMHC records for compliance with all medical record requirements. **BHI** had suspended its audit process for CMHC medical records during the review period. **BHI** must ensure that it monitors for compliance with all medical record requirements for CMHC providers.

Standard IX—Subcontracts and Delegation

Summary of Findings and Opportunities for Improvement

BHI provided HSAG reviewers with evidence that it conducted oversight of its delegates in some manner and therefore remained accountable for any delegated functions. **BHI** had a written agreement with each delegate that included the majority of the required provisions. **BHI** provided evidence of having requested corrective action plans, where appropriate and having worked with the CMHCs to follow up.

Formal review in the form of comprehensive audit, conducted in June 2010 for the three CMHCs provided evidence of meeting the Department's contract requirement for formal delegation review.

Summary of Strengths

BHI had a process for evaluating prospective delegates for the ability to perform the activities to be delegated, and described its pre-delegation evaluation activities conducted prior to delegating certain functions to Colorado Access. Ongoing reports submitted by Colorado Access included information regarding the progress and status of each delegated activity and information about activities that were further subcontracted to DST Solutions.

Summary of Required Actions

BHI's Delegation policy addressed annual audits, but did not address ongoing monitoring. Although there was clear evidence of ongoing monitoring for Colorado Access (**BHI**'s administrative service organization [ASO]), there was no organized information or evidence regarding the ongoing monitoring of the CMHCs for the performance of utilization management activities. While **BHI** conducted a formal review of the three CMHCs, there was incomplete evidence of a formal review of Colorado Access since the delegation agreement was entered into in July 2009. **BHI** must revise its current policies and procedures or develop new policies and procedures to address requirements related to the provision of ongoing monitoring of its subcontractors and delegates. **BHI** must also ensure the completion of both ongoing monitoring and formal review (according to the State-established schedule) for each of its delegates.

BHI must review delegation agreements with the CMHCs to specify reporting responsibilities related to the delegated activity and the provision to require reporting of federal expenditures from all sources equal to or in excess of $500,000. **BHI** must ensure accurate description of performance evaluation in the delegation agreements.

3. Follow-Up on FY 2010–2011 Corrective Action Plan

for **Behavioral HealthCare, Inc.**

Methodology

As a follow-up to the FY 2010–2011 site review, each BHO that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the BHO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether 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 2010–2011 compliance monitoring site review.

Summary of 2010–2011 Required Actions

As a result of the 2010–2011 site review, **BHI** was required to submit a corrective action plan that addressed the following:

- The on-site record review did not contain clear documentation that authorization denials were based on utilization review (UR) criteria. In addition, there were notices of actions sent for situations that may not have required a notice of action. **BHI** was required to ensure that all denial decisions were based on UR criteria.
- **BHI**'s Utilization Management program description stated that **BHI** UM staff engaged in ongoing consultation with the provider throughout the episode of care; however, it 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** was required to ensure that the appropriate policy included a mechanism to consult with the requesting provider and to adequately document any and all consultation with the requesting provider, if applicable.
- HSAG found that the template **BHI** used for notice of actions included an incorrect time frame for appeal and/or requesting continuation of benefits related to cases that involved the termination, suspension, or reduction of previously authorized services. **BHI** must revise its template to include accurate time frames. 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.

- **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** was required to revise existing policies or develop new policies to address continuity of care for services provided.

Summary of Corrective Action/Document Review

BHI submitted its proposed plan of corrective action to HSAG and the Department in May 2011. HSAG and the Department determined that, if implemented as written, **BHI** would address all required actions. HSAG and the Department approved **BHI**'s plan on May 25, 2011.

BHI submitted documents that demonstrated it had implemented its plan at the end of June 2011. HSAG and the Department reviewed the documents and concluded that **BHI** had successfully completed all required actions in July 2011.

Summary of Continued Required Actions

BHI successfully addressed all FY 2010–2011 required actions. There were no required actions continued from FY 2010–2011.

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor provides all enrollment notices, informational materials and instructional materials relating to members in a manner and format that may be easily understood. ◆ The Contractor makes written information available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency and informs members of how to access those formats. *42CFR438.10(b)(1),(d)* *Contract: II.F.4.a, d, g*	BHI Member and Family Handbook BHI Member and Family Handbook Large Print BHI Member and Family Handbook Spanish OMFA-605 Member Client Rights ppFY12 (Page 1) OMFA-609 Written Member Materials-Prevalent Languages & Alternate Formats ppFY12 BHI members receive enrollment notices upon Medicaid eligibility through a mailer that includes the BHI Member and Family Handbook. This information is available on tape, English, Spanish, other languages, and Large Print formats. The materials are also written at a 6th grade reading level. The Member and Family Handbook contains information specific to the benefit plan, member rights, grievance and appeals processes, etc. Page 1 of the BHI Member and Family Handbook provides members with contact information on how to obtain all member materials in other formats that may be necessary to help meet special needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Member and Family Handbook (member handbook) was available in English, Spanish, and large print formats. The Member and Family Handbook welcome page stated that the handbook was available in large print, on tape, or in another language, and provided a contact number for requests. The handbook listed the teletypewriter (TTY) number and contained a Spanish statement regarding the availability of the information in Spanish. Members were encouraged to call the BHI customer service number for an explanation of any information in the handbook. The handbook was written in easy-to-understand language.

The Written Member Materials—Prevalent Languages and Alternative Formats policy stated that BHI would notify all members through the new member mailing that written information is available, upon request, in prevalent non-English languages (Spanish) and alternate formats (large print and audio tape), with instructions on how to access these resources. The policy stated that members would be referred to the BHI customer service telephone number for requests and alternative formats would be forwarded within 10 days of the request.

Required Actions:
None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. ◆ The Contractor educates members on: • The availability and use of the mental health system. • Appropriate preventative health care procedures. • Self care. • Appropriate health care utilization. • How to navigate the mental health system. • How to locate information and updates to the Colorado Prescription List (PDL) program. *42CFR438.10(b)(3)* *Contract: II.F.4.b, h*	BHI Member and Family Handbook (Pages 10, 15, 16, 21) www.bhicares.org OMFA-606 Member Information ppFY12 ADMHN wellness flyer WRAP March 2011 Quarterly Resource Day at CC - Medicaid mailing Online Screenings OMFA-611 Wellness Programming ppFY12 BHI's Member Information policy describes the type of information that is provided to members as well as the mechanism to help members understand the plan requirements and benefits. BHI informs members of the Medicaid requirements and benefits through the BHI Member and Family Handbook, on BHI's Web site, and by calling the main phone number. BHI's Web site provides all the above information including the BHI Member and Family Handbook. Resources on the Web site include educational material, screenings, and programs for prevention such as smoking cessation and nutrition education. BHI's wellness program, drop in centers, and peer specialists serve as mechanisms for outreaching members and community stakeholders to help understand the requirements and benefits of the plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Member Information policy stated that BHI will mail informational materials to members within a reasonable time after notification of enrollment. The policy also described the required content of the Member and Family Handbook. The Member and Family Handbook included information regarding types of services available, a description of routine mental health benefits—including limitations and required authorizations, a description of when and how to access after-hours and emergency services, provider listings, what to expect in appointment availability, and any expected costs if the member chooses to receive non-covered or non-authorized services. The handbook also included a description of wellness services and provided frequent

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
reference to the BHI customer service telephone number for assistance with access to services, as well as the contact numbers for obtaining information on covered medications and Medicaid services that are provided outside of the BHI plan. The BHI member Web site provided access to the Member and Family Handbook, as well as online wellness and prevention information and screenings. Flyers advertising the BHI Quarterly Resource Day (wellness flyer, quarterly resource day mailer) were mailed to members to invite participation in community-based programs that included information on nutrition, relaxation therapies, physical exercise, and community resources. The Wellness Recovery Action Plan (WRAP) brochure described the eight-week program designed to assist members with incorporating wellness tools and strategies into their lives to maintain long-term mental health wellness.		
Required Actions: None.		
3. The Contractor makes its written information available in the prevalent non-English languages in its particular service area and notifies its members that written information is available in prevalent non-English languages and how to access those materials. *42CFR438.10(c)(3) and (5)* *Contract: II.F.4.c*	BHI Member and Family Handbook (Page 1) BHI Member and Family Handbook Spanish OMFA-609 Written Member Materials-Prevalent Languages & Alternate Formats ppFY12 OMFA-607 Protocol for Accessing Interpreter Service ppFY12 BHI has policies that guide the dissemination of written material in the prevalent non-English languages. Information on how to obtain translated versions of written material is available on our Web site, in our member handbooks, and by calling BHI's main number.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member and Family Handbook was available in English and Spanish. The welcome page stated that the handbook was available in large print, on audio tape, or in another language, and provided a contact number for requests. The handbook also contained a statement in Spanish regarding the availability of information in Spanish. The Written Member Materials—Prevalent Languages and Alternative Formats policy stated that BHI would notify all members through the new member mailing that written information is available, upon request, in prevalent non-English languages (Spanish), including instructions on how to access these resources. The policy stated that members would be referred to the BHI phone number for requests and alternative formats would be forwarded within 10 days. The Member Client Rights policy stated that the member has a right to receive information in prevalent languages of the area. The member handbook also included a listing of these member rights. The Protocol for Accessing Interpreter Service policy stated that oral interpreter services would be provided for any non-English language, not just those determined to be prevalent in the community.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
During the on-site interview, BHI staff members stated that Spanish is the only non-English language prevalent enough among members to require routine printing of member materials. Staff members confirmed that numerous other languages are spoken among members, and that Cyracom is the subcontractor for document translation on an as-needed basis. BHI described an example of having had the entire member handbook translated into Korean within a five-day time frame.		
Required Actions: None.		
4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services. *42CFR438.10(c)(4)&(5)* *Contract: II.F.4.c, f*	BHI Member and Family Handbook (Page 24) BHI Member and Family Handbook Spanish OMFA-606 Member Information ppFY12 (Page 5) OMFA-607 Protocol for Accessing Interpreter Service ppFY12 (Page 1) The member handbook provides notification that members can get services from a provider who speaks their language or interpretation services in any language needed. BHI has policies such as the Member Information policy and the Protocol for Accessing Interpreter Services that mandates BHI providers to make oral interpretation services available.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Protocol for Accessing Interpreter Service policy outlined the procedure for providers to access oral interpreter services and stated that oral interpreter services would be provided for any language free of charge through BHI's interpreter vendor, Cyracom, or an interpreter of the provider's choice. The policy stated that BHI would notify clients of the availability of interpreter services and how to access them. The Member Information policy stated that new member materials would include the right for members with communication disabilities or for non-English speaking members to receive oral interpretation services. Member materials also included both a statement that oral interpretation services are available in any language and instructions on how to access these resources. The member handbook informed members of the right to receive interpreter services in any language. Each page of the handbook directed members to the toll-free and local telephone number for BHI for questions or to ask for help. Members were also directed to the BHI Web site for additional information.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
5. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information, upon request [information required at 438.10(f)(6) and 438.10(g)(and (h)]. *42CFR438.10(f)(2)* *Contract: II.F.4.m*	OMFA-606 Member Information ppFY12 (Page 5) English Annual Mailer letter Spanish Annual Mailer letter BHI Provider List HIPAA Notice English HIPAA Notice Spanish Written information is available via our Web site, a mailer at the time of enrollment, annual mailing to all members, and by calling BHI's main phone number, (720) 490-4400. The monthly mailer includes an informational letter, Member and Family Handbook, HIPAA Notice, and provider list. In addition, an annual mailer of the Member and Family Handbook is sent to all members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Member Information policy stated that upon enrollment, members would receive the information listed in the policy and be notified annually of their right to request and receive information that includes a provider listing; any restrictions on freedom of choice of providers; member rights; grievance and appeals procedures; scope of benefits and authorization requirements; emergency, after-hours, and post-stabilization coverage; advance directives; specialty referrals; out-of-network and transportation services; and structure and operations of BHI.

The annual member letter, available in Spanish and English, informed members of their right to request a copy of the member handbook. The letter summarized the type of information available in the member handbook, including information on covered services, member rights, approval processes, referrals, emergency services, advance directives, and grievances and appeals. The letter directed members to call BHI's customer service to request a copy of the handbook. The member handbook also referred members to the BHI Web site for the detailed BHI provider list.

Required Actions:
None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
6. The Contractor gives written notice of any significant change (as defined by the State) in the information [required at 438.10(f)(6) and 438.10(g)] provided to members at least 30 days before the intended effective date of the change. *42CFR438.10(f)(4)* *Contract: II.F.4.k*	BHI Member and Family Handbook (Page 9) OMFA-606 Member Information ppFY12 (Page 5) BHI's Member Information policy addresses the requirement to give members written notice of significant changes. BHI's Member and Family Handbook also includes this information in 6th grade reading level to help notify members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Information policy stated that BHI would notify members of any significant change in information (as specified in detail in the policy), including member benefits, access to benefits, member rights and protections, grievances and appeals, or advance directives at least 30 days prior to the effective date of change. The Member and Family Handbook informed members that they would be notified in writing 30 days before a change "that may decrease or increase your mental health benefits or services."		
Required Actions: None.		
7. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary mental health care from, or was seen by, the terminated provider. *42CFR438.10(f)(5)* *Contract: II.F.4.l*	BHI Member and Family Handbook (Page 9) CRED-404 Client Notification of Termination of Providers ppFY12 Provider Termination Member Notification Letter Template BHI's policy on client notification of termination of providers addresses the requirement to give written notice to the member regarding termination of a member's contracted provider. BHI's Member and Family Handbook also includes this information in 6th grade reading level.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Client Notification of Termination of Provider policy stated that BHI would notify members of termination of their primary mental health provider within 15 days of receipt of a provider termination notice. The policy applied to members who have a direct relationship with the terminated provider. The Member and Family Handbook informed members that they would be notified in writing within 15 days of learning that the member's provider was leaving the BHI network, and that BHI would help members find a new provider. The notification of provider termination letter template, sent from the Provider Relations department, stated that BHI would work with the member to ensure continuation of needed services and transfer of information, and assist with the selection of a new provider. The BHI contact number for questions or assistance was listed twice in the letter. During the on-site interview, BHI staff members stated that there were three providers who terminated their relationship with the network in 2011, but		

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Requirement	**Evidence as Submitted by BHO**	**Score**
that none of those providers were serving any BHI members at the time of termination; therefore, notification of provider termination letters were not sent. Staff members described a case during 2010, in which a provider with multiple members was terminated by BHI. HSAG reviewed the case on-site. The notification of provider termination letters that were sent demonstrated that notification was sent more than two months prior to termination, and staff members stated that during that time, BHI worked closely with the provider to transfer all members into appropriate placement for their continued care.		
Required Actions: None.		
8. The required information (438.10(f)(6) and 438.10(g) is furnished to members within a reasonable time after notification from the State of the recipient's enrollment and includes: ◆ Notice that the member has been enrolled in the Community Mental Health Services Program operated by the Contractor and that enrollment is mandatory. ◆ The Contractor's hours of operation. *42CFR438.10(f)(3)* *Contract: II.F.4.i, j*	BHI Member and Family Handbook (Page 1) BHI sends out a monthly mailer to all new enrollees that includes the Member and Family Handbook. The handbook explains the program and provides hours of operation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Information policy stated that BHI would furnish information in writing to all new members within a reasonable time after it received notice of the recipient's enrollment, and outlined the specific information as specified in 438.10 (f)(6) and 438.10(g). The policy also specified additional information to be provided to members, which included hours of operation, and notice that the member was mandatorily enrolled in BHI. The welcome page of the member handbook explained that Medicaid recipients in Arapahoe, Douglas, or Adams Counties or the City of Aurora were automatically enrolled with BHI for mental health care. Hours of operation for BHI were specified, with after-hours telephone availability. During the on-site interview, staff members explained that the enrollment packet is sent to all new enrollees during their enrollment month and distribution is tracked by cross-checking the number of monthly enrollees with the number of units billed by the mailing service. In addition, staff members stated that all of the information in the member handbook was available to members at any time through the BHI Web site.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
9. The member information materials sent following enrollment include: ◆ Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers, including identification of providers who are not accepting new patients. ◆ Any restrictions on freedom of choice among network providers. *42CFR438.10(f)(6)(i) and (ii)* *Contract: II.F.4.i.1, 2*	QI-704 Network Adequacy ppFY12 BHI Member and Family Handbook (Page 16) BHI Provider List BHI's Network Adequacy policy guides BHI in maintaining a network that serves members with specific language needs. A provider list is available online, mailed out with our handbooks, and can be obtained by calling BHI's main number, (720) 490-4400. BHI does not restrict choice for network providers as long as the provider is able to meet credentialing guidelines. BHI has 121 Single Case Agreements that support member choice.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Member Information policy stated that member materials on enrollment would include a provider listing of names, locations, telephone numbers, non-English languages spoken by contracted providers, and identification of providers not accepting new patients. The policy also stated that materials would include any restrictions on the member's freedom of choice among network providers. The BHI Provider List, mailed to members at the time of enrollment and available on the BHI Web site, included city location, name and licensure of provider, address, phone number, type of provider (e.g., mental health center, individual provider), non-English languages spoken, and ages served. The Web site listing included a statement that all providers were accepting new patients.

