Colorado Medicaid
Community Mental Health Services Program

FY 2013–2014 Site Review Report

for

Behavioral HealthCare, Inc.

April 2014

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

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Introduction

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 federal health care regulations and managed care contract 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 report documents results of the FY 2013–2014 site review activities for the review period of January 1, 2013, through December 31, 2013. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the two standard areas reviewed this year. Section 2 contains graphical representation of results for all 10 standards across two, three-year cycles, as well as trending of required actions. Section 3 describes the background and methodology used for the 2013–2014 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2012–2013 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials 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 plan process the BHO will be required to complete for FY 2013–2014 and the required template for doing so.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any 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 some elements, regardless of the score. Recommendations for requirements scored as *Met* did not represent noncompliance with contract requirements or federal health care regulations.

Table 1-1 presents the scores for **Behavioral Healthcare, Inc.** (**BHI**) for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* 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)
I Coverage and Authorization of Services	31	31	25	5	1	0	81%
II Access and Availability	15	15	15	0	0	0	100%
Totals	**46**	**46**	**40**	**5**	**1**	**0**	**87%**

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

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)
Denials	150	102	94	8	48	92%
Totals	**150**	**102**	**94**	**8**	**48**	**92%**

Standard I—Coverage and Authorization of Services

Summary of Findings as Evidence of Compliance

Utilization Management (UM) policies and related documents outlined the procedures for authorizing pre-service and continued authorizations for higher levels of care and lower levels of care. Policies defined medical necessity as stated in the contract requirements. The medical necessity criteria and the provider manual definition of medical necessity incorporated references to prevention and treatment of health impairments, and the ability to maintain or regain functional capacity. **BHI** adopted clinical medical necessity criteria for higher levels of care (e.g., inpatient or partial hospitalization, subacute care) and lower levels of care (e.g., residential treatment, day treatment, intensive outpatient services). Staff members confirmed that these are the primary criteria applied in authorization decisions, supplemented by Interqual criteria as needed. Policies listed numerous sources of information used to make medical necessity determinations, and staff members stated that **BHI** requires providers to forward clinical records to **BHI** with authorization requests. Policies defined and reports demonstrated that **BHI** routinely monitors for under- and overutilization through multiple data parameters, at multiple levels of care, and by provider.

Procedures specified that higher levels of care be authorized by independently licensed professionals (LCSW, LPC, RN) 7 days a week, 24 hours a day by telephone, and lower levels of service by independently licensed professionals 5 days a week, 8 hours a day. Policies and program descriptions stated that UM staff members are supervised by the UM director and the chief medical officer (CMO). The CMO is a licensed, board-certified psychiatrist who oversees clinical decisions and all UM denials. Policies and on-site interviews verified that **BHI** offered an opportunity for peer-to-peer consultation when the rendering provider disagrees with the UM decision and prior to a denial being issued. The UM Program Description and the Corporate Compliance Plan included policy statements stating that **BHI** does not provide financial incentives for UM decisions that limit or deny services. In addition, providers were informed via the provider manual.

Policies accurately defined the time frames required for making standard and expedited authorization decisions and for granting extensions, as well as the required time frames and mechanisms for notifying members and providers of authorization decisions. On-site denial record reviews confirmed that denial decisions were made according to criteria and by a qualified clinician (MD). Notices of action (NOAs) contained all the required information and were written using easy-to-understand language.

Policies described a variety of methods for training and maintaining proficiency of the UM staff. Interrater reliability (IRR) reports documented that **BHI** performed IRR testing against medical necessity criteria biannually and implemented corrective action plans. In 2013, corrective actions included staff training, adoption of InterQual criteria, and plans to discontinue delegation of UM to the community mental health centers (CMHCs).

Staff provided an on-site demonstration of the Altruista UM Authorization System, which provided a central repository of easily accessible, searchable, and reportable information related to member authorization records. The system demonstrated documentation of most required data elements, as

well as documentation of reviewer notes, clinical information, and consultations with the requesting provider. InterQual criteria were integrated into the system database for reference.

The Emergency and Post Stabilization Services policy defined emergency medical condition, emergency services, and poststabilization services as required. The policy addressed numerous other contract requirements including no preauthorization requirement, obtaining services in or out of network, the treating provider's determination of sufficient stabilization, and circumstances determining **BHI**'s obligation to pay for emergency and poststabilization services.

The member handbook and the provider manual defined emergency medical condition using the prudent layperson definition and informed members and providers of the requirements related to emergency care as defined in the policy. The provider manual also stated that the clinician is expected to call **BHI** for an assessment of level of care or emergency mental health assessment for members in crisis.

During on-site interviews, staff members stated that **BHI** automatically covers all emergency services treatment and does not review or deny any emergency facility claims for reasons related to medical necessity. **BHI** provided evidence that emergency claims were identified for review based only on claims submission edits related to timely filing or other administrative requirements.

Summary of Strengths

BHI experienced significant changes in program leadership, personnel, and structure of its UM Program during 2013. Based on monitoring and assessment of the delegated UM processes performed by the CMHCs, **BHI** rescinded delegation of UM processes to the CMHCs in October 2013. **BHI** established criteria for approving the common higher levels of care and lower levels of care, adopted InterQual criteria, implemented the Altruista Utilization Management system, and centralized the UM processes at **BHI**. As a result, staff reported that the IRR increased, and **BHI** enhanced its relationships with CMHC providers who are now actively engaged in managing member treatment throughout the continuum of care.

NOA letters to members routinely included suggestions for the member to receive alternative services. This inclusion was not required but was offered by the plan in consideration of the member's best interests.

Summary of Findings Resulting in Opportunities for Improvement

Although policies and program descriptions incorporated many of the elements or language of the Medicaid contract requirements, procedures for operationalizing the policies were often written at a very high level and did not clearly outline the processes of implementation. Processes were described in numerous policies and other documents, which led to inconsistency across documents. In addition, although **BHI** discontinued delegation of UM activities in October 2013, several documents still included references to delegated processes. Although staff described the training process for new UM staff members to ensure understanding of procedures, **BHI** might consider consolidating the various policies and procedures that address utilization review and management into a master policy and procedure that includes all of the UM requirements.

HSAG recommended that **BHI** review all of its documents for consistency and current information, including any references to delegated processes. Specifically, **BHI** should consider amending the following:

- During on-site discussions, staff members stated that the member always receives a hardcopy written NOA, and that effective November 2013, **BHI** began sending the written notice to both provider and member via certified mail. **BHI** should consider removing references to the electronic notification to members from the UM Decision Timelines policy and update with current procedures.
- The provider manual states that expedited decisions are made within 3 calendar days. The UM Program Description stated that standard authorization decisions are made within 7 calendar days. While these statements are not out of compliance, they are inconsistent with **BHI**'s policy statements. It is recommended that **BHI** correct the provider manual to specify 3 business days and correct the UM Program Description to specify 10 calendar days to be consistent with **BHI** policies.
- The NOA policy described processes for the mental health centers to extend the authorization time frames, although delegation of the CMHCs has been discontinued. References to delegated processes should be removed.
- Although policies defined emergency services as required, and **BHI** confirmed that **BHI** pays all emergency claims, **BHI** may want to consider adding a statement in the Emergency and Post Stabilization Services policy to specify that **BHI** will not deny payment for emergency treatment for situations which a reasonable person outside the medical community would perceive as an emergency medical condition.
- Reviewers noted during the denial record review that the initial date of request for authorization and any notation of whether the request was standard or expedited were difficult to identify in the records. **BHI** has since converted to the Altruista UM documentation system. HSAG recommended that **BHI** ensure these elements are clearly documented in the new system. In addition, the Altruista system incorporates InterQual criteria, which is not the primary UM criteria **BHI** applies to authorization reviews. Therefore, **BHI** may want to pursue some mechanism to integrate its level of service criteria into the software system or ensure that the system allows documentation of the specific criteria used in making the UM decision.

Summary of Required Actions

Denial record reviews included NOAs that were written in easy-to-understand language in all cases; however, the revised NOA template letter contained language citing specific rules and regulations and state or federal guideline references by regulation number in the body of the letter. During on-site interviews, staff members confirmed that the NOA had been revised in late 2013 and explained that the regulatory references had been added to the letter based on advice from administrative law judges during State fair hearings. **BHI** must remove the technical language and State or federal regulation citations from the *main body* of the member's NOA letter to ensure ease of understanding by the member.

The NOA policy stated that the CMHCs may request an extension "to allow adequate time for **BHI** to conduct its clinical review." Records reviewed on-site included five extensions, which stated that the reason for the extension was to allow enough time for **BHI** to process the request. **BHI** must revise its NOA policy and ensure that if **BHI** extends the authorization decision time frame, it is in the member's interest, rather than a convenience for the BHO, and **BHI** must ensure that it is able to justify the need for the extension (upon request of the Department).

The on-site denial record review included two cases in which the NOA was not sent within the required 10-day time frame, an extension letter was not sent, and the member did not request an extension. **BHI** must ensure that NOAs are sent within the required time frame unless the member requests an extension or the BHO sends the notice of extension.

During the on-site denial record reviews, one of 15 denial records reviewed on-site did not include documentation that the member was notified of **BHI**'s denial for continued inpatient care. **BHI** only notified the requesting provider. **BHI** must ensure that the member is notified in writing of any decision to deny a service authorization.

The Utilization Management Decisions Timeline policy stated that the extension notice will include the reason for the extension and the member's right to file an *appeal* if he or she disagrees with the extension decision. During the on-site denial record reviews, five cases were reviewed that contained extension letters that did not inform the member of the right to file a grievance. **BHI** must inform the member in the written notice of extension of the right to file a grievance if the member disagrees with the decision to extend the time frame and correct its policy to accurately describe that the member has the right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination.

The Admission and Continued Stay Authorizations and Census Tracking policy stated that when a member presents at a hospital emergency facility, the facility contacts **BHI** and an emergency services clinician is dispatched to evaluate the member and may authorize inpatient hospitalization. The policy states that, "If there is a disagreement after-hours, the emergency department may choose to admit the patient with the hope that **BHI** will retro-authorize the next day or may choose to place the patient in observation status with **BHI** review in the morning." This process is not in compliance with regulations. **BHI** must revise its policies and procedures that address emergency and poststabilization services to ensure that if the **BHI** representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation (i.e., after hours), the health plan must allow for contact between the treating provider and the health plan medical director or physician designee, and the health plan must pay for the poststabilization services until one of these circumstances occurs—a plan physician assumes responsibility for the member's care, the treating physician and health plan reach an agreement, or the member is discharged.

