FY 2015–2016 Site Review Report

for

Behavioral Healthcare, Inc.

April 2016

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

HSAG Health Services Advisory Group

3133 East Camelback Road, Suite 100 ◆ Phoenix, AZ 85016-4545

Phone 602.801.6600 ◆ Fax 602.801.6051

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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 FY 2015–2016 site review activities for the review period of January 1, 2015, through December 31, 2015. 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 2015–2016 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2014–2015 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 credentialing and recredentialing record reviews. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the BHO will be required to complete for FY 2015–2016 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

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 documented findings and 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. At the request of the Department, HSAG designated select contract requirements within the Coordination and Continuity of Care standard as *Information Only* elements. These requirements were not scored. HSAG gathered information during on-site interviews regarding the BHO's implementation of these requirements. Detailed findings for each of these elements were outlined in the Compliance Monitoring Tool and are summarized below in Standard III—Continuity and Coordination of Care.

Table 1-1 presents the scores for **Behavioral Healthcare, Inc.** (**BHI**) for each of the standards. Findings for all 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)
III Coordination and Continuity of Care	10	10	9	1	0	0	90%
IV Member Rights and Protections	6	6	6	0	0	0	100%
VIII Credentialing and Recredentialing	46	46	44	2	0	0	96%
X Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
Totals	**76**	**76**	**73**	**3**	**0**	**0**	**96%**

Table 1-2 presents the scores for **BHI** for the credentialing and recredentialing 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)
Credentialing	90	81	81	0	9	100%
Recredentialing	90	71	69	2	19	97%
Totals	**180**	**152**	**150**	**2**	**28**	**99%**

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

BHI had policies and procedures and effective processes in place to ensure that it identifies members for and provides care coordination or case management based on the member's needs. **BHI** distinguishes between case management and care coordination. Case management is the day-to-day management and communication with other providers and is performed at the community mental health center (CMHC)-level by the primary therapist for all members. **BHI** monitors to ensure that each member is assigned to a primary therapist and that the primary therapists coordinate with primary care providers (PCPs), other BHOs, regional care collaborative organizations (RCCOs), or community agencies as applicable via a chart audit process. In addition to the day-to-day case management that the CMHCs are expected to do, **BHI** provides care management—which occurs at the BHO level—to remediate systems issues and barriers to care and to ensure the appropriate level of services.

BHI delegates complex care management to Colorado Access, another BHO in the state. Members who receive complex care management are receiving higher levels of care such as inpatient or residential treatment. Complex care management is also provided for members who are high utilizers of services (e.g., high emergency department [ED] utilization). **BHI** also has a transition coordinator who works specifically with members transitioning between levels of service (e.g., inpatient hospital to community-based care) or between systems of care (e.g., corrections facility to community-based care). The transitions coordinator works with the member during the transition and for a short time after (depending on needs) and then transfers the member to the appropriate care/case management program. **BHI**'s Health Insurance Portability and Accountability Act of 1996 (HIPAA) policies and practices were robust and included physical and electronic safeguards and use of business associate agreements (BAAs) and releases of information as appropriate.

Each member is assessed prior to receiving services from either a CMHC or a contracted provider. **BHI** ensures that assessments and treatment plans address all required components by using a chart audit process. The chart audit process uses a sampling methodology which ensures that both CMHC and contracted providers are audited for completeness and quality of documentation. **BHI**'s audit form included fields for evaluating whether the assessment addressed cultural and linguistic needs and screening for history of mental illness, substance use, and trauma disorders. In addition, members referred to the transition coordinator or to complex case management received a comprehensive Health Needs Assessment (HNA) that addressed medical, psychiatric, and social history as well as health behaviors and developmental needs. **BHI**'s process for allowing members to directly access a specialist for routine therapy occurs through use of a single case agreement if the specialty service is not available in the network. If the service is available in the network, no authorization is required for non-intensive levels of service. Specialty care that requires an intensive level of service such as inpatient hospitalization, residential treatment, or intensive outpatient services requires authorization based on the level of care.

BHI staff members reported that the medical director recently conducted a literature search regarding the definition of "medical necessity" and subsequently revised **BHI**'s definition of medical necessity to encompass a broader spectrum and to incorporate Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. CMHCs have an EPSDT screening tool that therapists are required to use if developmental issues are suspected. Providers are then required to refer members accordingly based on results of the screen.

During the on-site review, **BHI** provided case presentations that demonstrated the following for **BHI**:

- Coordination efforts with the member's medical providers. In one case presentation a member was admitted to a medical floor of a hospital due to self-harming behavior. The case presentation demonstrated **BHI**'s efforts to work with the hospital case managers to find an appropriate level of care for the member and to arrange for supportive services upon discharge. **BHI** also coordinated with the CMHC that would provide care upon discharge and explored potential programs such as residential treatment, assertive community treatment, and a potential out-of-state facility for this member.
- Efforts to coordinate care for members transitioning from the Colorado mental health institutes. **BHI**'s transition coordinator presented a case regarding a member who transitioned from the Colorado Mental Health Institute in Pueblo to the Jefferson County Detention Center. **BHI** worked with the Jefferson Center for Mental Health (a CMHC in another BHO region) to perform assessment of the member prior to discharge from the detention center. The case presentation demonstrated assisting the member in receiving transportation vouchers and coordination with other providers, the detention center staff, the public defender's office, and the Arapahoe-Douglas Mental Health Center where the member would be receiving services upon discharge. The transition coordinator followed the member for four months post discharge.
- Efforts to coordinate care for a member with complex medical needs. This member had a medical condition that exacerbated, causing deafness and blindness and therefore creating a barrier to discharging this member into the community. **BHI** was able to identify a Braille training program for this member to enable her to communicate. She was discharged to a nursing facility of her choice (after she visited the facility) and began participating in services at the mental health center near her placement.