The Member and Family Handbook welcome page and "Choice of Providers" section listed the BHI affiliated Community Mental Health Centers and contact numbers and directed members to the provider directory for choice of other providers. The handbook stated that the provider directory was included with the member handbook and could also be obtained online at the BHI Web site or by calling the BHI contact number provided. The handbook stated that the member may choose any provider from the provider directory or call BHI for any special provider requests, such as cultural background, language, or specialty. During the on-site interview, BHI staff members described that they are proceeding with a phone survey of all providers to update information in the provider listing, including a reconfirmation that providers are accepting new patients. This information will also be used to update the Web site provider listing.

Required Actions:
None.

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Requirement	**Evidence as Submitted by BHO**	**Score**
10. The member information materials sent following enrollment include the following member rights and protections as specified in 42CFR438.100(b)(2)–(3) and in the Medicaid managed care contract. Members have the right to: ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. ◆ Request and receive a copy of his or her medical records, and request that they be amended or corrected. ◆ Be furnished health care services in accordance with federal healthcare regulations for access and availability, care coordination and quality. ◆ Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its providers, or the State Medicaid agency treats the member. *42CFR438.10(f)(6)(iii)* *Contract: II.F.4.i.3*	OMFA-605 Member Client Rights ppFY12 BHI Member and Family Handbook (Pages 24, 25) BHI's Member and Client Rights policy describes all member rights and protections. This information is disseminated to members through the Member and Family Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member and Client Rights policy stated that members would receive information on their member rights within one month of enrollment or on request, and outlined specific rights to be addressed, including the rights to: be treated with respect, dignity, and privacy; participate in decisions regarding his or her health care, including the right to refuse treatment; receive information on available treatment options; be free from any form of		

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restraint or seclusion; request and receive a copy of medical records, and request that the records be corrected; receive information about mental health benefits and how to access care; and to be free to exercise rights without adverse treatment by BHI or providers. The Member and Family Handbook outlined each of the above member rights in easy-to-understand language in the "Your Rights" section. In addition the handbook explained that members could choose their own provider within the network, and could apply to be exempt from BHI if they were receiving ongoing treatment outside the network. The handbook frequently referenced the BHI contact number for members seeking assistance in obtaining access to services or arranging for special services. BHI's Notice of Privacy Rights, available in English and Spanish (distributed in the member enrollment packet), described HIPAA regulations in an easy-to-understand format, including: when information can be shared without member permission; when member permission is required for disclosure of information; member rights to obtain their own records, and request amendment of records. The notice also described members' rights to be informed of who receives protected health information (PHI), to restrict access to certain parties, and to request alternative modes of communicating PHI.		
Required Actions: None.		
11. The member information materials sent following enrollment include the following additional member rights. Members have the right to: ◆ Have an independent advocate. ◆ Request that a specific provider be considered for inclusion in the provider network. ◆ Receive a second opinion. ◆ Receive culturally appropriate and competent services from participating providers. ◆ Receive interpreter services for members with communication disabilities or for non-English speaking members. ◆ Prompt notification of termination or changes in services or providers. ◆ Express an opinion about the Contractor's services to regulatory agencies or the media without the Contractor causing any adverse effects upon the provision of covered services. *Contract: II.F.4.j.3*	OMFA-605 Member Client Rights ppFY12 BHI Member and Family Handbook (Pages 9, 16, 17, 24, 25) BHI's Member and Family Handbook includes all the additional member rights that are required by BHI's contract with HCPF.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: The Member and Client Rights policy stated that members would receive information on their member rights within one month of enrollment or on request, and outlined specific rights to be addressed, including the rights to: have an outside advocate; request that a specific provider be considered for inclusion in the provider network; receive a second opinion; receive culturally appropriate and competent services from participating providers; be told immediately if his or her provider has changed; receive help with communication difficulties, including services for non-English speaking members; and share concerns about BHI's services to government agencies or the media without any adverse effects on care. The Member and Family Handbook outlined each of the these member rights in easy-to-understand language in the "Your Rights" section. In addition, the policy stated that member rights were posted at all provider sites, on the BHI Web site, and communicated to providers in the provider manual. During the on-site interview, HSAG confirmed that member rights were posted on the BHI Web site and at the provider sites.		
Required Actions: None.		
12. Members are informed in these materials about: ◆ Assistance available through the Medicaid Managed Care Ombudsman program. ◆ Appointment Standards for routine, urgent and emergency situations. ◆ Procedures for requesting a second opinion. ◆ Procedures for requesting accommodation for special needs. ◆ Procedures for arranging transportation. ◆ Information on how members will be notified of any changes in services or service delivery sites. ◆ Procedures for requesting information about the contractor's quality improvement program. ◆ Information on any member and/or family advisory board(s) the contractor may have in place. *Contract: II.F.4.j.4–11*	BHI Member and Family Handbook (Pages 9, 16, 17, 18, 21, 24, 30, 35) OMFA-606 Member Information ppFY12 UM-801 Access and Availability ppFY12 (Page 3) UM-805 BHI Treatment Responsibilities ppFY12 UM-812 Psychiatric Consultations, Second Opinions ppFY12 CRED-404 Client Notification of Termination of Providers ppFY12 MAB Pamphlet What the Recovery Committee Does BHI's Member and Family Handbook includes information on these requirements. BHI's policy on member information indicates the need to provide members with information on the Ombudsman program as well how to access transportation. BHI's Access and Availability policy describes access and availability standards. BHI also has policies on requesting second opinion, requesting accommodation for special needs, and notification of service changes.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
	BHI posts flyers at the BHI drop in centers and Community Mental Health Centers (CMHCs) sites to inform members of advisory boards and committees.	

Findings:

The Member and Family Handbook:

- informed members of the availability of the Medicaid ombudsman to assist members with filing grievances and provided the local, toll free, and TTY phone contact numbers.
- described appointment access time frames for routine and urgent appointments and for follow-up visits after hospitalization, and provided the BHI phone number for assistance with obtaining appointments.
- described how to access emergency services and expected provider response times in emergency situations.
- described the process for obtaining a second opinion with examples of when to request a second opinion.
- instructed members to call the BHI Director of Utilization Management (UM) at the BHI contact number for assistance with special needs, such as finding a specialist or a non-English-speaking provider or provider of a particular cultural background.
- provided the contact numbers for the transportation vendor or BHI customer service for assistance with transportation needs.
- described the Quality Improvement Program and informed members that information was available on the Web site, through member newsletters, or by contacting BHI to request information about the QI program.

The corresponding member rights statements were included in the "Your Rights" section of the handbook. In addition, the member handbook included a brief description of the function of the Member Advisory Board with an invitation to members to participate and a phone number to request information. The handbook also included a statement of the member's right to "be notified promptly of any changes in benefits, services, or providers" and described that members would be informed in writing 30 days before any increase or decrease in mental health benefits and within 15 days of notice of termination of the member's provider. The Member Advisory Board brochure described the role of the Member Advisory Board, invited members to participate, and provided location, schedule, and contact information.

During the on-site interview, BHI staff members discussed the role of the Member Advisory Board, which rotates monthly meetings between provider centers to encourage participation and organizes member-related activities, such as member "Resource Day." Staff members stated that the Member Resource Board brochure is distributed to members at member events, is periodically included in monthly mailings, and is posted at all drop-in centers in the network.

Required Actions:

None.

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Requirement	**Evidence as Submitted by BHO**	**Score**
13. The member information materials sent following enrollment also include the following information regarding the grievance, appeal, and fair hearing procedures: ◆ The right to file grievances and appeals. ◆ The requirements and time frames for filing a grievance or appeal (including oral filing). ◆ The right to a State fair hearing: • The method for obtaining a State fair hearing, and the rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone. ◆ The fact that, when requested by the member: • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing, and the service authorization has not expired. • The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The right that providers may file an appeal on behalf of the member with the member's written consent. *42CFR438.10(f)(6)(iv) and438.10 (g)(1)(i–vii)* *Contract: II.F.4.i.4 and II.F.4.i.13*	BHI Member and Family Handbook (Pages 28, 29, 30, 31, 32, 33, 34, 35) OMFA-603 Grievance procedure UM - 804 Appeal Process ppFY12 BHI's policies on grievances and appeals describe the grievance, appeal, and State Fair Hearing procedures. This information is disseminated to members through Member and Family Handbook.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The member handbook included a statement regarding the member's right to file appeals and grievances. The "Grievance and Appeals" section of the member handbook described the grievance and appeals processes, included definitions of grievances and appeals with examples of when to file a grievance and an appeal, and included the time frames for filing. The handbook informed members how to file a grievance or an appeal, including contact

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numbers for assistance; the process for resolving grievances and appeals; information for contacting the Department for a second level review of a grievance, and how to request a State fair hearing. The handbook also included contact information for the Medicaid ombudsman, and other advocate groups for help with grievances and appeals. The handbook described the circumstances under which the member may request continuation of benefits during the appeal and the State fair hearing and payment implications if the appeal or hearing decision is not in favor of the member. The handbook informed members that the State fair hearing could be requested instead of, during, or after the BHI appeal process. The member handbook depicted the time frame for filing grievances and appeals and for requesting a State fair hearing as 20 calendar days. Under the continuation of services section the timely filing for appeals when requesting the continuation of previously authorized services was stated as, "Within 10 calendar days from the date on the letter, or before the authorization ends, whichever is less time." During the on-site review, HSAG staff members discussed the discrepancy in the required filing time frames between the Colorado Rule, the BHI policies, and the BHI Member and Family Handbook. BHI stated that revised copies of the member handbook were being printed.		
Required Actions: BHI must revise the information in its Member and Family Handbook regarding time frames for filing grievance, appeals, and requests for a State fair hearing to comply with the Colorado Rule and BHI policies, and reflect the 30-calendar-day-time frame for each. BHI must also revise the section of its member handbook that explains the continuation of services during an appeal related to the termination of previously authorized services. The handbook must accurately reflect the required time frame for filing an appeal or requesting a State fair hearing if requesting the continuation of previously authorized services (within 10 days from date of the notice of action or before the effective date of the termination or change in services, whichever is later).		
14. The member information materials sent following enrollment include: ◆ The amount, duration and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. ◆ Procedures for obtaining benefits including authorization requirements. ◆ The extent to which and how members may obtain benefits, from out-of-network providers. *42CFR438.10(f)(6)(v) through (vii)* *Contract: II.4.i.5–7*	BHI Member and Family Handbook (Pages 8, 9, 15, 16, 17, 20) UM-805 BHI Treatment Responsibilities ppFY12 BHI's policy on treatment responsibilities describes the amount, duration, and scope of benefits. Procedures for obtaining benefits, and how to receive services from out of network providers is also described in this policy. This information is disseminated to members through the Member and Family Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member and Family Handbook provided a description of the types of services available and provided a summary of routine benefits with defined limitations and authorization requirements for each type of service. The handbook indicated which services require authorization, and stated that		

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authorization would be requested by the provider. The handbook also informed members that utilization review criteria was used to determine necessity of services. Members were instructed to call the UM Department Manager at the BHI phone number for assistance with out-of-network provider requests. The BHI contact number was referenced throughout the member handbook for questions and for assistance in obtaining services.		
Required Actions: None.		
15. The member information materials sent following enrollment include the extent to which and how after hours and emergency coverage are provided, including: ◆ What constitutes an emergency medical condition, emergency services, and post-stabilization care services with reference to the definitions in 42CFR438.114(a). ◆ The fact that prior-authorization is not required for emergency services. ◆ The process and procedures for obtaining emergency and post-stabilization services, including the use of the 911-telephone system or its local equivalent. ◆ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services. ◆ The fact that the member has the right to use any hospital or other setting for emergency care. *42CFR438.10(f)(6)(viii)* *Contract: II.F.4.i.8*	BHI Member and Family Handbook (Pages 11, 12, 13, 14, 15) 818 Emergency and Post Stabilization Services ppFY11 BHI's policy on emergency and post stabilization describes how after hours and emergency coverage is provided. This information is disseminated to members through the Member and Family Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post-stabilization Services policy provided a definition of emergency services and post-stabilization services in accordance with definitions outlined in 42 CFR 438, and described that the member may access emergency services at the nearest provider, whether contracted or non-contracted by BHI; that services may be accessed through 911; and that emergency services do not require prior authorization.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
The Member and Family Handbook included a section "How to Get Emergency Mental Health Services," which included a definition of emergency, urgent, and post-stabilization care in easy-to-understand language; a listing of in-network locations for emergency care and a statement that members should go to any nearby emergency facility, even if it is out-of-network; a description of types of mental health emergency care, including crisis intervention, inpatient hospital, acute treatment unit, and post-stabilization services; instructions to use 911; a description that authorization is not required for emergency care, and that the provider would arrange for authorization of follow-up care.		
Required Actions: None.		
16. The member information materials sent following enrollment include the poststabilization care services rules at 422.113(c) and include: ◆ The contractor's financial responsibilities for poststabilization care services obtained within or outside the organization that are pre-approved by a plan provider or other plan representative. ◆ The contractor's financial responsibilities for poststabilization care services obtained within or outside the organization that are not pre-approved by a plan provider or other plan representative. ◆ That charges to members for poststabilization services must be limited to an amount no greater than what the organization would charge the member if he or she had obtained the services through the Contractor. ◆ That the organization's financial responsibility for poststabilization services it has not approved ends when: • A plan physician with privileges at the treating hospital assumes financial responsibility for the member's care; • A plan physician assumes responsibility for the member's care through transfer; • A plan representative and the treating	UM-805 BHI Treatment Responsibilities ppFY12 (Page 4) 818 Emergency and Post Stabilization Services ppFY12 (Page 3) BHI Member and Family Handbook (Page 13) It is the policy of BHI to ensure compliance with federal Medicaid Regulations related to the provision and the payment of emergency and post-stabilization services for Medicaid enrollees. This information is disseminated to members through the Member and Family Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
physician reach an agreement concerning the member's care; or • The member is discharged. *42CFR438.10(f)(6)(ix) and 42CFR422.113(c)* *Contract: II.F.4.i.9*		
Findings: The Emergency and Post-Stabilization policy stated that the member has a right to information on enrollment and annually thereafter concerning post-stabilization services, including that the enrollee is not liable for payment of screening and treatment necessary to stabilize the enrollee and that the attending physician determines when the enrollee is sufficiently stabilized for transfer or discharge. The policy also stated that BHI would be responsible for payment of authorized post-stabilization services in the specific circumstances outlined at 42CFR422.113 and that payment for post-stabilization services would end when one of the following occurs: a BHI plan physician assumed responsibility for care; BHI and the treating physician reached an agreement regarding care; or the member was discharged. The Member and Family Handbook included a definition of post-stabilization services in easy-to-understand language, and informed members that post-stabilization services were provided without limit based on provider justification and required authorization, which the provider would request.		
Required Actions: None.		
17. The member information materials sent following enrollment include: ◆ Policies on referral for specialty care and other services not provided by the member's care provider. ◆ That no fees will be charged for covered mental health services provided to members. ◆ How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract including how transportation is provided. *42CFR438.10(f)(6)(x) through (xii)* *Contract: II.F.4.i.10–12*	UM-805 BHI Treatment Responsibilities ppFY12 (Page 1, 2, 4) CRED-402 Prohibition of Provider Discrimination ppFY12 BHI Member and Family Handbook (Pages 6, 9, 10, 16, 17) A member can call any one of the BHI service locations or private provider offices in the community to request services, including specialty care. This information is disseminated to members through the Member and Family Handbook. BHI does not discriminate against particular practitioners that serve high-risk populations, or specialize in conditions that require costly treatment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: The BHI Treatment Responsibilities policy stated that BHI has a responsibility to provide referral for specialty care and other services not provided by the member's care provider; refer clients to other health care and human service agencies and providers as appropriate. The policy also stated that all medically necessary covered mental health services would be provided at no cost to the member. The Member and Family Handbook stated that all mental health services were free of charge as long as they were in-network, medically necessary, and authorized, if required. The handbook also described: ◆ that members could choose their provider and directed members to call BHI for assistance to find a specialist or with out-of-network provider requests ◆ the availability of other Medicaid services not covered under BHI, including physical health, long-term care, or home care services ◆ the contact number for the transportation vendor, as well as the BHI contact number for assistance with transportation needs		
Required Actions: None.		
18. Advance directives requirements: The Contractor maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving care by or through the BHO. Advance directives policies and procedures include: ◆ A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • The difference between institution-wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. ◆ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time	OMFA-601 Advanced Directives ppFY12 BHI Member and Family Handbook (Pages 16, 19) BHI's Member and Family Handbook provides information about advanced directives, what they are according to Colorado law, and that BHI respects members' rights to formulate these directives. BHI also describes in the Member and Family Handbook the exceptions to when members' advanced directives will not be followed. The handbook lists the phone number to the state agency to call with complaints, if BHI does not follow members' advanced directives. BHI as a behavioral health agency will be responsible for educating providers and consumers about advanced directives through the Member and Family Handbook, Provider Manual, and provider contracts. BHI will inform emergency medical providers if a member has executed an advanced directive, but will not implement the actual directives as they fall under the purview of medical services. Therefore BHI policies do not state the specifics	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. ◆ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. ◆ Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. ◆ The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive. ◆ Provisions for ensuring compliance with State laws regarding advance directives. ◆ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. ◆ Provisions for the education of staff concerning its policies and procedures on advance directives. ◆ Provisions for community education regarding advance directives that include: • What constitutes an advance directive. • Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. • Description of applicable state law concerning advance directives.	on conscientious objections, range of medical conditions affected by conscientious objection, provisions for providing advanced directives to the incapacitated member, and community education. When a member is provided treatment at a medical facility, which is in BHI's provider network, the facility's policy on advanced directives will be followed. If this provider raises any objections to honoring member's advanced directives, BHI will assist the member in finding another provider. BHI will collaborate with other BHOs, in consultation with HCPF to review current advanced directives policies if needed.	

