COLORADO
Department of Health Care Policy & Financing

FY 2014–2015 Site Review Report Executive Summary

for

Behavioral Healthcare, Inc.

April 2015

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

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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 healthcare regulations and managed care contract requirements. The Department of Health Care Policy & 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 fiscal year (FY) 2014–2015 site review activities for the review period of January 1, 2014, through December 31, 2014. 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 four 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 2014–2015 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2013–2014 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 grievance and appeals 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 2014–2015 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 healthcare regulations.

Table 1-1 presents the scores for **Behavioral Healthcare, Inc.** (**BHI**) for each of the standards. Findings for all *Met* requirements 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)
V Member Information	20	20	19	1	0	0	95%
VI Grievance System	26	26	19	7	0	0	73%
VII Provider Participation and Program Integrity	14	14	12	2	0	0	86%
IX Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals	**66**	**66**	**56**	**10**	**0**	**0**	**85%**

Table 1-2 presents the scores for **BHI** for the grievances and appeals 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)
Grievances	50	30	30	0	20	100%
Appeals	60	57	42	15	3	74%
Totals	**110**	**87**	**72**	**15**	**23**	**83%**

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

BHI's Member and Family Handbook (member handbook) provided well-organized information to assist members in understanding the behavioral health managed care program and how to obtain services through **BHI**. The member handbook was available in English and Spanish, and **BHI** had mechanisms in place to also provide the handbook in large print, audio tape, and other languages upon request. **BHI** had a telephone system that automatically transferred callers to the language line vendor when a caller chose the Spanish option in **BHI**'s interactive voice response system. In addition, **BHI**'s Office of Member and Family Affairs (OMFA) included a Spanish-speaking staff member.

The member handbook included a comprehensive description of covered benefits, including how and where to obtain emergency services, and included all other member handbook requirements. During the on-site interview, **BHI** staff members reported that they were developing a PowerPoint presentation for use at drop-in centers to help members understand **BHI** and its benefits and services. **BHI** also submitted postcard-sized quick reference cards that it used for community outreach. These quick reference cards were distributed at community health fairs, school-based clinics, and the diabetes fair. There were cards designed to provide information to potential members, and cards designed to help providers within the medical community and school-based health centers understand **BHI** and its services. **BHI** also offered Spanish versions of the cards. Members and providers were informed about member rights via the member handbook and provider manual, respectively, as well as member and provider newsletters. On-site, **BHI** staff members reported that **BHI** had recently engaged Colorado Access to distribute member welcome packets, and that **BHI** would monitor the Colorado Access activities via delegation oversight.

Summary of Findings Resulting in Opportunities for Improvement

BHI's annual member letter included the required content; however, HSAG recommended that **BHI** revise the letter to make the statement that members may request and obtain a member handbook more prominent.

BHI's website contained all required elements; however, not all items could be found easily. The list of member rights and information about grievances and appeals were located in the handbook, which was posted on the website under the Member Resources link. **BHI**'s Grievance Procedure policy and Appeal Procedure policy were both found under the For Providers link. HSAG recommended that **BHI** list separately or provide links to the member rights list and the grievance and appeal procedures under the Member Resources link.

Summary of Required Actions

BHI must send the privacy practices to members annually. **BHI** could consider including the content within one of the member newsletters or as an enclosure in the annual member letter.

Standard VI—Grievance System

Summary of Strengths and Findings as Evidence of Compliance

There was ample evidence that **BHI** had a well-defined process for responding to Medicaid member grievances and appeals. This process included assisting members with access to the State fair hearing process. **BHI**'s member handbook informed members that they may file grievances and appeals orally or in writing, and HSAG found evidence that **BHI** accepts grievances and appeals both orally and in writing. **BHI** maintained a grievance and appeal database and individual records, and reported grievances and appeals to the Department quarterly, as required. The on-site record review provided evidence that **BHI** staff members maintained communication throughout the process. Grievance resolution letters were easy to understand and addressed the member's concerns.