Other information provided during on-site interviews applicable to *Information Only* elements included:

- **BHI**'s Care Management program is based on the evidence-based practice of the Four Quadrant Clinical Integration Model founded by the National Council on Community Behavioral Healthcare. **BHI**'s Care Management Program Description stated that **BHI**'s clinical practice guidelines were used to develop case management and care management processes and described identification, assessment, and treatment planning. During the on-site interviews, **BHI** staff members described case management that occurs at **BHI**'s CMHCs, which included coordination with the members' PCPs and primary care medical providers (PCMPs) for those enrolled in a RCCO.
- **BHI** had policies that described care coordination specifically for members with developmental disabilities or traumatic brain injury, for members residing in nursing facilities, for members

who are dually diagnosed or involved with multiple treatment systems, for coordination with State waiver programs, and for coordination during transitions.

- Each of **BHI**'s in-network CMHCs had a process to ensure that an individual is designated to communicate with the single entry point (SEP) provider or the home and community-based services case manager. In most cases, the process of coordinating with these agencies was not different from the processes applied when members not enrolled in specialized Medicaid waiver programs needed day-to-day coordination with other systems or providers. If a member is in the complex care management program, the care manager will assess the member's service plan to determine if waiver services are needed and assist the member with application. The SEP in the **BHI** service area is Colorado Access, **BHI**'s delegate for complex care management. **BHI** has a BAA with Colorado Access to allow for release of information.
- **BHI** staff members reported that the transition coordinator is the point of contact for departments of human services (DHS). Staff members reported that **BHI** has provided one training to DHS case workers. Training included explanation of how medical necessity is determined and description of services available. **BHI** plans to provide trainings quarterly. **BHI** has providers in the network with experience treating children in the foster system and maintains a list of providers with such experience. In addition, foster care experience may be entered as a search parameter in the provider search on **BHI**'s website. **BHI** has been participating in a seven-county initiative to provide trauma assessment when a case is opened with DHS. **BHI** provides an initial screen to determine the appropriate trauma assessment. **BHI** staff members also described a collaborative project with DHS to provide multidisciplinary therapy services to children with autism and using fee-for-service (FFS) billing.
- **BHI**'s transition coordinator is the point of contact for working with the Department of Corrections (DOC) and with jails to ensure that members receive appropriate services following release. The BHOs have developed a collaborative group and have had numerous meetings with the DOC to develop a process for referral. Staff members reported that the most important change that has occurred in this process is that State regulations now allow members to apply for Medicaid 41 days prior to release. The DOC has case managers, and the transition coordinator works with these case managers when possible to ensure application for Medicaid and referral to the appropriate CMHC. The transition coordinator also identifies a parole officer to coordinate with once the member has been released. One barrier encountered was the change of vendor for case management services for the DOC. The BHO group has had some difficulty coordinating with the new vendor on a system level. Timely release of medical records remains a barrier. The BHO group is working with the DOC to develop a BAA that would allow release of pertinent records for the purpose of care coordination.
- **BHI**'s transition coordinator has identified re-entry specialists at the county jails. The transition coordinator has also been working with county sheriffs to coordinate payment for hospitalizations longer than 24 hours. **BHI** staff members reported that outreach occurs to all counties in the metro area, stating, "Members do not necessarily get arrested in the same county where they live."
- **BHI** staff members reported that thus far the CMHCs have been responsible for working directly with the nursing facilities where their members reside. **BHI** policies require that the CMHC providers have monthly contact with their members residing in nursing or assisted living facilities. **BHI** staff members reported believing that the CMHCs have done a good job working

with the nursing facilities. Staff members reported that **BHI** has begun reaching out to some nursing facilities in the service area with only moderate success. Staff reported that staff members have attempted to meet quarterly with the nursing facilities to discuss system issues (such as substance use), while the CMHCs' work is member-specific. **BHI** staff indicated that more work needs to be done with the nursing facilities at the BHO level.

