Colorado Medicaid
Community Mental Health Services Program

FY 2012–2013 Site Review Report

for

Behavioral HealthCare, Inc.

March 2013

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

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CONTENTS

Overview of FY 2012–2013 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 Colorado's behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the ninth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2012–2013 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 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 BHO's administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. 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 practitioners who had been credentialed or recredentialed in the previous 36 months. For the record review, the BHO received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal regulations was evaluated through review of the four standards. 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 2012–2013 site review activities for the review period—January 1, 2012, through December 31, 2012. 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 2011–2012 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 credentialing and recredentialing record reviews. 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 2012–2013 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, NCQA Credentialing and Recredentialing Standards and Guidelines, 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 2012–2013 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 V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

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 BHOs (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, NCQA Credentialing and Recredentialing Standards and Guidelines, 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*, or *Not Applicable*. HSAG assigned required actions to any individual requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for enhancement for some 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	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III Coordination and Continuity of Care	8	8	8	0	0	0	100%
IV Member Rights and Protections	5	5	5	0	0	0	100%
VIII Credentialing and Recredentialing	49	47	45	1	1	2	96%
X Quality Assessment and Performance Improvement	16	16	15	0	1	0	94%
Totals	**78**	**76**	**73**	**1**	**2**	**2**	**96%**

Table 1-2 presents the scores for **BHI** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-2—Summary of Scores for the Record Reviews

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing Record Review	60	60	60	0	0	100%
Recredentialing Record Review	60	60	60	0	0	100%
Totals	120	120	120	0	0	100%

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 96 percent. **BHI**'s strongest performances were in Standard III—Coordination and Continuity of Care and Standard IV—Member Rights and Protections, both of which earned a compliance score of 100 percent. Although HSAG identified two required actions in Standard VIII—Credentialing and Recredentialing, (96 percent compliant), and one required action in Standard X—Quality Assessment and Performance Improvement (94 percent compliant), **BHI** demonstrated strong performance overall and a comprehensive understanding of the federal health care regulations, the Colorado Medicaid Managed Care Contract, and NCQA Standards and Guidelines.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

BHI provided policies and procedures that addressed coordination and continuity of care, access to services, coordination with multiple providers and agencies for members with complex needs, sharing of member needs assessments to prevent duplication of services, development of treatment plans that incorporated all the required elements, and safeguarding of protected health information (PHI) in compliance with Health Insurance Portability and Accountability Act (HIPAA) privacy requirements. **BHI** documents also outlined the responsibilities of its delegate, Colorado Access, and of the network Community Mental Health Centers (CMHCs) related to care coordination.

During on-site interviews, staff presented three care coordination cases: one individual with multiple medical, behavioral, and community service needs who had received services from multiple providers and had numerous emergency room (ER) visits; one individual with numerous behavioral health hospitalizations and long-term unemployment, who was attempting to transition to independent living in the community; and one individual who had experienced difficulty with placement in care environments, long-term behavioral health hospitalizations, and homelessness, and who was residing in a locked, long-term care facility. Case presentations and treatment record reviews demonstrated that **BHI** (1) provided active care coordination with multiple providers and entities, designated primary therapists, PCPs, and care coordinators, and (2) assessed individual members' needs, as required. Care coordination records contained member-signed release of information (ROI) forms allowing for sharing of appropriate information among providers; treatment plans with measurable goals and interventions, documentation of member involvement, and documentation of frequent follow-up; and evidence of services provided on-site at a nursing care facility.

Summary of Strengths

BHI contracted with Colorado Access for the performance and management of care coordination services for members, due to the established care coordination experience and systems of Colorado Access. **BHI** and Colorado Access have jointly established on-site care coordinators in each of the network community mental health centers (CMHCs). **BHI** provided policy oversight and guidance to the care coordinators regarding **BHI** members. This approach capitalized on the strengths of each participating entity and provided significant depth in the care coordination resources available to members with complex needs. The three cases selected by **BHI** for the care coordination presentation demonstrated that **BHI** engaged in coordinating care for members with very complex needs that required multiple providers and services. The care coordinators actively performed ongoing, hands-on care management and follow-up with members, families, providers, and agencies. Each case also demonstrated **BHI**'s commitment to evaluate, pursue, and organize services to meet the care coordination challenges presented by members with complex needs.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

BHI had numerous policies and procedures that included each of the member rights as stated in federal health care regulations and the Medicaid Managed Care contract. These policies and procedures articulated **BHI**'s processes for informing members and providers of these rights. **BHI** provided evidence of on-site audits of the CMHCs to ensure that rights are posted, as required.

Summary of Strengths

BHI provided evidence of numerous member-focused programs designed to actively engage members in treatment, decision-making, and their own health and wellness, and to keep information about mental health benefits and rights visible to both members and providers. Programs included wellness classes; peer specialist programs; life skills trainings; the Recovery-based, Individualized Strengths-based Education (RISE) program; and the Whole Health Active Management (WHAM) program. Staff members described the active roles of both the Office of Member and Family Affairs (OMFA) and care management staff, located at the CMHCs, in these programs.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

BHI had a well-defined credentialing program that included NCQA compliant policies, procedures, and practices. **BHI**'s credentialing policies and procedures included all but one of the elements required by NCQA. **BHI** delegated credentials verification and credentialing committee activities to Colorado Access, **BHI**'s administrative service organization. Although **BHI** delegated the credentialing and recredentialing decisions to Colorado Access, it was clear that **BHI** retained the right to approve, suspend, or terminate providers by using the peer review process in its Utilization Management (UM) Committee as the final approval or veto of actions made by Colorado Access' credentialing committee.

Summary of Strengths

There was ample evidence of **BHI**'s monitoring and oversight of Colorado Access. **BHI** had a good relationship with its delegate and a clear understanding of Colorado Access' processes and activities. On-site record review of contracted provider records demonstrated that primary source verification for credentialing and recredentialing was completed within the required time frames and that recredentialing was completed within the 36-month time frame. The delegate's credentialing records and **BHI**'s on-site contracting files for each contracted provider were well organized. Organizational provider records were also well organized and contained the required information.

Summary of Required Actions

Although **BHI** provided evidence of activities designed to prevent discriminatory credentialing processes, **BHI** must also develop a mechanism to monitor the credentialing/recredentialing program at least annually to ensure nondiscriminatory credentialing and recredentialing. The mechanism must be described in **BHI**'s policies and procedures.

BHI provided evidence of assessment and subsequent reassessment of organizational providers; however, in four of the four applicable organizational provider files reviewed, reassessment had not occurred within the 36-month time frame required by NCQA. **BHI** must develop a mechanism to ensure that organizational providers are reassessed every three years (36 months).

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

BHI had a comprehensive Quality Assessment and Performance Improvement (QAPI) Program outlined in the Quality Improvement (QI) Program Description, Annual Quality Report, **BHI** Report Card, and numerous quality monitoring data reports. **BHI** provided samples of reports and described mechanisms for detecting over- and underutilization and assessing quality and appropriateness of services. Meeting minutes reflected reporting of QI activities to the quality oversight committees. The Annual Quality Report included a summary of most quality improvement results for the year and identified specific activities to be continued in the subsequent year's QI Work Plan. Staff reported that the QI Report Card was reviewed quarterly by the CMHCs, but results of those reviews and any corrective actions taken were not reflected in the QI oversight committee minutes. In addition, the Annual Quality Report and the PAC committee minutes frequently did not include documentation of the conclusions and recommendations related to the monitoring activities or data reported.

HSAG recommended that documentation of the overall impact and effectiveness of the QAPI program could be enhanced by including a thorough discussion of conclusions and recommendations related to quality of care findings in the annual report and committee meeting minutes. In addition, the Annual Quality Report should clearly identify any focused areas or concerns for improvement to be pursued in the subsequent year's QI Work Plan with benchmark goals, as appropriate. **BHI** should also ensure that the **BHI** Report Card or other information provided to the CMHCs for review and corrective action is reported back to the PAC and documented in the meeting minutes.

BHI adopted clinical practice guidelines appropriate to the needs of local members and providers, and made guidelines available to providers and members. Member grievance information and adverse incidents were reviewed for identification of patterns or quality of care concerns, and corrective action was taken as needed. **BHI** monitored member perceptions of quality and accessibility of services through the Mental Health Corporation of America Survey, but it did not review the results of the Mental Health Statistics Improvement Program (MHSIP), the Youth Services Surveys (YSS), and the Youth Services Surveys for Families (YSS-F) in FY 2012. HSAG recommended that **BHI** incorporate summaries of grievances, quality of care concerns, and member satisfaction survey outcomes in the Annual Quality Report and/or QI Committee minutes.

Summary of Strengths

BHI had a well-defined QAPI Program that incorporated multiple data sources for monitoring and reporting, including performance indicators, utilization, grievances, focus studies, and quality of care concerns. Within the last year, **BHI** added staff to support the **BHI** QI program and re-introduced the Report Card process to its network CMHCs. Implementation of the **BHI** Report Card required the CMHCs to review many of the key quality monitoring parameters quarterly. **BHI** designated accountability for oversight of QI functions to internal executive and management

leadership, the Provider Advisory Committee (PAC), the Program Evaluation and Outcomes (PEO) Committee, and the delegated QI committees of the CMHCs. **BHI** assigned development of clinical practice guidelines to the Standards of Practice (SOP) Committee, which reviews and adapts clinical guidelines while considering local member needs and provider expertise. **BHI** had a comprehensive integrated health information system, which provided both routine and ad-hoc reports for QI monitoring activities.

Summary of Required Actions

BHI's quality program did not incorporate review of results from the MHSIP, YSS, and YSS-F member satisfaction surveys in 2012. **BHI** must incorporate review of future MHSIP, YSS, and YSS-F satisfaction survey results into the 2013 QA Work Plan and provide evidence of review and action as needed by the appropriate QI oversight committees.

Methodology

As a follow-up to the FY 2011–2012 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 2011–2012 compliance monitoring site review.

Summary of 2011–2012 Required Actions

The 2011–2012 site review results required that **BHI** address 12 required actions as follows:

- Revise the information in its Member and Family Handbook (member handbook) regarding time frames for filing grievances and appeals and for requesting a State fair hearing to comply with the Colorado statute and **BHI** policies, and to reflect the 30-calendar-day time frame for each.
- Revise the section of the member handbook that explained the continuation of services during an appeal or State fair hearing related to the termination of previously authorized services.
- Include a statement in the member information materials concerning the availability, upon request, of information concerning physician incentive plans.
- Develop a mechanism to address staff education concerning **BHI**'s policies and procedures on advance directives and revise the policy to describe the mechanism.
- Review processes to ensure that members receive accurate information during the appeal process as it relates to the time frame for filing appeals.
- Review and revise training materials and applicable documents to ensure consistency and accuracy of information given to staff and providers related to processing and resolution of appeals.
- Evaluate systems and take steps to ensure that appeal acknowledgement letters are sent within the required time frame and that policies and procedures regarding the appeal process are followed.
- Revise templates used for member communication during the appeal 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.

- Review distribution patterns for the member handbook and ensure that all documents, including the provider manual and mailings or postings that include the member handbook, contain correct information.
- Ensure that **BHI** monitors for compliance with all medical record requirements for CMHC providers.
- Revise or develop policies and procedures to address requirements related to the provision of ongoing monitoring of **BHI**'s subcontractors and delegates and ensure the completion of both ongoing monitoring and formal review for each of its delegates.
- 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.

Summary of Corrective Action/Document Review

BHI submitted a corrective action plan to the Department and HSAG in February 2012. HSAG and the Department reviewed the plan and determined that, if implemented as written, **BHI** would achieve full compliance. In August 2012, **BHI** submitted documents to HSAG and the Department that demonstrated it had implemented the corrective action plan. In September 2012, after having required **BHI** to make additional edits to a few documents, HSAG and the Department determined that **BHI** successfully completed all required actions.

Summary of Continued Required Actions

BHI successfully addressed all FY 2011–2012 required actions. There were no required actions continued from FY 2011–2012.

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has written policies and procedures to ensure timely coordination of the provision of Covered Services to its members and to ensure: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care to promote maintenance of health and maximize independent living. Contract: II.E.1.g.1	**Documents Submitted/Location Within Documents:** UM 801- Access and Availability pp13 (Pgs. 1-2) UM 817 - Coordination and Continuity of Care pp13 (Pg. 1) Clin 203- DD/MI and TBI/MI pp13 **Description of Process:** BHI's policy on Access and Availability as well as the policy on Coordination of Care outline procedures to ensure timely service accessibility and coordination. BHI ensures that services promote recovery, health maintenance, and maximize independent living.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Access and Availability policy listed appointment availability standards (as defined by the Department) and procedures for members to access routine, urgent, and emergency services. The policy explained that BHI monitors community mental health centers' (CMHCs') and independent providers' compliance with the standards through periodic audits. The Coordination and Continuity of Care policy stated that each member seeking services is assigned a care coordinator, who is responsible for assessing members' needs and coordinating care with all providers, agencies, and other support services necessary to promote health maintenance and maximize independent living.		
Required Actions: None.		
2. The Contractor has policies and procedures that address, and the Contractor provides for the coordination and provision of Covered Services in conjunction with: ◆ Any other MCO or PIHP. ◆ Other behavioral health care providers. ◆ Physical health care providers. ◆ Long term care providers. ◆ Waiver services providers. ◆ Pharmacists. ◆ County and State agencies. ◆ Other provider organizations that provide wraparound services. ◆ The Single Entry Point (SEP) care manager, as applicable.	**Documents Submitted/Location Within Documents:** UM 817 - Coordination and Continuity of Care pp13 (Pgs. 2-3) MHC-BHO Policy Douglas County 1451 MOU Amendment to Douglas County 1451 MOU FY12 Douglas County 1451 MOU Evidence of Attendance and Minutes Colorado Access Care Management Contract **Description of Process:** BHI's Policy on Coordination and Continuity of Care addresses the need to ensure comprehensive and collaborative treatment activities with other medical and behavioral health service providers, local agencies, advocacy groups, other insurance	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
42CFR438.208(b)(2) Contract: II.E.1.g.1—3	carriers, and other individuals or organizations that are involved in a member's treatment and recovery process. BHI has a contract with the all CMHC's out of network to provide services in accordance with the BHO program, rules and regulations and to treat a BHI Medicaid member as one of their own BHO Medicaid members. BHI participates in multiple clinical and operation forums with other community agencies for the purpose of Coordination and Continuity of Care. ◆ County Departments of Human Services (DHS) a. 1451 interagency collaborations: BHI participates in 1451 collaborations in Adams and Arapahoe Counties. These plans bring community agencies together to address psychosocial, educational, and behavioral health needs of high-risk youth served through DHS. 1451 initiatives include reducing truancy and educational neglect, services to youth and families with developmental disabilities and/or mental illness, responding to needs of children and families experiencing domestic violence, and advocacy for youth in the juvenile corrections system. b. Co-location of mental health clinicians in DHS settings: Community Reach Center has embedded mental health clinicians in DHS settings to facilitate timely access for children and families in need of mental health services. ◆ Coordination with Developmental Disability agencies: BHI has developed mechanisms for coordination with Community Center Boards (CCBs), the agencies responsible for serving consumers with developmental disabilities. BHI partners with Developmental Pathways in developing	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	interagency training, forums for complex case review of shared clients, interagency clinical consultation, and expanding community based services for mutual clients. Community Reach Center has a mental health clinician co-located within North Metro Community Services, the CCB serving Adams County. This co-location ensures timely access to needed mental health care, clinical consultation and care coordination. BHI has directly coordinated with North Metro for the expedient provision of services for shared members. ◆ CDHS, Division of Child Welfare problem solving forum. Collaboration between CDHS, BHI, COA, and specific TRCCFs in the Denver metropolitan area to discuss and problem solve use of least restrictive environment for foster care children. ◆ BHI and University Hospital maintain a contract for the treatment and clinician training to serve women at risk for or experiencing perinatal depression. ◆ Emergency triage and response: BHI is actively involved in interagency collaboration that includes mental health centers, BHOs, law enforcement, advocacy groups, and elected officials for the Denver area to discuss issues or emergency response for individual with mental health disorders, substance abusing behaviors, and co-occurring mental health and substance abuse disorders. Aurora Mental Health Center recently contracted with Arapahoe House and Aurora Police Department to utilize Arapahoe House for detox purposes as a way to provide the best and most appropriate intervention for these individuals rather than place them in a detention or jail facility or bring them to an emergency department for out of control behaviors.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	◆ Care Management: BHI contracts with Colorado Access to provide care management services to high risk, high need mental health consumers. Care managers are embedded in each of the three BHI centers and work to ensure timely access to needed medical care, coordination of behavioral health and medical services, and disease management for chronic medical conditions.	