BHI's grievance and appeal processes included a mechanism to extend resolution dates if requested by the member or if **BHI** needed additional information to make the determination. **BHI** also had an expedited appeal process that included the required provisions. **BHI**'s member handbook included information about the process for members to request continuation of previously authorized services during the appeal or State fair hearing.

Summary of Findings Resulting in Opportunities for Improvement

There were no opportunities for improvement identified for this standard.

Summary of Required Actions

BHI's policies accurately defined "action"; however, in response to the statement found in Standard VI, Requirement 2 of the contract, "the failure to act within the time frames for grievances and appeals," **BHI** stated in its member handbook, "when we do not provide information to you within timelines required by the State." This statement in the handbook does not accurately inform members of the situation in which they may file an appeal (i.e., the BHO's failure to meet the time frame for resolution of grievances and appeals), and it also inaccurately alludes that members may file an appeal when no appeal right exists (e.g., when the time frame for sending the member handbook or an annual letter is not met). **BHI** must revise the member handbook section informing members when they may file appeals (i.e., actions) to accurately state that members may file an appeal when **BHI** fails to meet grievance and appeal resolution time frames.

BHI's notice of action letters accurately informed members of the time frames for filing appeals; however, the Appeal Procedure policy stated that for concurrent appeals (defined in the policy as requests to change actions that terminate a previously authorized course of treatment, typically associated with inpatient or residential services), the time frame for filing is 10 calendar days prior to the effective date of the action. **BHI** must revise applicable policies and procedures to clarify the following concepts:

- Not all concurrent reviews and appeals are associated with the termination of previously authorized services that are subject to the 10-day timely filing time frames. For example, if an

inpatient authorization expires and the member requests an extended stay, this is treated as a new request for service and is not subject to continuation of services and the 10-day timely filing requirements.

- The BHO must provide a 10-day advance notice for services that have been authorized; the member is receiving; and the BHO is proposing to terminate, suspend, or reduce prior to the expiration of the authorization. If the member files an appeal (or requests a State fair hearing) with a request that the services continue during the appeal or State fair hearing, the member must file within 10 days after the notice of action *or* before the intended effective date of the action, whichever is later (not *10 days prior to the effective date*). If the member does not request that the services continue during the appeal or State fair hearing, these timely filing requirements do not apply and the member has the full 30 days to file an appeal.

BHI's policies and the member handbook accurately stated that **BHI** will send an acknowledgement letter within two working days of the receipt of the appeal. During the on-site record review, HSAG found that five out of seven standard appeal records included documentation that a written acknowledgement was sent to the member within the two-working-day time frame. **BHI** must ensure that, for all standard appeals, a written acknowledgement is sent to the member and/or provider/designated client representative (DCR) within the two-working-day time frame.

BHI's policy stated, "post-service appeals, typically being claims appeals, are always processed in a 30-day timeframe," regardless of whether they are considered member or provider appeals. **BHI** must ensure that all member appeals (for claims appeals, those claims that were denied for substantive issues such as medical necessity, or related to whether the service was a covered benefit) are processed within the 10-working-day time frame as required by Colorado regulation at *10 CCR 2505-10, Section 8. 209.*

BHI's Appeal Resolution letters included the required continuation of benefits language; however, this language was confusing and inaccurate, as it addressed continuation of services during the "appeal or State fair hearing." The information also stated that the member must file the *appeal* within 30 calendar days of the notice of action letter if **BHI** *denies or limits* services and 10 calendar days of the letter if **BHI** reduces, suspends, or terminates a service the member was already receiving. **BHI** must clarify the Appeal Resolution template letters to clarify the following:

- The member has the right to request the continuation of the disputed services only in situations whereby the services have been authorized by **BHI** and the member has been receiving the services; **BHI** has provided the required 10-day advance notice of the termination, suspension, or reduction of the services; and the authorization has not yet expired. New requests for services are not subject to continuation requirements (i.e., since no services have started, there are no services to continue); therefore, the 30-day filing time frame should be removed from the discussion of continuation of services during the appeal or State fair hearing.
- Appeal resolution letters should refer only to continuation of the disputed services during the State fair hearing (and not offer timelines for filing an appeal), as at this point, the member has completed the appeal process.
- If a member has chosen to request continuation of services during the appeal/State fair hearing, and chooses to file the appeal and the State fair hearing concurrently, the member must file both (with the request for continuation) within 10 calendar days of the advance notice of action to

terminate, reduce, or suspend services, or before the intended effective date. If the member chooses to complete **BHI**'s internal appeal process first, then requests a State fair hearing with continuation of services during the State fair hearing, the member must file (with the request for continuation) within 10 days from the appeal resolution, if the limits of the original authorization have not expired.