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Requirement	**Evidence as Submitted by BHO**	**Score**
The member information materials regarding advance directives include: ◆ The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. ◆ The Contractor's policies respecting implementation of advance directives. ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the Colorado Department of Public Health and Environment. *42CFR438.10(g)(2) and 42CFR422.128* *Contract: II.F.4.i.14*		

Findings:

The Advance Directives policy stated that:

- written information concerning advance directives would be provided to members upon enrollment and annually thereafter, including applicable state laws;
- any changes in state law would be incorporated into member information no later than 90 days after the effective date of change;
- core BHI providers would document member's advance directives in the medical record and would not provide care that conflicts with the advance directives, except in situations specified in state law;
- if any BHI provider could not comply with a member's advance directives based on objections of conscience, BHI would assist transfer of the member to a new provider;
- no member would be discriminated against or provision of care affected by the presence or absence of advance directives;
- providers would be informed of rights and responsibilities concerning advance directives through the BHI Web site, provider manual, and provider contract.

The provider manual included a copy of the Advance Directives policy and stated that internal staff members would receive training on advance directives at orientation and annually thereafter. However, the policy did not include the provision for staff education regarding advance directives and there was no evidence of staff education regarding advance directives. During the on-site interview, staff members confirmed there are no processes for staff education regarding advance directives.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
The Member and Family Handbook listed that the member had a right to: written information on advance directives; refuse or stop treatment, except as provided by law; and participate in decisions regarding their mental health care. The "Advance Directives" section of the handbook described, in easy-to-understand language, the purpose of advance directives and the various forms of advance directives, including living will, medical durable power of attorney, and cardiopulmonary resuscitation. The Colorado Department of Public Health & Environment contact information was provided for reporting concerns if advance directives were not followed. The handbook stated that BHI does not object to providing services based or moral or religious grounds. The handbook directed members to the BHI Web site for additional information on advance directives. The member Web site included the full BHI Advance Directives policy. During the on-site interview, BHI staff members stated that information concerning advance directives was distributed on enrollment through the Member & Family Handbook and that information was included on the BHI Web site for access at any time by providers, members, or the general community. Staff members stated that, since they are a behavioral health provider and by the nature of the State's automatic enrollment system, BHI would not be aware if the member were incapacitated at time of enrollment, but that information was distributed by mail on enrollment for access by family members or the member when no longer incapacitated. Staff members confirmed that BHI does not have any conscientious objection to provision of services. Staff members stated that issues regarding behavioral health advance directives vs. physical health advance directives were being discussed by the BHO collaborative committee as well as the BHI Provider Advisory Committee.		
Required Actions: BHI must develop a process to address education of staff concerning its policies and procedures regarding advance directives, and revise the Advance Directives policy accordingly.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
19. The member information materials sent following enrollment include: ◆ Notice that additional information that is available upon request, includes information on: • The structure and operation of the Contractor. • Physician incentive plans. *42CFR438.10(g)(3)* *Contract: II.F.4.i.15*	OMFA-606 Member Information ppFY12 (Page 4) BHI Member and Family Handbook (Page 27) BHI's policy on member information indicates that members can receive information on BHI's structure and operations and physician incentive plans. This information is disseminated to members through the Member and Family Handbook.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Information policy stated that members would be informed that they may receive information on request regarding the structure and operation of BHI and physician incentive plans. The Member and Family Handbook stated that members may request information at any time on how BHI is structured and how it operates and on BHI's quality improvement program.		
Required Actions: BHI must include a statement in the member information materials concerning the availability upon request of information concerning physician incentive plans.		

Results for Standard V—Member Information							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	19	**Total Score**		=	16

Total Score ÷ Total Applicable	=	84%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has a system in place that includes a **grievance** process, an **appeal** process, and access to the **State fair hearing** process. *42CFR438.402(a)* *Contract: II.F.10* *Grievance and Appeal State Rule (version 11—January 2011): 8.209*	UM-804 Appeal Process ppFY12 UM-810 Notice of Action (NOA) ppFY12 (Page 2) BHI Advocacy Contact Form 2005-10-21 Attachment-BHI Action and Appeals Training 30 day Appeal Information attachment Notice of Action letter template English Notice of Action letter template Spanish OMFA-603 Grievance Procedure ppFY12 BHI Member and Family Handbook (Pages 28-35) Provider Manual (Section VII: Grievance, Actions, and Appeals, PDF Page 199) BHI has several policies that describe the grievance and appeal process. These policies define a grievance and appeal, provide time frames for filing, follow-up, and resolution. The policies also delineate who can file the grievance, the steps to appeal processing, and the right to access the State Fair Hearing. Notice of Action letters are mailed to members along with the 30-day appeals information attachment. These inform the member on relevant processes and time frames for appeals and State Fair Hearing. BHI uses the Advocacy Contact Form to collect needed information for grievance review. BHI's Member and Family Handbook is in the process of being reviewed. BHI will update the timeline for filing grievances, appeals, and state fair hearing requests from 20 to 30 days. This version will be available at the site visit. Providers are trained on these processes through the BHI Action and Appeal PowerPoint that is used at the MHC new employee orientation and annually. The policies and provider manuals are	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	posted on BHI's Web site for access by CPN. Members are notified of the process through the BHI Member and Family Handbook.	
Findings: The Grievance Procedure policy described BHI's grievance processes. The Appeal Process policy described BHI's internal appeal processes and described processes for member access the State's fair hearing process. The Member and Family Handbook informed members of their right to file grievances, appeals, and to request a State fair hearing and informed members how to do so. The provider manual informed providers about BHI's member grievance and appeal processes and how members may access the State's fair hearing process. During the on-site record review, on-site review of reports printed from the grievance and appeal database, and discussions during the on-site interview, HSAG confirmed BHI's grievance and appeal processes.		
Required Actions: None.		
2. The Contractor defines Action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole, or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals. ◆ For a resident of a rural area with only one MCO or PIHP, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: • The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. • The provider is not part of the network, but is the main source of a service to the member—provided that:	UM-810 Notice of Action (NOA) ppFY12 (Page 1) BHI's Notice of Action policy defines the term action, explains the action process and its associated time frames. The policy also describes a member's right to request a provider from outside the network. BHI has strong participation in the Contracted Provided Network (CPN).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
o The provider is given the opportunity to become a participating provider. o If the provider does not choose to join the network or does not meet the BHO's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42CFR438.400(b)* *(42CFR438.52(b)(2)(ii)* *State Rule: 8.209.2*		
Findings: The Appeal Process policy and the Notice of Action policy included the required definition of action. The Member and Family Handbook described situations under which members were entitled to an appeal or access to a State fair hearing. The Member and Family Handbook description of when members may file an appeal was consistent with the federal health care definition of an action, and was at the required readability level. The on-site record review demonstrated that BHI's appeal process was based on the correct interpretation of actions and appeals.		
Required Actions: None.		
3. The Contractor defines Appeal as a request for review of an Action. *42CFR438.400(b)* *State Rule: 8.209.2*	BHI Member and Family Handbook (Page 30) Provider Manual (Section VII: Grievance, Action and Appeals, PDF Page 199) UM-804 Appeal Process ppFY12 (Page 1) Notice of Action Letter English (Page1) Notice of Action Letter Spanish 30 day Appeal Information attachment The Appeal policy defines an appeal as a request for review of an action taken by BHI. The Notice of Action Letter that a member, guardian, and/or designated client representative (DCR) receives also describes the right to file an appeal. Along with the Notice of Action Letter, there is an attachment included which describes	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	how to file an appeal or request a State Fair Hearing. The Member and Family handbook and the Provider Manual describes this process. Both the Member and Family Handbook and the Provider Manual are found on the BHI Web site.	
Findings: The Appeals Process policy stated the definition of appeal as a request for review of an action. The Member and Family Handbook defined appeal more descriptively and was at the required readability level. The appeal information attachment included the definition of action from the Member and Family Handbook. During the on-site interview staff members reported that BHI's UM staff members processed appeals.		
Required Actions: None.		
4. The Contractor defines Grievance as an oral or written expression of dissatisfaction about any matter other than an Action. *42CFR438.400(b)* *State Rule: 8.209.2*	BHI Member and Family Handbook (Pages 28, 29) OMFA-603 Grievance Procedure ppFY12 (Page 1) BHI's Grievance Procedure defines a grievance as an oral or written expression of dissatisfaction about any matter other than an action. The BHI Member and Family Handbook informs BHI members of the same definition in 6th grade reading level.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Grievance Procedure policy included the required definition of a grievance. The Member and Family Handbook informed members of their right to file grievances in a manner that was easily understood and provided examples of possible grievance situations. During the on-site interview, BHI staff members reported that BHI has grievance coordinators, employed by BHI's Office of Member and Family Affairs (OMFA), located at each community mental health center (CMHC)—1 child/family representative and 1 adult representative. BHI staff members stated that the on-site grievance coordinators processed the grievances and documented the content and timeliness of such using BHI's grievance and appeals database. Staff reported that grievances may also be filed through BHI's OMFA representative.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
5. The Contractor has provisions for who may file: ◆ A member may file a grievance, a BHO-level appeal, and may request a State fair hearing. ◆ A provider may file a grievance on behalf of a member, given that the State permits the provider to act as the member's authorized representative. ◆ A provider, acting on behalf of the member and with the member's written consent may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member, given that the State permits the provider to act as the member's authorized representative. *42CFR438.402(b)(1)* *State Rule: 8.209.2*	OMFA-603 Grievance Procedure ppFY12 (Pages 1, 2) UM-804 Appeal Process ppFY12 (Pages 1-3) BHI Member and Family Handbook (Pages 28, 30, 31, 34) 30 Day Appeal Information attachment BHI's Grievance Procedure and Appeal policy describe the provisions of who may file for a grievance, appeal, and State Fair Hearing. The BHI Member and Family Handbook informs BHI members of the same provisions in 6th grade reading level. Since January 2011 to present, BHI had no instances of request for an appeal or a State Fair Hearing by anyone other than the member or his/her guardian.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Grievance Procedure policy stated that a grievance may be filed by a member, family member, advocate, or designated client representative (DCR). The policy included a treating health care professional in the definition of DCR. The Appeal Process policy stated that a member, or DCR may file an appeal and specifically stated that a provider acting on behalf of the member with the member's written consent may file an appeal. The Appeals Process policy stated that a member or DCR may request a State fair hearing and included a treating health care professional in the definition of DCR. The Member and Family Handbook informed members that they or a DCR may file a grievance or request a State fair hearing and that a provider may file an appeal or help as the DCR. In the "Appeals and Grievances" section of the handbook, BHI addressed how to use a DCR and who may be a DCR. The Grievance Procedure and the Appeals Process policies were reproduced in the provider manual. BHI tracked who filed grievances and appeals in the grievance and appeals database. The appeals records reviewed on site contained documentation of who filed the appeal.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
6. The Contractor accepts grievances orally or in writing. *42CFR438.402(b)(3)(i)* *State Rule: 8.209.5.D*	BHI Member and Family Handbook (Page 28) OMFA-603 Grievance Procedure ppFY12 (Page 2) BHI's Grievance Procedure states that grievances are accepted orally or in writing. The member handbook informs BHI members of the same criteria in 6th grade reading level.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Grievance Procedure policy defined a grievance as an oral or written expression of dissatisfaction about any matter other than an action, and provided examples of common grievances. The policy also stated that grievances may be filed either verbally or in writing. The Member and Family Handbook provided members the option to call BHI's OMFA, complete the grievance form provided in the handbook, or write a letter. The handbook provided the address and the phone number for filing. In addition, BHI OMFA staff members were located at each CMHC for members wishing to file grievances at the CMHCs.		
Required Actions: None.		
7. Members have 30 calendar days from the date of the incident to file a grievance. *42CFR438.402(b)(2)* *State Rule: 8.209.5.A*	OMFA-603 Grievance Procedure ppFY12 (Page 2) BHI Member and Family Handbook (Page 29) 30 Day Appeal Information attachment BHI's Grievance Procedure delineates timeline for filing a grievance. BHI's Member and Family Handbook informs members on the timeline for filing grievances in 6th grade reading level.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
Findings: The Grievance Procedure policy indicated that members have 30 calendar days to file a grievance. (See the Member Information standard, requirement 13 for scoring specific to the member handbook information regarding filing time frames for grievances.) During the on-site interview, staff members reported that BHI staff became aware of the filing time frame rule change approximately July 2011. While Section VII of the provider manual included a copy of the Grievance Procedure policy correctly stating the 30-calendar day filing time frame for grievances, Section II of the manual also included a reproduction of the Member and Family Handbook, which stated a 20-calendar-day time frame for filing grievances.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
8. The Contractor sends written acknowledgement of each grievance within two working days of receipt. *42CFR438.406(a)(2)* *State Rule: 8.209.B*	OMFA-603 Grievance Procedure ppFY12 (Page 3) BHI Member and Family Handbook (Page 29) Example Grievance Acknowledgement Letter BHI sends a letter to the member acknowledging the receipt of the grievance, the date it was received, and the possible date of resolution.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Grievance Procedure policy included the provision that BHI sends a grievance acknowledgement letter within two business days of receipt of the grievance. The policy also included required content for the acknowledgement letter. BHI provided a sample of a grievance acknowledgement letter that was sent during the review period. Members were informed in the Member and Family Handbook of the grievance process, including receipt of the acknowledgement letter. During the on-site portion of the review, BHI provided a sample report printed from the grievance and appeal database, which demonstrated that grievance acknowledgement letters were sent within the required time frames.		
Required Actions: None.		
9. The Contractor must dispose of each grievance and provide notice of the disposition in writing as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the BHO receives the grievance. *42CFR438.408(b)(1) and (d)(1)* *State Rule: 8.209.5.D.1, 8.209.5.F*	OMFA-603 Grievance Procedure ppFY12 (Page 3) Example Grievance Acknowledgement Letter BHI Member and Family Handbook (Page 29) BHI's Grievance Acknowledgement Letter indicates the possible resolution date. This date is 15 days from the receipt of the grievance. BHI's Grievance Procedure states that members will be notified of the disposition as expeditiously as the member's mental health condition requires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Grievance Procedure policy included the provision that BHI sends a grievance resolution letter within 15 working days of receipt of the grievance. Members were informed via the member handbook that resolution letters are sent 15 business days after receipt of the grievance. The sample grievance acknowledgement letter informed the member of the estimated resolution date and was easily understood. BHI provided a sample grievance resolution letter. During the on-site portion of the review, BHI also provided a sample report printed from the grievance and appeal database, which demonstrated that grievance resolution letters were sent within the required time frames.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
10. The written notice of grievance resolution includes: ◆ The results of the disposition/resolution process. ◆ The date it was completed. *State Rule: 8.209.5.G*	OMFA-603 Grievance Procedure ppFY12 (Page 3) BHI Member and Family Handbook (Pg 29) Example Grievance Resolution Letter BHI's Grievance Resolution Letter details the disposition or resolution of the grievance. The letter indicates the date the grievance was completed. BHI's Member and Family Handbook and the Grievance Procedure provide guidelines for member notification of grievance resolution.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Grievance Procedure policy stated that the grievance resolution letter includes the name, title, and credentials, of the individual investigating the grievance, the date of the completion of the resolution process, the disposition of the grievance, and the opportunity to have the decision reviewed by the Department. The sample grievance resolution letter included each of the required elements and the telephone number of the individual who investigated the grievance. The letter also included the telephone number for the Department and informed the member that they may call the Department if not happy with the resolution of the grievance, or call the Medicaid ombudsman or BHI for assistance. The letter provided the telephone number for the Medicaid ombudsman. BHI may want to consider working with the Department to verify the telephone number(s) that should be given to members for this purpose. The sample letter included a local number and two toll-free numbers, none of which were the same numbers provided in the Member and Family Handbook. BHI may also want to consider providing an address for the Department.		
Required Actions: None.		
11. Members may file an appeal within 30 calendar days from the date of the notice of action. *42CFR438.402(b)(2)* *State Rule: 8.209.4.B*	UM-804 Appeal Process ppFY12 (Page 2) BHI Member and Family Handbook (Page 31) Provider Manual (Section VII: Grievance, Actions and Appeals, PDF Page 199) Attachment - BHI Action & Appeals Training PowerPoint Delegation Agreement CRC (Page 3) 30 Day Appeal Information attachment Members are informed of their right to file an appeal within 30 days of any Action taken by BHI about their mental health services. BHI ensures that all members receive a written notice of action along with information on the grievance, appeal and State	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Fair Hearing process and associated time frames. All clinical staff at the CMHCs in BHI's network and the Utilization Management (UM) Department at BHI are required to complete annual trainings on Notice of Actions and Appeals.	
Findings: The Appeals Process policy indicated that members have 30 calendar days to file an appeal related to the denial or limited authorization of a service. (See the Member Information standard, requirement 13 for scoring specific to the member handbook information about filing time frames for appeals.) The notice of action letter included a field to add the due date of the appeal. Notices of actions in the appeals records reviewed on-site contained the 20-calendar day filing time frame. BHI had developed an attachment letter for insertion into the notices of action. The attachment letter included complete and accurate information about filing appeals related to the denial or limited authorization of services. Staff members reported that BHI began using the attachment letters approximately July, 2011.		
Required Actions: While BHI began implementing the revised rule from the 20-calendar-day time frame to the 30-calendar-day time frame for filing appeals, BHI must review current processes to ensure that members receive current information provided during the appeal process regarding the time frame for filing appeals.		
12. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42CFR438.402(b)(3)(ii)* *State Rule: 8.209.4.F*	UM-804 Appeal Process ppFY12 (Page 2) 30 Day Appeal Information attachment BHI Member and Family Handbook (Page 32, 34) Notice of Action Letter template Provider Manual (Section VII: Grievance, Actions and Appeals, Page 199) A member, guardian, or DCR may file an appeal orally through a phone call or in person, or in writing within 30 days of a Notice of Action. The member, guardian, or DCR must submit a written, signed appeal request following an oral request, except when requesting an expedited appeal resolution. From January 1, 2011 to current, there have been eight appeals filed in response to a Notice of Action. All eight appeals were filed within 30 days of the Notice of Action and all Appeal Decisions were made within 10 days of the appeal being filed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Two of the eight appeals rescinded their appeal request prior to the appeal panel review.	
Findings: The Appeals Process policy included the provision that appeals may be filed orally or in writing, and, unless the member requests expedited resolution oral requests must be followed by a written, signed appeal. The Member and Family Handbook informed members that appeals may be filed in writing, or that the member may start the appeal by calling the Grievance and Appeal Department. Members were also informed via the Appeal Information attachment provided with the notice of action, beginning in July 2011. During the on-site interview, BHI staff members reported that the written follow-up was not necessarily enforced but that lack of such had not created a barrier to processing appeals.		
Required Actions: None.		
13. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms required, putting oral requests for a State fair hearing into writing, and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42CFR438.406(a)(1)* *State Rule: 8.209.4.C*	UM-804 Appeal Process ppFY12 (Page 3) OMFA-603 Grievance Procedure ppFY12 (Page 2) BHI Member and Family Handbook (Pages 1, 29, 35) 30 Day Appeal Information attachment BHI will give the member, guardian or DCR reasonable assistance in completing any forms required, putting oral requests for a Grievances, Appeal, or State Fair Hearing into writing, and taking other procedural steps to assist the member in filing, preparing and writing an appeal request. Assistance includes interpretive services or TTY/TTD capability. The 30-Day Appeal Information attachment directs members/guardians to contact the BHI UM Department to assist in completing any requests for appeals or State Fair hearings. The BHI UM Department had no requests for this assistance since January 2011. The OMFA Department assists in filing any grievances at the state level. However, there have been no instances of this assistance being requested during the review period.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Grievance Procedure policy and the Appeal Process policy both included the provision that BHI will provide any reasonable assistance with forms and interpreter services and provided toll-free numbers for contacting BHI. The Member and Family Handbook offered assistance writing or filing		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
grievances and appeals. The footer of each page of the Member and Family Handbook included the OMFA local number and the toll-free numbers for voice and TTY. The appeal attachment to the notice of action letter offered help with the appeal process.		
Required Actions: None.		
14. The Contractor sends the member a written acknowledgement of each appeal within two working days of receipt, unless the member or the designated client representative (DCR) requests an expedited resolution. *42CFR438.406(a)(2)* *State Rule: 8.209.4.D*	UM-804 Appeal Process ppFY12 (Page 3) Attachment - Expedited Appeal Request Denied Letter Appeals Tracking Template BHI will send the Member and DCR written acknowledgement of the Appeal request within two (2) working days of receipt, unless the Member or DCR requests an expedited resolution. There have been no instances since January 2011 where an expedited resolution was requested. All documentation pertaining to an action and appeal are kept in one file. We track this information on the Appeals Tracking Template.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Although the Appeal Process policy and the Member and Family Handbook included the provision, and informed members that BHI sends a written acknowledgement to the member within two working days following the receipt of the appeal, the appeal records reviewed on-site contained no acknowledgement letters (of seven applicable records). During the on-site interview, staff members reported that BHI's understanding was that the appeal acknowledgement letter was optional.		
Required Actions: Although BHI's documents (including the training PowerPoint presentation) clearly described appeal acknowledgement, this process had not occurred during the review period. BHI must evaluate its systems and take steps to ensure that appeal acknowledgement letters are sent within the required time frame and that BHI's policies and procedures regarding the appeals process are followed.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
15. The Contractor's appeal process must provide: ◆ That oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date). ◆ The member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The contractor must inform the member of the limited time available for this in the case of expedited resolution.) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents considered during the appeals process. ◆ That included, as parties to the appeal, are: • The member and his or her representative; or • The legal representative of a deceased member's estate. *42CFR438.406(b)* *State Rule: 8.209.4.G, 8.209.4.H, 8.209.4.I*	UM-804 Appeal Process ppFY12 (Pages 2, 4) Appeal Panel Review - Example BHI will provide the member, guardian, or DCR a reasonable opportunity to present evidence in person as well as in writing, to the Appeal panel. In the case of expedited resolution, BHI will make reasonable effort to inform verbally, the member and DCR, of the limited time available at the time the Appeal is requested. BHI will provide the member, guardian, or DCR the opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents and records considered during the appeal process. BHI will include as parties to the Appeal, the member, guardian and the DCR, or the legal representative of a deceased member's estate. A member of the BHI UM staff facilitates the Appeal Panel but does not share his/her clinical input and merely facilitates the discussion of the clinical record and the overall process. The Appeal Review Guidelines is provided to all participating members on the Appeal Panel. This guideline indicates that no member involved in any previous authorization decisions are involved in the Appeal Panel.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Member and Family Handbook and the appeal information attachment to the notice of action letter informed members to call customer service in order to start the appeal process, and informed members how to follow the oral appeal in writing, or file in writing. The Appeal Process policy included provisions to allow members to examine documents associated with the appeal, and to present evidence in person or in writing. The policy also included the provision that oral inquiries seeking to appeal an action are treated as appeals to establish the earliest possible filing date. The Member and Family Handbook and the appeal information attachment to the notice of action letter informed members of the right to provide BHI with more information and tell them why BHI should change the decision, as well as the right to review records having to do with the appeal. The handbook informed members that for expedited appeals, the time available to review records or provide additional information is short. The Appeal Process policy described parties to the