- **BHI** has a memorandum of understanding with Colorado Access, the RCCO in **BHI**'s service area. **BHI** has been outreaching to some of the RCCO's smaller providers to encourage partnering with **BHI** for behavioral health service provision and for helping some provider sites with care integration. One of **BHI**'s in-network CMHCs has an embedded pediatric PCMP. Some barriers encountered have been sharing of medical records with incompatible electronic medical record systems and understanding billing codes. **BHI** staff members also described coordination work between the RCCO care manager and **BHI**'s care manager. In some cases, the Colorado Access care manager is identified as both; however, in some instances, the CMHC and the RCCO must work together to identify a primary care manager and determine how to ensure that duplicative work does not occur.
- **BHI** submitted comprehensive documentation describing strong relationships with partners and agencies including:
  - **Colorado Department of Human Services (CDHS) Division of Developmental Disabilities (DDD): BHI** collaborates with case managers to obtain and support specialized placements for members with developmental disabilities and provides mental health assessments for members to determine if their symptoms are due to a covered mental health diagnosis or if services should be provided under the Developmental Disabilities (DD) waiver. When appropriate, **BHI** and its CMHCs provide services for individuals also served by the DDD. These services are designed to coordinate with and compliment DDD services. One of **BHI**'s CMHCs has an embedded pediatric clinic providing specialty therapy services to children with developmental disabilities.
  - **CDHS Division of Child Welfare: BHI** providers offer services within the home environment. **BHI** is represented on the Title IV-E Waiver (including trauma-informed care practices) and participates in a work group dedicated to developing optimal behavioral health services for children and families involved with the child welfare system. The goal of the group is to create a vision for behavioral health care for the child welfare system in Colorado. **BHI** works with youth involved in both the criminal justice and child welfare systems, offers training to **BHI** providers and partners on trauma-informed care, and collaborates with CDHS on issues involving adult protective services. **BHI** has provided training to DHS workers on the definition of "medical necessity" and covered services under the managed care contract.
  - **CDHS Office of Behavioral Health (OBH): BHI** routinely collaborates with OBH. Examples include working with OBH to develop critical incident reporting policy, OBH awarding **BHI** a grant for "Modernizing Treatment Through Trauma-Informed Care and Peer Support Services at the Mental Health Institutes," and **BHI**'s CMHCs working closely with OBH (meeting all requirements of the Child Mental Health Treatment Act by evaluating needs and by providing/coordinating care and transitions for children at risk for out-of-home placement and with no other funding source for these services). OBH also awarded **BHI** the Continuity of Care with Transition Specialists (CTCS) contract.

- **CDHS Division of Youth Corrections (DYC): BHI** collaborates and supports the DYC by contracting with providers to conduct emergency mental health evaluations for members and providing co-located mental health services at the Foote Detention Center and Adams Youth Services Center. **BHI** provides training to judicial staff on trauma, residential care for youth, and a variety of behavioral health issues.
- **Colorado Department of Public Health and Environment (CDPHE): BHI** joins the Department in addressing "The Winnable Battles" of postpartum depression and substance abuse. **BHI** aligns its health promotion programs with the priorities of the Department and uses resources provided by CDPHE to provide wellness-focused services. **BHI** participates with the Office of Suicide Prevention in its community programs and advisory committee.
- **Colorado Department of Corrections (DOC): BHI**'s CHMCs provide outreach and community-based treatment and psychiatric services for offenders. As part of its collaboration with DOC, these providers use telepsychiatry to engage with inmates who, once released, will become **BHI** members to ensure successful reintegration into their communities.

- **BHI** staff members reported that each of **BHI**'s CMHCs is capable of providing services under Medicare. In addition, **BHI** identifies, in its network, contracted providers qualified to provide services under Medicare. **BHI**'s website provider search feature has a field to mark Medicare provider as a search parameter.
- **BHI** had adequate policies and procedures for treating members with development disabilities (DD) and traumatic brain injury. **BHI** staff members reported that **BHI** collaborated with the Department's Client and Clinical Care Program Office to meet with providers to discuss the populations of members with DD and autism and to problem solve treatment and payment strategies. Staff reported that Community Reach Center (CRC) has an embedded clinic that provides behavioral health and other therapy services (such as occupational therapy) and is able to bill FFS for these services.
- **BHI** holds the CTCS contract with OBH for a statewide transition program. In addition, **BHI** has a transition coordinator who works specifically with **BHI**'s Medicaid members. **BHI**'s transition coordinator's role is to bridge the gap and ensure transition between systems. The transition coordinator receives referrals from the mental health institutes, the corrections system, and nursing facilities. During the on-site interview, staff members reported one system issue being that individuals moving from the institutes to a correctional facility before being released to the community were getting lost in the system. **BHI**'s transition specialist worked with the mental health institutes to ensure coordination of services. One system change that has improved the process is that members are now allowed to apply for Medicaid 41 days prior to release from the institute. On-site, **BHI** staff presented a case study that demonstrated how **BHI** coordinated with the Mental Health Institute in Pueblo and the county jail system to successfully integrate the member into the community.

Summary of Findings Resulting in Opportunities for Improvement

As the expectations for CMHC providers related to assessment and treatment planning evolve, **BHI** may want to consider some revision to its chart audit tool to provide **BHI** with more detail of assessment and treatment plan content.

As **BHI**'s care coordination and case management programs continue to evolve, **BHI** may want to consider reviewing its policies and procedures related to care coordination and case management to ensure that the policies reflect the robust nature of **BHI**'s programs.

BHI may also want to consider developing standard reporting requirements for CMHCs to be able to better monitor the CMHCs' compliance with the requirement to coordinate with medical providers and ensure that members receive adequate medical care.