Standard II—Access and Availability

Summary of Findings as Evidence of Compliance

Policy and procedures articulated **BHI**'s commitment to maintaining an adequate provider network, including analysis to determine the number, mix, and geographic distribution of providers to meet the anticipated mental health needs of **BHI**'s Medicaid population. Policies stated that **BHI** contracts with all CMHCs and Federally Qualified Health Centers (FQHCs) in the service area, as well as multispecialty clinics, residential care facilities, day treatment centers, and individual practitioners. **BHI** performed the analysis of network adequacy and subcontracted the development of quarterly Network Access reports to Colorado Access. The quarterly network adequacy reports depicted numbers of providers by provider type, by county, by geographic location compared to the location of Medicaid members, members located further than 30 miles from a provider, and number of single case agreements, as well as trending this information between quarters. The annual access report also included analysis of languages spoken within the provider network and provider-to-member ratios for the three service area counties. Staff reported that **BHI** contracts with or has offered a contract to all essential community providers in the service area. **BHI** contracted with out-of-network providers through single case agreements to expand the network of available providers for geographically remote members. Quarterly access reports stated that the number of providers for the population served was adequate overall. During on-site interviews, staff members discussed various methods of projecting growth in the Medicaid population within the service area, as well as analysis of data on use of inpatient and outpatient services according to specific demographic characteristics. **BHI** established internal standards for provider-to-member ratios by provider type, based on research of national norms. Staff members stated that **BHI** defined a goal to increase its penetration rate from 12 to 14 percent in 2014 and has an overall goal to improve the penetration rate over each subsequent year. Staff members indicated that **BHI** is continuously trying to recruit additional psychiatrists into the network, acknowledging that the shortage of prescribing providers for Medicaid populations was a nationwide problem.

Policies and procedures described the processes by which members may request and obtain a second opinion in network or out of network and the process for using out-of-network providers when medically necessary services cannot be provided within **BHI**'s network. Policies stated that single case agreements were pursued with qualified out-of-network providers, and qualified providers were ultimately offered an application for a network contract. Staff reported that **BHI** had 135 single case agreements, primarily to accommodate members located in sparsely populated counties. Staff members stated that **BHI** considers single case agreements a strategic advantage by enabling **BHI** to established formal relationships with providers in outlying areas that may be asked to treat additional members in those counties. **BHI**'s single case agreement duplicated the full provider contract with all associated provider requirements, included specific payment rates, and specified that the provider will accept **BHI** compensation as payment in full and may not bill the member for any additional costs. Staff members explained that for out-of-network providers who do not have a single case agreement, **BHI** has established standard reimbursement rates which are significantly lower than contracted rates, in order to provide incentives to providers to contract with **BHI**.

Policies addressed requirements for timely member access to emergency service evaluations and stated that members may obtain emergency services from any local hospital emergency room. Policies stated that providers must notify the **BHI** Emergency Services (ES) team, available 24 hours a day, 7 days per week, of the need for a mental health emergency evaluation. The **BHI** Member and Family Handbook informed members of the layperson definition of emergency services and how to access emergency services. Policies and the **BHI** Provider Contract specified that all providers must maintain hours of operation for **BHI** members that are comparable to those offered to Medicaid fee-for-service, Medicare, or commercial plan members. In addition, policies outlined the required appointment standards and benchmark performance requirements, as well as procedures for monitoring appointment availability. The provider manual, provider bulletins, and member handbook informed providers and members of the appointment standards. Several types of reports documented the quarterly results of monitoring compliance with access standards through secret shopper calls and review of CMHC data reports, member grievances, and member satisfaction surveys. Reports included pertinent analysis and recommended corrective actions. Several examples of corrective action reports from the CMHCs documented that **BHI** implemented interventions to improve performance that fell below the benchmarks.

Policies addressed procedures related to providing written translated materials and oral interpreter services as necessary to provide covered services to members. Policies also addressed the **BHI**'s commitment to contract with providers representing diverse languages and cultures, and aligning members with appropriate providers. The member handbook and provider manual informed members and providers of the availability of oral interpretation services, translated materials, and materials in alternate formats through Customer Services free-of-charge. Samples of a variety of member materials demonstrated that member communications were translated into Spanish.

A number of reports demonstrated analysis of the demographic breakdown of members in the service area, assessment of linguistic needs of the members, and assessment of languages spoken within the provider network. Access reports demonstrated that **BHI** has increased efforts to contract with bilingual Spanish-speaking providers, outreach into the Hispanic community, and hire bilingual staff. Reports stated that the 2014 goal is to better assess provider network cultural characteristics and align members with providers to meet their cultural needs. Staff members stated that **BHI** has identified key provider relationships in the Hispanic, Asian, Russian, and Jewish communities, and has been successful in addressing the needs of refugee populations. In addition, staff stated that the provider network included therapists certified in sign language, as well as providers who specialize in treating the physically or developmentally disabled. **BHI** conducted therapeutic groups in Spanish at its drop-in centers to better address needs specific to the Hispanic culture. **BHI** provided staff cultural competency training annually. Reports concluded that **BHI** believes the network meets the cultural needs of its members.

The provider manual informed providers of their responsibility to deliver services to members in a manner compatible with the members' cultural health beliefs, practices, and preferred language, and to address these characteristics in the individualized service plan (ISP). Staff stated that ISPs were monitored in the annual on-site provider reviews. **BHI** distributed a template assessment of member needs to providers, which included key cultural assessment questions.

During on-site interviews, staff members stated that **BHI** uses traditional data sources such as eligibility data and provider applications to identify members' and providers' languages and cultural

affiliations. To enhance this information, **BHI** implemented mechanisms to obtain more information from members through the **BHI** Web site, and added questions to the provider recredentialing application to gather information related to the broader cultural areas in which a provider may specialize (e.g., ethnic groups; age groups, such as the elderly; sexual orientation). Information was retained in the provider network files and was accessible to members on the **BHI** Web site and used by Customer Services staff.

Staff reported that the Cultural Competency Committee was working with contracted external consultants to begin to identify expanded definitions of cultural groups, such as the homeless, members associated with the criminal justice system, and older long-term care adults. **BHI** was expanding provider and staff educational tools to include training related to these additional cultural groups. In addition, the committee was exploring ways to identify more about the individual providers' cultural competencies and interests. The Cultural Competency Plan identified three-year goals and action items to improve cultural competency throughout the network.

Summary of Strengths

BHI demonstrated a commitment to expanding the identification and understanding of diverse cultural subgroups as well as associated behaviors and unique needs. **BHI** implemented mechanisms to identify the specialized cultural expertise of providers and align specific areas of interest/expertise with member characteristics. **BHI** was exploring methods to obtain more reliable and expanded cultural characteristic information from both members and providers, and has initiated some programs for members and education for providers and staff related to meeting the needs of specific subcultures. Staff described the enhanced cultural competency efforts as ongoing and continuously evolving to better align provider services with an expanded definition of members' cultural characteristics.

Reports reflected that **BHI** was performing regular and active analysis of a variety of data sources to assess adequacy and availability of the provider network and was researching additional measures or methods of establishing benchmarks to guide network development. **BHI** was using a consolidated review of data, member satisfaction surveys, and grievance information to monitor accessibility and adequacy of services. In addition, **BHI** demonstrated active engagement with the CHMCs to increase the level of accountability for effective interventions to improve provider performance as necessary.

Summary of Findings Resulting in Opportunities for Improvement

While reports demonstrated that **BHI** monitored multiple sources of provider network data, analysis, data interpretation, conclusions, or recommended actions were limited. HSAG encouraged **BHI** to enhance its reporting by documenting statements of interpretation, conclusions, and any specific plans for network development in the various network analysis reports. HSAG also encouraged **BHI** to continue exploring data sources for anticipating the characteristics of the expanding Medicaid populations, projecting the needs of those members, and proactively integrating the information into provider network development plans.

BHI should consider enhancing member communications to ensure that members understand:

- That in certain situations involving out-of-network services, members will not be held liable for costs—and exactly what those situations are.
- That the member should not be balance billed for any services.
- How to notify the health plan if the member is balance billed for services.

Summary of Required Actions

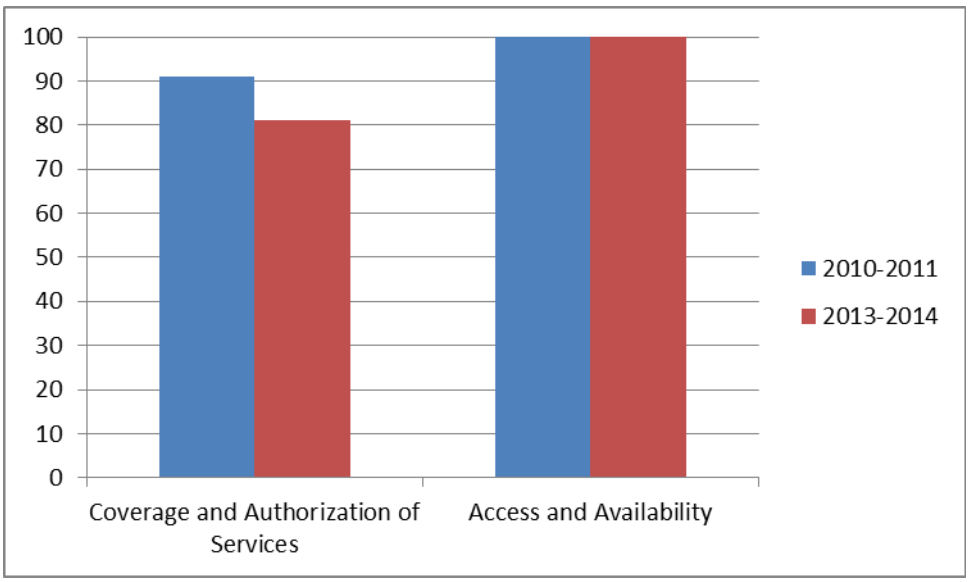
There were no required actions for Standard II.