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
appeal, as required. BHI provided an example of an appeal review panel record whereby the appellant presented information to the panel, and referred to the member's records, which the member had accessed prior to the appeal panel meeting.		
Required Actions: None.		
16. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: ◆ For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal. ◆ For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42CFR438.408(b)(2)&(d)(2)* *State Rule: 8.209.4.J, 8.209.4.L*	UM-804 Appeal Process ppFY12 (Page 4) Appeal Panel Review – Example Attachment E – Appeal Panel Resolution Letter Template Attachment - Expedited Appeal Request Denied Letter BHI resolves each Appeal, and provides notice as expeditiously as the Member's health condition requires. BHI adheres to all required time frames as indicated in the Appeals Process policy. BHI completed Appeal Panel Reviews and reached resolution within 10 days 100% of the time. BHI had no expedited appeal requests during this review period.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Appeal Process policy included the 10-working-day resolution time frame for standard appeals and the three-working-day resolution time frame for expedited appeals. The policy stated, "For standard resolution of the appeal and notice to the affected parties, ten working days from the day BHI receives the appeal request, either verbally or in writing." Similar language was present related to providing notice for expedited appeals. While the language in the policy could be interpreted correctly, the training materials (The action and appeals PowerPoint presentation) misconstrued the language and stated that both standard and expedited resolution was provided either verbally *or* in writing. The on-site record review demonstrated that appeal resolution letters were provided in all cases reviewed.		
Required Actions: Although the on-site appeals record review demonstrated that BHI sent appeal resolution letters as required, BHI must ensure that staff members and providers are trained appropriately. BHI must review and revise training materials and other applicable documents to ensure consistency and accuracy of information provided to staff members and providers related to resolution of appeals.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
17. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: • The right to request a State fair hearing, and how to do so. • The right to request that benefits while the hearing is pending, and how to make the request. • That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action. *42CFR438.408(e)* *State Rule: 8.209.4.M*	UM-804 Appeal Process ppFY12 (Pages 6-7) Attachment E – Appeal Panel Resolution Letter Template BHI informs the member, guardian or DCR immediately the decision made by the Appeal Panel. BHI also provides a written letter of appeal resolution decision. When the decision is not wholly in favor of the member, guardian, or DCR, BHI also provides information on how to request a State Fair Hearing. BHI had one instance during this review period where a guardian requested a State Fair Hearing. This was requested upon receipt of the Notice of Action Letter and prior to conducting an Appeal Panel Review. In this case, the Appeal Panel overturned the Notice of Action and was in agreement with the guardian's request for child and adolescent residential treatment services. Subsequently, the guardian withdrew her request for a State Fair Hearing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Appeal Process policy included the provision to include the required content in the appeal resolution letters. The Appeal Panel Resolution template letters addressed each of the required elements; however the filing time frame for requesting a State fair hearing with or without the request for continuation of services (benefits) was incorrect in the template as well as in the resolution letters reviewed during the on-site appeals record review. (The incorrect time frames for filing appeals will be scored in requirements 20 and 22 of this standard.)		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
18. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: ◆ Were not involved in any previous level of review or decision-making. ◆ Have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding the denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. *42CFR438.406(a)(3)(ii)* *State Rule: 8.209.4.E, 8.209.5.C*	UM-804 Appeal Process ppFY12 (Pages 3-4) OMFA-603 Grievance Procedure ppFY12 (Page 2) Appeal Panel Review – Example Appeal Review Guidelines Utilization Management Criteria – Medical Necessity BHI ensures that individuals who make decisions on grievances have the needed clinical expertise and were not involved in previous levels of review or decision-making. The Appeal Panel is comprised of a Board-certified, licensed psychiatrist and licensed mental health clinicians with expertise in the member's mental health condition or disorder. The Appeal Panel understands and receives copy of the appeal panel review guidelines and the medical necessity criteria for the mental health services or level of care requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Grievance Procedure policy stated that grievances are assigned to a BHI Member/Family representative who has had no prior direct involvement with the subject of the grievance and has appropriate clinical expertise when grievances involve clinical issues or denial of a request for expedited resolution. The Appeal Process policy stated that appeal decisions are made by individuals who were not involved in any previous level of review and who has the appropriate clinical expertise in treating the member's condition or disease. BHI's Appeal Review Guidelines specified that the appeal panel consists of one psychiatrist and two program supervisors from the two BHI CMHCs that were not involved in the notice of action process. The two program supervisors are selected based on the population in question (i.e., child/adolescent or adult). During the on-site interview, BHI staff members confirmed the appeal panel process and reported that staff members from OMFA processed grievances.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
19. The contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: ◆ The member requests the extension; or ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest. ◆ If the Contractor extends the time frames, it must—for any extension not requested by the member—give the member written notice of the reason for the delay. *42CFR438.408(c)* *State Rule: 8.209.4.K, 8.209.5.E*	UM-804 Appeal Process ppFY12 (Page 6) OMFA-603 Grievance Procedure ppFY12 (Page 3) Example Grievance Extension Letter BHI may extend the time frame for appeal or grievance resolution up to 14 days in specific situations as outlined in the Appeals Process policy and the Grievance Procedure. In situations where an extension occurs but was not requested by the member, guardian, or DCR, BHI provides a written notice of explanation of the extension. Example of an extension is provided. There have been no instances of extending the appeal resolution time during this review period. All appeal resolutions were determined within 10 working days from the date of request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
Both the Grievance Procedure policy and the Appeal Process policy included the provision that resolution of grievances or appeals (applicable to the policy) may be extended by up to 14 calendar days if the member requests the extension or the BHO indicated that it would be in the best interest of the member. The Member and Family Handbook informed members that BHI could ask for more time to review grievances and appeals and that the member or DCR could ask for additional time for the appeal. The appeal information attachment also informed members that BHI may request more time to make the decision, or the member or DCR may request more time. Both policies included the provision that prior written notice of the reason for delay be sent to the member for extensions not requested by the member or DCR. There were no extensions requested in the cases reviewed during the on-site appeals record review.

Required Actions:
None.

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
20. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing within 30 calendar days from the date of the notice of action. *42CFR438.402(b)(2)(ii)* *State Rule: 8.209.4.N*	UM-804 Appeal Process ppFY12 (Page 7) 30 Day Appeal Information attachment BHI Member and Family Handbook (Page 34) Members, guardians, and DCRs have the right to request a State Fair Hearing at any point within 30 days from the date of the Notice of Action. They do not need to go through BHI's internal appeals process in order to request a State Fair Hearing. BHI had one instance during this review period where a guardian requested a State Fair Hearing. This was requested upon receipt of the Notice of Action Letter and prior to conducting an Appeal Panel Review. In this case, the Appeal Panel overturned the Notice of Action and was in agreement with the guardian's request for child and adolescent residential treatment services. Subsequently, the guardian withdrew her request for a State Fair Hearing.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The Appeal Process policy included the provision that members may request a State fair hearing within 30 calendar days from the date of the notice of action, and that members need not exhaust BHI's appeal process. The appeal information attachment correctly stated the time frame as 30 calendar days; however, the appeal records reviewed on-site did not contain the appeal information attachment and informed members that the State fair hearing filing time frame was 20 days. During the on-site interview, staff members reported that BHI became aware of the filing time frame changes in approximately July 2011. Members were informed in the member handbook that they may request a State fair hearing instead of using BHI's internal appeal process, at any time during the BHI appeal, or if not happy with BHI's decision on the appeal. (See the Member Information standard, requirement 13 for scoring specific to the member handbook information about State fair hearing request time frames.) The resolution letters reviewed on-site during the record review included the 20-calendar-day time frame for requesting a State fair hearing. The updated template provided was not accurately changed and read "twenty (30) calendar days".

Required Actions:
While BHI began implementing the revised rule from the 20-calendar-day time frame to the 30-calendar-day time frame, BHI must review current processes and member communication used during the appeal process to ensure that members receive current information regarding the time frame for requesting a State fair hearing. BHI should also evaluate and/or revise internal communications or processes to ensure that changes and other State communications are implemented in a timely manner.

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
21. The Contractor maintains an expedited review process for appeals, when the Contractor determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow-up within two calendar days with a written notice. *42CFR438.410* *State Rule: 8.209.4.P–.R*	UM-804 Appeal Process ppFY12 (Pages 7-8) Attachment C – Expedited Appeal Request Denied Letter BHI maintains an expedited appeal process in instances where the standard appeal time frame may seriously jeopardize the member's safety, life, health, and ability to function at maximum potential. BHI adheres to the required time frames for expedited appeals. BHI make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow-up within two calendar days with a written notice. During this review period, there were neither instances where a member requested an expedited review process or where a provider indicated that taking time for a standard resolution could seriously jeopardize the member's life, health, or ability to regain maximum function.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Appeal Process policy described BHI's expedited review process, which included the required components. BHI provided an example of a notice to deny the expedited process. The Member and Family Handbook described the expedited ("rush") appeal review process in a manner that was easily understood. The on-site appeals record review contained no examples of an expedited appeal.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
22. The Contractor provides for continuation of benefits while the BHO-level appeal and the State fair hearing are pending if: ◆ The member or the provider files timely*—defined as on or before the later of the following: • Within 10 days of the Contractor mailing the notice of action. • The intended effective date of the proposed action. ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits. **This definition of timely filing only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.* *42CFR438.420(a) and (b)* *State Rule: 8.209.4.S*	UM-804 Appeal Process ppFY12 (Page 8, 9) BHI provides for continuation of benefits while the BHO-level appeal and the State Fair Hearing are pending. There were no instances during this time period where a member requested continuation of benefits while the appeal process was pending.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The Appeal Process policy included the provision for continuation of benefits and described the correct timely filing requirement for this type of appeal. The appeals resolution letter template, however, defined timely filing for this type of appeal (appeals related to the termination, suspension, or reduction or services and the member's request to continue those service during the appeal or the State fair hearing process) as 30 days. (See the Member Information standard, requirement 13 for scoring specific to the member handbook information about continuation of benefits.)

Required Actions:
BHI must revise templates used for member communication during the review process to accurately state that members may request continuation of services (when applicable) within 10 calendar days of the notice of action, or before the effective date of the intended action.