Summary of Required Actions

BHI's chart audit process did not evaluate whether the CMHCs' intake assessments addressed developmental needs. Therefore, while members who are involved in complex case management receive a comprehensive health needs assessment that addresses developmental needs, **BHI** did not have a mechanism to ensure that each member accessing services receives an individual assessment that addresses developmental needs. **BHI** must ensure that each member accessing services receives an individual assessment that addresses developmental needs.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

BHI had documents and processes to ensure provision of member rights and to communicate expectations to members, providers, and staff. **BHI** had a clear passion for creating positive relationships with members, employees, and providers; and it was evident that interviewees were committed to this vision. Staff members also described the active roles of the member services representatives located in the CMHCs and their focus on member rights.

BHI demonstrated active analysis of member grievances and member input to identify trends and opportunities for improvement. **BHI** described efforts to further assess that providers take member rights into account when furnishing services, including the recent addition of provider on-site auditing.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no findings resulting in opportunities for improvement related to member rights and protections.

Summary of Required Actions

HSAG required no corrective actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

BHI had a well-defined credentialing program that included National Committee for Quality Assurance (NCQA)-compliant policies, procedures, and practices. **BHI** delegated credentialing and recredentialing activities to Colorado Access; and it was clear that **BHI** retained the right to approve, suspend, or terminate providers. The delegate's credentialing records were well organized, and ample evidence demonstrated **BHI**'s monitoring and oversight of Colorado Access. On-site record review of contracted provider records demonstrated that primary source verification for credentialing was completed within the required time frames.

Summary of Findings Resulting in Opportunities for Improvement

BHI delegated credentialing and recredentialing to Colorado Access (COA). Although the delegation agreement and policy indicated that COA was responsible for verification activities and that **BHI** was responsible for credentialing and recredentialing decisions by virtue of the Credentialing Committee, during on-site interviews **BHI** staff members reported that **BHI** accepted COA's medical director approval as **BHI**'s credentialing/recredentialing date and that the **BHI** Credentialing Committee was used as a formality only to validate the COA approval and provide final denial if there were any concerns.

HSAG submitted a question to NCQA to obtain NCQA's evaluation of whether this process follows NCQA standards and guidelines. NCQA responded: "If the MBHO [managed behavioral healthcare organization] delegates decision-making to its delegate, then the delegate's credentialing decision date is the date that should be used for the credentialing/recredentialing date. Please note that the delegation agreement must be clear about the activities that are being delegated."

As the delegation agreement was somewhat unclear that credentialing and recredentialing decision-making were delegated to COA, HSAG recommends that **BHI** review its policy and delegation agreement to ensure that the language clearly states that credentialing/recredentialing decision-making are delegated.

Summary of Required Actions

BHI delegated credentialing and recredentialing to Colorado Access (COA) and effectively demonstrated evidence of completing recredentialing processes and procedures. During on-site review of ten recredentialing files; however, HSAG identified two practitioners recredentialed after the 36-month time period. **BHI** must develop a mechanism to ensure that providers are recredentialed every 36 months.

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

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

BHI's *FY16 Quality Improvement Program Description* addressed each required component. The annual quality report—**BHI**'s impact analysis document—was comprehensive and addressed required activities (performance measures results and performance improvement projects) and **BHI**'s additional quality initiatives based on findings from **BHI'**s internal quality initiatives and program monitoring activities. The annual report also included analysis of **BHI**'s internal member satisfaction survey and the Experience of Care and Health Outcomes (ECHO) survey administered by HSAG on behalf of the Department. **BHI**'s program included robust methods for detecting both over- and underutilization. **BHI** staff used analysis of key indicator reports from the health information system. Reports routinely produced included: *Top 100 Utilizers*, *Clinical Services Utilized*, *Frequency of Outpatient Services Use*, *ED Utilization*, *Number of Inpatient Admissions*, and *Inpatient Average Length of Stay*. During the on-site interview, **BHI** staff members reported that underutilization may often be detected by an increase in ED utilization for a member or by increase in social detoxification use. Underutilization is often a member-specific indicator, and in these cases overuse of the identified service may indicate underutilization of routine and maintenance services. **BHI**'s health information system also maintained data on provider and member demographics payor sources and claims. The Utilization Management (UM) Committee and operation staff review claims and payment trends.

BHI had a variety of methods to assess quality and appropriateness of services. **BHI** used both ongoing monitoring and formal audits. The Quality Improvement Committee reviews grievances for trends. The CMHCs used a clinical rounds process for peer review, and **BHI** staff members reported that **BHI** holds a weekly staff meeting with the medical director and convenes a case review meeting every other week with care managers to review more complex cases. In addition, **BHI** had a System of Care meeting monthly with representatives from UM, Quality Improvement, Care Management, and Clinical departments to coordinate and assess systems' issues to improve the care provided by **BHI**.

In January 2016 **BHI** expanded the current audit process used to monitor completeness and accuracy of documentation and to monitor whether or not the documentation provides evidence of appropriate care. In 2015 **BHI** used a compliance audit tool to monitor providers. The expanded audit will be a three-stage process: (1) a compliance audit that assesses the accuracy and completeness of chart documentation to support the claim, (2) an on-site visit that evaluates the adequacy of waiting room and treatment space and medical record keeping practices, and (3) a clinical quality chart review. **BHI** staff reported that providers will be selected for audit based on concerns raised by grievances or **BHI** staff member contact and by random sample. **BHI** plans to

begin with outpatient service providers. The process includes pulling a sample of 80 claims on which to perform the compliance audit, then performing the quality chart review for the charts associated with the unique members represented. In the most recent sample, 80 claims represented 36 unique members. **BHI** reported that the audit schedule is three providers per month.