During the on-site record review, HSAG found that **BHI** did not send a written notice of resolution for one of the three expedited appeals. One standard resolution letter was sent to the facility only (and not to the member), and two standard resolution letters did not include the date the resolution was completed (nor was the letter dated). Therefore, six of 10 records reviewed met the requirements for resolution notices containing the required content. In addition, four resolution letters reviewed did not meet the requirement that their content be easy to understand. The member-specific reason for the decision used words or phrases that were clearly above the sixth-grade reading level. **BHI** must ensure that Appeal Resolution letters include the required content, including the date the appeal was resolved, and are sent within the required time frames. **BHI** must also ensure that members are copied on all member appeal communication. If **BHI** chooses to copy the physician decision language directly into the member resolution letters, **BHI** must work with the physicians to use words and phrases at the sixth-grade reading level to the extent possible.

In one record reviewed on-site HSAG was unable to determine whether or not the individual who made the decision was involved in any previous level of review or had the appropriate clinical expertise to treat the member's condition. **BHI** must ensure that documentation exists to demonstrate that individuals who make appeal decisions have not been involved in any previous level of review and have the appropriate clinical expertise to treat the member's condition.

The **BHI** provider manual contained incomplete and inaccurate information regarding the grievance system requirements. The manual stated (1) if members are unhappy with the results of a grievance, they may request a State fair hearing; (2) member claims denials are resolved in 30 days (rather than 10 working days required by Colorado regulation); (3) concurrent appeals must be filed within 10 calendar days *prior* to the effective date of the action; and (4) an expedited appeal is a request to change a denial for urgent care. The section of the manual titled "Member Billing" stated, "A member may have to pay for services rendered if his/her appeal of a denial made by **BHI** is upheld through a local appeal or through a State Fair Hearing." In addition, the manual did not address the member's right to a State fair hearing following or concurrent with an appeal or the filing and representation rules for State fair hearings. The provider manual was also missing the toll-free number for filing grievances and appeals, the availability of assistance from **BHI** in filing grievances and appeals, and continuation of benefits information.

BHI must revise the provider manual to clarify the following:

- The second-level grievance review is with the Department contract manager and is not a State fair hearing.
- Member claims denials must be processed within the 10-working-day time frame required by Colorado regulations rather than a 30-day time frame.
- Not all appeals that are associated with a concurrent utilization review are subject to the 10-day timely filing requirements as stated in 42CFR438.420.

- Following is the 10-day timely filing requirement: For previously authorized services that **BHI** has proposed to terminate, suspend, or reduce, the member may request continuation of the disputed services during the appeal and/or State fair hearing if the member files the appeals and/or State fair hearing within 10 days of the date of the notice of action, or before the intended effective date, whichever is later.

In addition, **BHI** must clarify the definition of an "expedited appeal." Urgent care is not subject to prior authorization and therefore should not be denied during a utilization review. **BHI** must also clarify that the only circumstances under which a member may have to pay for the services if the appeal or State fair hearing decision is adverse to the member involves those services that were specifically continued in accordance with 42CFR438.420. Other final denials (e.g., claims denials related to provider procedural issues) may not result in members being held responsible for payment of services.