Findings:
The Care Coordination and Continuity of Care policy outlined the responsibilities and processes related to coordination of care, as required. The MHC—BHO policy described BHI's commitment to authorize and pay for services, including care management services, provided by out-of-area CMHCs that meet the same standards as the services provided within its network. BHI also submitted evidence of several organizational initiatives designed to promote coordination of services among multiple area agencies to benefit the coordination of care for members at high risk and who have complex needs. Initiatives included the Douglas County Department of Social Services' collaborative initiative, Colorado Access' (subcontractor) participation in managing multiple medical needs of behavioral health clients, foster care forums, and coordination with developmental disability agencies. During the on-site interview, staff explained that care coordination services are provided within each of the participating CMHCs with policy oversight by BHI utilization management (UM) staff. Staff also stated that BHI contracts with Colorado Access for the management of care coordination activities and personnel and the provision of care coordination services for members with complex behavioral health needs. BHI and Colorado Access jointly fund the CMHC on-site care coordinator positions.

During on-site interviews, staff presented three care coordination cases: one individual with multiple medical, behavioral, and community service needs who had received services from multiple providers and had numerous emergency room (ER) visits; one individual with numerous behavioral health hospitalizations and long-term unemployment who was attempting to transition to independent living in the community; and one individual who had experienced difficulty with placement in care environments, long-term behavioral health hospitalizations, and homelessness, and who was residing in a locked, long-term care facility.

Required Actions:
None.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary (behavioral health) care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. *42CFR438.208(b)(1)* Contract: None.	**Documents Submitted/Location Within Documents:** UM 817 – Coordination and Continuity of Care pp13 (Pgs.1-2) **Description of Process:** BHI members are all assigned a care coordinator at the time of admission into services. The member receives a comprehensive evaluation to determine needs across various life domains to determine what referrals may be beneficial for an individual. This care coordinator manages and coordinates the behavioral health care of Medicaid members to ensure comprehensive and collaborative treatment activities with other medical and behavioral health service provider, local agencies, advocacy groups, other insurance carriers, and other individuals or organizations that are involved in a member's treatment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Coordination and Continuity of Care policy stated that each member is assigned a care coordinator who is primarily responsible for coordinating covered services for the member. During the on-site interview, staff presented treatment records of three care coordination cases, which documented that each case had a designated primary behavioral health therapist, physical health provider, and designated care coordinator. The assigned care coordinator actively communicated member needs, services, and treatment plans between the behavioral and physical health providers.		
Required Actions: None.		
4. Contractor ensures that each member accessing services receives an individual mental health assessment and individual needs assessment. The mental health assessment addresses: ◆ Member demographics. ◆ Cultural and racial affiliations. ◆ Language and reading proficiency. ◆ Personal and family health history. ◆ Self-perceived health status to predict the member's likelihood of experiencing the most common mental illnesses.	**Documents Submitted/Location Within Documents:** CMHC Intake Form BHI Mental Health Assessment Form UM 817- Coordination and Continuity of Care pp13 (Pg. 1-2) UM 823- Treatment Record Content pp13 (Pg. 1-2) Provider Manual (Pgs.' 25-26) **Description of Process:** All intakes and assessments for BHI members are done individually by licensed mental health professionals. At the time of referral, a screening is completed to evaluate if there is a	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
◆ Personal health characteristics, including but not limited to: • Mental illness. • Alcohol consumption. • Substance use disorders. The individual needs assessment evaluates: ◆ Special transportation needs. ◆ Cultural and linguistic needs. *42CFR438.208(c)(2)* Contract: II.F.7	routine, emergent, or urgent need for an evaluation or crisis intervention. Contractual time frames are met according to level of care needed. At the time of intake as well as ongoing, members are provided information from their care coordinator about client rights and responsibilities, importance of attending scheduled appointments and how this impacts individual recovery, access to emergency services and coordination/continuity of care processes. BHI also provides example forms to CPN providers via the BHI website to assist with intake and assessment documentation compliance. BHI Mental Health Centers have all implemented electronic medical record systems that incorporate all required elements for clinical assessment, treatment planning, and documentation.	
Findings: The Coordination and Continuity of Care policy stated that the care coordinator is responsible for conducting a comprehensive clinical assessment of the member, which included all of the required elements. The care coordinator is also responsible for identifying other providers and agencies involved in the member's care and for developing appropriate continuity of care plans. The Treatment Record Content policy outlined the components of the intake mental health assessment, which included all of the required elements. BHI submitted a sample completed mental health center intake form, which demonstrated that the elements specified in the requirement were assessed. Staff stated that the BHI CMHCs have electronic health records that incorporate all elements of the assessment. During the on-site interview, staff presented three care coordination cases. Each case file contained a comprehensive mental health assessment and assessment of other individual needs.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: II.F.7.g	**Documents Submitted/Location Within Documents:** Assessment and Treatment of DDMI Members Clin 203 – DD/MI and TBI/MI Practice Guidelines UM 817 – Coordination and Continuity of Care pp13 (Pg.) Continuity of Care and Care Coordination Training PCP and EPSDT Screening Letter PCP Referral Form Clinica_020309 Signed Copy.pdf Colorado Access Care Management Contract **Description of Process:** BHI providers work with members with special health care needs who are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. BHI for providers and encourages coordination of care with allied agencies to prevent duplication of services. ◆ MH Providers send letters to PCPs to exchange contact and treatment information to facilitate coordination of care. Each BHI CMHC has a "Health Coordinator" located within the centers to provide coordination of care for consumers with a high need for both medical and psychiatric care. Integration of care is facilitated by BHI's longstanding collaborative relationships with medical care offices including primary care physicians and Federally Qualified Health Centers (FQHCs); substance abuse agencies, schools; advocacy agencies; county departments of human services; alternative care facilities and nursing BHI coordinates with the CMHCs to ensure individuals on the MI Waiver are not in nursing homes.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Coordination and Continuity of Care policy stated that if the member signs a release of information, BHI care coordinators will share the assessment of member needs with other organizations involved in the member's care to prevent duplication of services. The policy also stated that the care coordinator is responsible for providing the primary care provider (PCP) with information related to the member's mental health treatment plan and medications throughout the episode of behavioral health care. The PCP Referral Form requested a copy of any behavioral health assessments performed by the PCP for members being referred to behavioral health services and included a release of information by the member. The PCP/EPSDT Screening letter instructed providers to send a completed early periodic screening, diagnosis, and treatment (EPSDT) form to the behavioral health provider. The Developmental Disability (DD)/Mental Illness (MI) and Traumatic Brain Injury (TBI)/Mental Illness (MI) Practice Guidelines policy stated that all members with developmental disabilities referred for behavioral health services receive a face-to-face mental health assessment for determining appropriateness of behavioral services. Each of the three care coordination cases presented by BHI demonstrated that the member signed a release of information form, and that the care coordinator communicated information regarding member needs between pertinent providers and organizations. One case documented that the physical needs assessment and treatment plan was obtained from the physical health provider to integrate into the overall care coordination plan. Staff stated that both oversight of care coordination and authorization for services are performed by BHI's UM Department, thereby preventing duplication of member services.		
Required Actions: None.		
6. Each member has an individualized service plan (treatment plan/care plan) that includes: ◆ Measurable goals. ◆ Strategies to achieve the stated goals. ◆ Mechanism for monitoring and revising the service plan as appropriate. The service plan is developed by the member, the member's designated client representative (DCR) and the provider/treatment team and is signed by the member. (If a member chooses not to sign his/her service plan, documentation shall be provided in the member's medical record stating the member's reason for not signing the plan.)	**Documents Submitted/Location Within Documents:** BHI Outpatient Integrated Service Plan 11192012 UM 817 - Coordination and Continuity of Care pp13 (Pg.2) UM 823- Treatment Record Content pp13 (Pg. 3) Provider Manual (Pg. 28) **Description of Process:** For BHI providers, development of the plan is a collaborative effort among members, the parents or legal guardians of child and adolescent members, informal caregivers, family members or other important persons selected by the member and/or parents/guardians.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Service planning shall take place annually or if there is a change in the member's level of functioning and care needs. *42CFR438.208(c)(3)* Contract: II.F.9	◆ BHI providers' partner with members and their families to build strength based and individualized treatment plans. The treatment plans are reflective of the person's needs, wishes, and specific issues that have been identified in the assessment process. BHI policies ensure that providers develop service plans that are clear, specific and include measurable outcomes that reflect a member's recovery goals. Treatment plan templates are created to capture such measureable goals consistently. ◆ Both the member and the reviewing professional sign each treatment plan and any changes to it. If for any reason the member who participated in crafting the Individualized Service Plan does not wish to sign the plan, an addendum is added that explains, in the member's own words, why the member does not wish to sign. For BHI, service planning takes place at the beginning of treatment, anytime there is a change in the member's level of functioning and care, upon request of the member, but not less than annually.	

Findings:
The Coordination and Continuity of Care and the Treatment Record Content policies stated that the treatment plan would include the required content, be developed in conjunction with and signed by the member, and be updated no less than annually through regular progress monitoring. BHI staff members stated that the treatment plan is updated every six months. The BHI Provider Manual specified the content of the member treatment plan and was consistent with BHI policies. The Outpatient Integrated Service Plan template required documentation of measurable goals and objectives, specific interventions, and target dates for reassessment, as well as the member's/guardian's signature and the therapist's signature. BHI Staff stated the template may be used by independent care providers to communicate the information required in the care plan.

Each of the three care coordination cases presented during the on-site interview had an individualized service plan that included the required elements; was agreed upon and signed by the member and/or guardian and primary therapist; and included frequent, ongoing care coordinator progress notes.

Required Actions:
None.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. In all other operations as well the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Contract: II.E.1.g.1, VII.S	**Documents Submitted/Location Within Documents:** HIPAA-508 Disclosure of Protected Health Information ppFY13 2012-11-20 UM 817- Coordination and Continuity of Care pp13 (Pg. 3) Provider Contract (Pgs. 6,11 about HIPAA compliance) Business Associate Contract Form Annual BHI HIPAA Training BHI HIPAA TEST #4 **Description of Process:** Providers and Business associates are contractually required to follow all HIPAA and confidentiality laws. BHI staff and contracted providers participate in mandatory HIPAA training annually. BHI's Policy on Disclosure of Protected Health Information and Policy on Coordination and Continuity of Care ensure that all care coordination services are rendered in such a way as to ensure the client's confidentiality and privacy is protected as required by 45 C.F.R. Parts 160 and 164 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Additional HIPAA policies address: Accounting of disclosure of PHI, Alternate means of communication, Amendment of PHI, Authorizations and other release of information forms received by BHI, Business associate contact procedures, Client access to PHI, Client request for additional restrictions regarding use or disclosure of PHI, Minimum necessary rule regarding disclosure of PHI, Privacy regulation training, Notice of privacy rights, Treatment record content, and Work force access protected phi.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Disclosure of Protected Health Information policy and the Coordination and Continuity of Care policy stated that BHI ensures that all care coordination services protect client confidentiality and privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). BHI provided evidence of annual employee and provider training related to protected health information (PHI) and HIPAA requirements. The training included disclosure of PHI at the minimum amount necessary for the intended purpose, the responsibility to obtain a member release of information, and employee access to information controlled through assigned levels of access. BHI cited numerous additional policies and procedures that addressed operational controls and requirements related to PHI privacy and HIPAA regulations. The Business Associate Contract specified that all BHI business associates would maintain confidentiality of PHI in the performance of contracted functions. On-site presentation of three care coordination cases documented that release of information forms were obtained from the members to allow sharing of information between multiple physical, behavioral, and community providers, as needed. BHI staff stated that sharing of written behavioral health treatment information with other providers and agencies is restricted by Colorado law and is communicated only as needed, through the care coordination process.		
Required Actions: None.		
8. The Contractor may require nursing facility residents who are able to travel to a service delivery site to receive their mental health services at a service delivery site. The Contractor shall arrange for transportation for the member between the nursing facility and the service delivery site, but shall not be responsible for the cost of transportation. However, the Contractor shall provide medically necessary mental health services on-site in the nursing facility if transportation cannot be arranged. Contract: II.E.3	**Documents Submitted/Location Within Documents:** NHOPE Program Flyer OBRA Referral Form for Nursing Homes UM 817- Coordination and Continuity of Care pp13 (Pg. 4) CLIN 207 – Nursing Home Services pp13 **Description of Process:** BHI's NHOPE program is lesson-based and provides opportunities to socialize, receive education, and to participate in recreational activities that are creative. The intention of the program is to incorporate NHOPE participants into the community and enhance each participant's confidence and quality of life. BHI CMHCs coordinate and collaborate with nursing facilities and provide treatment to those who are unable to travel. CMHCs provide OBRA screenings on location at Nursing homes. BHI participates in meetings with HCPF Long Term Care and DHS to improve provision of services for nursing home clients.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Coordination and Continuity of Care policy stated that nursing home residents could be treated at the provider site, with arrangements for transportation provided by BHI, or they could be treated on-site at the nursing facility. The Nursing Home Services policy stated that all members would receive mental health services in the setting that best meets their needs, including on-site at the nursing facility, and that transportation to the service delivery site would be arranged by the provider or care coordinator. During the on-site interview, staff presented one care coordination case involving a member residing in a locked, long-term care facility. The case demonstrated that on-site mental health services were provided weekly at the facility, as well as periodically in an outside facility, and that transportation was arranged for provision of off-site services.		
Required Actions: None.		