Comparison of Results

Comparison of FY 2010–2011 Results to FY 2013–2014 Results

Figure 2-1 shows the scores from the FY 2010–2011 site review, when Standard I and Standard II were previously reviewed, compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **BHI**'s contract with the State may have changed, and may have contributed to performance changes.

Figure 2-1—Comparison of FY 2010–2011 Results to FY 2013–2014 Results



Review of Compliance Scores for All Standards

Figure 2-2 shows the scores for all standards reviewed over the last two, three-year cycles of compliance monitoring. The figure compares the score for each standard across two review periods and may be an indicator of overall improvement.

Figure 2-2—BHI's Compliance Scores for All Standards

Note: The older results are shown in blue. The most recent review results are shown in red.

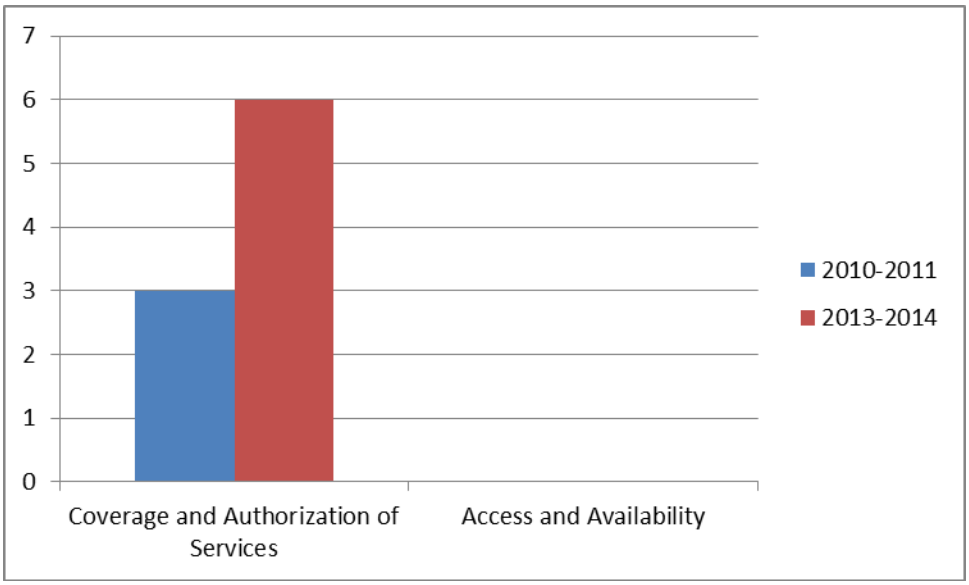
Table 2-1 presents the list of standards by review year.

Table 2-1—List of Standards by Review Year						
Standard	**2008–09**	**2009–10**	**2010–11**	**2011–12**	**2012–13**	**2013–14**
I—Coverage and Authorization of Services			X			X
II—Access and Availability			X			X
III—Coordination and Continuity of Care			X		X	
IV—Member Rights and Protections		X			X	
V—Member Information	X			X		
VI—Grievance System		X		X		
VII—Provider Participation and Program Integrity		X		X		
VIII—Credentialing and Recredentialing		X			X	
IX—Subcontracts and Delegation		X		X		
X—Quality Assessment and Performance Improvement		X			X	

Trending the Number of Required Actions

Figure 2-3 shows the number of requirements with required actions from the FY 2010–2011 site review, when Standard I and Standard II were previously reviewed, compared to the results from this year's review. Although the federal requirements did not change for the standards, **BHI**'s contract with the State may have changed, and may have contributed to performance changes.

Figure 2-3—Number of FY 2010–2011 and FY 2013–2014 Required Actions per Standard

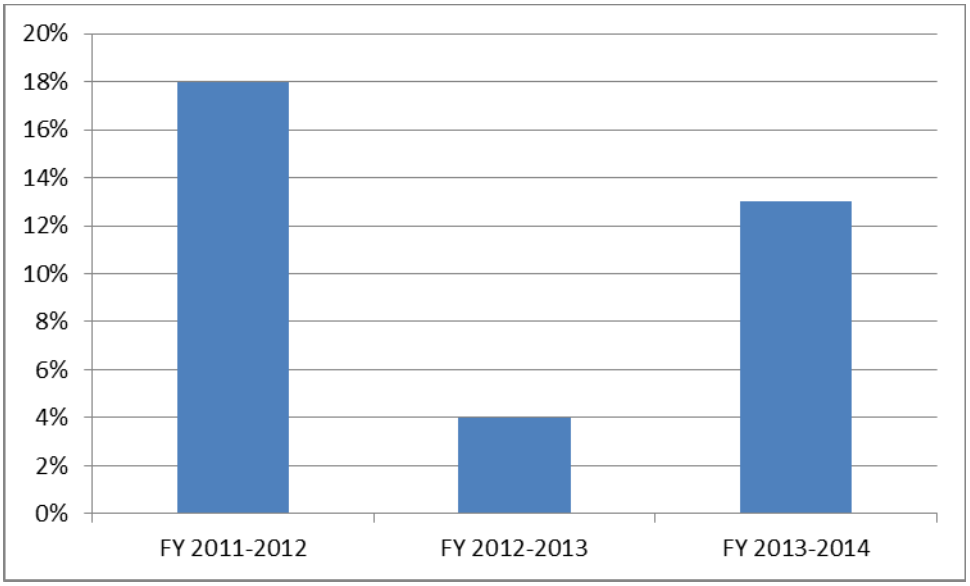


Note: BHI did not have any required actions for Standard II—Access and Availability during the 2010–2011 or the 2013–2014 compliance reviews.

Trending the Percentage of Required Actions

Figure 2-4 shows the percentage of requirements that resulted in required actions over the past three-year cycle of compliance monitoring. Each year represents the results for review of different standards.

Figure 2-4—Percentage of Required Actions—All Standards Reviewed



Overview of FY 2013–2014 Compliance Monitoring Activities

For the fiscal year (FY) 2013–2014 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities: a review of records, documents, and materials provided on-site; and on-site interviews of key BHO personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to BHO service and claims denials. In addition, HSAG conducted a high-level review of the BHO's authorization processes through a demonstration of the BHO's electronic system used to document and process requests for BHO services.

A sample of the BHO's administrative records related to Medicaid service and claims denials was also reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 15 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. For the record review, the BHO received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2013–2014 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—

Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

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 health care regulations and managed care contract requirements in the two 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 recommended to improve the quality of the BHO's services related to the standard areas reviewed.

4. Follow-up on Prior Year's Corrective Action Plan

for **Behavioral Healthcare, Inc.**

FY 2012–2013 Corrective Action Methodology

As a follow-up to the FY 2012–2013 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 it successfully completed each of the required actions. HSAG and the Department continued to work with **BHI** until it completed each of the required actions from the FY 2012–2013 compliance monitoring site review.

Summary of 2012–2013 Required Actions

As a result of the FY 2012–2013 compliance site review, **BHI** was required to address the following required actions:

Although **BHI** provided evidence of activities designed to prevent discriminatory credentialing processes, **BHI** was required to also develop a mechanism to monitor the credentialing/ recredentialing program at least annually to ensure nondiscriminatory credentialing and recredentialing. This 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 the National Committee for Quality Assurance (NCQA). **BHI** was required to develop a mechanism to ensure that organizational providers are reassessed every three years (36 months).

BHI's quality program did not incorporate review of results from the Mental Health Statistics Improvement Program (MHSIP), Youth Services Survey (YSS), and Youth Services Survey for Families (YSS-F) member satisfaction surveys in 2012. **BHI** was required to 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.

Summary of Corrective Action/Document Review

BHI submitted its CAP to HSAG and the Department in April 2013. After careful review, HSAG and the Department determined that, if implemented as written, **BHI** would achieve full compliance on its required actions. In July 2013, **BHI** began sending HSAG and the Department documents that demonstrated it had completed its corrective actions. By August 2013, HSAG and the Department determined that **BHI** had successfully completed all required actions.

Summary of Continued Required Actions

No required actions were continued from the FY 2012–2013 site review.

Appendix A. Compliance Monitoring Tool *for* Behavioral Healthcare, Inc.