BHI's medical director evaluated clinical practice guidelines in collaboration with the standards of the practice committee and maintained a review schedule ensuring that the guidelines are reviewed every two years (aligning with the NCQA requirement). **BHI**'s clinical practice guidelines are available on **BHI**'s website under the Provider tab. Under the Member tab **BHI** has included member versions of the practice guidelines revised to ensure an easy-to-understand reading level. **BHI** staff members reported that the medical director performed a literature search to assess **BHI**'s inpatient utilization review (UR) criteria and ensure consistency with the practice guidelines. As a result, **BHI** revised its UR criteria to become consistent with current literature and **BHI**'s practice.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to Quality Assessment and Performance Improvement.

Summary of Required Actions

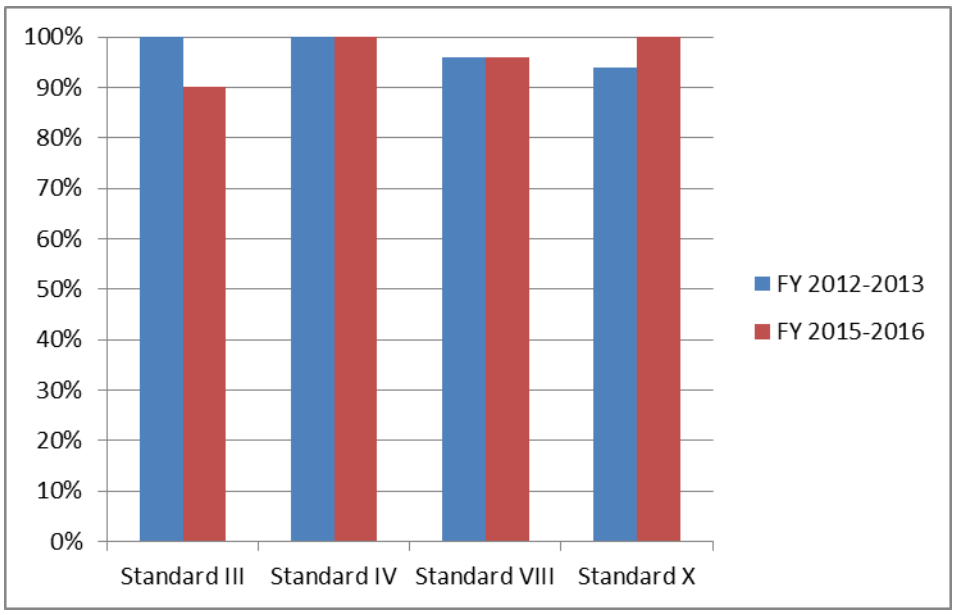
HSAG required no corrective actions for this standard.

Comparison of Results

Comparison of FY 2012–2013 Results to FY 2015–2016 Results

Figure 2-1 shows the scores from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X 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.

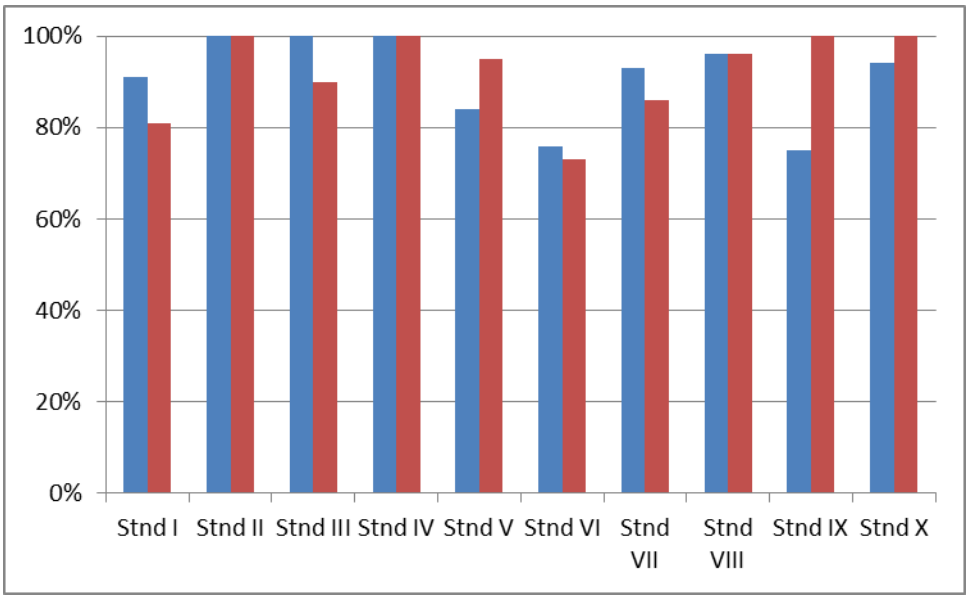
Figure 2-1—Comparison of FY 2012–2013 Results to FY 2015–2016 Results



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: Results shown in blue are from FY 2010–2011, FY 2011–2012, and FY 2012–2013. Results shown in red are from FY 2013–2014, FY 2014–2015, and FY 2015–2016.