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
23. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal. ◆ Ten days pass after the Contractor mails the notice providing the resolution (that is against the member) of the appeal, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. ◆ A State fair hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met. *42CFR438.420(c)* *State Rule: 8.209.4.T*	UM-804 Appeal Process ppFY12 (Page 9) BHI adheres to the regulations for continuation or reinstatement of benefits while an appeal is pending. During this review period, BHI had no instances where a State Fair Hearing was conducted.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Appeal Process policy included the provision for continuation of benefits and correctly described the length of time benefits will continue, if requested during the appeal or State fair hearing. There were no examples of appeals related to the termination, suspension, or reduction of previously authorized services in the on-site appeals record review. BHI may want to consider revising the member handbook language regarding this requirement. The handbook states, "…ten days pass after we mail the original notice to you that we are denying the appeal." HSAG recommends removing the word "original," as it may be confusing and lead the member to believe this refers to the notice of action.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
24. Effectuation of Appeal Resolution: ◆ If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. ◆ If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. ◆ If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. *42CFR438.420(d), 42CFR438.424* *State Rule: 8.209.4.U–W*	UM-804 Appeal Process ppFY12 (Page 9) 30 Day Appeal Information attachment BHI adheres to the regulations regarding the authorization and payment of services in instances where the resolution of the State Fair Hearing reverses the Notice of Action or BHO-level appeal decision. BHI had one case where a State Fair Hearing as requested by a guardian of a youth member. The Appeal Panel overturned the Notice of Action, resulting in provision of the requested service/level of care. The State Fair Hearing request was revoked by the guardian.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Appeal Process policy accurately included the provisions regarding effectuation of the appeal resolution for cases in which continued benefits were requested. Members were informed in the member handbook under both the appeal and State fair hearing sections that the member may have to pay for services continued during the appeal or State fair hearing if the decision was not in favor of the member. The handbook also informed members that if the decision was in favor of the member, BHI would pay for the services.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
25. The Contractor maintains records of all grievances and appeals and submits quarterly reports to the Department. *42CFR438.416* *State Rule: 8.209.3.C*	UM-804 Appeal Process ppFY12 (Page 9) OMFA-603 Grievance Procedure ppFY12 (Page 4) FY11 Q2 BHI Grievance Appeal Report 02142011 FY11 Q2 BHI Grievance Appeal Narrative 02142011 The Appeals Process and Grievance Procedure dictate that BHI maintain records of all grievances and appeals. BHI submits a quarterly Grievance and Appeals report to HCPF.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Appeal Process policy and the Grievance Procedure policy described the process for documenting grievances and appeals using the grievance and appeal database. BHI provided copies of quarterly grievance and appeal reports submitted to the Department. On-site review of the appeals records and a printed report of the grievance and appeals database provided evidence of BHI's grievance and appeals record keeping.		
Required Actions: None.		
26. The Contractor must provide the information about the grievance system specified in 42CFR438.10 (g) (1) to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. ◆ The right to a State fair hearing: • The method for obtaining a State fair hearing. • The rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by telephone. ◆ The fact that, when requested by the member: • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing.	Contract_execute_letter Provider Manual (Section VII: Grievance, Actions and Appeals, Page 199) http://www.bhicares.org/providers.htm Delegation Agreement CRC (Page 3) Attachment - BHI Action & Appeals Training (Page 50) BHI Consumer & Family Rep Posting 1-2010 Consumer and Family Representative Posting Spanish 6-1-11 2011 At the time of initial contract negotiations as well as at the time of final contract execution, BHI CPN providers receive a letter strongly encouraging them to visit the provider portion of BHI's Web site for the provider manual. The Provider Manual describes the grievance process and all specific information and forms needed. BHI has delegation agreements with the CMHCs regarding	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
• If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The member's right to have a provider file a grievance or an appeal on behalf of the member, with the member's written consent. *42CFR438.414* *State Rule: 8.209.3.B*	responsibility for training and dissemination of BHI's grievance processes. Each BHI CMHC has two consumer representatives who are responsible for receiving and investigating grievances. The grievance is communicated to BHI through the use of a BHI contact form. Their investigation follows BHI's grievance time frames and regulations, and are always conducted in collaboration with the BHI OMFA director. The names of these consumer representatives are posted at each CMHC site.	
Findings: While Section VII of the provider manual included copies of the Appeal Process policy, the Notice of Action policy, and the Grievance Procedure policy correctly stating the 30-calendar day filing time frame for grievances, appeals, and State fair hearings, Section II of the manual also included a reproduction of the Member and Family Handbook, which stated a 20-calendar-day time frame for each filing process.		
Required Actions: BHI must review distribution patterns for the member handbook and ensure that all documents (and/or mailings or postings) containing the member handbook includes the correct information.		

Results for Standard VI—Grievance System							
Total	Met	=	19	X	1.00	=	19
	Partially Met	=	5	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable or Not Scored	=	1	X	NA	=	NA
Total Applicable		=	25	**Total Score**		=	19

Total Score ÷ Total Applicable	=	76%

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has a robust and thorough process, described in written policies and procedures, to evaluate potential providers before they provide care to members, and to reevaluate them periodically thereafter. The Contractor has adopted NCQA credentialing and recredentialing standards and guidelines for provider selection. *42CFR438.214(a)* *Contract: II.G.3.a, Exhibit O: I.A, I.B.3*	Provider Credentialing and Recredentialing ppFY12 (Pages 2, 3, 4) Credentialing Committee Guidelines Credentialing Form Provider Information Form BHI has a robust credentialing and recredentialing policy that defines evaluation and periodic re-evaluation of BHI providers. BHI's policy is adopted from the NCQA credentialing guidelines. BHI also developed a checklist of important elements that is discussed within the monthly Credentialing Committee to ensure that the providers requesting to join the network are capable, competent and have the required specialties needed to provide services to BHI's members. The Credentialing Form and Provider Update Form are used to summarize key elements within the provider's application and resume that is needed to evaluate potential providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Provider Credentialing and Recredentialing policy included the provision that BHI performs credentialing review of all practitioners and provider organizations with whom it contracts and listed the education and licensure requirements for each category of practitioner, as well as experience, liability coverage, and availability requirements. The procedures listed in the policy addressed:

- screening practitioners for criminal background or debarment/exclusion from federal program participation.
- BHI's delegation of the administrative processes of credentialing to Colorado Access—Colorado Access being responsible to verify all information in a practitioner's application and for the ongoing monitoring of provider sanctions.
- BHI's responsibility for final determination.

The Provider Credentialing and Recredentialing policy outlined the application flow and detailed verification of licensure, DEA certification, education, board certification, work history, liability insurance, Colorado Bureau of Investigation background status, and disciplinary sanctions. The policy outlined the procedures for a site visit, performed at initial credentialing and recredentialing. The policy described steps to maintain confidentiality of information and specified practitioner rights that would be respected throughout the credentialing process. The policy outlined criteria and procedures for corrective action and included the practitioner appeal process. The policy stated that BHI credentialing policies and procedures were reviewed annually for compliance with NCQA guidelines. The policy described credentialing activities that were delegated to Colorado Access and BHI's oversight functions.

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
The provider manual, available on the BHI Web site, contained a detailed description of the credentialing and re-credentialing processes, including how credentialing is initiated, confidentiality of credentialing files, credentialing committee responsibilities, site review, responsibilities of the provider to report revocation or disciplinary action by licensing agencies, and the provider appeal process as it related to credentialing and recredentialing. The Provider Credentialing and Recredentialing policy was included in the provider manual. The Credentialing Committee Guidelines provided a checklist of 13 categories of provider information to be reviewed in the credentialing or recredentialing processes. The Credentialing Form documented the decision of the Credentialing Committee concerning approval/disapproval of the individual provider, including committee discussion and any reasons for disapproval. During the on-site interview, BHI staff members stated that Colorado Access verified the credentialing information and performed the administrative preparation of provider files, and that BHI processed the information through the UM Committee, who serve as the internal BHI credentialing committee. Staff clarified that the previous Risk and Resource Committee had changed to the UM Committee. Staff members explained that the UM Committee and UM staff members have knowledge of any provider utilization and quality performance problems, which were considered in the recredentialing process.		
Required Actions: None.		
2. The Contractor has policies and procedures that describe methods of ongoing provider monitoring and that include: ◆ The frequency of monitoring. ◆ How providers are selected to be reviewed. ◆ Scoring benchmarks. ◆ The way record samples will be chosen. ◆ How many records will be reviewed. (The Department encourages a survey checklist for the actual provider visits.) *Contract: Exhibit O: I.A.2*	QI-706 Service Quality Measurement ppFY12 QI-701 Clinical Quality Measurement ppFY12 ADM-115 Subcontractual Relationships and Delegation ppFY12 411 final handout Provider Audit Form BHI CPN Site Visit Evaluation Form Final BHI FY11 411 Audit Report Delegation Oversight Final Report Template BHIs policies on service and clinical quality measurements, as well as the policy on sub-contractual relationships and delegation guide BHI in ongoing provider monitoring. BHI conducts an annual 411 audit to ensure accurate and adequate encounter/claim submission. BHI uses survey checklists to conduct this audit. BHI contracts with an experienced and licensed auditor to conduct a clinical review on the selected sample. BHI developed quarterly	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
	performance reports to monitor services provision such as inpatient and emergency services. BHI also conducts ad-hoc data analysis as needed on services such hospital diversion and specific providers' services. BHI's CEO and Director of Provider Relations review weekly check runs to monitor for over and underutilization.	

Findings:

The Provider Credentialing and Recredentialing policy stated that ongoing monitoring between credentialing cycles included monthly review of all providers for Medicare and Medicaid sanctions and Colorado licensure sanctions. In addition, the Provider Credentialing and Recredentialing policy stated that a provider site visit evaluation was performed prior to recredentialing (every three years). A form was used to score sites and a benchmark of at least 80 percent compliance with site visit standards was required. The Access and Availability policy defined the standards for routine, urgent, and emergency care response times and defined 100 percent compliance benchmarks for each. The policy stated that BHI would audit independent providers for adherence to standards. During the on-site interview, BHI staff members stated that access and availability standards were monitored quarterly.

The Service Quality Measurement policy and Clinical Quality Measurement policy defined the procedures for the development of clinical outcome and service performance measures, as follows: the QI Department was responsible for indicator design, data collection methodology, analysis, and reporting results to appropriate departments/committees; and the Program Evaluation and Outcome Committee provided oversight of development of quality indicators and studies, appropriate data collection methodologies, review of results, and recommendations for corrective action.

The UM Program description and the QI Program description, both included in the provider manual, defined the areas of focus and various measures and methods of program evaluation. Methods of monitoring included trending of numerous, specifically defined aggregate performance measures and comparison of results to national and local benchmarks. The plans described performance of individual case peer review related to grievances and appeals and quality of care concerns. In addition, the UM plan stated that prior authorization of services against medical necessity criteria and practice guidelines was based on review of supporting clinical documentation and was ongoing. The program description addressed methods of applying criteria and inter-rater reliability.

The final 411 audit report described the annual Encounter Validation Audit to verify completeness and accuracy of encounter data submitted to the Department compared to the data contained in provider medical records. The report stated that sample size and characteristics were determined by the Department and records were randomly selected from all providers.

During the on-site interview, BHI staff members described several methods of ongoing provider monitoring, including the site visit evaluation—performed prior to recredentialing or when complaints or billing patterns indicate a potential concern; the annual 411 Encounter Validation Audit; the monthly analysis

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
of check runs by the CEO to detect unusual patterns of provider payments; review of UM authorization results; and provider profiling results related to coding, denials, and billing errors. Staff stated that BHI was working with Colorado Access, the ASO for claims processing, to develop a report that will allow comparative benchmarking of BHI results. Staff members stated that aggregate performance measures were used to identify the need to do more in-depth review of medical records and provider-specific information.		
Required Actions: None.		
3. The Contractor monitors covered services rendered by provider agreements for: ◆ Quality ◆ Appropriateness ◆ Patient outcomes ◆ Compliance with: • Medical record requirements • Reporting requirements • Applicable provisions of the BHO's contract with the Department. *Contract: II.G.10.a.3–4*	Quarterly Performance Measures FY11 Q4 BHI Penetration Rate FY11 Q4 Provider Auth Letter UM Committee Meeting Minutes 06242011 BHI has adopted HCPF's annual performance measure calculations into quarterly reporting which allows for frequent monitoring of quality, appropriateness, and patient outcomes. BHI's UM Department clinically reviews the medical record prior to all authorizations and reauthorizations. This clinical review ensures completion of all required clinical documentation and medical necessity criteria. The Annual 411 audit also involves Medical Record Review. Prior to credentialing or re-credentialing BHI reviews provider performance and compliance with the UM Committee to ensure services rendered are in accordance with provider agreements.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The UM Program description stated that the UM department staff members monitored outcomes, appropriate utilization, and level and intensity of services in compliance with CMS 42 CFR 438, NCQA standards, and Medicaid managed care requirements. The program description included UM criteria for determining medical necessity, quarterly measures of under and over-utilization—including penetration rates, inpatient recidivism, length of hospitalization stay rates, utilization of services. The program description also described review of client satisfaction surveys, grievance and appeals review and peer review of records, access and availability of triage services, and provider appointments.		

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
The QI Program description stated that BHI monitored quality performance in the following areas: clinical practice guidelines for high-volume diagnoses, medical records documentation standards, accessibility and availability of providers, client satisfaction, volume of members served, utilization of services, and targeted performance improvement projects. The Service Quality Measurement policy specified that measures would include access measures, including availability and responsiveness of providers and telephone response rates as well utilization measures. The Clinical Quality Measurement policy stated that clinical outcome measures would include the Colorado Clinical Assessment Record (CCAR) measures and consumer satisfaction with clinical outcomes. BHI provided examples of provider monitoring reports: ◆ The BHI Annual Quality Report provided a narrative description of the BHI quality improvement program activities and related results, which included information on quarterly monitoring of behavioral health performance measures; quarterly monitoring of appointment availability for routine, urgent, and emergency care and after-hours call center response; annual Encounter Data Validation audit; annual member satisfaction surveys; and network adequacy. ◆ The Quarterly Performance Measures report documented quarterly monitoring of behavioral health measures: inpatient utilization; hospital readmissions within 7, 30, and 90 days; emergency department utilization; and post-hospitalization follow-up within 7, 30, and 90 days. ◆ The final 411 audit report described the annual Encounter Validation Audit of medical record information compared to encounter data to verify completeness and accuracy of encounter data submitted to the Department. During the on-site interview, staff members stated that in previous years, results of quality measures from a variety of sources were consolidated into a quality report card, which was provided quarterly to providers to give them feedback and required explanation of any results which fell below standard. The report card process was suspended during 2011 to allow for redesign of a new, expanded report card that will contain different measures of quality. Staff members stated that the revised report card is planned for implementation at the beginning of fiscal year 2012-2013. Although the Treatment Record Content policy outlined the specific components of the patient clinical record and the provider manual referenced an audit tool for ensuring compliance with medical record documentation requirements, BHI staff members stated that the medical record audits of medical record documentation standards had also not been performed during review period due to staff turnover and reorganization. Although the 411 encounter data validation audit evaluated for certain aspects of medical record requirements, the audit did not included a review for all medical record requirements (such as the presence and content of the assessment and treatment plan, and other elements that had been evaluated via the medical record audit form). Staff members also stated that in previous years, BHI staff had reviewed results of medical record audits performed by the CMHCs, but that review had also not occurred during the review period. For the contracted provider network, staff members stated that initial documentation such as the assessment and treatment plan were approved by the UM department prior to authorization of services and that the remaining medical record requirements were evaluated via the annual 411 audit (411 sampling included both contracted provider and CMHC provider records).		

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
Staff members reported that the Program Evaluation and Outcomes Committee, Standards of Practice Committee, UM Committee, and Provider Advisory Committee collectively perform oversight of various aspects of the Quality Improvement program and performance. Committee meeting minutes from 2011 documented review of proposed practice guidelines, discussion of performance improvement projects (PIPs), quality program protocols, and status of focus quality studies. In addition, minutes included review and discussion of quarterly grievance data and results of the focused study regarding the hospital diversion program, including analysis and potential problem resolution. Minutes did not document the routine review and reporting of the numerous performance measures outlined in the BHI policies or example reports. BHI staff members stated that ongoing measures of provider performance are analyzed by staff and processed internally and that only outlier information is presented to committees. Staff members also stated that the organization has been in transition and experienced staffing changes during the past year, which resulted in lack of consistency in auditing and reporting. BHI should consider routine measuring and reporting to appropriate oversight committees regarding the results of provider monitoring for quality, appropriateness, patient outcomes, as addressed in BHI's policies and procedures, and program descriptions. Staff members reported that the Corporate Compliance Quality Committee of the BHO collaborative effort was addressing tools and processes for auditing, including medical record compliance, that could be utilized by all BHOs, and that those tools were expected by April 2012. Staff members stated that BHI is also defining of 50+ measures of practice standard performance for future monitoring, and reported that a new Chief Medical Officer has been hired to oversee the QI programs. Staff members reported that peer review for quality of care concerns was performed by the delegated provider CMHCs and results reviewed in the delegation audit.		
Required Actions: BHI must ensure that it monitors for compliance with all medical record requirements.		
4. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the provider take corrective action. *Contract: II.G.10.a.5*	BHI CRC CAP BHI 411 Provider Follow-up Letter AuMHC FY11 Annual Quality Report (Pages 33, 34) BHI Access to Care Spreadsheet FY11Q4 CPN Provider Request Template When BHI identifies deficiencies or areas for improvement with a provider from the CPN, BHI will research the issue and when necessary require the provider to do a corrective action plan. In addition to requesting CAP, BHI provides training and education to address any deficiencies. For example, BHI has been working closely with the Professional Psychology Center (PPC) at DU throughout the year surrounding training and education on how	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
	and when to request Psychological Testing. PPC was having problems understanding the difference between BHI's definitions of an "assessment" and their definition of assessment. PPC's definition of "assessment" included Psychological Testing. Through these conversations, there was concern that they had been billing incorrectly for services, therefore the Director of Provider Relations and the Utilization Review Manager completed a site visit and medical record review at PPC. The medical records were appropriate for the services requested on the authorization therefore no further claims audits were done and no corrective action plans were developed. There were concerns voiced by CMHCs regarding why members were requesting services from the CPN rather than through the CMHCs. BHI UM Department tracked all phone calls for two months. The trend identified was that members were having difficulty making intake appointments. Since this feedback, CMHCs have improved access by providing walk-in intake appointments Monday through Friday. BHI provides feedback to providers on audits, results of quarterly reports or problems identified by stakeholders. The expectation is that providers will either develop a CAP or fix the issue immediately.	
Findings: The BHI Annual Quality Report described corrective actions taken in the various quality performance monitoring areas including encounter validation audit of medical records, access to care appointment availability, and call center response. Additional examples of corrective action were provided in the report responding to "HCPF concerns of provision of consumer choice by CRC" and the letter to the provider in question concerning results of the annual encounter validation audit.		
Required Actions: None.		