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor established and maintains a comprehensive Utilization Management (UM) Program to monitor the access to, use, consumption, levels, and intensity of care, outcomes of, and appropriate utilization of covered services. The Contractor evaluates the medical necessity, appropriateness, efficacy, efficiency of health care services, referrals, procedures, and settings. The Contractor's Utilization Management Policies and Procedures include: ◆ Prior authorization for identified intensive levels of care. ◆ Description of activities undertaken to specifically identify and address underutilization. ◆ Routine trending and analysis of data by level of care (including care not prior-authorized). ◆ Routine trending of services by provider. Contract: II.I.1.a., II.I.1.s, Exhibit V, IV.A and IV.B	**Description of Process:** BHI maintains a comprehensive and effective UM Program to monitor access to the outcomes, appropriate utilization, level, and intensity of covered behavioral health services. BHI's UM functions operate in a way to maximize the ability to provide flexible, individualized, timely treatment while working within all regulatory, NCQA, and contractual requirements. **Evidence of Compliance:** 2013-2014 Utilization Management Program Description (pg. 3-4) UM Annual Program Evaluation (whole document) UM-824 Pre-service and Concurrent Authorizations (pg. 1, IV. A) QI-706 Service Quality Measurement (pg. 1, III. B.) Additional Documents Submitted on-site: BHI Performance Report Card FY14 Quarter 1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor's Utilization Management Program Description is written so that staff members can understand the program and includes: ◆ Program goals. ◆ Program structure, scope, processes, and information sources, including the identification of all intensive levels of care. ◆ Roles and responsibilities. ◆ Evidence of Medical Director leadership in key aspects of the UM Program to include denial decisions and criteria development. ◆ A description of how oversight of any delegated UM function will occur. ◆ A description of how staff making utilization review	**Description of Process:** BHI ensures that enrollees consistently receive the appropriate type and amount of all medically necessary covered service that are the most effective and the least restrictive possible in supporting recovery. The UM Program is overseen by the Chief Medical Officer (CMO) of BHI. Services are authorized in sufficient amount, duration, or scope to achieve identified treatment objectives. All authorization decisions are based solely on the appropriateness of the care for the member based on defined medical criteria. The BHI UM Program supports member recovery by ensuring consistent access to the most effective and least restrictive medically necessary behavioral health services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
decisions are supervised. ◆ A statement regarding staff availability at least eight hours a day during normal business hours for inbound calls regarding UM issues. ◆ The mechanisms used to ensure that members receive equitable access to care and services across the network. ◆ The mechanisms used to ensure that the services authorized are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished. *42CFR438.210(a)(3)(i)* Contract: II.I.1.s, Exhibit V, I.A	**Evidence of Compliance:** 2013-2014 Utilization Management Program Description (whole document)	
3. The Contractor's UM Program is conducted under the auspices of a qualified clinician and has: ◆ Evidence of formal staff training designed to improve the quality of UR decisions. ◆ Policies and procedures to evaluate and improve the consistency with which UR staff apply criteria (e.g. inter-rater reliability) across multiple levels of care. ◆ Policies, procedures, and job descriptions to specify the qualifications of personnel responsible for each level of UR decision-making (e.g. review, denial). ◆ Policies and procedures to ensure that a practitioner with appropriate clinical expertise in treating the member's condition reviews any potential denial based on medical necessity. *42CFR438.210(b)(3)* Contract: II.I.1.a, II.I.1.h. Exhibit V, VA	**Description of Process:** BHI's UM program is under the direction of our CMO. BHI's UM program policies and procedures are updated, reviewed, and approved annually by the UM Committee and ultimately the CMO. **Evidence of Compliance:** 2013-2014 Utilization Management Program Description (pg. 1) UM-824 Pre-service and Concurrent Authorizations (pg. 1, A.4.) UM IRR Report 2013 (whole document) Chief Medical Officer Job Description (whole document) Ron Morley MD CV (whole document) Director of QIUM Job Description (whole document) Brian Hemmert Resume (whole document) UM-810 Notice of Action (pg. 2, B.1.a.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42CFR438.210(a)(3)(ii)* Contract: II.I.1.e.	**Description of Process:** BHI has established Utilization Management/Medical Necessity Criteria that serve as a basis for all clinical authorization decisions and as an assessment tool, which promotes consistent, clinically appropriate decision-making, sound, and efficient utilization of available resources. The UM criteria take into account individual needs and the local delivery system. BHI utilizes Interqual® is to assist in decision support making to ensure that the member is receiving "the right service, at the right time, with the right provider." BHI ensures our care delivery is system is built on a solid, scientifically valid foundation of medical evidence, both to improve quality and to become more efficient. BHI does not arbitrarily deny or reduce the amount, duration, or scope of required services solely based on diagnosis, type of illness, or condition of the member. **Evidence of Compliance:** 2013-2014 Utilization Management Program Description (pg. 5)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. *42CFR438.210(a)(3)(iii)* Contract: II.I.1.f.1. and II.I.1.f.2.	**Description of Process:** BHI requires that services meet established medical necessity criteria for authorization. This and other mechanisms ensure consistency and appropriateness in clinical decision making across the BHI system. A covered service is deemed medically necessary if it is found to be an equally effective treatment among other treatment options and if the services might be reasonably expected to prevent, reduce, assist, correct the symptoms of an illness, or if the service will or is reasonably expected to maintain a member's highest level of independent functioning. Per Medicaid Contract	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	requirements, BHI meets minimum UM Policy Standards as outlined in Contract Exhibit V. BHI's practice guidelines are consistent with UM/Medical necessity criteria per contract requirements. As an example of demonstrating compliance with this element, NOA letters will be available on-site during file review. **Evidence of Compliance:** 2013-2014 Utilization Management Program Description (pg. 2) BHI Medical Necessity Criteria (whole document) UM-806 BHI Utilization Management Criteria (whole document) 2013 BHI Provider Manual (pg. 21)	
6. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State Medicaid program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: • The prevention, diagnosis, and treatment of health impairments. • The ability to achieve age-appropriate growth and development. • The ability to attain, maintain, or regain functional capacity. *42CFR438.210(a)(4)* Contract: I.A.25.	**Description of Process:** BHI reviews service authorization requests based on medical necessity (as defined by the Colorado Medicaid Community Mental Health Services Program) and UM Criteria. Medical necessity is determined through the evaluation of a number of factors, including but not limited to: • Member and family/guardian identification of preferences and goals for recovery; • Ongoing consultation with the provider throughout the episode of care (EOC) to determine the medical necessity of services as established by changes in the member's condition and treatment needs and identified goals; and • Consultation with the member, family, informal supports, and/or person with legal custody about his/her treatment history, to identify unique and/or special client needs (e.g., cultural considerations, communications needs, and special clinical circumstances that may necessitate a unique approach	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	to treatment). Providers are notified of the UM criteria and medical necessity criteria through the Provider Manual. Providers are informed of any updates to UM Criteria/Medical Necessity Criteria via provider updates or the annually published Provider Manual. BHI UM/Medical Necessity criteria are also available to providers, members, family members, advocates, and interested others through the BHI website or by calling the UM Department. **Evidence of Compliance:** 2013-2014 Utilization Management Program Description (whole document) BHI Medical Necessity Criteria (whole document) UM-806 BHI Utilization Management Criteria (whole document) 2013 BHI Provider Manual (pg. 21)	
7. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42CFR438.210(b)* Contract: II.I.1.g.	**Description of Process:** BHI requires pre-authorization for behavioral health services, with the exception of emergency/post-stabilization services, routine outpatient visits, member-run alternative services (i.e., drop-in centers, and peer specialist services), and prevention/early intervention (PEI) services. Prior service authorizations are based on a thorough review of complete and current clinical information. If the documentation is incomplete, BHI UM staff members follow up with a verbal request to the provider for the missing clinical information. Documentation includes a Colorado Client Assessment Record (CCAR), Initial Assessment, Individualized Service Plan and admission forms, progress notes, Census Tracking and Authorization form for inpatient and hospital diversion programs (up to 9/30/13) psychiatric and medical evaluations, specialty evaluations/consultations, or equivalent information. All prior service authorization decisions are made in compliance with regulatory, NCQA, and contractually required	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	timelines and documentation standards. **Evidence of Compliance:** UM-824 Pre-Service and Concurrent Authorizations (whole document) UM-802 Admission and Continued Stay Authorizations and Census Tracking (whole document) 2013-2014 Utilization Management Program Description (pg. 4)	
8. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure that each staff member is applying criteria consistently, such as inter-rater reliability testing. The contractor takes action to improve consistency where possible. *42CFR438.210(b)(2)(i)* Contract: II.I.1.q	**Description of Process:** BHI maintains policies and procedures to ensure BHI Medical Necessity and UM criteria are consistently applied across the network and all levels of care (LOC). Periodic evaluations and reviews of service authorizations and inter-rater reliability studies are conducted by BHI. Sub-contracted providers were monitored through the delegation oversight process (up to 9/30/13). BHI UM Department identifies and examines utilization patterns outside of established criteria ranges through examination of performance data and over/under-utilization measures. Any significant variance and/or pattern of variance is reviewed in more detail (e.g., individual case reviews) and re-training is provided as needed. Additionally BHI researched evidence-based clinical decision support options as a means to improve efficacy and consistency. BHI has selected to contract with McKesson for the use of their InterQual Criteria product. The license for use of InterQual took effect in April 2013. This evidence-based product fosters alignment between BHI, as the payer, and our providers through focusing on consistent application of clinical criteria in making authorization and denial determinations. InterQual provides optimal care management through consistency and is designed to	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	help reduce over- and under-utilization of behavioral health services. InterQual will provide an enhanced level of defensibility and risk management in BHI's UM determinations. InterQual has been imbedded in the electronic care management and authorization system, which will allow for all aspects of the BHI UM determination to be consolidated in one system. **Evidence of Compliance:** UM-824 Pre-Service and Concurrent Authorizations (whole document) UM IRR Report 2013 (whole document)	
9. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *42CFR438.210(b)(2)(ii)* Contract: II.I.1.j.	**Description of Process:** BHI UM staff engages in ongoing consultation with the provider throughout the episode of care (EOC) to determine the medical necessity of behavioral health services as established by changes in the member's condition and treatment needs. A "Doctor to Doctor" may be requested by the provider (attending physician) and BHI's CMO for a review of authorization or denial decisions. In addition, when a notice of action is sent to a provider, the provider is notified that they can contact a member of the UM Department to discuss the denial decision. **Evidence of Compliance:** UM-824 Pre-Service and Concurrent Authorizations (whole document) 2013-2014 Utilization Management Program Description (pg. 3)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The Contractor has in place and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42CFR438.210(c)* Contract: II.I.1.j	**Description of Process:** Pre-service authorization decisions are communicated to members and providers in compliance with Medicaid regulations regarding timelines and notice content. BHI provides timely notification to members and providers regarding any denial, reduction, suspension, termination, or limited authorization of a requested type or level of service in accordance with Federal and State regulations. BHI provides notice to the member, guardian, or the Designated Client Representative (DCR) via certified mail. BHI notifies the requesting provider verbally then via certified mail of any decision to deny or reduce a service authorization request. **Evidence of Compliance:** UM-810 Notice of Action (pg. 4, C.) NOA Example	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: One of 15 denial records reviewed on-site did not include documentation that the member was notified of BHI's denial for continued inpatient care. BHI only notified the requesting provider.		
Required Actions: BHI must ensure that the member is notified in writing of any decision to deny a service authorization.		
11. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member's health condition requires not to exceed: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 business days. *42CFR438.210(d)*	**Description of Process:** Pre-service authorization decisions are communicated to BHI members and providers in compliance with Medicaid regulations regarding timelines and notice content. BHI monitors the timeliness of UM decision-making by tracking the date services are initially requested, the date on which the authorization decision is made, and whether this timeframe is within authorization response time requirements. BHI takes action to improve performance if authorization response standards are not met. BHI also conducts annual audits of UM timelines for service authorizations and denials. Policies and procedures require	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Contract: II.F.10, 10CCR2505—10, Sec 8.209.4.A.3.c	adherence to the timeframes for which prior service authorization, concurrent, and retrospective UM decisions are made. Standard service authorization decisions are made and communicated to the member and provider within 10 calendar days following the receipt of the request. An expedited UR process is used when BHI determines that the standard authorization timeline could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. These UR decisions are made and communicated to the member and provider as expeditiously as the member's condition requires and no later than three (3) working days after the receipt of the request for service authorization. **Evidence of Compliance:** UM-815 Utilization Management Decision Timelines (whole document) UM-810 Notice of Action (pg. 4, C.) 2013 BHI Provider Manual (pg. 17)	
12. The notices of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the time frames specified in 431.211: • The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214). ◆ For denial of payment, at the time of any action affecting the claim. ◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10	**Description of Process:** Notice of actions (NOAs) are mailed within the departmental timeframes as defined by HCPF. As of 11/1/13 these letters are sent certified return receipt to member and the provider to ensure delivery. **Evidence of Compliance:** UM-810 Notice of Action (whole document) NOA Example (whole document)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
calendar days following receipt of the request for services. ◆ For service authorization decisions not reached within the required time frames on the date time frames expire. ◆ For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 business days after receipt of the request for services. *42CFR438.404(c)* *42CFR438.400(b)(5)* Contract: II.F.10, 10CCR2505—10, Sec 8.209.4.A.3.a		
Findings: The Notice of Action (NOA) policy outlined the required timelines for notification of each type of action as required, with the exception that the policy did not address what happens when an expedited authorization decision is not reached within the required time frame of 3 business days. The UM Decision Timelines policy required that NOAs be mailed within the specified time frames, and stated that authorization decisions not reached within the required time frames should be communicated as outlined in the NOA policy. BHI should ensure that the NOA policy is updated to include language to address decisions not made within 3 business days for expedited authorizations. The provider manual stated that expedited decisions are made within 3 calendar days. The UM Program Description stated that standard authorization decisions are made within 7 calendar days. While these statements are not out of compliance, they are inconsistent with BHI's policy statements and should be revised for consistency with BHI's policy. BHI did not send the NOA within the required 10-day time frame and did not file an extension of the authorization time frame for two of the 15 denial records reviewed on-site.		
Required Actions: BHI must ensure that NOAs are sent within the required time frame unless the member requests an extension or BHI has sent a notice to extend the determination time frame.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
13. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42CFR438.404(a)* Contract: II.F.4.e, II.F.10 10CCR2505—10, Sec 8.209.4.A.1	**Description of Process:** BHI recognizes that NOAs may be confusing to the provider or the member. Due to this potential confusion, BHI reiterates in several places that they may contact BHI for any clarification that may be required. Accompanied with the NOA letter the member receives detailed yet understandable appeal information. **Evidence of Compliance:** UM-810 Notice of Action (pg. 1, I.) NOA Example (whole document)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The NOA policy stated that NOAs would be provided in writing to members in a format that was easy to understand and in the member's preferred language. The sample English version of the NOA contained a statement in Spanish informing the member how to request a copy in Spanish, and it also stated that the member may request large print or audio tape. Denial record reviews included NOAs that were written in easy-to-understand language in all cases. However, the revised NOA template letter contained language citing specific rules and regulations by number and State or federal guideline references in the body of the letter. During on-site interviews, staff members confirmed that the NOA had been revised in late 2013 and explained that the regulatory references had been added to the letter based on advice from administrative law judges during State fair hearings.		
Required Actions: BHI must remove the technical language citing State or federal regulations from the main body of the member's NOA letter to ensure ease of understanding by the member.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
14. Notices of action must contain: ◆ The action the Contractor (or its delegate) has taken or intends to take. ◆ The reasons for the action. ◆ The member's, the member's authorized representative's, or provider's (on behalf of the member) right to file an appeal and procedures for filing. ◆ The date the appeal is due. ◆ The member's right to a State fair hearing. ◆ The procedures for exercising the right to a State fair hearing. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. ◆ The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). ◆ Language clarifying that oral interpretation is available for all languages and how to access it. *42CFR438.404(b)* Contract: II.F.4.e, II.F.10, 10CCR2505—10, Sec 8.209.4.A.2	**Description of Process:** BHI's NOAs meet all requirements set forth by the Department as evidenced by policy and example. **Evidence of Compliance:** UM-810 Notice of Action (whole document) NOA Example (whole document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
15. The Contactor may extend the authorization decision time frame if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. The Contractor's written policies and procedures include the following time frames for possible extension of time frames for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days. *42CFR438.210(d)* Contract: II.F.10, 10CCR2505—10, Sec 8.209.4.A.3	**Description of Process:** Pre-service authorization decisions are communicated to BHI members and providers in compliance with Medicaid regulations regarding timelines and notice content. Service authorization decisions may be extended up to 14 calendar days if the member or provider requests an extension. BHI may request additional information to justify that the requested extension is in the member's best interest. **Evidence of Compliance:** UM-815 Utilization Management Decisions Timelines (whole document)	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: The UM Decision Timelines policy accurately stated that BHI may extend standard or expedited authorization by 14 calendar days for the reasons stated in the requirement. The NOA policy described processes for the community mental health centers (CMHCs) to extend the authorization time frames. During on-site interviews, staff members stated that the CMHCs are no longer delegated to perform UM activities. In addition, the policy stated that the CMHCs may request an extension "to allow adequate time for BHI to conduct its clinical review." Denial record reviews included five cases of extensions granted on or near the date of the initial request for authorization, and the reason described in the member extension notification referred to allowing enough time for BHI to process the request. During on-site discussions, staff members stated that these extensions were processed by the CMHCs prior to the date of de-delegation of UM.		
Required Actions: BHI must ensure that if BHI extends the authorization decision time frame, it is in the member's interest, rather than a convenience for the BHO, and BHI must ensure that it is able to justify the need for the extension (upon request of the Department).		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
16. If the Contractor extends the time frame for making a service authorization decision, it: ◆ Provides the member written notice of the reason for the decision to extend the time frame. ◆ Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. ◆ Carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires. *42CFR438.404(c)(4) and 438.210(d)(2)(ii)* Contract: II.F.10, 10CCR2505—10, Section 8.209.4.A.3.c	**Description of Process:** BHI's NOA policy outlines the process and procedure for requesting and receiving an extension for making a service authorization decision. The written notice provides the member with the reason for the decisions to extend the timeframe, and the members' right to file a grievance should they disagree. BHI carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires. **Evidence of Compliance:** UM-810 Notice of Action (pg. 5, E.)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The NOA policy stated that the member will be notified in writing of the decision to extend the time frame no later than 10 days from the original request and adequately addressed the other elements specified in the requirement. The UM Decision Timelines policy stated that the member will be notified in writing of the decision to extend either a standard or expedited authorization, and that such notice will include the reason for the extension and the member's right to file an *appeal* if he or she disagrees with the extension decision. The extension of the authorization timeline in not an action; therefore, the member has no right to appeal in this circumstance but may file a grievance. Denial records reviewed on-site included five cases with extensions in which the member's written notice did not inform the member of the right to file a grievance.		