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

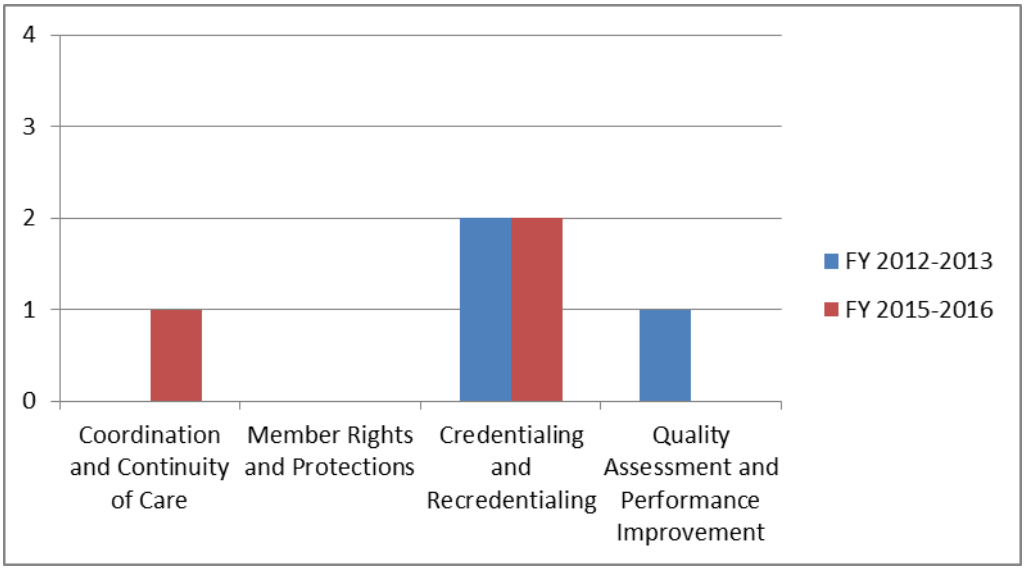
Table 2-1—List of Standards by Review Year

Standard	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
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 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X 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 2012–2013 and FY 2015–2016 Required Actions per Standard

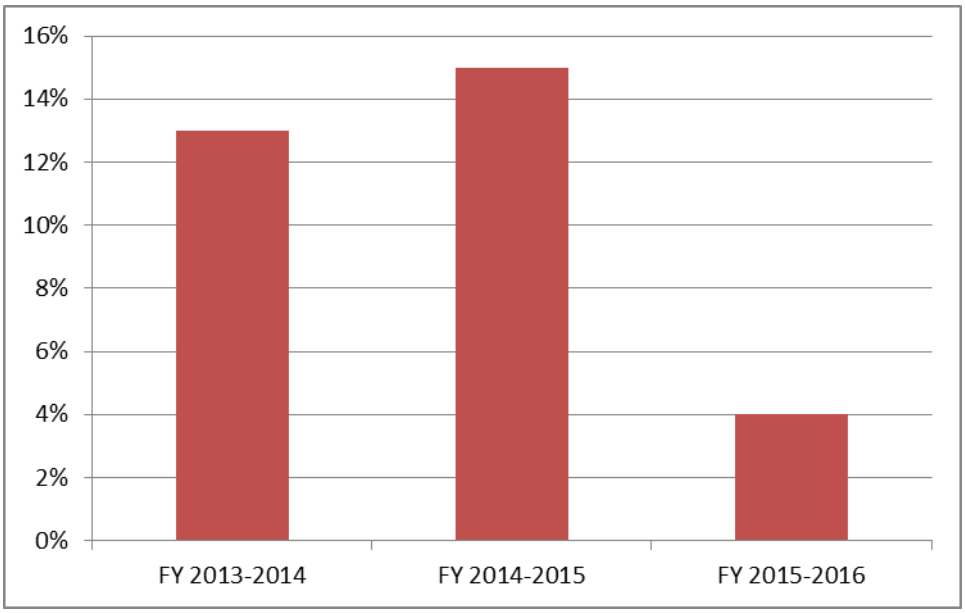


Note: **BHI** had no required actions for Coordination and Continuity of Care or Member Rights and Protections resulting from the FY 2012–2013 site review. **BHI** also had no required actions for Member Rights and Protections resulting from the FY 2015–2016 site review.

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, as indicated in Table 2-1 above.

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



Overview of FY 2015–2016 Compliance Monitoring Activities

For the fiscal year (FY) 2015–2016 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of 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 credentialing and recredentialing. HSAG documented detailed findings in the Compliance Monitoring tool for any requirement receiving a score *Partially Met* or *Not Met*.

A sample of the BHO's administrative records related to Medicaid credentialing and recredentialing were also reviewed to evaluate implementation of federal healthcare regulations and compliance with National Committee for Quality Assurance (NCQA) requirements, effective July 2015. HSAG used standardized monitoring tools to review records and document findings. Using a random sampling technique, HSAG selected a sample of 10 records with an oversample of five records from all of the BHO's credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. HSAG reviewed a sample of 10 credentialing records and 10 recredentialing records, to the extent possible. For the record review, the health plan received a score of *M* (met), *N* (not met), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and 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. The four standards chosen for the FY 2015–2016 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in

subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

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 healthcare regulations and managed care contract requirements in the four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the BHO into compliance with federal healthcare 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 2014–2015 Corrective Action Methodology

As a follow-up to the FY 2014–2015 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 2014–2015 compliance monitoring site review.