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
5. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: ◆ Discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. ◆ Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42CFR438.12(a)(1) and (2)* *42CFR438.214(c)* *Contract: II.G.3.b, II.G.4.a*	Provider Credentialing and Recredentialing ppFY12 (Page 4) Prohibition of Provider Discrimination Policy pp FY12 (Page 1) It is the policy of BHI not to discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification. BHI does not discriminate against particular practitioners that serve high-risk populations, or specialize in conditions that require costly treatment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Provider Credentialing and Recredentialing policy contained a non-discrimination statement, as required. As evidenced by the on-site review of committee meeting minutes, members of the Credentials Committee signed an acknowledgement form stating that they do not discriminate against providers when making credentialing and recredentialing decisions. The Prohibition of Provider Discrimination policy stated that BHI will not discriminate against providers that are in compliance with the related federal regulations (specified) and Medicaid managed care contract requirements.		
Required Actions: None.		

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
6. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: ◆ The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered. ◆ Any information the member needs in order to decide among all relevant treatment options. ◆ The risks, benefits, and consequences of treatment or non-treatment. ◆ The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42CFR438.102(a)* *Contract: II.E.1.h.1*	Practitioner Rights BHI Provider Contract – (Page 4 and Attachment C) OMFA-605 Member Client Rights ppFY12 Provider Manual (Section IV Provider Assistance and Support, Practitioner Rights, PDF Page 142) BHI provides member rights listed as an attachment to each provider contract as well as describes BHI's expectation in the Provider Obligations section of the Provider Contract. BHI also encourages providers to advocate on behalf of their clients. BHI demonstrates this through frequent consultation and complex case reviews with providers at their request. BHI also encourages providers to become designated client representatives when appropriate. BHIs contract with HCPF requires compliance with Provider Member communications as specified in 42CFR438.102 (a).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Practitioner Rights section of the provider manual stated that "Practitioners have the right to practice within the lawful scope of their licensure including advising and/or advocating on behalf of members regarding treatments that may be self-administered and the risks, benefits and consequences of treatment or non-treatment." The Provider Service Agreement stated that the provider is responsible to ensure that member rights are taken into account when furnishing services to Medicaid enrollees. Member rights in Attachment C to the provider service agreement included the rights to receive information about treatment options, participate in discussions and decisions about their mental health care, refuse or stop treatment, get a second opinion, and get information about medical directives.		
Required Actions: None.		

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
7. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: ◆ To the State. ◆ To member before and during enrollment. ◆ To members within 90 days after adopting the policy with respect to any particular service. *42CFR438.102(b)* *Contract: II.E.1.h.2*	BHI Member and Family Handbook (Page 8) There are no covered benefits in the contract that BHI has moral or religious objections to offering members. At no time in BHI's 15 years of continuous operation of the Medicaid Behavioral Health Contract with the Department has BHI ever objected to provide services based on moral or religious grounds.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: BHI staff members reported that BHI does not object to the provision of services on moral or religious grounds. During the on-site interview, BHI staff members stated that they are unaware of any contracted providers who object to providing certain services. BHI staff members stated that BHI would be alerted of such objections through the member grievance process, and review of initial assessments and treatment plans during the service authorization process. The Member and Family Handbook contained the statement that BHI does not object to providing any services, based on religious or moral objections. BHI may want to consider adding this statement to policy, as well.		
Required Actions: None.		
8. The Contractor does not employ or contract with providers excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act (This requirement also requires a policy). *42CFR438.214(d)* *Contract: II.G.3.e*	Corp Comp and Employee, Contractor Relations ppFY12 (Pages 2, 3) It is the policy of BHI to make reasonable inquiry into the bbackground of prospective employees and prospective vendors that are engaged in business or activity which by its nature might place BHI at risk for violation of the law or the Plan. In conjunction with policies and procedures developed and administered by the Human Resources, all employees and contractors shall be screened to determine whether they have been: ◆ Convicted of a criminal offense related to health care; or ◆ Listed by a Federal agency as debarred, excluded or otherwise ineligible for Federal program participation as required by current state laws and statutes.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
	For all new employees who have discretionary authority to make decisions that may involve compliance with the law or compliance with oversight, BHI conducts a reasonable and prudent background investigation, including reference checks, as part of every such employment application. The application specifically requires the applicant to disclose any criminal conviction for Medicaid/Medicare fraud and abuse as defined by 42 U.S.C. 1320a-7(I), or exclusion action. BHI prohibits the employment of individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded or otherwise ineligible for participation in Federal health care programs (as defined in 42 U.S.C. 1320a-7b(f). With regard to current employees or independent contractors, pending the resolution of any criminal charges or proposed debarment or exclusion, that individual will be removed from direct responsibility for, or involvement with any Federal health care program. If resolution of the matter results in conviction, debarment, or exclusion, BHI will terminate its employment or other contract arrangement with the individual or contractor.	

Findings:
The BHI Provider Service Agreement stated that BHI may terminate the agreement if the provider has "revocation, termination, suspension or probation with respect to licensure, certification, or Medicare or Medicaid participation status." The provider contract contained a signed acknowledgement of receipt of the BHI Corporate Compliance Plan and agreement to comply with the Plan. The Corporate Compliance Plan stated that all subcontracted clinical providers are screened to determine whether they have been convicted of a criminal offense related to health care or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation. The policy also stated that any employee or contractor found to have a conviction or sanction will be terminated. The Provider Credentialing and Recredentialing policy stated that providers identified as having been convicted of a criminal offense related to health care or listed by a federal agency as being debarred, excluded or otherwise ineligible for federal program participation will be excluded from participation as a BHI provider. BHI's information would be verified through the Office of Inspector General Exclusions (OIG) database at the HHS Web site. During the onsite interview, BHI staff members verified that all providers are screened monthly against the OIG database and Colorado licensure database.

Required Actions:
None.

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
9. The Contractor may not knowingly have a director, officer, partner, employee, consultant, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549. *42CFR438.610* *Contract: II.G.6*	BHI Provider Contract (Page 3 and Attachment E) BHI outlines in each provider contract the information regarding Executive Order 12549 and acquisition regulations. BHI has not had a director, partner officer, employee, subcontractor, or owner debarred, suspended or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549 in FY10.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The BHI Corporate Compliance Plan stated that all current or new employees and subcontracted clinical providers were screened to determine whether they have been convicted of a criminal offense related to health care or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation. The plan stated BHI would terminate its contract with any employee or contractor found to have a conviction or sanction. The Corporate Compliance and Employee, Contractor Relations policy contained the same policy statement as outlined in the Corporate Compliance Plan and described that new employee applicants were required to disclose any conviction for Medicare/Medicaid fraud and abuse or exclusion action. The policy stated that BHI prohibits employment of individuals who are convicted, debarred, excluded, or otherwise ineligible for participation in federal health care programs. The Provider Service Agreement disclosure form required disclosure of the identity of any individual having had violations related to any program under Medicare, Medicaid, or the Title XX services. During the on-site interview, BHI staff members stated that employees and contracted vendors are screened on initial employment or at time of contracting, and that the screening results are retained in the employee file in human resources.

Required Actions:
None.

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
10. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. *42CFR438.12(a)(1)* *Contract: II.G.4.b*	Provider Credentialing and Recredentialing pp FY12 (Page 5) Decline to Include in Network Letter Template The completed credentialing file is reviewed against BHI credentialing criteria. If the criteria are met, the application and report is presented to the BHI Credentialing Committee. Based on the decision fromm the Credentialing Committee, the practitioner will receive an acceptance or denial letter within seven days of the committee's decision. The denial letter includes information regarding the appeal process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Provider Credentialing and Recredentialing policy stated that the Risk and Resource Committee reviews all provider applications against BHI credentialing criteria and network need. Staff members clarified that this process was transitioned to the UM committee during the review period. Staff members stated that the committee determination is communicated to the practitioner through an acceptance or denial letter within seven days of the decision, and denial letters include information on the appeal process. The decline to include in network letter template included the reason for non-inclusion in the network. During the on-site interview, BHI staff members stated that there have been no denials of provider participation in the network during the review period.		
Required Actions: None.		
11. The Contractor must have administrative and management arrangements or procedures that are designed to guard against fraud and abuse and include: ◆ A mandatory compliance plan approved by the Contractor's CEO and Compliance officer. ◆ Submission of the compliance plan to the Department for review. ◆ Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards. ◆ Provisions for internal monitoring and auditing. ◆ Provision for prompt response to detected offenses	Corporate Compliance Plan (Pages 4, 14, 15, 16, 17, 18,19, 20, 21) Corp Comp and Employee, Contractor Relations ppFY12 BHI Employee Handbook 2010 (Page 12) Corporate Compliance New Employee Training Check List Corporate Compliance training_Final 2009 EVR Report will be available at site visit BHI's corporate compliance plan and corporate compliance policy describe in detail how BHI will guard against fraud and abuse. Teresa Summer is BHI's Corporate Compliance Officer.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
and for development of corrective action initiatives. ◆ Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste, and abuse including mechanisms to identify and report suspected instances of upcoding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided. ◆ The designation of a compliance officer and a compliance committee that are accountable to senior management. ◆ Effective training and education for the compliance officer and the Contractor's employees. ◆ Effective lines of communication between the compliance officer and the Contractor's employees ◆ Enforcement of Standards through well-publicized disciplinary guidelines. ◆ Effective processes to screen all provider claims, collectively and individually, for potential fraud waste or abuse. • Reporting: o The Contractor immediately reports indications or suspicions of fraud by giving a verbal report to the Contract manager. The Contractor shall then investigate its suspicions and submit its written findings to the contract manager within three business days of the verbal report. If the investigation is not complete within three business days, the Contractor shall continue to investigate and submit a final report within 15 business days (further extension may be approved by the contract manager).	BHI trains Staff on the corporate compliance plan. The plan is mailed to all BHI providers with their contracts. The providers sign an attestation form in the contract that the plan was read. BHI developed an encounter/claim validation report that provides an overall qualitative and quantitative view of services billed by BHI providers. This serves as a mechanism to identify fraud, waste, and abuse.	

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
o The Contractor reports known, confirmed intentional incidents of fraud and abuse to the contract manager and to the appropriate law enforcement agency, including the Colorado Medicaid Fraud Control Unit. *42CFR438.608* *Contract:II.G.5.d, II.G.5.g–l*		

Findings:
BHI's Corporate Compliance Plan (CCP), revised and approved by the board of directors in October 2010 and emailed to the Department in July 2011, addressed the following:

- BHI's intent to conduct operations in compliance with laws and regulations of the U.S., Colorado, and ethical practices of the industry
- Application of the CCP to all board members, employees, volunteers, consultants, vendors, and subcontracted clinical providers, with BHI remaining ultimately responsible and providing oversight of subcontractors
- Appointment of a Corporate Compliance Officer (CCO) and Corporate Compliance Committee (CCC), who are responsible to the board of directors
- Annual review and revision of the CCP
- The Corporate Code of Conduct, which included a listing of member rights, provider claims and financial incentives standards, financial operations standards, medical records confidentiality and HIPAA standards, monitoring of subcontracted claims processing and prior authorization, and employee relations/non-discrimination standards
- Education and training processes and components that included mandatory participation and multifaceted approaches
- Auditing and monitoring processes
- Effective communications between the CCO and employees, including false claims and whistleblowing laws
- Investigation and reporting processes
- Disciplinary enforcement mechanisms
- Background screening requirements for employees and clinical providers

The CCP stated that investigations that revealed possible criminal activity would result in disciplinary action by BHI and notification of the Medicaid Fraud Unit of the Colorado Office of the Attorney General and the Department behavioral health division director. The plan stated that BHI would provide immediate, verbal report to the Department. BHI would investigate the incident, submit a written report of preliminary findings to the Department within three days, and a final report within 15 days of the verbal report. The plan provided that the CCO was responsible for reporting statistical summaries of reports received and results of investigations to the CCC and board of directors annually.

The CCP stated that BHI monitors and audits claims submitted by providers and the ASO to ensure accurate claims data. BHI required the ASO to conduct pre- and post-submission random claims testing for accuracy. The plan stated BHI used external consultants to audit departmental compliance with the

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Requirement	**Evidence as Submitted by BHO**	**Score**

Code of Conduct, including site visits, interviews, questionnaires, records review, and sampling of claims/denials/authorizations, with implementation of corrective action as needed. The CCP described methods for open communication regarding possible violations, including the "duty to report," availability of multiple avenues for reporting (including an anonymous hotline), and protection against retaliation. The plan stated that violations would be documented in the employee personnel file. Disciplinary measures for employees, which included termination, were outlined in the employee handbook and actions for subcontractors, including contract termination, were outlined in the provider agreements.

BHI staff members reported that there was one investigation of suspected provider fraud and abuse during 2010. Staff members produced documentation that verified a preliminary investigation to confirm suspicion, immediate notification of the Department regarding suspicion, an exhaustive investigation of medical records against claims, and processing of results internally—including financial recovery, credentialing committee determinations, referral to legal authorities, placement of members with appropriate alternate providers. The file also demonstrated regular notification and communication with the Department throughout the process. A final report to the Department was submitted one month following identification of suspicion. This case demonstrated thorough examination, reporting, and resolution of a very complex incident. Staff members stated that there have been no other cases of suspected fraud within BHI.

The Subcontractual Relationships and Delegation policy required that delegates follow BHI's performance standards, the Medicaid contract, or regulatory requirements and allow BHI to access records for auditing, including response to any corrective actions set forth by BHI. The policy outlined the responsibilities of the delegates, and the BHI Delegation Oversight Committee. The BHI Claims Processing policy stated that the ASO was required to perform accurate processing of contracted provider claims, including verification of eligibility, provider identification, dates and types of services, and payments, and was to conduct quarterly audits for claims accuracy.

The Provider Service Agreement template and Mental Health Center (MHC) Facility Service Agreement stated that the provider agrees to comply with the BHI CCP and included a signed attestation acknowledging receipt of the CCP. By signing the agreement, the provider agreed to conduct business in accordance with the Code of Conduct; acknowledges that violations may be cause for termination, and that the provider has a responsibility to report violations. The CCP was embedded in the BHI provider manual in its entirety. The provider service agreements outlined provider billing responsibilities, defined payment rates for services, and stated that the provider would permit access to financial and medical records for assessment of the type and extent of costs and services provided.

The BHI FY11 411 Audit Report provided evidence of an annual evaluation of sample encounter claims for verification of accuracy and completeness of claims that were submitted to the Department compared to medical record documentation. The report included corrective action plans to address deficiencies, as appropriate.

During the on-site interview, BHI staff members stated that employee training on corporate compliance is conducted annually and that employees must pass an associated quiz. BHI established a hotline for confidential reporting of suspected fraud or abuse and arranged for an external audit that included an assessment of internal staff compliance with the CCP through mechanisms such as timesheet audits, interviews with staff members concerning awareness and reporting of suspected fraud or abuse. BHI staff members described the encounter verification process conducted monthly as a screen against claims

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Requirement	**Evidence as Submitted by BHO**	**Score**
within the automated claims processing system, which is programmed to apply numerous criteria for identifying errors in diagnosis coding, duplication of charges, charges outside of defined parameters, etc. This process produced a detailed error report by provider facility, which was submitted to the provider for correction of errors. BHI reviewed the monthly and annual summary of encounter verification results. In addition, BHI required Colorado Access (the delegated ASO for claims payment) to audit of 3 percent of claims, including claims appeals, for accuracy and performance of 95 percent or above. Colorado Access reported the results to BHI in the Contract Performance Summary.		
Required Actions: None.		
12. The Contractor provides that Medicaid members are not held liable for: ◆ The Contractor's debts in the event of the Contractor's insolvency. ◆ Covered services provided to the member for which the State does not pay the Contractor. ◆ Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. ◆ Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42CFR438.106* *Contract: II.G.11*	BHI Provider Contract, (Page 7., Section 4.4: "Payment in Full" and Page 8, Section 4.8: "No Recourse Against Covered Persons" There is a hold harmless clause in the BHI provider contract if the provider is unable to receive payment for a covered service rendered. In cases in which a client has been billed for a covered service, the BHI Director of Utilization Management has contacted the provider and explained this clause in their contract. BHI attests by signing the contract with HCPF that we will not hold a Medicaid Member liable in the case of insolvency.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Provider Services Agreement and MHC Facility Services Agreement stated that the provider agrees to receive payment for covered services solely from BHI and under no circumstance would the provider make any charge or claim against a member for covered services. The Member and Family Handbook stated in several places that members would not be charged for covered services that are received from BHI network providers. During the on-site interview, BHI staff members stated that member complaints regarding provider charges would alert BHI to address the problem with the member and reeducate the provider regarding Medicaid payment policies. Member grievance documentation was retained in the provider file.		
Required Actions: None.		