Required Actions: BHI must revise its policies to accurately inform the member of the right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame, and must ensure that the member is informed, via the written notice of extension, of the right to file a grievance if the member disagrees with the decision.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
17. The Contractor has in place and follows written policies and procedures that provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42CFR438.210(e)* Contract: II.I.1.c.	**Description of Process:** BHI does not offer incentives of any kind for individuals or entities conducting UM functions to limit, discontinue, or deny medically necessary services to any member. **Evidence of Compliance:** 2013-2014 Utilization Management Program Description (pg. 5) Corporate Compliance Plan (pg. 9) BHI Member and Family Handbook (pg. 33)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. ◆ Serious impairment to bodily functions. ◆ Serious dysfunction of any bodily organ or part. *42CFR438.114(a)* Contract: I.A.12	**Description of Process:** BHI appropriately and accurately defines emergency medical condition in our policy as well as in the Member and Family handbook. **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 1, A.) BHI Member and Family Handbook (pg. 15) 2013 BHI Provider Manual (pg. 11)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
19. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition. *42CFR438.114(a)* Contract: II.A.13	**Description of Process:** BHI appropriately and accurately defines emergency services in our policy as well as in the Member and Family Handbook. **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 3, B. III) BHI Member and Family Handbook (pgs. 15-18)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42CFR438.114(c)(1)(i)* Contract: II.D.6.a.1	BHI's policy and procedures, as well as member materials, ensure payment of medically necessary Emergency Services, regardless of whether the provider has a contract with BHI. **Evidence of Compliance** UM-818 Emergency and Post Stabilization Services (pg. 2, IV, 1.A.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor does not require prior authorization for emergency services. *42CFR438.10(f)(6)(viii)(B)* Contract: II.I.1.p.1.	**Description of Process:** BHI's contracts with hospitals and other emergency services providers clearly state that prior service authorization is not required for coverage and payment of Emergency Services. The BHI Member and Family Handbook and the Provider Manual informs members and providers that a prior service authorization is not required for Emergency Services. **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 2, A, 1. E). 2013 BHI Provider Manual (pg. 12) BHI Member and Family Handbook (pgs. 16 and 17)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
22. The Contractor may not deny payment for treatment obtained under the following circumstances: ◆ A member had an emergency medical condition, and the absence of immediate medical attention would ***have*** had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. ◆ Situations which a reasonable person outside the medical community would perceive as an emergency medical condition but the absence of immediate medical attention would ***not*** have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. ◆ A representative of the Contractor's organization instructed the member to seek emergency services. *42CFR438.114(c)(1)(ii)* Contract: II.D.6.a.2.	**Description of Process:** BHI's policies and procedures prohibit the denial of payment for treatment obtained by the member under the specific circumstances defined in 42 CFR 438.114 (c) (1) (ii). **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 2, IV, B.) BHI Member and Family Handbook (pgs. 9, 15-19)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
23. The Contractor does not: ◆ Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42CFR438.114(d)(1)* Contract: II.D.6.b.	**Description of Process:** BHI's policy and procedures prohibit the restriction of Emergency Medical Conditions based on a list of diagnoses or symptoms. **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 2, IV, B. a)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. The Contractor will be responsible for Emergency Services when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. Contract: II.D.6.i.2.	**Description of Process:** BHI is responsible for Emergency Services when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures that treat a secondary medical diagnosis. **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
25. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42CFR438.114(d)(2)* Contract: II.D.6.c.	BHI's policies and procedures ensure that members are not billed for Emergency and/or Post-Stabilization Care Services, pursuant to 42 CFR 438.114 (d) (2). BHI's Member and Family Handbook inform members that Emergency Services are free of charge to them. **Evidence of Compliance?** UM-818 Emergency and Post-Stabilization Services (pg. 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
26. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42CFR438.114(d)(3)* Contract: II.D.6.d.	**Description of Process:** BHI defers to the attending emergency physician or treating provider in determining when the member is stabilized for transfer or discharge, pursuant to 42 CFR 438.114 (d) (3). The process of emergency evaluation of a Medicaid member is a collaboration between the member, emergency services clinician, Emergency Department (ED) attending physician, family and other collateral contacts involved in emergency response. This process includes a thorough review of the member's condition, safety needs, preferences of the member and/or family, availability of community based resources that can safely and effectively meet the member's immediate needs for treatment and stabilization, and medical necessity criteria for level of care. Ultimately, the decision about post-stabilization care is the responsibility of the emergency room physician and provider, but is conducted with a thoughtful review of all available, relevant information from involved informants. **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 2, IV, A. 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
27. The Contractor defines Post-stabilization Care as covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42CFR438.114(a)* Contract: II.A.32.	**Description of Process:** BHI's definition of Post-Stabilization Care Services is consistent with the language found in 42 CFR 438.114 (a). The Emergency Services clinician evaluates Member's progress through clinical interview, which includes risk assessment, and mental status examinations to ensure no suicidal or homicidal ideation, plan or intent exist and that consumer does not meet criteria for grave disability. Emergency Services clinicians consult with the Emergency Department (ED) attending physician and nurse regarding clinical impressions and recommendations based on their assessment. As stated above the attending physician or treating provider shall make the final determinations of when member is stabilized for transfer or discharge. **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 1, III, C.) BHI Member and Family Handbook (pgs. 17 and 33)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
28. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42CFR438.114(e)* *42CFR422.113(c)* Contract: II.D.6.e.	**Description of Process:** BHI is responsible for payment of post-stabilization services when BHI has authorized such services. **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 3)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
29. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances: ◆ Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. ◆ The Contractor does not respond to a request for pre-approval within 1 hour. ◆ The Contractor cannot be contacted. ◆ The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached, or the Contractor's financial responsibility for poststabilization care services it *has not* pre-approved ends. *42CFR438.114(e)* *42CFR422.113(c)* Contract: II.D.6.f.1–3.	**Description of Process:** BHI's policy 818 clearly defines the contractor's responsibility for financial responsibility of post stabilization. **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 2 a-d)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post Stabilization Services policy defined the responsibility for payment of poststabilization services in network or out of network when the services have been pre-approved or when any of the above circumstances occur. During the on-site review, UM staff stated that if the UM staff member and the attending physician do not agree on the need for post-emergency inpatient admission, the physician is offered an opportunity to consult with the BHI medical director.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The Admission and Continued Stay Authorizations and Census Tracking policy stated that when a member presents at a hospital emergency facility, the facility contacts BHI and an emergency services clinician is dispatched to evaluate the member and may authorize inpatient hospitalization (poststabilization care). The policy states that, "If there is a disagreement after-hours, the emergency department may choose to admit the patient with the hope that BHI will retro-authorize the next day or may choose to place the patient in observation status with BHI review in the morning." This process is not in compliance with regulations.		
Required Actions: BHI must clarify its policy and procedures to ensure that if the BHI representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation (i.e., after hours), the BHO must allow for contact between the treating provider and the BHO medical director or physician designee, and the BHO must pay for the services until one of these circumstances occurs—a BHO physician assumes responsibility for the member's care, the treating physician and BHO reach an agreement, or the member is discharged.		
30. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when: ◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care. ◆ A plan physician assumes responsibility for the member's care through transfer. ◆ A plan representative and the treating physician reach an agreement concerning the member's care. ◆ The member is discharged. *42CFR438.114(e)* *42CFR422.113(c)* Contract: II.D.6.g.	**Description of Process:** BHI responsibility for post-stabilization care services it has not pre-approved ends when a BHI plan physician with privileges at the treating hospital assumes responsibility for the member's care, a BHI plan physician assumes responsibility for the member's care through transfer; a BHI representative and the treating physician reach an agreement concerning the member's care; or the member is discharged. These decisions are reached in collaboration between the Member, ED attending physician, emergency services clinician, and others involved in the emergency response. **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 3, 2.e)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
31. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42CFR438.114(e)* *42CFR422.113(c)* Contract: II.D.6.f.4.	**Description of Process:** BHI does not charge members for post-stabilization care services. **Evidence of Compliance:** UM-818 Emergency and Post Stabilization Services (pg. 2, IV. 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	25	X	1.00	=	25
	Partially Met	=	5	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	25