Summary of 2014–2015 Required Actions

As a result of the FY 2014–2015 site review, **BHI** was required to address one *Partially Met* element in Standard V—Member Information, seven *Partially Met* elements in Standard VI—Grievance System, and two *Partially Met* elements in Standard VII—Provider Participation and Program Integrity.

For Standard V, **BHI** was required to send privacy practices to members annually. Most of **BHI**'s required actions for Standard VI were related to the various time frames associated with grievances, appeals, State fair hearings, and the continuation of benefits. For Standard VII, **BHI** was required to enhance its provider audit/oversight processes and develop more definitive policies and procedures for identifying potential fraud, waste, and abuse.

Summary of Corrective Action/Document Review

BHI submitted its CAP to HSAG and the Department in May 2015. HSAG and the Department reviewed the proposed plan of correction and approved it as written. **BHI** began submitting documents that demonstrated implementation of the plan in July 2015. HSAG and the Department reviewed documents submitted by **BHI** to demonstrate implementation of the plan at several intervals between July and December 2015 and determined in December 2015 that **BHI** had successfully completed all corrective actions.

Summary of Continued Required Actions

BHI had no required actions continued from FY 2014–2015.

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

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has written policies and procedures that address the timely coordination of the provision of covered services to its members, service accessibility, attention to individual needs, and continuity of care to promote maintenance of health and maximize independent living. Contract: Exhibit A—2.4.2.1.1.1.–2.4.2.1.1.4	**Documents Submitted:** UM-801 Access and Availability (whole document) CLIN-203 DDMI and TBIMI Practice Standards (whole document) CLIN-207 Nursing Home Services (whole document) CLIN-209 State Plan and Waiver Services (whole document) CLIN-210 Coordination of Care (whole document) CLIN-211 Continuity of Care (whole document) **Description of the Process** The following written policies and procedures demonstrate that BHI addresses the timely coordination of the provision of covered services to its members, service accessibility, attention to individual needs, and continuity of care to promote the maintenance of health and maximize independent living. Specifically: **Policy UM-801 Access and Availability** outlines procedures and standards related to the provision and monitoring of services that will ensure the appropriate access and availability for members, to include the timely access to covered medically necessary services. **Policy CLIN-203 DD/MI and TBI/MI Practice Standards** details the procedures to ensure that the appropriate and effective assessment and service provisions for those members who have both DD and or TBI diagnoses. **Policy CLIN-207 Home Nursing Services** outlines the specific procedures for BHI to outreach and coordinate for the provision of behavioral health services for those members who reside in nursing facilities and assisted living residences. **CLIN-209 – State Plan and Waiver Services** outlines our procedures to ensure that BHI is complying with all state regulations to assure that its members receive all medically necessary services in a timely manner, thus ensuring that attention is paid to the individual needs of our members and continuity of care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Policy CLIN-210 Coordination of Care outlines the coordination of care for members to ensure collaborative treatment activities with other medical and behavioral health services to ensure continuity of care to promote maintenance of health and maximize independent living skills for our members. **Policy CLIN-211 Continuity of Care** outlines and details the BHO's policy for continuity of care to ensure that when members transition from one setting to another member have continued access to services during these times, including provider termination from the network and alternative care if services are unavailable.	
2. The Contractor has policies and procedures that address, and the Contractor provides for, the coordination and provision of covered services in conjunction with: ◆ Any other MCO or PIHP. ◆ Other behavioral healthcare providers. ◆ Physical healthcare providers. ◆ Long-term care providers. ◆ Waiver services providers. ◆ Pharmacists. ◆ County and State agencies. ◆ Public health agencies. ◆ Organizations that provide wraparound services. *42CFR438.208(b)(2)* Contract: Exhibit A—2.4.2.1.1.5; 2.4.2.2.1.3	**Description of the Process:** The below listed policies and procedures address and demonstrate how the coordination and provision of covered services are facilitated: **Documents Submitted:** CLIN-209 State Plan and Waiver Services (whole document) CLIN-210 Coordination of Care (whole document) CLIN-211 Continuity of Care (whole document) Care Management Delegation Agreement (pgs. 2 and 3) ADM-106 Coordination of Medicaid and Medicare Benefits (whole document CCTS Contract Exhibit A-Statement of Work (whole document) An example of Committee/Initiative involvement specifically related to county/state agencies/public health agencies: • HCPF in collaboration with BHI Transition Coordinator and the Transition Specialist Program through the Office of Behavioral Health assist in the transition of persons from state institutes including hospitals, jails nursing homes to their home communities. This is described in the CCTS contract and Exhibit A- Statement of Work.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