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	8	**Total Score**		=	8

Total Score ÷ Total Applicable	=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: II.F.3.a	**Documents Submitted/Location Within Documents:** Member Rights and Responsibilities pp13 (Pgs. 1-4) BHI Member Handbook (Pgs. 28-29) **Description of Process:** BHI's Enrollee/Member Rights and Responsibilities Policy and the Member Handbook specify the member rights for all BHI Medicaid members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Member Rights and Responsibilities policy included each of the rights at 42CFR438.100 and as described in the Colorado Medicaid Managed Care contract. The policy also described the procedures for notifying members of these rights. The policy described how member materials, which included explanation of member rights, were distributed to members. BHI also had topic-specific rights policies such as grievances and appeals and advance directives policies.		
Required Actions: None.		
2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: II.F.3.a	**Documents Submitted/Location Within Documents:** Consumer Rights Posting BHI Member Handbook (Pgs. 28-29) BHI Provider Contract (Pg. 3 Article II; Pgs. 17-19, Addendum C) Community Mental Health Center Delegation Agreement (Pg. 4, Section 2.C.) BHI Member and Family Newsletter Spring 2012 (Pg. 3) Grievance and Appeal Training for Consumer Representatives.ppt (Slide 3) Mental Health Recovery ppt (Slide 4) Provider Manual (Pgs. 12-13) Secret Shopper Script Focus Group B Secret Shopper Questions **Description of Process:** BHI ensures member rights are taken in to account when services are provided by posting Medicaid Member Rights at all clinical sites. BHI also monitors member rights through the grievance process, which is outlined in delegation agreements with Community	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Mental Health Centers and in the BHI Provider Contract. BHI ensures member rights are taken into account by: ◆ Providing members with information in various formats about their rights including the BHI Member Handbook and BHI Member and Family newsletter ◆ BHI provides a Member Representative training annually to ensure they understand member rights and the grievance process. ◆ Member rights are available to Providers at BHICares.org/Providers and given to Providers when they join our network through our Provider Manual. ◆ Conducting focus groups and following up with Secret Shopper questions with CMHCs, CPNs, and members to identify member concerns ◆ Working with providers to address concerns related to member rights expressed by members	

Findings:
BHI's provider manual listed member rights as stated at 42CFR438.100, described provider responsibilities for ensuring member rights, and included the responsibilities of the Office of Member and Family Affairs (OMFA). BHI's provider agreement template included a list of member rights and informed providers of the expectation that providers take members' rights into account when furnishing services. The grievance and appeal training PowerPoint submitted demonstrated the content of training for customer service representatives related to selected member rights topics. The delegation agreement between BHI and network CMHCs required the CMHCs to maintain policies and procedures on member rights and grievance and appeal processes and to disseminate information related to specified rights such as advance directives. The agreement also required CMHCs to post a list of member rights, information on grievances and appeals, and how to contact the Medicaid ombudsman. The BHI Web site listed member rights under the provider and member tabs, and rights were included in the member newsletter (a quarterly publication) at least annually. During the on-site interview, BHI staff confirmed that network providers and CMHCs are audited by BHI for compliance with posting member rights in a visible place and described initial and ongoing provider communication to remind providers about member rights and provider responsibilities. Staff also discussed numerous member programs provided by BHI designed to keep the culture of member participation and rights visible to both members and providers. Programs included wellness classes; life skills trainings; the Recovery-based, Individualized Strengths-based Education (RISE) program; and the Whole Health Active Management (WHAM) program. Staff members described the active roles of both OMFA and care management staff, located at the CMHCs, in these programs.

Required Actions:
None.

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment, and the right to a second opinion. ◆ 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 requirements for access and quality of services (42CFR438.206 and 42CFR438.210). Additional member rights, include 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	**Documents Submitted/Location Within Documents:** Member Rights and Responsibilities Policy pp13 (Pg.1-4) HIPAA-511 The Notice of Privacy Rights ppFY13 2012-11-15 (Section 1A) Member Access to Protected Health Information Policy (Section 1) Amendment of Protected Health Information Policy (Section 1) Member Information Policy (Pg. 1-5) BHI Provider Contract (Pg. 3 Article II; Pgs. 17-19, Addendum C) Community Mental Health Center Delegation Agreement (Pg. 4, Section 2.C.) **Description of Process:** Clients receive all information in accordance with 42CFR438.10 as specified in the written materials policies. All client rights are listed in the Member Rights and Responsibilities Policy. In addition, Dignity and privacy rights are listed in the Notice of Privacy Rights policy and Member Information Policy and information on receiving medical records is addressed in the Amendment of Protected Health Information policy, and the Member Access to Protected Health Information Policy. BHI ensures it contractor's treat members in a manner consist with specified rights in the Provider Contract and in the Delegation agreements.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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, legislative bodies, or the media without the Contractor causing any adverse effects upon the provision of Covered Services. *42CFR438.100(b)(2) and (3)* Contract: II.F.1, II.F.4.j.3		
Findings: The Member Rights and Responsibilities policy included each of the member rights. The list of member rights was available on the BHI Web site under both the provider and member tabs. The provider manual and the provider contract template included each of the member rights and described provider responsibilities related to member rights. Additional methods of keeping the member rights conversation active at the CMHCs included member participation in the member advisory board meetings and Recovery and Wellness Committee meetings, as evidenced by on-site review of board meeting and committee meeting minutes.		
Required Actions: None.		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* Contract: II.F.1.h	**Documents Submitted/Location Within Documents:** Member Rights and Responsibilities Policy pp13 (pg. 3 number 28: pg. 4 Section B) Member Information Policy pp13 (pg. 5, 17.g.) BHI Member Handbook – Pgs. 28-29 inform members of their rights **Description of Process:** This right is addressed in the Members Rights and Responsibilities and Member Information policies, and in the Member and Family Handbook, and monitored through the grievance process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Member Rights and Responsibilities policy listed the right to express an opinion and to file a grievance without retaliation. Member and provider materials also listed this right. During the on-site interview, BHI staff members described several mechanisms to encourage members to exercise their		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
rights, particularly grievance and appeal rights. Staff reported that this occurs through the OMFA staff duties and the member advisory board meetings and is monitored through grievance and appeal reporting and trending.		
Required Actions: None.		
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* Contract: VII.T	**Documents Submitted/Location Within Documents:** Compliance with Applicable Law pp13 **Description of Process:** BHI complies with all state and federal laws as specified in the Compliance with Applicable Law Policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Compliance with Applicable Law policy described the rights associated with each of these legislations. Nondiscrimination was on the list of rights in the member handbook. BHI staff members reported that anti-discrimination training is required for BHI staff at new employee orientation and annually.		
Required Actions: None.		

Results for Standard IV—Member Rights and Protections							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	5