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
13. The Contractor has a written agreement with each provider. *Contract: II.G.10.a.2*	BHI Provider Contract (Page 19) BHI MHC Contract AuMHC BHI has a contract with each provider within the Contracted Provider Network and with CMHCs. The contract also includes a Corporate Compliance Acknowledgement form for the provider to attest to the receipt and understanding of the BHI Corporate Compliance Plan. Each provider is required to sign off on this form.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Provider Services Agreement template and the signed and executed MHC Facility Services Agreements with the major provider groups, including Aurora Mental Health Center, Community Reach Center, and Arapahoe/Douglas Mental Health Network, provided evidence that BHI had written agreements with each provider. All Facility Service Agreements were executed July 2007 and automatically renew annually. Any amendments to the contract were appended. BHI staff members reported that providers in the contracted provider network were added to the provider list, only after completing the credentialing and initial contracting processes.		
Required Actions: None		
14. Written provider agreements specify: ◆ The activities to be performed by the provider. ◆ Reporting responsibilities of the provider. ◆ Provisions for revoking the provider agreement or imposing other sanctions if the provider's performance is inadequate. ◆ Provisions for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53 *Contract: II.G.10.a.2,7*	BHI Provider Contract (Pages 4, 5, 9, 10) The BHI Provider Contract details the requirements and responsibilities of each provider for the Contracted Provider Network. This information is included under Article III Provider Obligations. This section includes Provision of Covered Services and Reports. Article V Confidentiality and Access requires providers to permit access to BHI for all records as well as the appropriate state authorities, including the Department of Health Care Policy and Finance and the Division of Insurance, and federal authorities, including the US Department of Health and Human Services as specified in 45CFR74.53. The BHI Provider Contract under Article VII Term and Termination outlines the provisions for revoking the provider agreement.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: The Provider Services Agreement template and MHC Facilities Services Agreements addressed: • Provider obligations, which included provision of covered services (detailed) and performance of eligibility verification and authorization processes • Reporting of information on each member that received services from the provider, and submission of patient encounter information monthly • Permitting access to records by BHI, the Department, the Department of Insurance, or Department of Health and Human Services for assessment of quality of care, medical necessity, extent of costs and services provided, member appeals, or compliance with laws • Provisions for terminating the agreement, including BHI or provider choice or for reasons of cause as specifically outlined		
Required Actions: None.		
15. The Contractor provides a copy of its claims filing requirements to every participating provider upon acceptance of the provider into the Contractor's network, and to every provider within 15 calendar days after any change in the standard form or requirements. *Contract: II.G.10.c.17*	BHI Claim Processing Policy pp FY12(Page 2) BHI Provider Letter COA 05042011 (Page 2) BHI sends a letter to all providers with every new contract and at that time, their re-credentialing application has been reviewed and approved. This letter provides information to the provider on how to acquire an authorization, where to send claims and information to remember to include on their claim submission. The letter also directs providers to the BHI Web site for additional detailed information on how to submit a claim. The BHI Claims Processing Policy requires COA to notify BHI of any claims processing changes or requirements 30 days prior to the change. This allows BHI adequate time to notify providers of the changes within the required 15 calendar days after a change is implemented.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The BHI Claim Processing policy, stated that Colorado Access will inform BHI 30 days in advance of any claims processing changes and that BHI would notify providers within 15 calendar days after any change is implemented. During the on-site interview, BHI staff members stated that there have been no changes in the claims filing requirements within the last year. The Provider Services Agreement template included a description of the "form and payment of provider claim" including submission of claims for all covered services—reasonable, necessary, and supported in medical record documentation, the billing format and required data items, time frames for claim		

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Requirement	**Evidence as Submitted by BHO**	**Score**
submission, and time frames for BHI payment. The provider manual, available on the BHI Web site, provided detailed billing instructions including required forms, required data/information, time frames for submission, corrected billing procedures, helpful tips, and a description of the provider claims appeal process. The provider letter, sent from Colorado Access at the time of initial contracting (as part of the Colorado Access delegated activities), was sent to all providers to clarify the claims processing and prior authorization procedures. The letter also outlined the claims submission process, provided contact information for claims submission and questions, and provided helpful hints related to claims submission.		
Required Actions: None,		

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	15	**Total Score**		=	14

Total Score ÷ Total Applicable	=	93%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor. *42CFR438.230(a)(1)* *Contract: II.B.1*	ADM-115 Subcontractual Relationships and Delegation ppFY12 (Page1) Delegation Agreement CRC Delegation Oversight Final Report Template BHI's Subcontractual Relationships and Delegation policy describes BHI's responsibility in overseeing and being accountable for responsibilities delegated to its subcontractors. This policy serves as a guide in fulfilling BHI responsibilities for all functions delegated to subcontractors.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Subcontractual Relationships and Delegation policy described processes for delegation and annual oversight (formal review). BHI's ASO Deliverables list (specific to the contract with Colorado Access) and the Annual Oversight Reports for each of BHI's CMHCs demonstrated oversight and accountability for delegated activities. BHI delegated provider network management, credentialing, claims adjudication, and care management to Colorado access. During the review period BHI delegated certain utilization management tasks (authorization of services and provision of notices of action) to the Community Reach Center, the Arapahoe Douglas Mental Health Network, and the Aurora Mental Health Center. During the on-site interview, BHI staff members reported that although the three CMHCs continued to authorize services for providers in the contracted provider network, BHI terminated the delegation of sending notices of action in approximately April 2011.		
Required Actions: None.		
2. Before any delegation, the Contractor evaluates (and documents in writing that it has) the prospective subcontractor's ability to perform the activities to be delegated. *42CFR438.230(b)(1)* *Contract: II.B.2, Exhibit S—II.A*	ADM-115 Subcontractual Relationships and Delegation ppFY12 (Page 3) Prior to entering into any contract that includes delegated functions BHI thoroughly evaluates the capabilities of potential sub-contractors. During this review period, BHI did not contract with any new delegated provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Subcontractual Relationships and Delegation policy included the provision to perform a predelegation evaluation prior to contracting with a new delegate. During the on-site interview, BHI staff members described predelegation evaluation activities conducted prior to entering into the delegation agreement with Colorado Access in July 2009. Staff members reported that the predelegation review of Colorado Access consisted of reviewing policies and procedures, reviewing reference letters, and reviewing Colorado Access' claims adjudication specifications. Staff also reported performing a comparative evaluation of another potential delegate before entering into an agreement with Colorado Access.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
Required Actions: None.		
3. The Contractor has written policies and procedures for the monitoring of subcontractor performance, monitors the subcontractor's performance on an ongoing basis, and subjects it to a formal review according to the periodic schedule established by the State. *42CFR438.230(b)(3)* *Contract: II.B.2, Exhibit S—I.A, IV.A*	ADM-115 Subcontractual Relationships and Delegation ppFY12 (Page 2) Delegation Oversight Final Report Template BHI SFY10-11 Quarterly Contract Performance Summary Q4 BHI monitors delegate's performance on an annual basis according to industry standards. BHI is currently working on the eighth year of formal delegation oversight reviews with the BHI CMHCs. BHI has increased expectations over the years and CMHCs continue to meet or exceed requirements for delegated activities. In addition, BHI is in the process of revising delegation agreements with the CMHCs. Revised delegation agreements will include required language related to BBA regulations and new Medicaid contract obligations. BHI's delegation agreements with the CMHCs detail the reporting requirements, schedules, and responsible parties for data and information needed to meet BHI's reporting obligations to HCPF. Colorado Access submits quarterly reports summarizing performance in processing credentialing and re-credentialing files and serves as a tool for BHI oversight.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Subcontractual Relationships and Delegation policy described BHI's processes for delegation of responsibilities under the Medicaid Managed Care contract. Certain sections of the policy were specific to the processes for delegation of activities to the CMHCs. BHI may want to consider revising the policy such that it could be applied to all delegates. While the policy addressed formal review (annual audit) activities, it did not address ongoing monitoring. The quarterly contract performance reports submitted by Colorado Access demonstrated BHI's ongoing monitoring of Colorado Access. The quarterly report provided detailed information about each of the delegated tasks (provider network management, credentialing, claims adjudication, and care management). For the CMHCs; however, BHI staff members were unclear as to how ongoing monitoring of delegated activities (specifically UM		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
authorizations) occurred. BHI staff members were unable to provide an updated list of CMHC deliverables or describe how authorization activities were monitored on an ongoing basis. Regarding formal review, BHI submitted audit reports (June 2010) for each of the three CMHCs. The Department's established schedule is to subject the delegate to a formal review on the first anniversary of the contract, then at least once every three years thereafter. The June 2010 CHMC audits met the Department's requirement for formal review of the CMHCs and included a review of delegated UM activities. BHI; however, was unable to provide the first annual review (or other formal review) of Colorado Access. During the on-site interview, BHI staff members reported that certain aspects of Colorado Access' data activities were reviewed during the annual 411 audit process; however, the entirety of Colorado Access' tasks and responsibilities have not been subjected to formal review.		
Required Actions: BHI must evaluate its processes for delegate oversight and ensure that both ongoing monitoring and formal review are conducted for each delegate. Specifically, BHI must address ongoing monitoring for UM tasks delegated to its partner CMHCs and formal review of provider network management, credentialing, claims adjudication, and care management tasks delegated to Colorado Access. BHI must also revise its policy to address both ongoing monitoring and annual audit activities related to oversight of delegates.		
4. The Contractor ensures that work further subcontracted by a subcontractor is monitored by the delegating subcontractor. *Contract: II.B.2, Exhibit S—IV.B*	Corrective Action Plan for Colorado Access BHI ensures that any work further subcontracted by a subcontractor is monitored by the delegating subcontractor. Attached is an example of a Corrective Action Plan that BHI's subcontractor Colorado Access provided due to an error by their subcontractor DST. Any provider subcontracts by BHI's subcontractors are with participating providers solely for the provision of behavioral health services to members, and subsequently are not subject to the requirements of Exhibit S regarding subcontracts.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Quarterly Contract Performance Summary report from Colorado Access included performance information on activities subdelegated.		
Required Actions: None.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
5. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance the Contractor and the subcontractor take corrective action. *42CFR438.230(b)(4)* *Contract: II.B.2, Exhibit S—IV.C*	BHI CRC CAP BHI requires that subcontractors submit Corrective Action Plans when performance deficiencies are identified.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Subcontractual Relationships and Delegation policy included the provision for corrective action when delegate performance is deficient. The policy indicated that the delegate will provide a CAP within 15 business days. BHI provided CAP requests sent to the CMHCs following the June 2010 audits and an example of a CAP from CRC and from Colorado Access. During the on-site interview, BHI staff members described informal processes working with the CMHCs to problem solve rather than formal corrective actions. BHI may want to consider documenting these collaborative efforts in minutes or other forms of communication.		
Required Actions: None.		
6. There is a written agreement with each delegate. *42CFR438.230(b)(2)* *Contract: II.B.2, Exhibit S—III.A*	Delegation Agreement CRC BHI COA Delegation Agreement 2009 BHI has written delegation agreements with the three BHI CMHCs and with Colorado Access for Provider Credentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: BHI provided signed executed delegation agreements with the AuMHC, ADMHN, CRC, and Colorado Access.		
Required Actions: None.		
7. The written delegation agreement: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. ◆ Specifies that the subcontractor shall comply with the standards specified in the Contractor's agreement with the Department. ◆ Requires at least semi-annual reporting of progress and findings to the Contractor.	Delegation Agreement CRC MHC_DeliverablesCalendar_FY08_Attachment_F BHI COA Delegation Agreement 2009 BHI has delegation agreements with the CMHCs for the purpose of defining and monitoring delegated functions including access, referral, utilization management, care coordination, triage, member services, and quality improvement responsibilities.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Describes the process which the Contractor will use to evaluate the subcontractor's performance. ◆ If the subcontractor will perform utilization management, the agreement provides that the compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services (reference 42CFR438.12(e). ◆ Includes a provision that the subcontractor shall maintain complete files of all records, documents, communications, and other materials which pertain to the operation of the subcontract or to the delivery of services under the subcontract sufficient to disclose fully the nature and extent of services/goods provided to each member and to document all activities and services under the agreement. ◆ Includes provisions permitting duly authorized agents of the Department, State and federal government to access the subcontractor's premises during normal business hours to inspect, audit, monitor, or otherwise evaluate the quality, appropriateness, timeliness, or any other aspect of the subcontractor's performance of subcontracted services. ◆ Provides for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53. ◆ Requires the subcontractor and any other subrecipients to notify the Department when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. *42CFR438.230(b)(2)* *Contract: II.B.2, Exhibit S—III.B–M*	Specific activities are detailed in the delegation agreements with the CMHCs. The agreement also details criteria for revoking delegation or sanctions that will be imposed if performance is inadequate. BHI made contract amendments in 2007 delineating financial sanctions to be imposed if CMHCs do not meet BHI deadlines for data submission. In addition, BHI has a formal delegation agreement with Colorado Access for provider credentialing functions, which includes all required elements for NCQA delegated activities.	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**

Findings:

Delegation agreements reviewed included Aurora Mental Health Center, July 1, 2007; Arapahoe/Douglas Mental Health Network, November 2, 2011; and Community Reach Center, November 2, 2011. Service Agreements reviewed included agreements with AUMHC, ADMHN, and CRC revision dates June 30, 2005.

The Colorado Access delegation agreement specified the delegated activities and reporting responsibilities as well as the remainder of the requirements for content of the delegation agreement.

Each of the CMHC delegation agreements in effect at the time of the site review included provisions for remedies related to insufficient performance of the contract responsibilities. Remedies included required corrective action and possible termination of the agreement. The CMHC agreements also included provisions requiring the CMHCs to comply with the standards specified in BHI's agreement with the Department, the provision to maintain complete files and records, and the required provisions for access to records.

Each of the CMHC delegation agreements indicated that the CMHCs were responsible for sending notices of action to members. During the on-site interview, BHI staff members reported that this specific task was no longer delegated to the CMHCs. On-site BHI provided updated delegation agreements for two of the three CMHCs (CRC and ADMHN). These agreements (the 2011 CMHC agreements) reflected the delegation of authorizing and tracking services provided by the contracted provider network. The Aurora Mental Health Center agreement addressed authorization of services by the CMHC, although in a different manner. The Aurora Mental Health Center agreement signed in 2007 included a deliverables calendar, which specified regular reporting responsibilities. The 2011 delegations agreements for ADMHN and CRC did not specify regular reporting responsibilities related to the delegated activities.

While the CMHC delegation agreements described the process by which BHI planned to evaluate the delegates' performance, the activities described (annual audits and oversight of peer review processes) did not occur during the calendar year 2011.

Regarding the required provision that "if the subcontractor will perform utilization management, the agreement provides that the compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services," BHI referred to the service agreements with each CMHC. The service agreements required compliance with BHI's corporate compliance plan. The corporate compliance plan stated, "BHI does not provide incentives to core providers or subcontracted clinical providers to reduce or limit services to Medicaid beneficiaries…" BHI may want to consider incorporating this provision into the body of the delegation agreement, given that the CMHCs provide delegated utilization management services.

The provision to require reporting of federal expenditures from all sources equal to or in excess of $500,000 was not present in the CMHC delegation or service agreements.

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
Required Actions: BHI must review delegation agreements with the CMHCs that provide delegated activities to specify reporting responsibilities and the provision to require reporting of federal expenditures from all sources equal to or in excess of $500,000. BHI must also evaluate its processes to evaluate the CMHC delegates' performance and ensure accurate reflection in the delegation agreements.		
8. The Contractor provides a description of the grievance, appeal and fair hearing procedures, approved by the Department, and time frames to all Subcontractors at the time the subcontractor enters into a contract with the Contractor. The description includes: ◆ The member's right to file grievances and appeals. ◆ The requirements and time frames for filing grievances and appeals. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers that the member can use to file a grievance or an appeal by telephone. ◆ The member's right to a State fair hearing for appeals: • The method to obtain a State fair hearing • The rules that govern representation at the hearing ◆ The fact that, when requested by the member: • Benefits will continue if the member files an appeal or a request for a State fair hearing within the time frames specified for filing. • The member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the member. *Contract: II.B.2, Exhibit S–V*	Contract_execute_letter At the time of initial contract negotiations as well as at the time of final contract execution, BHI CPN providers receive a letter strongly encouraging them to visit the provider portion of BHI's Web site for the provider manual. The provider manual describes the grievance, appeal, and State Fair Hearing procedures and all specific information and forms needed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Each of BHI's delegates (applicable to this requirement) were provided access to the provider manual and the member handbook via BHI's Web site, and were directed to such documents via enrollment letters welcoming the provider to the BHI provider network. (The specific accuracy of the provider manual content related to grievances and appeals is scored in Standard VI requirement 26).		
Required Actions: None.		

Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	8	**Total Score**		=	6

Total Score ÷ Total Applicable	=	75%

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

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Appeals Record Review Tool
for Behavioral HealthCare, Inc.

Review Period:	January 1, 2011–September 30, 2011
Date of Review:	November 3, 2011–November 4, 2011
Reviewer:	Barbara McConnell, MBA, OTR
Participating BHO Staff Member:	Jennifer Conrad and Jane Moore

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID	Date Appeal Received	Date of Acknow-ledgment Letter	Acknow-ledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame (10 W-days or 3 W-days)	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
1	******	2/16/11	None	M☐ N☒	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	2/24/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
2	******	3/4/11	None	M☐ N☒	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	3/8/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
3	******	3/23/11	None	M☐ N☒	NA	NA	NA	NA	NA	NA	NA	NA
Comments: The member verbally withdrew the appeal on 3/29/11.												
4	******	4/1/11	None	M☐ N☒	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	4/15/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
5	******	6/20/11	None	M☐ N☒	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	7/7/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
6	******	6/22/11	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Comments: The member verbally withdrew the appeal on 6/23/11.												
7	******	7/1/11		M☐ N☒	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	7/7/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Appeals Record Review Tool
for Behavioral HealthCare, Inc.