Total Score ÷ Total Applicable	=	81%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains a comprehensive provider network capable of serving the behavioral health needs of all members in the Medicaid Program, including any new populations. *42CFR438.206(b)(1)* Contract: II.E.1.c.1.	**Description of Process:** BHI has an established network of highly qualified behavioral health professionals that provide the full array of state plan services and Alternative/B-3 services. Inpatient psychiatric care is provided by 17 private and public hospitals. Community-based services for both adults and youth include residential care, individual, group and family therapy, psychiatric services and medication management, emergency services, and cases management. Specialized services for children and families include in-home and school based treatment. BHI's network includes providers from a broad range of cultural and ethnic backgrounds, clinical specialties, and experience working with members with complex co-occurring medical, substance use and developmental disability, and other complex diagnoses. In FY12, the BHI Contracted Provider Network (CPN) had 997 providers serving approximately 160,000 covered lives. In FY13, the BHI CPN has grown to 1,181 providers serving approximately 180,000 Medicaid eligible members. **Evidence of Compliance:** QI-704 Network Adequacy (whole document) BHI FY13 Annual Quality Report (pgs. 10-12) Annual Network Adequacy Report FY13 (whole document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated Medicaid enrollment. ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. *42CFR438.206(b)(1)(i) through (v)* Contract: II.E.1.c.1.	**Description of Process:** BHI methodically and regularly evaluates network adequacy and adjusts for needs. Data comes from many sources, including: • Trend analysis of Single Case Agreements • Assessment of access times to ensure providers are able to remain well within standards • Member input through the grievance and appeal process, focus groups, member and provider committees and member comments to providers • Provider feedback • Quarterly analysis of demographic data and trends • Regular tracking of special population needs The Director of Provider Relations and the executive management team at BHI monitor the input continuously. Additionally, BHI's core mental health centers are required, as part of their contract with BHI, to expand capacity whenever necessary to assure adequate access for any BHI member. **Evidence of Compliance:** QI-704 Network Adequacy (pg. 1, IV, A, 3 and 5) BHI FY13 Annual Quality Report (pgs. 10-12) Annual Network Adequacy Report FY13 (whole document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor has a network plan and it, at a minimum, addresses the following: ◆ The numbers, types, and specialties of providers required to furnish the contracted Medicaid services, including care coordination. ◆ The number of network providers accepting/not accepting new Medicaid members. ◆ The geographic location of providers in relationship to where Medicaid members live. ◆ The potential physical barriers to accessing providers' locations. ◆ The cultural and language expertise of providers. ◆ Provider-to-member ratios for behavioral health care services. *42CFR438.206(b)(1)(i) through (v)* Contract: II.E.1.c.1.i–vi.	**Description of Process:** BHI annually evaluates the adequacy of the BHI provider network, including the following aspects of the network: the geographic distribution, cultural specialties, the availability of services in languages other than English, and the array of providers that provide services across all contractually required State Plan and Alternative/B-3 services. BHI has concluded that our provider network is more than sufficient to meet the needs of BHI's Medicaid membership. Recognizing that membership is likely to increase in the future due to changes in eligibility requirements and health care reform efforts, BHI will continue to monitor and respond to changes in geographic distribution of members and cultural and ethnic mix of our membership. **Evidence of Compliance:** QI-704 Network Adequacy (pgs. 1 and 2) BHI FY13 Annual Quality Report (pgs. 10-12) Annual Network Adequacy Report FY13 (whole document) Additional Documents Submitted On-site: FY13Q1 Network Adequacy---Network Availability	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor ensures that its members have access to a provider within 30 miles or 30 minutes travel time, whichever is larger, to the extent, such services are available. Contract: II.E.1.a.8.	**Description of Process:** BHI analyzes the Medicaid member outliers and provider locations on a quarterly basis. The analysis of the 4th quarter for FY13 continues to show that less than 1% of BHI's total Medicaid membership of Medicaid eligible members continues to reside outside the Metro East service area. These members are within an average of 47.93 miles of a contracted provider, which includes the locations of all mental health center treatment sites across the state. This average is an improvement over the Q3 average of 53.42 miles. In FY13 Q4, BHI had 168 members located outside the 30-mile radius of a provider. This is a slight increase from	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Q3of 144 members outside the 30-mile radius. BHI is committed to providing members an adequate provider network and continues its work with Colorado Access in combining our networks to provide greater geographic accessibility to our Medicaid membership. **Evidence of Compliance:** QI-704 Network Adequacy (pg. 1, IV, A. 1; pg. 2, B.) Annual Network Adequacy Report FY13 (whole document) BHI Network Adequacy Report FY13 Q4 (whole document)	
5. The contractor offers to contract with essential community providers located in the Contractor's geographic service area, as defined in Section 25.5-5-404(2) C.R.S. The Contractor's network shall include both essential community providers and other private/non-profit providers, thus allowing members choice and facilitating continuity of care. Contract: II.E.1.c.2.	**Description of Process:** BHI has a commitment to treat members as partners in the therapeutic relationship. Choice of providers is essential to fulfilling that commitment. Toward that goal, BHI has an extensive network of providers. BHI will negotiate a contract or single case agreement with a provider requested by a member or family member so long as the provider meets minimum BHI credentialing and quality-of-care requirements and agrees to BHI rates. A Care Coordinator is assigned to every case to ensure that services are well coordinated, effective, and consistent with member-stated preferences and identified clinical needs. **Evidence of Compliance:** 2013 BHI Provider Manual 2013 (pg. 36) BHI Member and Family Handbook (pg. 20) QI-704 Network Adequacy (pg. 3, D.) BHI FY13 Annual Quality Report (pgs. 10-12) Annual Network Adequacy Report FY13 (whole document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
6. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. *42CFR438.206(b)(3)* Contract: II.E.1.a.12.	**Description of Process:** UM policy 812 clearly defines the process in which psychiatric consults and or second opinions (inside or outside the BHI network) are available to members at no charge. **Evidence of Compliance:** UM-812 Psychiatric Consultations Second Opinions (whole document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network at no cost to the member for as long as the Contractor is unable to provide them. *42CFR438.206(b)(4)* Contract: II.E.1.c.3. and II.E.1.d.1.	**Description of Process:** BHI is able to offer a Single Case Agreement to out of network providers to provide services to members who are unable to utilize an in-network provider for various reasons. Single Case Agreements are offered to providers in instances where a) medically necessary services cannot be provided by BHI's provider network or b) a member identifies a qualified provider of choice that is not a part of the BHI network. BHI currently has 135 single case agreements. **Evidence of Compliance:** CRED-401 Out of Network Providers – Single Case Agreements (whole document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor coordinates with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42CFR438.206(b)(5)* Contract: II.E.1.d.2.	**Description of Process:** All providers under a Single Case Agreement are expected to comply with BHI policies regarding prior authorization, timely filing of claims, corporate compliance requirements, and member rights and responsibilities. **Evidence of Compliance:** CRED-401 Out of Network Providers – Single Case Agreements (whole document) BHI Single Case Agreement Contract 01-01-2013 (pgs. 6-8)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary. *42CFR438.206(c)(1)(iii)* Contract: II.E.1.a.5.	**Description of Process:** The BHI provider network offers emergency services 24 hours a day, 7 days a week, and 365 days a year. A member, family member, provider, or advocate can call BHI or 24 hours a day, 7 days a week for emergency or non-emergency situations, clinical assessment, and/or referral to a provider. This information is communicated to members through the Member and Family Handbook. **Evidence of Compliance:** UM-801 Access and Availability (pg. 3) BHI Member and Family Handbook (pg. 12)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members. *42CFR438.206(c)(1)(ii)* Contract: II.E.1.a.4.	**Description of Process:** It is a contractual requirement that all BHI providers maintain hours of operation that are comparable to those offered to Medicaid fee-for-service, Medicare, or other commercial plan members. **Evidence of Compliance:** UM-801 Access and Availability (pg. 2) Provider Contract Template (pgs. 4-5)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Emergency services are available: • By phone, including TTY accessibility, within 15 minutes of initial contact. • In person within one hour of contact in urban and suburban areas. • In person within two hours of contact in rural	**Description of Process:** All providers are expected to comply with BHI policies and procedures including access and availability standards. BHI's access and availability requirements are listed in the BHI Provider Manual. Providers are reminded of these standards through mechanisms such as the Provider Bulletin. **Evidence of Compliance:** UM-801 Access and Availability (pg. 2, IV, B.) 2013 BHI Provider Manual (pgs. 11-12)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
and frontier areas. ◆ Urgently needed services are provided within 24 hours from the initial identification of need. ◆ Routine services are available upon initial request within 7 business days. (Routine services include but are not limited to an initial individual intake and assessment appointment. Placing members on waiting lists for initial routine service requests is not acceptable.) ◆ Outpatient follow-up appointments within 7 business days of an inpatient psychiatric hospitalization or residential facility. *42CFR438.206(c)(1)(i)* Contract: II.E.1.a.6 and 7	Provider Bulletin Volume 1 Issue 1 (pg. 3)	
12. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access. *42CFR438.206(c)(1)(iv) through (vi)* Contract: II.E.1.a.9–11	**Description of Process:** BHI has several mechanisms in place to monitor compliance with Access to Care Standards. Each of BHI's core community mental health centers submit quarterly aggregate data for each of the above Access to Care standards to the BHI Quality Improvement Department. This data is reported to the Department of Health Care Policy and Financing and reported through the BHI Performance Report Card. If a community mental health center falls below identified benchmarks, corrective action plans are required and monitored until compliance has been met. BHI has also recently contracted with MarketPower Enterprises, one of the nation's only behavioral health "secret shopper" companies in order to effectively monitor a larger number of CPN provider and community mental health center compliance with Access to Care standards. Any non-compliance will require	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	corrective action. The results of BHI's previous "secret shopper" calls can be found in the NCQA Access to Care Report. BHI also monitors member perception of access to care through analysis of grievances and member satisfaction surveys, and takes action if a pattern of non-compliance emerges. The results of these analyses can be found in the NCQA Access to Care Report. **Evidence of Compliance:** UM-801 Access and Availability (pg. 3, V.) NCQA Access to Care Report (whole document) BHI Performance Report Card FY14 Q1 (pgs. 3-6) Signed MarketPower Contract (whole document) Additional Documents Submitted On-site: Admhn cap q3 completed Admhn cap response letter Admhn fy13 q3 cap letter Aumhc cap q3 completed Aumhc cap response letter Aumhc fy13 q3 cap letter Crc cap q3 completed Crc cap response letter Crc fy13 q3 cap letter 5-10-13 peo minutes	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
13. The Contractor has developed policies and procedures for monitoring the performance of providers on an ongoing basis related to the timeliness of services, and has monitored providers annually to determine compliance. Contract: II.G.10.a.3, II.G.10.a.4, Exhibit S, IV.A	**Description of Process:** BHI's procedures for monitoring the timeliness of services delivery is outlined in the BHI policy UM-801 Access and Availability. Each of the monitoring mechanisms outlined above (in Response #12) are reported and analyzed in the NCQA Access to Care Report. **Evidence of Compliance:** UM-801 Access and Availability (pg. 4) NCQA Access to Care Report (whole document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by: ◆ Developing, implementing, and promoting a written strategic Cultural Competency Plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services. ◆ Maintaining policies that support the provision of health care services that respect individual health care attitudes, beliefs, customs and practices of members related to cultural affiliation. ◆ Having sufficient cultural competency staff to implement and oversee compliance with the Contractor's Cultural Competency Plan, policies, and contract requirements and to oversee compliance with all cultural competency requirements and limited English proficiency needs. ◆ Making a reasonable effort to identify members	**Description of Process:** BHI strives to be a leader in innovating and promoting the culture of recovery and fostering supportive attitudes and practices within the communities we serve. BHI's policies, procedures, Provider Manual, Member and Family Handbook, and the Cultural Competency Plan detail and describe this organizational commitment. The Cultural Competency Committee oversees compliance with the Cultural Compliance Plan and includes diverse membership of BHI staff, network providers, members, and community partners. The BHI policy ADM-119 outlines the procedures for providing verbal or written materials for members with limited English proficiency. Each member mailing notes how to access materials in Spanish and Large Print. Member handbooks are available in Spanish and Large print. BHI also translates any member information to any language at the request of a member, as explained in the Member and family Handbook. BHI also outreaches members whose cultural norms may affect their access to healthcare. The Outreach Flyers show some examples of this – information about the Bienvenido program, information about the Child and Family Resource Day (translated into Spanish), etc.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
whose cultural norms and practices may affect their access to health care. Such efforts may include: • Inquiries conducted by the Contractor of the language proficiency of members during the Contractor's orientation calls. • Being served by participating providers. • Improving access to health care through community outreach and Contractor publications. ◆ Developing and/or providing cultural competency training programs, as needed, to the network providers and Contractor staff regarding: • Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. • The medical risks associated with the client population's racial, ethnic, and socioeconomic conditions. ◆ Making a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse, and culturally competent clinical providers that represent the racial and ethnic communities being served. ◆ Providing access to interpretive services by a qualified interpreter for deaf or hard of hearing members in such a way that it promotes accessibility and availability of covered services. ◆ Providing to members in their preferred language verbal offers and written notices, upon request, informing them of their rights to receive language assistance services. ◆ Materials, including member handbook,	These flyers are posted at local schools, coffee shops, and community centers to encourage access to behavioral health services. Our service network provides professionals who have competencies in serving diverse communities. The NCQA Cultural Needs and Preferences Report demonstrates the diverse cultural specialties and linguistic capabilities of the BHI provider network. BHI and the Cultural Competency Committee are in the process of developing a network-wide training for Spring 2014. Please reference the Cultural Competency Minutes 10-4-13 for details. Per the Cultural Competency Plan, BHI hopes to develop semi-annual trainings for both BHI staff and the entire provider network. **Evidence of Compliance:** QI-703 Culturally Appropriate and Competent Services (whole document) ADM-119 Communication with Persons with Limited English Proficiency (whole document) FY14 BHI Cultural Competency Plan (whole document) Cultural Competency Committee Description FY14 (whole document) Cultural Competency Minutes 10-4-13 (whole document) Outreach Flyers (whole document) NCQA Cultural Needs and Preferences Report (whole document) 2013 BHI Provider Manual (pg. 6) BHI Member and Family Handbook (pg. 14) BHI Member and Family Handbook – Spanish BHI Member and Family Handbook – Large Print	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
correspondence, and newsletters. Written member information and correspondence shall be made available in languages spoken by prevalent non-English-speaking member populations within the Contractor's service area. ◆ Providing language assistance services, including bilingual staff and interpreter services, at no cost to any member with limited English proficiency at all points of contact, in a timely manner during all hours of operation. ◆ Ensuring the competence of language assistance provided to limited English proficient members by interpreters and bilingual staff. Family and friend should not be used to provide interpretation services (except on request by the member). ◆ Making available easily understood member-related materials and posting signage in the languages of the commonly encountered groups and/or groups represented in the service area. ◆ Developing policies and procedures, as needed, on how the contractor responds to requests from participating providers for interpreter services by a qualified interpreter. ◆ Ensuring that when providing or arranging for the provision of all medically necessary covered behavioral health services that they are linguistically and culturally accessible to all members, including racially and ethnically diverse communities, the disability community, and deaf and hard of hearing members. ◆ Addressing the language and cultural expertise of providers in the network plan.	Additional Documents Submitted On-site: Mental Health Assessment Template	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
◆ Evaluating members' cultural and linguistic needs in the individual needs assessment and using information gathered (regarding cultural and linguistic needs) in the service plan. *42CFR438.206(c)(2)* Contract: II.E.1.c.1.v; II.F.4.j.3.iv; II.F.7.d.1; II.F.7.d.8; and II.F.9.a; II.I.9; Exhibit N, I.A.4		
15. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor uses tools including member surveys, anecdotal information, and grievance and appeals data. Contract: II.H.2.m.1	**Description of Process:** In addition to quarterly data collection and "secret shopper" assessment of BHI provider compliance with Access to Care standards, BHI also assesses member perception of the accessibility and adequacy of services across the BHI network. Detailed analysis of grievance and appeal data (performed annually) and Member satisfaction survey responses is presented in both the NCQA Member Satisfaction Report and the NCQA Access to Care Report. **Evidence of Compliance:** NCQA Member Satisfaction Report FY13 (whole document) NCQA Access to Care Report (whole document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	15