Total Score ÷ Total Applicable	=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. NCQA CR1	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 pg. 2-4 **Description of Process:** BHI has delegated individual provider credentialing activities to Colorado Access (COA) through its Administrative Service Organization Agreement. The purpose of this delegation agreement with COA is to streamline provider credentialing for common providers between Access Behavioral Care and BHI. BHI, in conjunction with COA, requires all practitioners to complete the Colorado Health Care Professional Credentials Application. Colorado Access also utilizes the Counsel for Affordable Quality Healthcare (CAQH) to obtain applications as well as the traditional paper copies of applications for credentialing and recredentialing. The practitioner credentialing and recredentialing processes begin with the completion of an application, signed, and dated attestation and submission of requested documentation to either CAQH or Colorado Access. The applications include an attestation by the applicant regarding all required guidelines as outlined by NCQA Standards. Upon request from a provider for network participation, the Director of Provider Relations emails a request to COA to begin credentialing. COA reviews its provider network to determine if the provider has already been credentialed through COA. If the provider has been credentialed and all required information is current and in good standing, COA forwards a Provider Profile, which is a summary of the providers credentialing file to BHI. This summary includes license verification, insurance, and sanction information as well as demographic information. The Director of Provider Relations then compiles the provider-	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	credentialing file for review by the Credentialing Committee. This file includes the information sent by COA, provider's CV or Resume, summary of specialties and populations served and the W9 all of which are provided by the provider to BHI. If the provider has not been credentialed by COA, then the credentialing department at COA sends the Colorado Health Care Professional Credentials Application to the provider. COA also utilizes the Counsel for Affordable Quality Healthcare (CAQH) to obtain applications for credentialing and recredentialing. Once verification of all NCQA required elements has been completed, the Credentialing Program Coordinator at COA reviews the file for completeness and timeliness of the elements as required by the credentialing policy and the file is forwarded to BHI to be presented at the Credentialing Committee for approval of credentialing. BHI's Utilization Management (UM) Committee acts as the BHI Credentialing Committee. The completed credentialing file is then reviewed against BHI Credentialing Criteria. If criteria are met, the application and report is presented to the BHI UM Committee. Based on the decision from the UM Committee, the practitioner will receive an acceptance or denial letter within seven (7) days. The denial letter will include the appeal process.	
Findings: BHI's Provider Credentialing and Recredentialing policy thoroughly described the credentialing and recredentialing processes and demonstrated compliance with NCQA requirements. BHI delegated credentialing activities to Colorado Access, BHI's administrative service organization.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include psychiatrists, psychologists, clinical social workers, psychiatric nurse specialists, and or licensed professional counselors.) *42CFR438.214(a)* NCQA CR1—Element A1	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp12 (pg. 2) BHI Provider List Website 100312 **Description of Process:** BHI's provider network generally consists of, but is not limited to, Doctors of Medicine (MDs), Doctors of Osteopathic Medicine (DOs), PhD, PsyD, LPsy, LCSW, LPC, LMFT, RN NP or CNS or RXN and other licensed independent practitioners with whom it contracts and who render services to members, and who fall within the Contractor's scope of authority and action.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Provider Credentialing and Recredentialing policy described each type of practitioner that Colorado Access credentials and recredentials on behalf of BHI.		
Required Actions: None.		
2.B. The verification sources used. NCQA CR1—Element A2	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg. 8-11) **Description of Process:** The following elements and sources are researched and/or documentation gathered in support of the credentialing and recredentialing application. ◆ Licensure – Verification of licensure is obtained via the Internet (DORA) along with investigation of restrictions, limitations, or sanctions. Sanction activity is obtained through a query of the National Practitioner Data Bank (NPDB). ◆ DEA (Drug Enforcement Agency) or CDS (Controlled	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Dangerous Substances) - A copy or fax of the certificate from the practitioner, primary verification from the DEA website (www.deadiversion.usdoj.gov), verification from the American Medical Associate (AMA) Physician profile, or documented visual inspection of the original certificate are all acceptable sources. ◆ Education and Training - Verification of residency training or graduation from a medical school or graduate school is obtained through verification of licensure with the applicable State board. Other acceptable sources of verification may include either verbal or written verification from the institution awarding the degree (graduate school, medical school or residency program), verification received from the American Medical Association (AMA), or American Osteopathic Association (AOA) Master File (Physician Profile). ◆ Board Certification - Board certification is verified using an electronic source (Internet) that utilizes current information from the American Board of Medical Specialties (ABMS) or the American Medical Association (AMA) or American Osteopathic Association (AOA) Physician Master Files. ◆ Work History - Work history is not primary source verified; however, the practitioner is required to either submit a curriculum vitae or resume, or document a minimum of the past five (5) years of work history, on the credentialing application. Practitioners with work gaps that exceed one (1) year will be requested to provide documentation detailing how the practitioner maintained affiliation with the profession during the work gap. The Credentialing Program Coordinator clarifies either verbally or in writing with the practitioner any gaps in	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	work history that exceed 6 months and document in the file. Verbal communication is documented appropriately in the credentialing file. ◆ Malpractice Insurance Coverage - Malpractice coverage is confirmed through the signed attestation on the application that includes the dates and amounts of the current malpractice insurance coverage or a copy of the insurance face sheet that includes the practitioner's name, dates and amounts of coverage. ◆ Colorado Bureau of Investigation - BHI requires a background investigation of all practitioners. When Colorado Access obtains a criminal history record through the Colorado Bureau of Investigation, the verification also includes a sex offender search. If an offender is a registered sex offender in Colorado, a "Registered Sex Offender" notation will show up on their criminal history.	
Findings: The primary verification sources described in BHI's policy met NCQA requirements for primary source verification. Colorado Access, on behalf of BHI used primary sources such as the Colorado Department of Regulatory Agencies (DORA) to verify State licenses, the National Practitioner Data Bank (NPDB) and the federal Office of Inspector General (OIG) database to verify eligibility to participate in federal health care programs.		
Required Actions: None.		
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg. 2-4) **Description of Process:** BHI uses the following criteria to outline the minimum requirements to be met by an applying network practitioner. ◆ Psychiatrists – Must be MD or DO, board certified or eligible, licensed by the state of CO, and have a valid	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	DEA & CDS certificate ◆ Psychologists - Must be licensed independently as a clinical psychologist and possess a Doctoral Degree in Psychology (PhD, EdD, PsyD) from an accredited college or university ◆ Social Workers - Must possess a Master's Degree in Social Work and be licensed by the state ◆ Psychiatric Nurses/Clinical Specialists (APN/NP/CS/CNS/RXN) - Must possess a Master's degree in psychiatric nursing and be licensed by the state. If RXN, must be licensed by the state of Colorado with prescriptive authority privileges. ◆ Other Clinicians (LMFT, LPC) - Must possess a Master's degree and be licensed by the state. All eligible practitioners must have a minimum of three (3) years post licensure experience in a mental health/substance abuse setting providing direct patient care or otherwise approved by the credentialing committee. BHI requires practitioners to carry minimum Professional Liability Coverage of $1,000,000 per individual episode; $3,000,000 aggregate and Comprehensive general or Umbrella Liability of $1,000,000 per individual episode; $1,000,000 aggregate. All practitioners must be accessible 24 hours a day, seven days a week or make appropriate arrangements for client care when they are unavailable. In addition, each practitioner must agree to make every effort to be available for appointments as follows: ◆ Emergency evaluation/face to face within 1 hour ◆ Urgent needs met within 48 hours ◆ Initial Routine appointments within seven (7) days	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Provider Credentialing and Recredentialing policy described the credentialing criteria for each type of practitioner that Colorado Access credentials and recredentials on behalf of BHI.		
Required Actions: None.		
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 pg. 7) Cred Committee Form_100609 Cred Committee Guidelines_100609 **Description of Process:** BHI utilizes the multidisciplinary Utilization Management Committee appointed by the Provider Advisory Council of BHI as the Credentialing Committee. BHI's Medical Director is a member of the Utilization Management Committee and as such participates in all credentialing decisions. The Credentialing Committee meets monthly, to review and discuss documentation delineating the result of primary source verifications and other pertinent information. The committee then approves or declines the provider's request, and the provider is advised of the result. Only the BHI Medical Director has the authority to determine if the file meets the BHI credentialing criteria and to sign off on any final credentialing decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI's policy described processes for making credentialing and recredentialing decisions and delineated the role of the credentialing committee. BHI provided the checklist used to document the completion of credentialing tasks and to document the credentialing committee decision. The policy described the committee process to make decisions against established BHI criteria.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg 5-6) **Description of Process:** BHI presents all credentialing files to the Credentialing Committee for review. A current provider profile is maintained through COA for each provider contracted with BHI. The information contained in the file includes but is not limited to the following: ◆ A current application and CV, which includes a five (5) year work history ◆ Current State Professional License to practice ◆ Current DEA license, as applicable ◆ Current Professional Liability Policy face sheet ◆ Evidence of professional medical education including ECFMG, as applicable ◆ Evidence of Board Certification, as applicable ◆ NPDB (National Practitioners Data Bank) query, which includes Medicare and Medicaid sanction activity, as applicable ◆ FSMB (Federation of State Medical Boards) query, as applicable ◆ Evidence of site review, as applicable ◆ Colorado Bureau of Investigation (CBI) Query ◆ Sanctions List BHI presents all credentialing files to the Credentialing Committee for review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Provider Credentialing and Recredentialing policy listed the documents that must be present for the credentialing and recredentialing files to be complete. On-site, BHI staff clarified that Colorado Access completes the credentialing process, including medical director sign-off and credentialing committee decision-making, and that the Colorado Access approval date is the credentialing date of record. BHI staff also maintained a contracting file containing pertinent credentialing information for each contracted provider.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Required Actions: None.		
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg. 21, 22) BHI_COA Delegation Agreement 2009 **Description of Process:** COA agrees to credential and recredential behavioral health practitioners within its scope who have requested or are participating in BHI's Contracted Provider Network. COA credentialing program complies with the most recent standards and substandards set forth by the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), BHI, and any other applicable federal or state regulatory authority and agrees to perform the following credentialing and recredentialing functions in accordance with these NCQA Standards: Initial Credentialing Verification, Application and Attestation, Initial Sanction Information, Verification of Clinical Privileges, Recredentialing Verification, Recredentialing Cycle Length, and Ongoing Sanctions Monitoring.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Provider Credentialing and Recredentialing policy described processes for delegation and delegation oversight of Colorado Access in credentialing and recredentialing BHI practitioners. The policy described activities delegated to Colorado Access and required provisions for content of the delegation agreement. Staff stated that although the Colorado Access approval date is the credentialing date of record, all files are submitted to the BHI credentialing committee for final approval and assignment of a participation effective date.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes). NCQA CR1—Element A7	**Documents Submitted/Location Within Documents:** Non-discrimination and Confidentiality Attestation Provider Credentialing and Recredentialing pp13 (pg. 4) Culturally Appropriate & Compliant Services pp12 Cultural Competence Goals & Objectives (pg. 4) **Description of Process:** BHI does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, type of practice, or types of patients the practitioner may specialize in treating. In addition, BHI and its Credentialing Committee do not discriminate against practitioners who serve high-risk populations or who specialize in the treatment of costly conditions. BHI will not discriminate in terms of participation, reimbursement, or indemnification against any healthcare professional that is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. This does not prevent BHI from including practitioners in its network who may meet certain demographic, cultural, or special needs. All participating committee members sign an acknowledgement form stating they do not discriminate when making credentialing and recredentialing decisions. The BHI Cultural Competency Committee is actively working on policies to increase the diversity of the contracted provider network as the demographics of the service area have changed.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI's policy stated that members of committees and individuals involved in the credentialing program sign the nondiscrimination agreement. On-site, BHI staff members and the Colorado Access (delegate) representative described decision-making that is based on the established credentialing criteria. BHI staff members also stated that credentialing committee members must sign the non-discrimination agreement annually. BHI was able to provide evidence of prevention but not monitoring to ensure nondiscriminatory credentialing and recredentialing processes.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Required Actions: BHI must develop a mechanism to monitor the credentialing/recredentialing program at least annually to ensure nondiscriminatory credentialing and recredentialing. The mechanism must be described in BHI's policies and procedures.		
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	**Documents Submitted/Location Within Documents:** CHCP Credential App10-2011 (pg. 23) Provider Credentialing and Recredentialing pp13 (pg. 7-8) Provider Manual – Practitioner Rights (pg. 41) **Description of Process:** When a practitioner has submitted their credentialing application the application is reviewed for completeness. If the application contains information that varies substantially from the information acquired during the credentialing process, the practitioner is given the opportunity to correct the information and/or explain the discrepancy. The provider is notified by any available means – phone, fax, mail and email. If the provider returns the application with the information corrected or the applicable explanations then the application is entered back into the review process and the new information is verified. If the provider does not respond to the request for additional information the credentialing is request is closed. All the above is completed within the 180 day credentialing cycle. Provider Rights are included in the credentialing application (p. 23) and in the provider manual.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site, BHI staff provided an additional policy—Provider Rights (effective 12/18/2012), that described the process for notifying the applicant in writing of discrepancies in information, and the content of that written notice.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg. 5, 13) **Description of Process:** The completed credentialing file is reviewed against BHI Credentialing Criteria. If criteria are met, the application and report is presented to the BHI Credentialing Committee. Based on the decision from the Credentialing Committee, the practitioner will receive an acceptance or denial letter within seven (7) days. The denial letter will include the appeal process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Provider Credentialing and Recredentialing policy described processes for notifying applicants within 7 days of credentialing and recredentialing decisions.		
Required Actions: None.		
2.J. The medical director's or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg. 6) **Description of Process:** BHI's Medical Director is a member of the Utilization Management Committee and as such participates in all credentialing decisions. Only the BHI Medical Director has the authority to determine if the file meets the BHI credentialing criteria and to sign off on it as complete, clean, and approved by the Credentialing Committee. Only the BHI Medical Director has the authority to sign off on all credentialing decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy stated that the medical director is a member of the credentialing committee and can sign off on clean files. On-site, BHI staff members clarified that the Colorado Access medical director sign-off or Colorado credentialing committee date is the credentialing date; however, the BHI medical director sign-off or BHI credentialing committee date is considered the effective date for network participation.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law. NCQA CR1—Element A11	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg. 6) Provider Manual (pg. 38) Non-discrimination and Confidentiality Attestation **Description of Process:** Confidential handling includes securing credentialing files and credentialing minutes in locked file cabinets. Access to the credentialing files is granted on a need to know basis under the direction of the credentialing staff. The software used to track credentialing is password protected and access granted only to the credentialing staff. Extraneous materials gathered or generated for Risk and Resource Committee meetings are disposed of in locked shred bins.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Confidentiality procedures described in BHI's policy included limited electronic and physical access based on job category and need for the information. Need for the information was related to completion of the credentialing or recredentialing processes. Limited physical access included maintaining applications in a locked file cabinet. Electronic security included password protections based on job category. Other processes described included staff training and a required attestation/agreement to maintain confidentiality for staff members involved in the credentialing process.		
Required Actions: None.		
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Documents Submitted/Location Within Documents:** Provider Information Form Provider Info Update Form BHI-COA Delegation Agreement (pg. 3) Provider Credentialing and Recredentialing pp13 (pg. 23) **Description of Process:** BHI utilizes the Provider Information Form with all its credentialing and recredentialing files. The Provider Information	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Form is faxed to all providers during credentialing and recredentialing to maintain accurate information regarding education, training, certification and specialty information. This information is used to update the provider directory as well as any other member material. BHI also uses the Provider Info Update Form on the website for providers to submit address, phone, fax, tax id, or other status update information. On behalf of BHI, Colorado Access verifies that the information pertaining to credentialed practitioners that is contained in member materials including provider directories is consistent with the information obtained during credentialing by conducting audits, at least annually. Examples of elements audited may include verification of the practitioner's name, education, training, certification, and specialty. Results of the audits are communicated to BHI and corrections are made immediately.	
Findings: BHI's policy stated that provider directories are printed directly from the credentialing database, and that BHI staff audits for consistency between the credentialing information and member materials. During the on-site interview, BHI staff members clarified that provider information from the Colorado Access database is imported into a BHI MS Excel database file, which is used for provider directories and other member materials. Staff confirmed quarterly audits to ensure consistency of information between materials.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request. NCQA CR1—Element B1	**Documents Submitted/Location Within Documents:** BHI Provider Manual – Practitioner Rights (pg. 41) Provider Credentialing and Recredentialing pp13 (pg. 7) CHCP Credential App10-2011 (pg. 23) **Description of Process:** BHI Provider Rights are included in the Provider Manual that is available on our website and in hard copy upon the provider's request. Provider Rights are also included in the Colorado Credentialing Application. Included in those rights is the provider's right to review information related to their credentialing application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Provider Credentialing and Recredentialing policy described the process for providing information to applicants upon request. Applicants were informed of this right via the provider application and the provider manual.		
Required Actions: None.		
2.N. The right of practitioners to correct erroneous information. NCQA CR1—Element B2	**Documents Submitted/Location Within Documents:** BHI Provider Manual – Practitioner Rights (pg. 41) Provider Credentialing and Recredentialing pp13 (pg. 7) CHCP Credential App10-2011 (pg. 23) **Description of Process:** BHI Provider Rights are included in the Provider Manual that is available on our website and in hard copy upon the provider's request. Included in those rights is the provider's right to correct erroneous information.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy addressed the applicant's right to correct erroneous information. Applicants were informed of this right in the provider application and the provider manual.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.O. The right of practitioners, upon request, to receive the status of their application. NCQA CR1—Element B3	**Documents Submitted/Location Within Documents:** BHI Provider Manual – Practitioner Rights (pg. 41) CHCP Credential App10-2011 (pg. 23) Provider Credentialing and Recredentialing pp13 (pg. 7) **Description of Process:** BHI Provider Rights are included in the Provider Manual that is available on our website and in hard copy upon the provider's request. Provider Rights are also included in the Colorado Credentialing Application. Included in those rights is the provider's right upon request, to receive the status of their application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy stated that applicants may request and receive the status of their credentialing or recredentialing application. Providers were informed via the application and the provider manual.		
Required Actions: None.		
2.P. The right of applicants to receive notification of their rights under the credentialing program. NCQA CR1—Element B4	**Documents Submitted/Location Within Documents:** BHI Provider Manual – Practitioner Rights (pg. 41) Provider Credentialing and Recredentialing pp13 (pg. 7) **Description of Process:** BHI Provider Rights are included in the Provider Manual that is available on our website and in hard copy upon the provider's request. Included in those rights is the provider's right to receive notification of their rights under the credentialing program.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy stated applicants are notified of their rights under the credentialing program in the provider manual. The provider manual included applicant rights under the credentialing program. In addition, the Colorado standard provider application informed applicants of their rights under the credentialing program.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR9—Element A	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg. 5) **Description of Process:** Colorado Access conducts ongoing monitoring of practitioners contracted to participate in the BHI network that fall within the scope of credentialing activities. BHI will take appropriate action based on the findings. The ongoing monitoring activities conducted between recredentialing cycles will include monthly review of Medicare and Medicaid sanctions or exclusions and Colorado State licensing sanctions or limitations on licensure. Practitioner-specific member grievances and occurrences of adverse events will be reviewed and investigated by the Quality Improvement Department and presented at the next occurring Risk and Resource Committee meeting. If a practitioner has been disciplined, Colorado Access will retrieve documentation from the applicable issuing agency and forward to BHI for a more detailed investigation. Failure by the practitioner to comply with the corrective action plan as set forth by BHI will be evidenced through ongoing monitoring activities as outlined in appropriate departmental policies including but not limited to the Grievance Procedure and Quality of Care Concern Policy. When instances of poor quality are identified, BHI takes appropriate action. In 2012, BHI has received and investigated several potential quality of care concerns involving various providers. Moreover, while all QOCCs have been unsubstantiated after investigation, BHI was still able to make recommendations to providers for improving quality and coordination of care, including improving communication between providers, improving documentation, policy development, and/or review, and improving transitions for client as they move to different levels of care.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Provider Credentialing and Recredentialing policy stated that Colorado Access, on behalf of BHI, performs a monthly review of the OIG sanctions database and Colorado licensing agencies. The policy also described a quality review of grievances and adverse events. During the on-site interview, BHI staff members stated that the Director of Provider Relations and Contracting reviews monthly OIG and DORA downloads, and that BHI's leadership committee as well as the UM Committee (which functions as the credentialing committee) reviews grievances and quality of care information, as needed.		
Required Actions: None.		
2.R. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR10—Element A1	**Documents Submitted/Location Within Documents:** QI-702 Clinical Quality of Care Concerns ppFY13 Provider Credentialing and Recredentialing pp13 (pg. 13, 14) **Description of Process:** All decisions about altering the practitioner's relationship with BHI include, but are not limited to, issues of quality of care and service, information submitted by the practitioner, as well as objective evidence. Decisions are guided by mental health client care considerations. Corrective action may include suspension of all or part of participation privileges, written warnings, letter of reprimand, probation, requirement of consultation and termination. If action is less severe than reduction of privileges or suspension or termination, the action will take effect immediately.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Clinical Quality of Care Concerns policy provided examples of reasons to alter the conditions of the agreement and the range of actions. Possible actions included warning, reprimand, suspension of privileges, probation, consultation, and termination.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR10—Element A2 and B	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg. 15) **Description of Process:** All physicians and licensed clinicians are subject to reporting of adverse actions to the appropriate State Licensing Board, Healthcare Policy and Finance and the National Practitioner Data Bank.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI's policy addressed reporting to NPDB, State licensing agencies, and the Department. BHI staff reported that there had been no adverse actions taken against practitioners during the review period.		
Required Actions: None.		
2.T. A well-defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision.	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg. 14, 15) Provider Manual (pg. 39) **Description of Process:** The practitioner will be notified of the right to appeal the decision made by the Credentialing Committee within seven (7) days of receipt of the decision. If the provider wishes to appeal, they have 30 days to provide written notification to the Director of Provider Relations of their intent to appeal. The provider must then provide appeal information in written format within 30 days of their notification to the Director of Provider Relations. They will be given the opportunity to present evidence in person or by phone to the BHI Provider Advisory Council. Corrective actions, which will be reviewed by the Credentialing Committee, with a recommendation for approval or disapproval include: ◆ Termination - the practitioner will be notified in writing of BHI's decision to terminate within seven (7) days of the decision. The BHI Provider Termination Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
NCQA CR10—Element A3and C	Template advises the provider to contact the Director of Provider Relations in writing within thirty (30) days of notification to initiate an appeal. Appropriate tracking systems will be updated to reflect the decision. ◆ The practitioner has the right to appeal the decision to the committee within thirty (30) days of the decision. ◆ Not more than one appellate review will be considered. The Provider Advisory Council will make the final decision. BHI will notify the appropriate authorities for behaviors violating the law or ethical standards or practice.	
Findings: The Provider Credentialing and Recredentialing policy described the appeal process for providers for whom BHI has taken action or changed the conditions of the provider's participation based on quality of care issues. Appeal processes included all the required processes.		
Required Actions: None.		
2.U. Making the appeal process known to practitioners. NCQA CR10—Element A4	**Documents Submitted/Location Within Documents:** Provider Termination Letter Decline to Include in Network Letter Provider Manual (pg. 39) **Description of Process:** BHI notifies providers of the appeal process in letter format that is mailed via certified mail to the provider within 7 days of the Credentialing Committee's decision. The appeal process is also included in the Provider Manual which is available on our website or a paper copy can be requested by the provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI's policies stated that applicants are notified of the appeal process in writing when notified of the adverse decision. BHI provided a template letter to deny participation in the network, which informed the provider of how to appeal the decision. The provider manual also informed providers of their right to appeal adverse decisions, and how to do so.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A	**Documents Submitted/Location Within Documents:** UM Committee Meeting Minutes 10252012 BHI Utilization Management Committee Member List 2012 BHI Credentialing 10252012 **Description of Process:** BHI utilizes the multidisciplinary Utilization Management Committee appointed by the Provider Advisory Council as the Credentialing Committee for BHI. Members of the Credentialing Committee will represent the following disciplines: Psychiatry, Psychology, Social Work, Nursing, and Professional Counseling.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI's policy described the BHI Credentialing Committee process to review information received by Colorado Access and determine final approval as appropriate. The committee member roster included a range of provider types, representative of BHI's contracted provider network.		
Required Actions: None.		
4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds. ◆ Medical director or equally qualified individual review and approval of clean files. NCQA CR2—Element B	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg. 6, 7) BHI Credentialing 10252012 **Description of Process:** The Credentialing Committee meets monthly to review and discuss documentation delineating the result of primary source verifications and other pertinent information. The Credentialing Committee receives and reviews credentialing files for all practitioners who have applied for consideration including those who do not meet BHI's established criteria. BHI's Medical Director is a member of the Credentialing Committee and as such participates in all credentialing decisions. Only the BHI Medical Director has the authority to determine if	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	the file meets the BHI credentialing criteria and to sign off on it as complete, clean, and approved by the Credentialing Committee. Only the BHI Medical Director has the authority to sign off on all credentialing decisions.	
Findings: On-site review of credentialing committee minutes demonstrated review and discussion of selected provider files, as required. BHI staff reported that if the medical director is unable to attend a meeting, his review of the minutes and final sign-off is required to assign a provider effective date.		
Required Actions: None.		
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification [board certification time limit = 180 calendar days]). ◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days).	**Documents Submitted/Location Within Documents:** Provider Credentialing and Recredentialing pp13 (pg. 8-11) **Description of Process:** BHI presents all credentialing files to the Credentialing Committee for review. A current provider profile is maintained through COA for each provider contracted with BHI. The information contained in the file includes but is not limited to the following: ◆ A current application and CV, which includes a five (5) year work history ◆ Current State Professional License to practice ◆ Current DEA license, as applicable ◆ Current Professional Liability Policy face sheet ◆ Evidence of professional medical education including ECFMG, as applicable ◆ Evidence of Board Certification, as applicable ◆ NPDB (National Practitioners Data Bank) query, which includes Medicare and Medicaid sanction activity, as applicable ◆ FSMB (Federation of State Medical Boards) query, as applicable	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
NCQA CR3—Elements A and B	◆ Evidence of site review, as applicable ◆ Colorado Bureau of Investigation (CBI) Query ◆ Sanctions List All information above must be completed within 180 days of signed attestation application date. BHI presents all credentialing files to the Credentialing Committee for review.	
Findings: BHI's policy described the processes to conduct timely primary source verification using NCQA-compliant sources. On-site review of 10 credentialing records demonstrated that in each record reviewed, all primary source verification was conducted within NCQA-compliant time frames.		
Required Actions: None.		
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil). ◆ The correctness and completeness of the application. NCQA CR4—Element A NCQA CR7—Element C C.R.S.—13-64-301-302	**Documents Submitted/Location Within Documents:** CHCP Credential App10-2011 (pg. 17, 20, 21, 25, 26) **Description of Process:** The practitioner credentialing and recredentialing processes begin with the completion of an application, signed, and dated attestation and submission of requested documentation to either CAQH or Colorado Access. If the signed attestation exceeds 180 calendar days before the credentialing decision, the practitioner must attest only that the information in the application remains correct and complete and does not need to complete another application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: On-site review of 10 credentialing and 10 recredentialing records demonstrated BHI's use of the Colorado-required credentials application. Each record contained the completed application, which included all of the requirements. The record review also demonstrated that the Council for Affordable Quality Healthcare (CAQH) on-line application uses the Colorado required application questions and prints in the Colorado application format.		
Required Actions: None.		
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. NCQA CR5—Element A NCQA CR7—Element D	**Documents Submitted/Location Within Documents:** Sample Provider Licensure and OIG EPLS Provider Credentialing and Recredentialing pp13 (pg. 11, 12) **Description of Process:** COA reviews the DORA, OIG, and EPLS websites when processing the providers' credentialing file. When the file is received by BHI the Director of Provider Relations also reviews these websites. Results from the provider search from all three those websites are printed and kept on site in the providers credentialing file and are reviewed during the Credentialing Committee meetings.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Provider Credentialing and Recredentialing policy included the processes used to query for sanction activity using NCQA-compliant sources. Each of 10 credentialing and 10 recredentialing records reviewed on-site demonstrated that Medicare and Medicaid sanction queries and State licensure queries were performed in all cases using NCQA-approved sources.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR6—Element A	**Documents Submitted/Location Within Documents:** BHI CPN Site Visit Evaluation Form BHI Organizational Site Visit Tool Provider Credentialing and Recredentialing pp13 (pg. 12) **Description of Process:** BHI has developed a site visit tool for both individual providers and organizations that are used for all site visits. Providers are required to meet eighty percent (80%) compliance against the following site visit standards: ◆ Physical accessibility ◆ Physical appearance ◆ Adequacy of waiting and examining room space ◆ Availability of appointments ◆ Adequacy of treatment record keeping, including: o Secure, confidential filing system o Legible file markers o Records are easily located	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Provider Credentialing and Recredentialing policy stated that BHI's criteria for complaints that trigger a site visit (for individual practitioners) is any complaint related to office site quality, and any office move to a new location. The Contracted Provider Network (CPN) Visit Tool was thorough. BHI staff stated that no practitioners met the threshold for requiring a site visit during the review period.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Monitoring member complaints for all practitioner sites at least every six months. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR6—Element B	**Documents Submitted/Location Within Documents:** Grievance Procedure ppFY13 2012-10-10 (pg. 4) Credentialing and Re-credentialing Policy pp13 (pg. 12) **Description of Process:** If during a practitioner's participation in BHI's network BHI receives a complaint about the physical office of a provider, a site visit will be conducted. If the provider does not meet the eighty percent (80%) standard on the site visit tool, a follow-up site visit will be conducted within ninety (90) days. If the initial site visit produces any significant concerns, they will be immediately presented to the credentialing committee for review. The provider may be suspended from the network if the office does not meet BHI's standards after the second audit. All documentation for site visits is kept in the provider's on-site credentialing file. The BHI Department of Member and Family Affairs Director reviews all member grievances quarterly as they are completed. The director tracks any trends about specific providers or sites and reviews this information with the Credentialing Committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI's policy stated that if an office site did not meet BHI's standards, a re-visit is performed in 90 days; then, the provider may be suspended if corrections had not been made. The policy also stated that any trending noted would be taken to the UM/Credentialing Committee.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid DEA or CDS certificate (effective at the time of recredentialing). ◆ Board certification (verification time limit = 180 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR7—Elements A and B NCQA CR8— Element A	**Documents Submitted/Location Within Documents:** Credentialing and Recredentialing Policy pp13 (pg. 12, 13) **Description of Process:** BHI recredentials all providers every three years. Recredentialing applications are obtained by Colorado Access from CAQH for currently contracted and previously credentialed practitioners. A request is generated approximately ninety (90) calendar days prior to the recredentialing due date. The recredentialing process is identical to the credentialing process except primary source verification does not re-collect educational verification; and provider utilization data, and any complaints and quality information is presented for consideration in the decision making process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy described recredentialing independent practitioners, at least every 36 months, using primary source verification and all required processes. On-site review of 10 practitioner recredentialing records demonstrated that practitioners were recredentialed within the required 36-month time frame.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with State and federal regulatory bodies. NCQA CR11—Element A1	**Documents Submitted/Location Within Documents:** Credentialing and Recredentialing Policy pp13 (pg. 15-21) **Description of Process:** BHI has a written policy and procedure for initial and recredentialing of Organizational Providers. BHI confirms that all Organizational providers are in good standing with state and federal regulatory bodies. BHI retains a screen print displaying the query results from the Office of Inspector General (OIG) Federal Program Exclusions Database (Medicaid and Medicare status). www.oig.hhs.gov	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI's policy described NCQA-compliant procedures for assessing organizational providers. On-site review of five organizational provider records demonstrated that BHI had documentation of organizational provider assessments.		
Required Actions: None.		
11.B. The Contractor confirms that the provider has been reviewed and approved by an accrediting body. NCQA CR11—Element A2	**Documents Submitted/Location Within Documents:** Cedar Springs JCAHO Accreditation Facility-Organization Provider Application Credentialing and Recredentialing Policy pp13 (pg. 17) **Description of Process:** BHI collects and reviews current organization accreditation information from JCAHO, CARF, CHAP, or COA. BHI also collects completed site review reports from CMS, DMH, or ADAD as well as any other requested documentation to ensure the organization complies with BHI standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy described verification of whether the organizational provider has been reviewed and approved by an accrediting body. On-site record review demonstrated that BHI verified accreditation status for accredited organizations. Accrediting bodies found in organizational provider files reviewed included The Joint Commission (TJC) and the Council on Accreditation (COA).		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status. NCQA CR11—Element A3	**Documents Submitted/Location Within Documents:** Credentialing and Recredentialing Policy pp13 (pg. 17) Tennyson Site Visit Example **Description of Process:** Non-accredited organizational provider(s) are subject to an on-site assessment by BHI to confirm that they meet BHI quality standards. BHI will review policies and procedures related to the credentialing of direct care providers and supervisory practices, evidence of criminal background checks and Child Abuse Registry checks, and licensure verifications via the Colorado Department of Regulatory Affairs if applicable. BHI will utilize the CMS site survey conducted by the Colorado Department of Public Health and Environment (CDHPE), the DMH site review conducted on behalf of the Department of Human Services (DHS) or the Alcohol and Drug Abuse Division (ADAD) Site Inspection in lieu of conducting a site visit. In these instances, BHI will require a copy of the reports from the state agency to verify that the assessment complies with BHI standards and to ensure that the organizations credentialing and personnel policies and procedures were reviewed. If the organizational provider has not undergone a site visit by one of the above, or the documentation does not support BHI standards, BHI will perform a site visit.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Provider Credentialing and Recredentialing policy described the process for performing site reviews for non-accredited organizational providers. BHI's Organizational Site Visit Tool was comprehensive. Four records reviewed on-site were accredited facilities and one facility was nonaccredited. BHI followed its policy and ensured that the facility had been reviewed by a State agency. No site review was required by BHI.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** Credentialing and Recredentialing Policy pp13 (pg. 20) **Description of Process:** Recredentialing will take place every three years. The recredentialing process will begin at least ninety (90) days prior to the date at which initial credentialing or recredentialing will expire. BHI follows the procedures for the initial Organizational Provider Credentialing. All requirements and documents listed for Organization Credentialing will be current at the time of credentialing and recredentialing. BHI conducts a site visit every three years for all organizational providers not reviewed and approved by and accrediting body.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: BHI's policy addressed re-assessment of organizational providers each three years, including site visits. On-site review of organizational providers demonstrated that BHI had not successfully reassessed organizational providers at the 36-month time frame. One record reviewed was an initial assessment. The remaining four records were reassessed at 37 months; 39 months; 4 years, 3 months; and 4 years, 8 months.		
Required Actions: BHI must develop a mechanism to ensure that organizational providers are reassessed every three years (36 months).		
11.E. The Contractor's policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.) NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** Credentialing and Recredentialing Policy pp13 (pg. 2, 16, 17) **Description of Process:** BHI will consider contracting with Community Mental Health Centers, Child Placement Agencies, Group Practices, hospitals, Residential Facilities, and Rehabilitation Facilities to provide services in the Contract Provider Network. The organizational provider must provide evidence of one of the following accreditations and have a site visit performed by BHI to be considered for participation or ongoing participation. ◆ JCAHO	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	◆ COA ◆ CARF ◆ CMS Site Review ◆ DMH Site Review ◆ ADAD Site Inspection	
Findings: BHI's policy listed acceptable accrediting bodies, which included TJC, COA, and the Commission on Accreditation of Rehabilitation Facilities (CARF). Records reviewed on-site included organizations accredited by TJC and COA.		
Required Actions: None.		
12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** BHI Organizational Site Visit Tool **Description of Process:** BHI will assess organizational providers with which it intends to contract. These providers include hospitals, residential care facilities, Community Mental Health Centers, outpatient provider groups, and child placement agencies. BHI's Organization Site Review Tool includes assessments of services provided by Inpatient, Residential, and Ambulatory Facilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI's policy listed the site visit criteria. The site visit tool was comprehensive and assessed each of the criteria in BHI's policy.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** BHI Organizational Site Visit Tool Credentialing and Recredentialing Policy pp13 (pg. 17) **Description of Process:** BHI will perform a site visit for all non-accredited. BHI will conduct its own site visit and include a copy of the organization's credentialing or Human Resources policies for screening and verification of staff training. BHI will review policies and procedures related to the credentialing of direct care providers and supervisory practices, evidence of criminal background checks and Child Abuse Registry checks, and licensure verifications via the Colorado Department of Regulatory Affairs if applicable.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Organizational Site Visit Tool included a section to ensure that the organizational provider had a credentialing process.		
Required Actions: None.		
14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization's standard.	**Documents Submitted/Location Within Documents:** Credentialing and Recredentialing Policy pp13 (pg. 17) Boulder MHC CMS Review **Description of Process:** BHI will utilize the CMS site survey conducted by the Colorado Department of Public Health and Environment (CDHPE), the DMH site review conducted on behalf of the Department of Human Services (DHS) or the Alcohol and Drug Abuse Division (ADAD) Site Inspection in lieu of conducting a site visit. In these instances, BHI will require a copy of the reports from the state agency to verify that the assessment complies with BHI standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
NCQA CR11—Element A	and to ensure that the organizations credentialing and personnel policies and procedures were reviewed. The CMS or state review must not be greater than three years old at the time of verification. If the organizational provider has not undergone a site visit by one of the above, or the documentation does not support BHI standards, BHI will perform a site visit.	
Findings: BHI's policy stated that a CMS or State survey may be accepted in lieu of a site visit for non-accredited organizational providers. The policy also stated that BHI checks the surveys against BHI standards to ensure that the survey meets BHI standards. During the on-site interview, BHI staff reported that the Division of Behavioral Health (DBH) site reviewed has been accepted in lieu of a BHI site review and that the director of provider relations and contracting reviews the site review for BHI requirements at the time of that organizational provider's assessment.		
Required Actions: None.		
15. The Contractor's organizational provider assessment policies and process includes assessment of at least: ◆ Inpatient facilities. ◆ Residential facilities. ◆ Ambulatory facilities. NCQA CR11—Element B	**Documents Submitted/Location Within Documents:** BHI Organizational Site Visit Tool **Description of Process:** BHI will assess organizational providers with which it intends to contract. These providers include hospitals, residential care facilities, Community Mental Health Centers, outpatient provider groups, and child placement agencies. BHI's Organization Site Review Tool includes assessments of services provided by Inpatient, Residential, and Ambulatory Facilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI's policy included criteria and processes for inpatient, outpatient/ambulatory, and residential facilities.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
16. The Contractor has documentation that it has assessed contracted behavioral health care (organizational) providers. NCQA CR11—Element C	**Documents Submitted/Location Within Documents:** BHI Organizational Credentialing Checklist Tennyson Site Review Tool Example **Description of Process:** BHI utilizes the Organizational Credentialing Checklist when credentialing a facility to adequately review and ensure requirements have been established and met. BHI retains copies of the site review tool in the organizational providers credentialing file.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Records reviewed on-site demonstrated that BHI maintained comprehensive records for organizational providers. Organizational provider records reviewed on-site included a CMHC, an outpatient facility, and three residential treatment facilities.		
Required Actions: None.		
17. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR12	**Documents Submitted/Location Within Documents:** BHI_COA Delegation Agreement 2009 BHI SFY12 Quarterly Contract Performance Summary Q4 Final **Description of Process:** BHI has a written delegation agreement with COA to provide individual provider credential functions on behalf of BHI. Within the delegation agreement, BHI retains the right to approve, suspend, and terminate individual providers credentialing. On a periodic basis, but not less than annually, BHI will conduct a review or audit of COA's policies, procedures, and records pertaining to the delegated functions. COA's credentialing program will, at a minimum, satisfy all the most recent standards and sub-standards set forth by the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), BHI, and any other applicable federal	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	or state regulatory authority. BHI will monitor the performance of COA by reviewing reports of credentialing activities on a monthly basis. BHI's Credentialing Committee will review annual audit findings, make applicable recommendations for improvement, oversee compliance with reporting, review actions plans, and perform follow-up activities.	
Findings: BHI delegated credentialing and recredentialing activities to Colorado Access, BHI's administrative service organization. BHI provided examples of quarterly reporting by Colorado Access and a report of the annual audit of Colorado Access completed on 12/10/2012.		
Required Actions: None.		
18. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill its obligations. NCQA CR12—Element A	**Documents Submitted/Location Within Documents:** BHI_COA Delegation Agreement 2009 BHI SFY12 Quarterly Contract Performance Summary Q4 Final **Description of Process:** BHI has a written delegation agreement with COA to provide individual provider credential functions on behalf of BHI. Within the delegation agreement, BHI retains the right to approve, suspend, and terminate individual providers credentialing. On a periodic basis, but not less than annually, BHI will conduct a review or audit of COA's policies, procedures, and records pertaining to the delegated functions. COA's credentialing program will, at a minimum, satisfy all the most recent standards and sub-standards set forth by the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), BHI, and any other applicable federal or state regulatory authority. BHI will monitor the performance of COA by reviewing reports of credentialing activities on a monthly basis. BHI'S Risk & Resource (Credentialing) Committee will review annual audit findings, make applicable	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	recommendations for improvement, oversee compliance with reporting, review actions plans, and perform follow-up activities.	
Findings: BHI provided a copy of the delegation agreement signed by both parties, which included each of the required provisions.		
Required Actions: None.		
19. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR12—Element B	**Documents Submitted/Location Within Documents:** BHI_COA Delegation Agreement 2009 **Description of Process:** The delegation agreement with COA for credentialing functions does not include any PHI.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: BHI staff reported that Colorado Access does not use member-level data when reviewing complaints and that if member level data must be reviewed, BHI's credentialing committee performs this level of review.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
20. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR12—Element C	**Documents Submitted/Location Within Documents:** BHI_COA Delegation Agreement 2009 (pg. 5) **Description of Process:** Within the delegation agreement, BHI retains the right to approve, suspend, and terminate individual providers credentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Delegation Agreement between BHI and Colorado Access included the provision that BHI retains the right to approve, suspend, or terminate practitioners, providers, and sites. In practice, BHI does a final credentialing committee review and approval of each practitioner credentialed by Colorado Access on behalf of BHI.		
Required Actions: None.		
21. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR12—Element D	**Documents Submitted/Location Within Documents:** BHI_COA Delegation Agreement 2009 **Description of Process:** The delegations agreement with COA for credentialing functions has been in place since 2009.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: Not Applicable.		
Required Actions: None.		
22. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR12—Element E	**Documents Submitted/Location Within Documents:** Credentialing Audit Tool Score Sheet 2012 Credentialing Tool for File Review **Description of Process:** The BHI/COA Credentialing Delegation Audit has been scheduled for December 10, 2012.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: BHI submitted an audit report that demonstrated BHI's monitoring of its delegate. The audit process included a file review for compliance with NCQA standards.		
Required Actions: None.		
23. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR12—Element F	**Documents Submitted/Location Within Documents:** 2012 Credentialing Policies_Activities Audit Tool **Description of Process:** The BHI/COA Credentialing Delegation Audit has been scheduled for December 10, 2012.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI submitted an audit report that demonstrated BHI's monitoring of its delegate. The audit process included a review of policies and procedures and a review for compliance with NCQA standards.		
Required Actions: None.		
24. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR12—Element G	**Documents Submitted/Location Within Documents:** BHI SFY12 Quarterly Contract Performance Summary Q1-Q4 FINAL **Description of Process:** BHI reviews the quarterly contract performance summaries, which include the number of files that have been credentialed and recredentialed for that quarter.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Both BHI's policy and the delegation agreement included the provision for quarterly reporting by Colorado Access. BHI provided examples of quarterly performance reports submitted to BHI by Colorado Access. During the on-site interview. BHI staff reported that quarterly reports submitted by Colorado Access are reviewed by the leadership team and that any concerns would then be referred to topic-specific committees (i.e., quality, UM) for follow-up.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
25. The Contractor identifies and follows up on opportunities for improvement, if applicable. NCQA CR12—Element H	**Documents Submitted/Location Within Documents:** Credentialing Audit Tool Score Sheet 2012 Credentialing Tool for File Review 2012 Credentialing Policies Activities Audit Tool **Description of Process:** BHI has scheduled the credentialing for December 12, 2012. BHI will follow on any opportunities for improvement.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The delegation agreement between BHI and Colorado Access specified the process for corrective action and follow-up for insufficient performance under the contract. The reports submitted had no content that required follow-up. BHI staff reported that there had been no performance concerns in the past year.		
Required Actions: None.		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	45	X	1.00	=	45
	Partially Met	=	1	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	47	**Total Score**		=	45