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID	Date Appeal Received	Date of Acknow-ledgment Letter	Acknow-ledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame (10 W-days or 3 W-days)	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
8	******	7/13/11	None	M☐ N☒	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	7/21/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
# Applicable Elements				7	6	6				6	6	6
# Compliant Elements				0	6	6				6	6	6
Percent Compliant				0	100%	100%				100%	100%	100%

Note: M = Met, N = Not met, U = Unknown, Y = Yes, N = No

Total # Applicable Elements	**37**
Total # Compliant Elements	**30**
Total Percent Compliant	**81%**

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

Table C-1 lists the participants in the FY 2011–2012 site review of **BHI**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Katherine Bartilotta, BSN	Project Manager
BHI Participants	**Title**
Jennifer Conrad	Director of Utilization Management
Joseph Gear	R.I.S.E. Academy Manager
Jeff George	Quality Improvement Analyst
Roger Gunter	Chief Executive Officer
Laura Hill	Quality Improvement Research Analyst
Rebecca Hill	Executive Assistant
Samatha Kommana	Director of Quality Improvement
Melissa Kulasekere	Program Evaluator/Disease Management Specialist
Anji McConnell	Claims/Authorization Coordinator
Lee A. Merrifield	Wellness Program Manager
Christina Mitsch	BHI Authorization Coordinator
Jane Moore	Manager of Utilization Review
Alicia Nix	Program Manager
Rian G. Nowitzki	Chief Financial Officer/Controller
Belai I. Nunoz	Administrative Support
Jerome Stiller	Senior Data Analyst
Teresa Summers	Director of Provider Relations
Scott Utash	Director of Member and Family Affairs
Department Observers	**Title**
Russell Kennedy	Quality and Compliance Specialist
Jerry Ware	Quality and Compliance Specialist
Marceil Case (via telephone)	Behavioral Health Specialist

Appendix D. Corrective Action Plan Process for FY 2011–2012 for Behavioral HealthCare, Inc.

If applicable, **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 required action, the BHO should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the BHO must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	If applicable, the BHO will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final 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 to HSAG and the Department. The BHO will submit the CAP using the template provided. 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 or HSAG will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the CAP, the BHO should implement all the planned interventions and submit evidence of such implementation to HSAG via 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 or HSAG will inform the BHO as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the BHO must submit additional documentation. The Department or HSAG will inform each BHO in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the BHO into full compliance with all the applicable federal Medicaid managed care regulations and contract requirements.

The template for the CAP follows.

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard V: Member Information		
Requirement	**Findings**	**Required Actions**
Requirement 13: The member information materials sent following enrollment also include the following information regarding the grievance, appeal, and fair hearing procedures: ♦ The right to file grievances and appeals. ♦ The requirements and time frames for filing a grievance or appeal (including oral filing). ♦ The right to a State fair hearing: ▪ The method for obtaining a State fair hearing, and the rules that govern representation at the State fair hearing. ♦ The availability of assistance in the filing process. ♦ The toll-free numbers the member may use to file a grievance or an appeal by phone. ♦ The fact that, when requested by the member: ▪ Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing, and the service authorization has not expired. ▪ The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ♦ The right that providers may file an appeal on behalf of the member with the member's written consent.	The member handbook depicted the time frame for filing grievances and appeals and for requesting a State fair hearing as 20 calendar days. Under the continuation of services section the timely filing for appeals when requesting the continuation of previously authorized services was stated as, "Within 10 calendar days from the date on the letter, or before the authorization ends, whichever is less time." During the on-site review, HSAG staff members discussed the discrepancy in the required filing time frames between the Colorado Rule, the BHI policies, and the BHI Member and Family Handbook. BHI stated that revised copies of the member handbook were being printed.	BHI must revise the information in its Member and Family Handbook regarding time frames for filing grievance, appeals, and requests for a State fair hearing to comply with the Colorado Rule and BHI policies, and reflect the 30-calendar-day-time frame for each. BHI must also revise the section of its member handbook that explains the continuation of services during an appeal related to the termination of previously authorized services. The handbook must accurately reflect the required time frame for filing an appeal or requesting a State fair hearing if requesting the continuation of previously authorized services (within 10 days from date of the notice of action or before the effective date of the termination or change in services, whichever is later).
Planned Interventions:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI
Standard V: Member Information
Person(s)/Committee(s) Responsible and Anticipated Completion Date:
Training Required:
Monitoring and Follow-up Planned:
Documents to be Submitted as Evidence of Completion:

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard V: Member Information		
Requirement	**Findings**	**Required Actions**
Requirement 18: Advance directives requirements: The Contractor maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving care by or through the BHO. Advance directives policies and procedures include: ♦ A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. ▪ The difference between institution-wide conscientious objections and those raised by individual physicians. ▪ Identification of the State legal authority permitting such objection. ▪ Description of the range of medical conditions or procedures affected by the conscientious objection. ♦ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. ♦ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. ♦ Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. ♦ The provision that the decision to provide care to a member is not conditioned on whether the member	The provider manual included a copy of the Advance Directives policy and stated that internal staff members would receive training on advance directives at orientation and annually thereafter. However, the policy did not include the provision for staff education regarding advance directives and there was no evidence of staff education regarding advance directives. During the on-site interview, staff members confirmed there are no processes for staff education regarding advance directives.	BHI must develop a process to address education of staff concerning its policies and procedures regarding advance directives, and revise the Advance Directives policy accordingly.

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard V: Member Information		
has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive. ♦ Provisions for ensuring compliance with State laws regarding advance directives. ♦ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. ♦ Provisions for the education of staff concerning its policies and procedures on advance directives. ♦ Provisions for community education regarding advance directives that include: ▪ What constitutes an advance directive. ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. ▪ Description of applicable state law concerning advance directives. The member information materials regarding advance directives include: ♦ The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. ♦ The Contractor's policies respecting implementation of advance directives. ♦ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the Colorado Department of Public Health and Environment.		

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI
Standard V: Member Information
Planned Interventions:
Person(s)/Committee(s) Responsible and Anticipated Completion Date:
Training Required:
Monitoring and Follow-up Planned:
Documents to be Submitted as Evidence of Completion:

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard V: Member Information		
Requirement	**Findings**	**Required Actions**
Requirement 19: The member information materials sent following enrollment include: ♦ Notice that additional information that is available upon request, includes information on: ♦ The structure and operation of the Contractor. ♦ Physician incentive plans.	The Member Information policy stated that members would be informed that they may receive information on request regarding the structure and operation of BHI and physician incentive plans. The Member and Family Handbook stated that members may request information at any time on how BHI is structured and how it operates and on BHI's quality improvement program.	BHI must include a statement in the member information materials concerning the availability upon request of information concerning physician incentive plans.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard VI: Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 11: Members may file an appeal within 30 calendar days from the date of the notice of action.	The notice of action letter included a field to add the due date of the appeal. Notices of actions in the appeals records reviewed on-site contained the 20-calendar day filing time frame.	While BHI began implementing the revised rule from the 20-calendar-day time frame to the 30-calendar-day time frame for filing appeals, BHI must review current processes to ensure that members receive current information provided during the appeal process regarding the time frame for filing appeals.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard VI: Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 14: The Contractor sends the member a written acknowledgement of each appeal within two working days of receipt, unless the member or the designated client representative (DCR) requests an expedited resolution.	Although the Appeal Process policy and the Member and Family Handbook included the provision, and informed members that BHI sends a written acknowledgement to the member within two working days following the receipt of the appeal, the appeal records reviewed on-site contained no acknowledgement letters (of seven applicable records). During the on-site interview, staff members reported that BHI's understanding was that the appeal acknowledgement letter was optional.	Although BHI's documents (including the training PowerPoint presentation) clearly described appeal acknowledgement, this process had not occurred during the review period. BHI must evaluate its systems and take steps to ensure that appeal acknowledgement letters are sent within the required time frame and that BHI's policies and procedures regarding the appeals process are followed.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard VI: Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 16: The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: ♦ For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. ♦ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal. ♦ For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution.	The Appeal Process policy included the 10-working-day resolution time frame for standard appeals and the three-working-day resolution time frame for expedited appeals. The policy stated, "For standard resolution of the appeal and notice to the affected parties, ten working days from the day BHI receives the appeal request, either verbally or in writing." Similar language was present related to providing notice for expedited appeals. While the language in the policy could be interpreted correctly, the training materials (The action and appeals PowerPoint presentation) misconstrued the language and stated that both standard and expedited resolution was provided either verbally *or* in writing. The on-site record review demonstrated that appeal resolution letters were provided in all cases reviewed.	Although the on-site appeals record review demonstrated that BHI sent appeal resolution letters as required, BHI must ensure that staff members and providers are trained appropriately. BHI must review and revise training materials and other applicable documents to ensure consistency and accuracy of information provided to staff members and providers related to resolution of appeals.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard VI: Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 20: A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing within 30 calendar days from the date of the notice of action.	The Appeal Process policy included the provision that members may request a State fair hearing within 30 calendar days from the date of the notice of action, and that members need not exhaust BHI's appeal process. The appeal information attachment correctly stated the time frame as 30 calendar days; however, the appeal records reviewed on-site did not contain the appeal information attachment and informed members that the State fair hearing filing time frame was 20 days. During the on-site interview, staff members reported that BHI became aware of the filing time frame changes in approximately July 2011. The resolution letters reviewed on-site during the record review included the 20-calendar-day time frame for requesting a State fair hearing. The updated template provided was not accurately changed and read "twenty (30) calendar days".	While BHI began implementing the revised rule from the 20-calendar-day time frame to the 30-calendar-day time frame, BHI must review current processes and member communication used during the appeal process to ensure that members receive current information regarding the time frame for requesting a State fair hearing. BHI should also evaluate and/or revise internal communications or processes to ensure that changes and other State communications are implemented in a timely manner.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard VI: Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 22: The Contractor provides for continuation of benefits while the BHO-level appeal and the State fair hearing are pending if: ♦ The member or the provider files timely*—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice of action. ▪ The intended effective date of the proposed action. ♦ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ♦ The services were ordered by an authorized provider. ♦ The original period covered by the original authorization has not expired. ♦ The member requests extension of benefits.	The Appeal Process policy included the provision for continuation of benefits and described the correct timely filing requirement for this type of appeal. The appeals resolution letter template, however, defined timely filing for this type of appeal (appeals related to the termination, suspension, or reduction or services and the member's request to continue those service during the appeal or the State fair hearing process) as 30 days.	BHI must revise templates used for member communication during the review process to accurately state that members may request continuation of services (when applicable) within 10 calendar days of the notice of action, or before the effective date of the intended action.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard VI: Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 26: The Contractor must provide the information about the grievance system specified in 42CFR438.10 (g) (1) to all providers and subcontractors at the time they enter into a contract. The information includes: ♦ The member's right to file grievances and appeals. ▪ The requirements and time frames for filing grievances and appeals. ♦ The right to a State fair hearing: ▪ The method for obtaining a State fair hearing. ▪ The rules that govern representation at the State fair hearing. ♦ The availability of assistance in the filing process. ♦ The toll-free numbers the member may use to file a grievance or an appeal by telephone. ♦ The fact that, when requested by the member: ▪ Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. ▪ If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ♦ The member's right to have a provider file a grievance or an appeal on behalf of the member, with the member's written consent.	While Section VII of the provider manual included copies of the Appeal Process policy, the Notice of Action policy, and the Grievance Procedure policy correctly stating the 30-calendar day filing time frame for grievances, appeals, and State fair hearings, Section II of the manual also included a reproduction of the Member and Family Handbook, which stated a 20-calendar-day time frame for each filing process.	BHI must review distribution patterns for the member handbook and ensure that all documents (and/or mailings or postings) containing the member handbook includes the correct information.

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI
Standard VI: Grievance System
Planned Interventions:
Person(s)/Committee(s) Responsible and Anticipated Completion Date:
Training Required:
Monitoring and Follow-up Planned:
Documents to be Submitted as Evidence of Completion:

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard VII: Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Actions**
Requirement 3: The Contractor monitors covered services rendered by provider agreements for: ♦ Quality ♦ Appropriateness ♦ Patient outcomes ♦ Compliance with: ▪ Medical record requirements ▪ Reporting requirements ▪ Applicable provisions of the BHO's contract with the Department.	Although the Treatment Record Content policy outlined the specific components of the patient clinical record and the provider manual referenced an audit tool for ensuring compliance with medical record documentation requirements, BHI staff members stated that the medical record audits of medical record documentation standards had also not been performed during review period due to staff turnover and reorganization. Although the 411 encounter data validation audit evaluated for certain aspects of medical record requirements, the audit did not included a review for all medical record requirements (such as the presence and content of the assessment and treatment plan, and other elements that had been evaluated via the medical record audit form). Staff members also stated that in previous years, BHI staff had reviewed results of medical record audits performed by the CMHCs, but that review had also not occurred during the review period.	BHI must ensure that it monitors for compliance with all medical record requirements.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard IX: Subcontracts and Delegation		
Requirement	**Findings**	**Required Actions**
Requirement 3: The Contractor has written policies and procedures for the monitoring of subcontractor performance, monitors the subcontractor's performance on an ongoing basis, and subjects it to a formal review according to the periodic schedule established by the State.	The Subcontractual Relationships and Delegation policy described BHI's processes for delegation of responsibilities under the Medicaid Managed Care contract. Certain sections of the policy were specific to the processes for delegation of activities to the CMHCs. BHI may want to consider revising the policy such that it could be applied to all delegates. While the policy addressed formal review (annual audit) activities, it did not address ongoing monitoring. The quarterly contract performance reports submitted by Colorado Access demonstrated BHI's ongoing monitoring of Colorado Access. The quarterly report provided detailed information about each of the delegated tasks (provider network management, credentialing, claims adjudication, and care management). For the CMHCs; however, BHI staff members were unclear as to how ongoing monitoring of delegated activities (specifically UM authorizations) occurred. BHI staff members were unable to provide an updated list of CMHC deliverables or describe how authorization activities were monitored on an ongoing basis. Regarding formal review, BHI submitted audit reports (June 2010) for each of the three CMHCs. The Department's established schedule is to subject the delegate to a formal review on the first anniversary of the contract, then at least once every three years thereafter. The June 2010 CHMC audits met the Department's requirement for formal review of the CMHCs and included a	BHI must evaluate its processes for delegate oversight and ensure that both ongoing monitoring and formal review are conducted for each delegate. Specifically, BHI must address ongoing monitoring for UM tasks delegated to its partner CMHCs and formal review of provider network management, credentialing, claims adjudication, and care management tasks delegated to Colorado Access. BHI must also revise its policy to address both ongoing monitoring and annual audit activities related to oversight of delegates.

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard IX: Subcontracts and Delegation		
	review of delegated UM activities. BHI; however, was unable to provide the first annual review (or other formal review) of Colorado Access. During the on-site interview, BHI staff members reported that certain aspects of Colorado Access' data activities were reviewed during the annual 411 audit process; however, the entirety of Colorado Access' tasks and responsibilities have not been subjected to formal review.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* BHI		
Standard IX: Subcontracts and Delegation		
Requirement	**Findings**	**Required Actions**
Requirement 7: The written delegation agreement: ♦ Specifies the activities and reporting responsibilities delegated to the subcontractor. ♦ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. ♦ Specifies that the subcontractor shall comply with the standards specified in the Contractor's agreement with the Department. ♦ Requires at least semi-annual reporting of progress and findings to the Contractor. ♦ Describes the process which the Contractor will use to evaluate the subcontractor's performance. ♦ If the subcontractor will perform utilization management, the agreement provides that the compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services (reference 42CFR438.12(e). ♦ Includes a provision that the subcontractor shall maintain complete files of all records, documents, communications, and other materials which pertain to the operation of the subcontract or to the delivery of services under the subcontract sufficient to disclose fully the nature and extent of services/goods provided to each member and to document all activities and services under the agreement. ♦ Includes provisions permitting duly authorized agents of the Department, State and federal	While the CMHC delegation agreements described the process by which BHI planned to evaluate the delegates' performance, the activities described (annual audits and oversight of peer review processes) did not occur during the calendar year 2011. The provision to require reporting of federal expenditures from all sources equal to or in excess of $500,000 was not present in the CMHC delegation or service agreements.	BHI must review delegation agreements with the CMHCs that provide delegated activities to specify reporting responsibilities and the provision to require reporting of federal expenditures from all sources equal to or in excess of $500,000. BHI must also evaluate its processes to evaluate the CMHC delegates' performance and ensure accurate reflection in the delegation agreements.

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Standard IX: Subcontracts and Delegation		
government to access the subcontractor's premises during normal business hours to inspect, audit, monitor, or otherwise evaluate the quality, appropriateness, timeliness, or any other aspect of the subcontractor's performance of subcontracted services. ♦ Provides for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53. ♦ Requires the subcontractor and any other subrecipients to notify the Department when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

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: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the dates of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff attended Behavioral Health Quality Improvement Committee (BQUIC) meetings to discuss the FY 2011–2012 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions 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 BHOs were prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the federal Medicaid managed care regulations (the BBA) and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, on-site agenda, record review tool, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific managed care regulations or contract requirements. ◆ HSAG considered the Department's responses when determining compliance and analyzing findings.
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 review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the "evidence as submitted by the BHO" section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected 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.) ◆ 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. ◆ HSAG used the FY 2011–2012 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions required of the BHO to achieve full compliance with federal Medicaid managed care regulations and associated contract requirements.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2011–2012 Site Review Report. ◆ HSAG submitted the site review report to the BHO and the Department for review and comment. ◆ HSAG incorporated the BHO's and Department's comments, as applicable, and finalized the report. ◆ HSAG distributed the final report to the BHO and the Department.