Total Score ÷ Total Applicable	=	100%

Appendix B. Record Review Tool *for* Behavioral Healthcare, Inc.

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Behavioral Healthcare, Inc.

Review Period:	January 1, 2013–December 31, 2013
Date of Review:	January 30, 2014
Reviewer:	Kathy Bartilotta and Rachel Henrichs
Participating Plan Staff Member:	Brian Hemmert and Jessie Nelson

Requirement	File 1	File 2	File 3	File 4	File 5
1. Member ID	*******	*******	*******	******	*******
2. Date of initial request	12/27/12	1/3/13	1/3/13	1/25/13	1/16/13
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR	NR	NR	NR	NR
4. Standard (S) or Expedited (E)	S	S	S	S	S
5. Date notice of action sent	1/7/13	1/14/13	1/9/13	2/1/13	2/15/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	11	11	6	7	Decision (2 days); NOA (19 days)
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	NC	C	C	C
9. Was authorization decision timeline extended? (Y or N)	Y	N	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	C	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NC	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	C	C	C	C	C
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C	C	C	C
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	8	6	6	6	6
Total Compliant Elements	7	5	6	6	6
Score (Number Compliant / Number Applicable) = %	88%	83%	100%	100%	100%

C = Compliant; NC = Not Compliant (scored items)
Y = Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Bus = Business; Cal = Calendar

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Behavioral Healthcare, Inc.

Requirement	File 6	File 7	File 8	File 9	File 10
1. Member ID	*******	*******	*******	******	*******
2. Date of initial request	2/8/13	2/18/13	3/6/13	3/26/13	4/11/13
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR	NR	NR	NR	NR
4. Standard (S) or Expedited (E)	S	S	S	S	S
5. Date notice of action sent	2/19/13	2/28/13	3/15/13	4/2/13	4/24/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	11	10	9	7	13
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	NC	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	Y
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	C
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NC
10. Notice of Action includes required content? (C or NC)	C	C	C	C	C
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C	C	C	C
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	C	NA	C	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	6	7	6	7	8
Total Compliant Elements	5	7	6	7	7
Score (Number Compliant / Number Applicable = %)	83%	100%	100%	100%	88%

C = Compliant; NC = Not Compliant (scored items)
Y = Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Bus = Business; Cal = Calendar

Requirement	File 11	File 12	File 13	File 14	File 15
1. Member ID	*******	*******	*******	******	******
2. Date of initial request	5/2/13	4/30/13	5/17/13	5/20/13	9/30/13
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR	NR	NR	NR	NR
4. Standard (S) or Expedited (E)	E	S	S	S	E
5. Date notice of action sent	5/7/13	5/14/13	6/3/13	6/12/13	9/30/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	NC
7. Number of days for decision/notice	3	14	17	23	1
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	Y	Y	Y	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	C	C	C	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NC	NC	NC	NA
10. Notice of Action includes required content? (C or NC)	C	C	C	C	C
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C	C	C	C
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	6	8	8	8	6
Total Compliant Elements	6	7	7	7	5
Score (Number Compliant / Number Applicable = %)	100%	88%	88%	88%	83%

Comments:

Records # 1, 10, 12, 13, and 14 included an extension notification, but the extension letter did not include the member's right to file a grievance if the member did not agree with the extension.

Records #2 and 6: The notice of action letters were mailed to the member more than 10 days after the request for services without BHI having sent an extension letter.

Record # 5: The denial decision was made within the required time frame, but the notice of action letter could not be mailed until the health plan identified the court-appointed guardian. The health plan attempted to identify the guardian on two occasions within the time frame for the notice of action. Therefore, the case was scored as compliant for the NOA within the required time frame (Criteria # 8).

Record #15: The notice of action was sent only to the requesting provider, not the member.

Total Record Review Score	Total Applicable Elements: 102	Total Compliant Elements: 94	Total Score: 92%

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Bus = Business; Cal = Calendar

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

Table C-1 lists the participants in the FY 2013–2014 site review of **BHI**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
BHI Participants	**Title**
Brian Hemmert	Director QI/UM
Roger Gunter	Chief Operating Officer
Jessie Nelson	Quality Improvement Project Manager
Shelly Spalding	Chief Executive Officer
Beth Tarasenko	Director of Compliance
Nathan Wagner	HR Director
Scott Utash	OMFA Director
Jennifer Lacov	Chief Financial Officer
Laura Hill	Director of Wellness, Outreach & Education
Teresa Summers	Director of Provider Relations
Chuck Griffo, RN	UM/Care Manager
Emily Schrader	UM/Care Manager
Department Observers	**Title**
Russell Kennedy	Quality and Health Improvement Unit

Appendix D. Corrective Action Plan Template for FY 2013–2014 *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 compliance site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification to HSAG and the Department. The BHO must submit the CAP using the template provided. For each element 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 health care regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2013–2014 Corrective Action Plan *for* BHI		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
10. The Contractor has in place and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).	One of 15 denial records reviewed on-site did not include documentation that the member was notified of BHI's denial for continued inpatient care. BHI only notified the requesting provider.	BHI must ensure that the member is notified in writing of any decision to deny a service authorization.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-2—FY 2013–2014 Corrective Action Plan *for* BHI		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
12. The notices of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the time frames specified in 431.211: • The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist. ◆ For denial of payment, at the time of any action affecting the claim. ◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. ◆ For service authorization decisions not reached within the required time frames on the date time frames expire. ◆ For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 business days after receipt of the request for services.	The provider manual stated that expedited decisions are made within 3 calendar days. The UM Program Description stated that standard authorization decisions are made within 7 calendar days. While these statements are not out of compliance, they are inconsistent with BHI's policy statements and should be revised for consistency with BHI's policy. BHI did not send the notice of action (NOA) within the required 10-day time frame and did not file an extension of the authorization time frame for two of the 15 denial records reviewed on-site.	BHI must ensure that NOAs are sent within the required time frame unless the member requests an extension or BHI has sent a notice to extend the determination time frame.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-2—FY 2013–2014 Corrective Action Plan *for* BHI		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
13. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area).	The sample English version of the NOA contained a statement in Spanish informing the member how to request a copy in Spanish, and it also stated that the member may request large print or audio tape. Denial record reviews included NOAs that were written in easy-to-understand language in all cases. However, the revised NOA template letter contained language citing specific rules and regulations by number and State or federal guideline references in the body of the letter. During on-site interviews, staff members confirmed that the NOA had been revised in late 2013 and explained that the regulatory references had been added to the letter based on advice from administrative law judges during State fair hearings.	BHI must remove the technical language citing State or federal regulations from the main body of the member's NOA letter to ensure ease of understanding by the member.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-2—FY 2013–2014 Corrective Action Plan *for* BHI		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. The Contactor may extend the authorization decision time frame if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. The Contractor's written policies and procedures include the following time frames for possible extension of time frames for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days.	The NOA policy described processes for the community mental health centers (CMHCs) to extend the authorization time frames. In addition, the policy stated that the CMHCs may request an extension "to allow adequate time for BHI to conduct its clinical review." Denial record reviews included five cases of extensions granted on or near the date of the initial request for authorization, and the reason described in the member extension notification referred to allowing enough time for BHI to process the request. During on-site discussions, staff members stated that these extensions were processed by the CMHCs prior to the date of de-delegation of UM.	BHI must ensure that if BHI extends the authorization decision time frame, it is in the member's interest, rather than a convenience for the BHO, and BHI must ensure that it is able to justify the need for the extension (upon request of the Department).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-2—FY 2013–2014 Corrective Action Plan *for* BHI		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
16. If the Contractor extends the time frame for making a service authorization decision, it: ◆ Provides the member written notice of the reason for the decision to extend the time frame. ◆ Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. ◆ Carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	The UM Decision Timelines policy stated that the member will be notified in writing of the decision to extend either a standard or expedited authorization, and that such notice will include the reason for the extension and the member's right to file an *appeal* if he or she disagrees with the extension decision. The extension of the authorization timeline in not an action; therefore, the member has no right to appeal in this circumstance but may file a grievance. Denial records reviewed on-site included five cases with extensions in which the member's written notice did not inform the member of the right to file a grievance.	BHI must revise its policies to accurately inform the member of the right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame, and must ensure that the member is informed, via the written notice of extension, of the right to file a grievance if the member disagrees with the decision.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-2—FY 2013–2014 Corrective Action Plan *for* BHI		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
29. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances: ◆ Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. ◆ The Contractor does not respond to a request for pre-approval within 1 hour. ◆ The Contractor cannot be contacted. ◆ The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached, or the Contractor's financial responsibility for poststabilization care services it *has not* pre-approved ends.	The Admission and Continued Stay Authorizations and Census Tracking policy stated that when a member presents at a hospital emergency facility, the facility contacts BHI and an emergency services clinician is dispatched to evaluate the member and may authorize inpatient hospitalization (poststabilization care). The policy states that, "If there is a disagreement after-hours, the emergency department may choose to admit the patient with the hope that BHI will retro-authorize the next day or may choose to place the patient in observation status with BHI review in the morning." This process is not in compliance with regulations.	BHI must clarify its policy and procedures to ensure that if the BHI representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation (i.e., after hours), the BHO must allow for contact between the treating provider and the BHO medical director or physician designee, and the BHO must pay for the services until one of these circumstances occurs—a BHO physician assumes responsibility for the member's care, the treating physician and BHO reach an agreement, or the member is discharged.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol 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' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	◆ HSAG attended the Department's Behavioral Health Quality Improvement Committee (BQuIC) meetings and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the request for desk review documents 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 two standards and on-site activities. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site 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. The BHOs also submitted a list of all Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. HSAG used a random sampling technique to select records for review during the site visit. ◆ 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 3:	**Conduct Site Visit**
	◆ 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. ◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to BHO service and claims denials and notices of action.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ Also while on-site, 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 confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with BHO staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	◆ HSAG used the FY 2013–2014 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. ◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	◆ HSAG populated the report template. ◆ 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.