Total Score ÷ Total Applicable	=	96%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. 42CFR438.*240*(a) Contract: II.H.1	**Documents Submitted/Location Within Documents:** QI-Reference Document - Quality Improvement Program Description ppFY13 2012-06-08 PEO SOP Minutes 2012-10-10 PAC Minutes **Description of Process:** BHI's QAPI program identifies processes that serve to ensure that the spectrum of behavioral health care services are identified, prioritized, intervened upon and tracked for improvement. The QAPI program uses a system of performance indicators and outcome measures to address a full range of issues and questions for both stakeholders and clients. Standards of Practice, Program Evaluation and Outcomes, and Provider Advisory Committees prioritize, implement, and monitor QAPI plans and programs for optimal impact.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The Quality Assessment (QA) Program Description outlined the components of a comprehensive quality improvement (QI) program, which included monitoring of utilizations trends, performance indicators, satisfaction surveys, member grievances, compliance with standards of practice, and clinical chart reviews. The QA Program Description also addressed performance of focused QI studies and described the responsibility of the Program Evaluation and Outcomes (PEO) Committee for program oversight, analysis, and recommendations. The Annual Quality Report stated that BHI performs oversight of functions delegated to the CMHCs, which included access, referral, utilization management, care coordination, triage, member services, and QI. A sample CMHC Quality Improvement Plan (Arapahoe/Douglas Mental Health Network) outlined a comprehensive committee structure and review process within the CMHC for performance of multiple QI functions.