BHI must also include the following information in the provider manual:

- The member's right to file grievances and appeals.
- The requirements and time frames for filing grievances and appeals.
- The right to a State fair hearing:
  - The method for obtaining a State fair hearing.
  - The rules that govern representation at the State fair hearing.
- The availability of assistance in filing grievances and appeals, or requesting a State fair hearing.
- The toll-free numbers the member may use to file a grievance or appeal by telephone.
- When requested by the member:
  - Benefits will continue if the appeal or request for a State fair hearing is filed within the time frames specified for filing.
  - If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending, if the final decision is adverse to the member.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

All providers contracted with **BHI** were subject to its credentialing and recredentialing policies and procedures. **BHI** had delegated its individual provider credentialing activities to Colorado Access through its Administrative Service Organization Agreement. The credentialing policies and procedures were reviewed annually to ensure compliance with the National Committee for Quality Assurance (NCQA) standards. **BHI**'s policies and processes for conducting ongoing provider monitoring were well defined, although the robust amount of information examined for the chart audits limited the number of provider audits completed to between 10 and 15 providers per year. Corrective action plans were instituted for all providers scoring less than 9 percent on their provider chart audit. **BHI**'s policy for monitoring of provider sanctions included the application of corrective action plans for adverse events such as violations of **BHI**'s policies and regulations, and failure to achieve satisfactory utilization and quality standards. This policy outlined Colorado Access' and **BHI**'s respective responsibilities for monitoring and reporting **BHI**'s provider exclusions and sanctions. For example, Colorado Access monitors provider sanctions and exclusions monthly. For adverse events, **BHI** would determine and report a reduction in privileges, suspension, or termination for a provider accordingly. The provider contracts delineated the responsibilities and performance standards between **BHI** and its providers. The **BHI** provider contracts also required that members were not held liable for covered services.

Summary of Findings Resulting in Opportunities for Improvement

BHI included State law information about conscientious objection (language from the Colorado Medical Treatment Decision Act [C.R.S. 15-18-102]) requirements. Since **BHI** does not direct or provide medical care, **BHI** staff members stated that, as an organization, there are no treatments or procedures within **BHI**'s scope of work that it could not provide based on moral or religious objections. Given that **BHI**'s member handbook clearly stated that **BHI** will not deny services based on moral or religious grounds, HSAG recommended that **BHI** remove this statement from its advance directives policy to minimize any potential confusion for staff members.

Summary of Required Actions

Due to **BHI**'s extensive audit methodologies, the number of providers audited each year was limited. **BHI**'s processes examined outlier providers through monitoring for sanctions and adverse events. Additional proactive approaches to monitoring provider performance were not evident. Based on the information provided, there was no comprehensive oversight protocol in place to ensure that all providers were regularly monitored for compliance with contract requirements and agreements. **BHI** should enhance its provider monitoring and mechanisms to ensure that all providers' performance is monitored for compliance with contractual requirements as indicated in 42CFR438.230(b)(3). Aggregate monitoring activities include leveraging **BHI**'s existing data sources to identify providers appropriate for more targeted monitoring.

BHI must also develop more definitive policies and procedures for identifying potential fraud, waste, and abuse (FWA) with specific tools to identify and report suspected incidences of upcoding, unbundling of services, and identifying services that were never rendered or billed at an inflated rate. While's **BHI**'s policies for monitoring for and reporting FWA in accordance with **BHI**'s Corporate Compliance Program Plan are intended to meet the regulations specified in 42CFR438.608, based on the training curriculum provided, it would be more effective for the staff to receive in-depth training on specific FWA examples and be provided tools for identifying FWA in the context of behavioral healthcare services.

Standard IX—Subcontracts and Delegation

Summary of Strengths and Findings as Evidence of Compliance

In addition to individual provider credentialing, **BHI** had delegated enrollment processing, claims processing, and care management to Colorado Access. The delegation agreement included the key performance metrics and the related reporting requirements. In addition to the quarterly review of Colorado Access' contract performance summary, **BHI** conducted an annual audit. **BHI** demonstrated appropriate remediation and oversight strategies when Colorado Access had previous difficulties in meeting the performance expectations related to claims processing.

Summary of Findings Resulting in Opportunities for Improvement

There were no opportunities for improvement identified for this standard.

Summary of Required Actions

There were no required actions identified for this standard.