During the on-site interview, staff clarified that the results of QI monitoring activities are reviewed by both the PEO Committee and the Provider Advisory Committee (PAC), with ultimate accountability to the board of directors through the PAC. The network CMHCs conduct active analysis of results and perform corrective actions for each CMHC, and each CMHC has a representative on the BHI PAC.

Required Actions:
None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: II.H.2.n	**Documents Submitted/Location Within Documents:** FY13 Q1 Grievance and Appeal Report Grievance and Appeal Narrative BHI 35-Visit Outpatient Benefit Limit Monitoring Report FY12 45 Day Inpatient Bed Limit FY12 BHI ED Heavy Hitter Sept and Oct 12 ED Heavy Hitter Submission to CMHC Quality Improvement Program Description ppFY13 (Pg 2) BHI UM Program Description 11162012 (Pg. 3) CMHC Summary ALOS July thru Oct 22 2012 CMHC Summary ALOS July thru Oct 22 2012 FY12 BHI Annual Quality Report – FINAL Report Card Process BHI FY12 Q3 B3 031512 Report **Description of Process:** Over and under-utilization is detected through performance measurement findings such as grievance and complaint data, 35 Session outpatient benefit limit utilization, 45-Day in-patient benefit limit utilization, and alternative services received. Ad Hoc reports are created on emergency department utilization or other service utilization patterns. These reports directly identify outliers in service categories or member populations BHI's QAPI and UM programs identify mechanisms to detect both under and over utilization in their program description policies. QI report cards summarize findings from identified performance reports provide management and staff with the ability to quickly analyze information at the program level. BHI staff and MHC teams may compare their utilization rates to other teams at other MHCs and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	other Behavioral Health Organizations (BHOs) as well as by age groups, periods of time, and other measures of performance. Providers develop corrective action plans if they do not meet established standards. Significant information about utilization is described in the Annual Quality Report for distribution to consumers, BHI Board of directors, HCPF and other stakeholders. BHI's CEO implemented a new process to look for over and under-utilization: Weekly, BHI transfers Explanations of Payments (EOPs) aka Check Run, which typically occurs each Tuesday after 10 am from Colorado Access' network, to BHI's network. BHI stores the EOPs online in weekly and monthly folders. The weekly folders must also include a scanned copy of the signed authorization form. The hard copies of the EOPs must be labeled and filed weekly in the CFO's office. BHI prints out the EOPs each week and prepare them for review. The EOPs are entered into the corporation's financial software package, Business Works, each Tuesday and the associated reports are run and attached to the printed version. All claims are flagged on both the check register and the actual checks that exceed $5,000 as those checks require two authorized signatures, one from the BHI CEO, and one from a CMHC CEO. Each and every week, the check run is reviewed by the BHI CEO. He looks for proper billing codes, over and underutilization trends by provider, improper billing codes that result in denials, errors in claim processing that could include inaccurate COB (Coordination of Benefits). He looks for claims that could be considered wasteful, abusive, and or potentially fraudulent. All claims that have a question are flagged. This process is then repeated by the Director of Provider contracting who looks at the same issues along with making sure that the claims are being paid in accordance to each provider's contract. Any claims that she finds that may be questionable are flagged and an	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	email is sent to the contract administrator with Colorado Access, BHI's ASO, for follow-up, in cases where an error is found, that claim may be pulled and reprocessed. Then the flagged claims are reviewed with the CEO and the contract administrator to review each item in question. Additional follow-up may be required as well as an identification process for claims audits have resulted from this practice. Audits may be requested by the CEO and performed by QI staff. These audits are both from data and trends aspects as well as auditing for claim documentation. Audits may result in providing additional training to full-scale take backs up to and including termination from the program. Once the EOPs have been approved by all parties, a scanned copy of the signed authorization sheet is sent to Colorado Access, so that the checks can be released.	

Findings:
The QA Program Description stated that the QI program monitors for over- and underutilization of services through quarterly review of performance indicators including inpatient length of stay, re-hospitalization, follow-up after hospitalization, emergency department visits, and outpatient utilization. The UM Program Description stated that the UM Committee, the QI department, and all network providers collect data and analyze key quantitative measures of over- and underutilization such as penetration rates, inpatient recidivism, inpatient length of stay, and inpatient admissions and days. BHI provided example reports of various utilization outcome measures, the BHI Report Card, and the QI Annual Report, which included many of these measures.

During the on-site interview, staff explained that the chief executive officer (CEO) reviews the weekly reimbursement to providers report to detect payment indicators of over- or underutilization of services. Flagged cases are further investigated with the CMHC administrator. Staff stated that this process has been effective in detecting and correcting inappropriate provider billing and utilization patterns. Staff stated that the BHI Report Card, which contains utilization performance measures, is reviewed quarterly by the internal QI, UM, and OMFA staff, as well as the individual CMHCs, for analysis and corrective action.

Required Actions:
None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to all members. *42CFR438.240(b)(4)* Contract: II.H.2.m.6	**Documents Submitted/Location Within Documents:** Provider Credentialing and Re-credentialing ppFY13 **Description of Process:** BHI has an extensive array of high-quality providers that specialize in working with consumers with special healthcare needs. Examples include Developmental Disability Consultants (specialists in intensive home based services to children with mental illness and developmental disability), National Jewish Hospital works with consumers with complex co-morbid medical conditions, and MHCD Deaf Counseling (a comprehensive mental health program that specializes in services to deaf consumers). Translation services are provided whenever needed or requested and at no charge to the consumer. Language Line services are immediately available for phone translation. BHI monitors the quality of services provided to enrollees with special health care needs during provider re-credentialing. Provider performance in the areas of utilization management, quality of care, and member satisfaction are reviewed by the credentialing committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The QI Program Description and UM Program Description outlined numerous mechanisms for the assessment of quality and appropriateness of services. Analysis included BHI enrollment data, client satisfaction, client grievances and appeals, peer review of treatment records, and utilization of services data. The program description also stated that individual clinical case discussions allowed for identification of access issues, barriers to discharge, and gaps in the BHI service continuum. BHI Staff stated that the participating CMHCs perform quarterly review of the BHI Report Card, which includes many of the QI performance measures. Staff stated that individual provider performance in the areas of utilization management, quality of care, and member satisfaction is also reviewed by the UM/Credentialing Committee. BHI submitted examples of a variety of reports that were used to monitor quality and appropriateness of care.

The PAC minutes (QI oversight) did not reflect discussion and recommendations based on the QI data submitted to the committee, including the results of analysis of the BHI Report Card. HSAG staff recommended that committee meeting minutes reflect the conclusions and recommendations derived from

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
the QI monitoring data. In addition, HSAG recommended that BHI should ensure that CMHCs report to the PAC the conclusions and corrective actions based on review of the BHI Report Card. PAC minutes should reflect the discussions to provide adequate documentation of the committee's QI oversight responsibilities.		
Required Actions: None.		
4. The Contractor has a process for evaluating the QI Program on an annual basis. The annual quality report describes: ◆ The Contractor's performance on the standard measures on which it is required to report. ◆ The results of each performance improvement project. ◆ The techniques used by the Contractor to improve its performance, effectiveness, and quality outcomes. ◆ Qualitative and quantitative impact the techniques had on quality. ◆ The overall impact and effectiveness of the quality assessment and improvement program. ◆ How past quality assessment and performance improvement activities will be used to target improvement for the next year. ◆ A description and organizational chart for each quality committee. *42CFR438.240(e)(2)* Contract: II.H.2.s.1 Exhibit R3	**Documents Submitted/Location Within Documents:** FY12 BHI Annual Quality Report - FINAL **Description of Process:** BHI conducts an annual evaluation of BHI's programs and services including the impact and effectiveness of the QAPI program. The Annual Quality Report is distributed to all stakeholders including consumers, provider, and BHI's board of directors. BHI develops an annual QI work plan that details the activities of the QAPI program for the year. The progress made on the previous year's QI plan is described in the program evaluation. BHI's QI Program Evaluation and Outcomes committee as well as the Standards of Practice committee evaluate the QAPI program on an ongoing basis.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The BHI Annual Quality report included a description of each QI committee and summarized activities and findings within each QI program focus area. QI focus areas included ongoing performance measures, performance improvement projects, CMHC QI initiatives, member satisfaction surveys, utilization monitoring measures, and quality of care (QOC) concerns. The report included summarized and highlighted data findings within each program		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
area and documented the status of progress on the year's work plan goals and activities. The report included the subsequent year's QI Work Plan activities. Staff stated that the Annual Evaluation Report is presented to the PEO Committee and distributed to member and provider stakeholders and the BHI Board of Directors. The PEO Committee also evaluated program results on an ongoing basis. Neither the Annual Quality Report nor the QI Committee meeting minutes clearly documented conclusions and recommendations of the PEO or PAC quality oversight committees related to the data and information presented or the overall impact and effectiveness of the QI program. In addition, the subsequent year's QI Work Plan did not clearly link to concerns from the previous year's outcomes or outline measurable goals for improvement in the QOC. HSAG recommended that BHI consider documenting the PEO and PAC committee's conclusions regarding the impact of the quality program activities in the annual evaluation report and/or QI oversight committee minutes. HSAG suggested that BHI could improve its documentation by more clearly identifying continuing areas for quality improvement in the subsequent year's QI Work Plan, defining measurable goals for improvement, and ensuring that CMHCs' conclusions regarding the BHI Report Card are reported to the PAC and recorded in the meeting minutes.		
Required Actions: None.		
5. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting health care professionals. ◆ Are reviewed and updated periodically as appropriate. *42CFR438.236(b)* Contract: II.H.2.h	**Documents Submitted/Location Within Documents:** BHI suicide risk assessment form CLIN-202 Clinical Practice Guidelines ppFY13 BHI Coverage Position on Vagal Nerve Stimulation 2011-1-11 Practice Guidelines Tracking Spreadsheet **Description of Process:** BHI's Clinical Practice Guidelines policy describes contract requirements for adoption of practice guidelines. BHI uses clinical practice guidelines approved by BHI's Standards of Practice Committee to ensure adequate and appropriate service provision. Each new practice guidelines uses specific criteria for the approval process. Practice guidelines are periodically reviewed based on the tracking sheet.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The BHI Annual Quality Report stated that the BHI Standards of Practice (SOP) Committee adopts practice guidelines that meet the required criteria. The report listed the individual practice guidelines that had been adopted. The Clinical Practice Guidelines policy specified the procedures for adopting clinical guidelines, which addressed all of the requirements. The Practice Guidelines Tracking Spreadsheet documented the information related to each of the requirements outlined in the standard for each BHI practice guideline. BHI provided samples of existing practice guidelines.		
Required Actions: None.		
6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost. *42CFR438.236(c)* Contract: II.H.2.h.2	**Documents Submitted/Location Within Documents:** CLIN-202 Clinical Practice Guidelines ppFY13 Pg. 3, describes the dissemination process ADMHN Delegation-Pg 5 describes the MHC responsibility regarding practice guidelines http://www.bhicares.org/guidelines.htm shows the link on BHI's website where practice guidelines can be accessed. **Description of Process:** BHI's clinical practice guidelines are disseminated to all providers upon approval by the standards of practice committee. Practice guidelines are posted to the BHI website for members, providers, and potential members. Copies of the guidelines are available upon request to all BHI members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practice Guidelines Tracking Spreadsheet documented the method of distribution to practitioners for each BHI guideline. The Clinical Practice Guideline policy stated that adopted guidelines are disseminated to all affected providers, are available on the BHI Web site for provider and member access, and may be requested by members/potential enrollees or the member's clinician. During the on-site interview, staff confirmed that the CMHCs distribute practice guidelines to prescribers within the CMHCs and that the SOP distributes guidelines to a broad set of providers. BHI also informed providers through blast fax communications and mailings. Staff stated that the provider manual and the member handbook were being enhanced to inform providers and members, respectively, that clinical guidelines could be accessed through the BHI Web site. The BHI Web site does not require a member login, thereby providing the public or potential enrollees access to clinical guidelines.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: II.H.2.h.3	**Documents Submitted/Location Within Documents:** UM-806 BHI Utilization Management Criteria ppFY13 UM-809 Medical Necessity ppFY13 UM-815 Utilization Management Decision Timelines ppFY13docx BHI EMDR Coverage Position Statement FY11 **Description of Process:** The UM criteria, medical necessity criteria, and clinical practice guidelines inform all service authorizations, denials and service planning. These criteria and guidelines also assist in educating members, guardians and designated client representatives about the rationale for determinations and recommendations. For example, BHI's practice guideline for EMDR serves as a tool for UM determination of appropriate level of care.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The Clinical Practice Guidelines policy stated that decisions for UM, enrollee education, coverage of services, and other areas to which the guidelines apply must be consistent with the guidelines. The policy stated that guidelines are available in the provider handbook, are referenced in the provider peer review process, and are used in review of appeals. The UM Decisions policy stated that UM criteria will be consistent with and support BHI-adopted clinical practice guidelines. The Practice Guidelines Tracking Spreadsheet documented UM Committee review of each BHI Practice Guideline for consistency with UM processes and member covered benefits.

During the on-site interview, staff stated that the SOP process for development of clinical guidelines includes representation from all of the clinical and administrative departments that use the guidelines (e.g., utilization/care management, member services, CMHCs), and that these representatives ensure practice guidelines are followed in their respective operational activities. Staff described examples of practice guidelines that have been specifically modified in consideration of local member needs and provider expertise.

Required Actions:
None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42CFR438.242(a)* Contract: II.H.2.q.2	**Documents Submitted/Location Within Documents:** BHI Lives Analysis Report 201211 shows lives across eligibility categories and allows BHI to analyze trends in enrollment. FY13 Q1 Grievance and Appeal Report Grievance and Appeal Narrative 35 Session Outpatient Benefit Limit Report FY12 45 Day Inpatient Bed Limit Report FY 12 ED Heavy Hitter Report for September and October 2012 ED Heavy Hitter Email Submission to CMHCs Clients Served Comparison BHI's Financial summary report will be shown at the site visit **Description of Process:** BHI's HIS informs business and program development decisions. Utilization is detected through data in grievance and complaint reports, alternative services received, and encounter data summaries. BHI's UM Department uses ad hoc and canned reports developed from BHI's HIS to inform utilization decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI provided an overview diagram of the components of the health information system, including provider claims analysis and adjudication, eligibility and enrollment, care management, pharmacy claims, and member services information. All data are integrated into a central data warehouse that provides routine and ad-hoc reporting for decision support, QI monitoring, care coordination, UM decision-making, financial analysis, and other management functions. BHI submitted several examples of health information system reports that analyzed and reported information from the claims system, enrollment files, and grievance and appeal databases. During the on-site interview, staff stated that the CMHCs submit to BHI summarized data related to delegated QI activities or data for focus studies that are integrated with other system data for reporting. Staff stated that grievances and appeals are tracked in a separate MS Access database.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor's health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. *42CFR438.242(a)* Contract: II.H.2.q.2	**Documents Submitted/Location Within Documents:** FY13 Q1 Grievance and Appeal Report is compiled from the Grievance and Appeal databases and analyzed for any trends Grievance and Appeal Narrative 35 Session Outpatient Benefit Limit Report FY12 shows members that are reaching the 35 day outpatient benefit limit so alternate service planning is done in a timely fashion. 45 Day Inpatient Bed Limit Report FY 12 ED Heavy Hitter Report for September and October 2012 ED Heavy Hitter Email Submission to CMHCs FY10 Q1 BHI BHI Lives Analysis Report 201211 shows lives across eligibility categories and allows BHI to analyze trends in enrollment. **Description of Process:** BHI's HIS systems track member demographics, Medicaid eligibility, and service utilization which inform all BHI operations. BHI uses Microsoft Access and Excel databases to track grievances, actions, and appeals. State eligibility files are processed daily to identify member eligibility, new enrollments, and dis-enrollments.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI submitted several examples of health information system reports that analyzed and reported information from the claims system including utilization outlier reports, utilization of allocated State hospital beds, utilization of alternative services, enrollment by member county and source of payment, and summary reports of grievances and appeals. Staff stated that financial reports, which are produced monthly, summarize patterns of utilization, and are reviewed by the PAC and board of directors. During the on-site interview, staff explained that the State notifies BHI directly of any member dis-enrollments due to dissatisfaction, but reported that this circumstance has never occurred. State eligibility files are integrated into the health information system and processed daily to identify enrollments and dis-enrollments. Staff stated that authorization decisions are maintained in the Altruista Care Management system through Colorado Access, and this information is integrated with other data in the health information system to provide reports for UM and care coordination. Staff stated that grievance and appeals data are maintained in a separate database and reviewed quarterly.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* Contract: None.	**Documents Submitted/Location Within Documents:** Access To Care FY12Q4 BHI-revised 7-31-12 helps ensure that access guidelines are met. Utilization of State Hospital Bed SFY12 Q1 monitors the number of members in allocated beds. FY13 Q1 Grievance and Appeal Report helps monitor consumer concerns about services received. Annual Performance Measures Trended and Graphed are annual performance indicators calculated by both BHI and HCPF that help review several key services. NW Adequacy Report Q2 FY12 Final, is a report of current providers and facilities, counties where they serve, geographic distance from BHI members, and whether they currently accept members. **Description of Process:** BHI's annual, quarterly, monthly, and Ad-Hoc reports help monitor provider characteristics, and services provided to members through network adequacy reports, penetration rates, inpatient statistics such as admissions, re-hospitalization rates, follow-up after hospitalization. In addition, outpatient services and emergency room visits are also reviewed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
BHI submitted several report examples that demonstrated reporting of services rendered to members. The Access to Care Narrative report included monitoring results of standards for timely access to services. The Annual Performance Measures report included year-to-year trends in established quality performance indicators, such as re-hospitalization and follow-up after discharge. The Network Providers Adequacy report trended the number of providers by professional qualification (e.g., prescribers, licensed practitioners, unlicensed counselors).

During the on-site interview, staff stated that member characteristics are collected through enrollment files and claims/encounter data, and that CMHCs collect and update member characteristics through member encounters. Staff stated that provider characteristics are initially collected through the credentialing process. Provider characteristics are maintained in the credentialing system, the geographical information database (network adequacy report), and the provider contracting component of the claims database.

Required Actions:
None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member surveys. ◆ Anecdotal information. ◆ Grievance and appeals data. Contract: II.H.2.m.1	**Documents Submitted/Location Within Documents:** Access To Care FY12Q4 BHI-revised 7-31-12 FY12 BHI Annual Quality Report – FINAL (Pg 41) FY13 Q1 Grievance and Appeal Report is compiled from the Grievance and Appeal databases and analyzed for any trends Grievance and Appeal Narrative **Description of Process:** BHI monitors access and adequacy of service issues on a number of levels. BHI's quarterly access to care reports gives an overview of provider provision of services. The grievance process serves as an alert system for any issues members may face. BHI has recently used anecdotal information about level of care issue that led to a quality of concern. BHI deems any information received through any channel as an opportunity to monitor services. In addition to MHSIP and YSS, BHI conducts an internal satisfaction survey, the Mental Health Corporation of America's (MHCA) satisfaction survey. BHI has scored in the high range son this survey through the years.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The Grievance and Appeal summary report documented types of member grievances organized by category, including access and availability, clinical care, and customer services. The BHI Annual Quality Report included the results of the Mental Health Corporation of America (MHCA) member satisfaction survey (conducted annually), which evaluated member perception of outcomes, overall satisfaction with services, participation in treatment planning, and member perceptions of quality of services.

During the on-site interview, staff stated that member survey information and summary grievance and appeals data were included in the BHI Report Card for each CMHC to review quarterly. HSAG recommended that BHI ensure that the CMHCs report their findings and actions back to the PAC Committee, which is responsible for QI oversight. Staff stated that member satisfaction and grievance data was also reviewed by the internal department leadership group for investigation of any potential trends, and ultimately by the PEO/SOP Committee and the board of directors. HSAG recommended that BHI document the conclusions related to these reviews in the appropriate committee meeting minutes.

Required Actions:
None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
12. The Contractor monitors member perceptions of well-being and functional status as well as accessibility and adequacy of services provided by the Contractor by reviewing the results of the statewide Mental Health Statistics Improvement Program (MHSIP), the Youth Services Surveys (YSS), and the Youth Services Surveys for Families (YSS-F). Contract: II.H.2.m.2	**Documents Submitted/Location Within Documents:** FY12 BHI Annual Quality Report – FINAL (Pg. 41) **Description of Process:** BHI participates in Division of Behavioral Health's (DBH) MHSIP and YSS surveys. The results received from DBH are analyzed and used to assess member satisfaction. The results of the MHCA are summarized in BHI's annual quality report and shared with all stakeholders.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: BHI stated that results of the Mental Health Statistics Improvement Program (MHSIP) survey, Youth Services Surveys (YSS), and Youth Services Surveys for Families (YSS-F) are analyzed to assess member satisfaction. The BHI Annual Quality Report included the results of the Mental Health Corporations of America (MHCA) member satisfaction survey, but the report did not include results of the MHSIP, YSS, or YSS-F. Staff explained that, due to new QI staff being hired during 2012, BHI overlooked the distribution of the survey results from the Department and inadvertently eliminated the member satisfaction results from the QI Committee review schedule.		
Required Actions: BHI must re-introduce the review of the MHSIP, YSS, and YSS-F results into the QA Program and provide evidence of review by quality oversight committees.		
13. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported. Contract: II.H.2.m.5	**Documents Submitted/Location Within Documents:** FY12 BHI Annual Quality Report – FINAL Grievance Procedure ppFY13 2012-10-10 Provider Credentialing and Re-credentialing ppFY13 **Description of Process:** BHI has always performed well on satisfaction surveys. BHI uses several mechanisms to monitor dissatisfaction, patterns of complaints, or serious complaint is reported. BHI policies on grievance, QOCC, and provider credentialing guide this monitoring. BHI has not required a corrective action plan this year. BHI's drop in centers and peer specialists serve as great advocates for member satisfaction.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Provider Credentialing and Recredentialing policy stated that provider-related complaints and quality information is presented for consideration in the recredentialing process. The Grievance Procedure stated that grievances related to potential QOC concerns are referred for thorough investigation of the concern. The BHI Annual Quality Report stated that QOC concerns may be identified from member complaints or a variety of adverse events. One QOC concern during FY2012 resulted in a corrective action requirement. During the on-site interview, staff outlined the process for review of individual member grievances to identify potential QOC concerns. The QI department reviews grievances for evidence of any serious concern or patterns of complaints that require corrective action. Staff reported that only one formal corrective action plan was requested within the review period, which resulted in multiple program changes to improve deficiencies. Neither the Annual Quality Report nor the QI Committee meeting minutes documented review and recommendations related to member complaint data. Staff stated that member survey information and summary grievance and appeals data were included in the BHI Report Card for each network CMHC to review quarterly and implement corrective action, as needed. HSAG recommended that BHI ensure that the CMHCs report their findings and actions back to the PAC, which is responsible for QI oversight.		
Required Actions: None.		
14. The Contractor investigates, analyzes, tracks, and trends quality of care (QOC) concerns. (Client complaints about care are not quality of care concerns under this section and should be processed as grievances, unless the Department instructs otherwise.) Contract: II.H.2.o	**Documents Submitted/Location Within Documents:** QI-702 Clinical Quality of Care Concerns ppFY13 QOCC Analysis FY12 BHI Annual Quality Report – FINAL (Pg. 37) **Description of Process:** BHI's policy on QOCC guides the investigation of all quality of care issues. BHI uses a database to save information on all QOCCs after investigations. This database is analyzed at least annually for trends. This information is shared through the Annual quality Report as well as internal communications.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Clinical Quality of Care Concerns policy outlined the procedures for investigating and resolving individual quality of care concerns. The policy stated that a potential QOC concern can be reported by anyone; and BHI will investigate, analyze, track, trend, and resolve QOC concerns. QOC concerns involving physicians are investigated by the BHI medical director and Professional Review Committee (PRC). Investigation and results are documented in a QOC concern file. The BHI Annual Report included a section on QOC concerns as triggered by adverse events or member complaints. The report described the process for investigation of QOC concerns and corrective action by the QOC Concerns Committee. The QOC Concerns Analysis report to		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
BHI leadership validated that QOC concerns were investigated: most were unsubstantiated concerns, one corrective action was implemented, and opportunities for improvement were identified. During the on-site interview, staff stated that each complaint is investigated to determine a potential QOC issue, and any potential QOC concern is reviewed by BHI leadership, which includes the CEO, chief medical officer (CMO), and QI staff. The QI department reviews grievances for evidence of any serious concern or patterns of complaints that require corrective action. The UM Committee, which also serves as the provider credentialing committee, oversees the QOC concern process. Staff provided evidence that all grievance investigations and QOC concerns are tracked in an MS Excel database.		
Required Actions: None.		
15. When a quality of care concern is raised, the Contractor : ◆ Sends an acknowledgement letter to the originator of the concern. ◆ Investigates the QOC issue(s). ◆ Conducts follow-up with the member to determine if the immediate health care needs are being met. ◆ Sends a resolution letter to the originator of the QOC concern, which contains: • Sufficient detail to foster an understanding of the resolution. • Description of how the member's health care needs have been met. • A contact name and telephone number to call for assistance or to express any unresolved concerns. Contract: II.H.2.o	**Documents Submitted/Location Within Documents:** QI-702 Clinical Quality of Care Concerns ppFY13 QOCC Acknowledgement letter QOCC Follow up, Report, and Attachments QOCC Notification form QOCC Resolution letter **Description of Process:** BHI's policy on QOCC guides the QOCC investigations to ensure all parties involved are notified of the complaint, the investigation process, the resolution, and any corrective action plans. BHI maintains files on each investigation with all necessary documents.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Clinical Quality of Care Concerns policy outlined the procedures for resolving QOC concerns, including all of the required processes. BHI provided a sample acknowledgement letter, investigation documentation, and a detailed resolution letter that substantiated compliance with this requirement. During the on-site interview, staff explained that BHI monitors treatment record documentation and also contacts the member's assigned care coordinator to determine if the member's immediate health care needs have been met when a potential QOC concern has been identified.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Required Actions: None.		
16. The Contractor's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. *42CFR438.242(b)(2)* Contract: II.H.2.q.1	**Documents Submitted/Location Within Documents:** Attachment 13. DST QA Process Attachment 13a. COA QA Client Summary Report June 2012 Attachment 13b. August_2011 Monthly Audit Report Attachment 3. Claims Flow ADMHN_August_2012_ EVR FY12 Q2 Minutes BHI-CoAc-MHC IT Meeting **Description of Process:** BHI collects service data in standardized formats such as the 837 format using standardized processes. In order to maximize efficiency and eliminate redundancies, provider data are screened, standardized, and verified by Colorado Access. BHI uses Encounter Validation Reports to check for trends in provider data submission. This information is discussed in meetings with CMHCs, COA, and BHI.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: BHI stated that claims are processed by Colorado Access, BHI's administrative services organization. The Claims Flow diagram documented that claims are entered into the Colorado Access claims processing system using standardized formats, are electronically screened using the Department of Health Care Policy and Financing (HCPF) data validation edits, and error reports are produced and sent to BHI. The DST Systems claims auditing process document outlined the process of auditing claims for accuracy of payment information. The BHI Annual Quality Report stated that, in collaboration with Colorado Access and the CMHCs, BHI implemented a thorough data validation check process to verify the accuracy and completeness of all encounter data submitted to the Department. BHI also conducted an annual encounter data validation audit that reviews providers' documentation for accuracy. BHI provided sample encounter validation error reports used for monitoring and correcting errors.		
Required Actions: None.		

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	16	**Total Score**		=	15

Total Score ÷ Total Applicable	=	94%

The completed record review tools follow this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Credentialing Record Review Tool
for Behavioral HealthCare, Inc.

Reviewer:	Rachel Henrichs	**Review Period:**	January 1, 2012–December 31, 2012
Participating Plan Staff Member:	Jennifer Rogers, Teresa Summers	**Date of Review:**	January 7, 2013

SAMPLE	1		2		3		4		5		6		7		8		9		10	
Provider ID#	8622		9463		9991		10061		10038		10568		2619		10773		10951		11203	
Provider Type (MD, PhD, NP, PA, MSW)	LCSW		LPC		LPC		LPC		LCSW		LPC				LPC		LPC		LCSW	
Application Date	6/8/10		11/30/10		7/8/11		7/25/11		7/26/11		1/5/12				7/9/12		7/19/12		9/26/12	
Specialty	Social Worker		Counselor		Counselor		Counselor		Social Worker		Counselor				Counselor		Counselor		Social Worker	
Credentialing Date (Committee/Medical Director Approval Date)	6/30/10		1/20/11		7/21/11		8/11/11		9/22/11		1/19/12				7/12/12		8/30/12		10/11/12	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Initial Credentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X				X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	NA		NA		NA		NA		NA		NA				NA		NA		NA	
♦ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is board certified)	NA		NA		NA		NA		NA		NA				NA		NA		NA	
♦ Work history	X		X		X		X		X		X				X		X		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X				X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X				X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X				X		X		X	
♦ The provider's credentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X				X		X		X	
Applicable Elements	**6**		**6**		**6**		**6**		**6**		**6**				**6**		**6**		**6**	
Point Score	**6**		**6**		**6**		**6**		**6**		**6**				**6**		**6**		**6**	
Percentage Score	**100%**		**100%**		**100%**		**100%**		**100%**		**100%**				**100%**		**100%**		**100%**	

Notes:
Record #2 showed an employment gap from October 2009 through May 2011. The file included documentation that Colorado Access had researched the gap, which turned out to be a mistake.
Record #3 also included documentation that Colorado Access had researched an employment gap, which was a maternity leave.
Record #7 was a recredentialing file, so one file from the oversample was used instead.

Appendix B. Colorado Department of Health Care Policy and Financing
Credentialing Record Review Tool
for Behavioral HealthCare, Inc.

OVERSAMPLE	1		2		3		4		5									
Provider ID#	8373																	
Provider Type (MD, PhD, NP, PA, MSW)	LCSW																	
Application Date	1/19/10																	
Specialty	Social Worker																	
Credentialing Date (Committee/Medical Director Approval Date)	3/2/10																	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**								
Initial Credentialing Verification The contractor, using primary sources, verifies that the following are present:																		
♦ A current, valid license to practice (with verification that no State sanctions exist)	X																	
♦ A valid DEA or CDS certificate (if applicable)	NA																	
♦ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is board certified)	NA																	
♦ Work history	X																	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X																	
♦ Verification that the provider has not been excluded from federal participation	X																	
♦ Signed application and attestation	X																	
♦ The provider's credentialing was completed within verification time limits (see specific verification element—180/365 days)	X																	
Applicable Elements	**6**																	
Point Score	**6**																	
Percentage Score	**100%**																	
Total Record Review Score									**Total Applicable: 60**				**Total Point Score: 60**				**Total Percentage: 100%**	

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Behavioral HealthCare, Inc.

Reviewer:	Barbara McConnell	**Review Period:**	January 1, 2012–December 31, 2012
Participating Plan Staff Member:	Jennifer Rogers, Teresa Summers	**Date of Review:**	January 7, 2013

SAMPLE	1		2		3		4		5		6		7		8		9		10	
Provider ID#	1395		4415		901		902		7335		1265		1768		1583		8325		2859	
Provider Type (MD, PhD, NP, PA, MSW)	LPC		LMFT		LPC		LPC		LPC		PsyD		LPC		LCSW		LPC		LCSW	
Application/Attestation Date	11/14/12		10/25/10		10/6/10		1/17/11		10/4/11		2/2/12		6/27/12		8/2/12		7/29/12		8/25/12	
Specialty	Counselor		Therapist		Counselor		Counselor		Counselor		Psychologist		Counselor		Social Worker		Counselor		Social Worker	
Last Credentialing/Recredentialing Date	2/11/10		1/7/08		3/14/08		3/14/08		2/11/09		7/22/09		10/15/09		12/21/09		1/14/10		1/28/10	
Recredentialing Date (Committee/Medical Director Approval Date)	12/27/12		12/9/10		1/13/11		3/3/11		12/8/11		6/21/12		8/9/12		10/4/12		11/8/12		11/16/12	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Recredentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	NA		NA		NA		NA		NA		NA		NA		NA		NA		NA	
♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	NA		NA		NA		NA		NA		NA		NA		NA		NA		NA	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date	X		X		X		X		X		X		X		X		X		X	
Applicable Elements	**6**		**6**		**6**		**6**		**6**		**6**		**6**		**6**		**6**		**6**	
Point Score	**6**		**6**		**6**		**6**		**6**		**6**		**6**		**6**		**6**		**6**	
Percentage Score	**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**	
Total Record Review Score									**Total Applicable: 60**				**Total Point Score: 60**				**Total Percentage: 100%**			
Notes:																				

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

Table C-1 lists the participants in the FY 2012–2013 site review of **BHI**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
BHI Participants	**Title**
Jennifer Conrad	Director, Utilization Management
Roger Gunter	Chief Executive Officer
Rebecca Hill	Executive Assistant
Samatha Kommana	Director, Quality Improvement
Christina Mitsch	Authorization Coordinator/Utilization Management
Jane Moore	Utilization Review Manager
Alicia Nix	Program Manager Outreach
Kimberly Nordstrom	Chief Medical Officer
Megan Pope	Quality Improvement and Research Analyst
Jennifer Rogers	Manager, Credentialing Program (Colorado Access)
Teresa Summers	Director, Provider Relations
Beth Tarasenko	Corporate Compliance Officer
Scott Utash	Director, Office of Member and Family Affairs
Nathan Wagner	Human Resources Director
Department Observers	**Title**
Russ Kennedy	Quality Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2012–2013 for Behavioral HealthCare, Inc.

If applicable, the BHO 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 2012–2013 Corrective Action Plan *for* BHI					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
Standard VIII—Credentialing and Recredentialing 2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes).	BHI was able to provide evidence of prevention but not monitoring to ensure nondiscriminatory credentialing and recredentialing processes. BHI must develop a mechanism to monitor the credentialing/recredentialing program at least annually to ensure nondiscriminatory credentialing and recredentialing. The mechanism must be described in BHI's policies and procedures.				

Table D-2—FY 2012–2013 Corrective Action Plan *for* BHI					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status.	On-site review of organizational providers demonstrated that BHI had not successfully reassessed organizational providers at the 36-month time frame. BHI must develop a mechanism to ensure that organizational providers are reassessed every three years (36 months).				

Table D-2—FY 2012–2013 Corrective Action Plan *for* BHI					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
Standard X—Quality Assessment and Performance Improvement 12. The Contractor monitors member perceptions of well-being and functional status as well as accessibility and adequacy of services provided by the Contractor by reviewing the results of the statewide Mental Health Statistics Improvement Program (MHSIP), the Youth Services Surveys (YSS), and the Youth Services Surveys for Families (YSS-F).	The BHI Annual Quality Report included the results of the Mental Health Corporations of America (MHCA) member satisfaction survey, but the report did not include results of the MHSIP, YSS, or YSS-F. Staff explained that, due to new QI staff being hired during 2012, BHI overlooked the distribution of the survey results from the Department and inadvertently eliminated the member satisfaction results from the QI Committee review schedule. BHI must re-introduce the review of the MHSIP, YSS, and YSS-F results into the QA Program and provide evidence of review by quality oversight committees.				

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 2012–2013 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 BBA Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, on-site agenda, record review tools, 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 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 BHO's 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.)
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 2012–2013 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 Medicaid managed care regulations and associated contract requirements.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2012–2013 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.