2.A. The Contractor develops specialized treatment and service plans for female members for one year postpartum to ensure that the behavioral and physical needs of the mother and child are being met. Contract: Exhibit A—2.4.2.4.2.6.1	**Documents Submitted:** CLIN-212 Coordination of Care for Special Populations FY16 (whole document) Transition Coordinator Job Description (Pgs. 1 and 3) Early Childhood Center Brochure Mama TalkFlyerNG Pregnancy-Related Depression Project (screen shot) Perinatal Learning Collaborative Minutes 11-16-15 **Description of Process:** BHI's CLIN-212 Coordination of Care for Special Populations policy outlines how BHI staff will work with BHI's provider network and community partners that offer specialized programs geared towards female members one year postpartum with behavioral health concerns. BHI providers and community partners offer the services outlined below for BHI Medicaid Members: Colorado Access (Co Access), as the region 3 Regional Care Collaborative Organization (RCCO), shared with BHI's catchment area, has implemented an initiative in working with pregnant and post-partum women. Tri-County Health, in partnership with BHI providers offers the Mama Talk Program and Postpartum Depression Project that screens for postpartum depression and provides services or will refer to BHI providers for additional services. This catchments area CHMC's have significant relationships with our community partners and have systems in place to receive referrals from our community partners. The CRC screen shot and the Early Childhood Center Brochure describe the specialized programs that our catchment	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	areas mental health centers provide for our members that work with perinatal Medicaid clients. BHI in collaboration with BHI providers and community programs has formed a Perinatal Committee to discuss programs available to this population, identify gaps in services and to work to ensure that the behavioral and physical needs of the mother and child are being met in the community.	
Findings: BHI staff members stated that members identified as pregnant are referred to BHI's transitions coordinator. The transitions coordinator works with the mental health centers to ensure members timely access to services upon discharge from the hospital. Staff reported that the CMHCs are screening for depression in members who are pregnant or postpartum. BHI has been developing a program to improve identification of pregnant and postpartum women with depression. BHI plans to use data to determine which obstetrics and gynecology (OB/GYN) practitioners are seeing most of BHI's members. BHI also plans to hire an integrated care liaison to provide community outreach to groups of physicians for education purposes. Once identified, these providers would receive outreach and training regarding depression screening. BHI has brought together a learning collaborative to study the issues and barriers to providing services to these members. The learning collaborative consists of representatives from BHI, the mental health centers, and care coordinators from Colorado Access. The Mama Talk program offers gift card incentives to members for attending support groups.		
2.B. The Contractor coordinates with the member's medical health providers to facilitate the delivery of health services, and makes reasonable efforts to assist individuals to obtain necessary medical treatment. If a member is unable to arrange for supportive services necessary to obtain medical care due to her/his behavioral health disorders, the Contractor will arrange for supportive services whenever possible. Contract: Exhibit A—2.4.2.2.2	**Documents Submitted:** BHI CM Program Description (whole document) 2B CMHC Care Coordination Programs (whole document) ADMHN Care Coordination Agreement (whole document) AuMHC Care Coordination Agreement (whole document) CRC Care Coordination Agreement (whole document) **Description of Process:** BHI CM Management Program describes in detail how the BHI care managers work in collaboration with the member's medical health providers to facilitate the delivery of physical health services. The plan details the goals and methods by which the care management team assists individuals to obtain their necessary medical treatment, and makes arrangements for supportive services necessary to obtain medical care due to his/her behavioral health disorders.	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	In addition, BHI has agreements with the Mental Health Centers to support the coordination of care and determine if members are engaged in treatment, support members with complex needs, determine medical needs and linking members with necessary services.	
Findings: BHI's Care Management program is based on the evidence-based practice of the Four Quadrant Clinical Integration Model founded by the National Council on Community Behavioral Healthcare. BHI's *Care Management Program Description* stated that BHI's clinical practice guidelines were used to develop case management and care management processes and described identification, assessment, and treatment planning. During the on-site interviews, BHI staff members described case management that occurs at BHI's CMHCs, which included coordination with the members' PCPs and PCMPs for those enrolled in a RCCO. BHI distinguishes between case management and care coordination. Case management is the day-to-day management and communication with other providers and is performed at the community mental health center (CMHC)-level by the primary therapist for all members. BHI monitors to ensure that therapists coordinate with PCPs, other BHOs, or community agencies via a chart audit process. BHI also provides care management for more complex members. On-site, BHI's staff members provided a case example. The case demonstrated BHI's coordination efforts with the member's medical providers and the medical floor of the hospital where the member was admitted. The case presentation demonstrated BHI's efforts to work with the hospital case managers to find an appropriate level of care for the member and to arrange for supportive services upon discharge. While BHI's audit tool had a field to evaluate whether a release of information is present in the chart, there is no way to evaluate whether the primary therapist has communicated with the PCP when necessary or assessed whether the member is receiving appropriate medical care. BHI staff members stated that BHI will begin requiring monthly reporting from the CMHCs in March 2016 regarding members receiving care management from the CMHC, but that may only include reporting on more complex members. Since these activities occur at the provider level, HSAG recommended that BHI develop standard reporting requirements to be able to better monitor the CMHCs' compliance with the requirement to coordinate with medical providers and ensure that members receive adequate medical care.		
2.C. The Contractor provides for care coordination and continuity of care for special populations and complex members, including those who are involved in multiple systems and those who have multiple needs, such as: ◆ Members residing in long-term care/nursing facilities. ◆ Dually or multiply eligible members. ◆ Dually or multi-diagnosed members. ◆ Members involved with the correctional system. ◆ Child/Youth members in out-of-home placements, foster care, and subsidized adoptions.	**Documents Submitted:** CLIN-203 DDMI and TBIMI Practice Standards (whole document) CLIN-207 Nursing Home Services Facility and Assisted Living Residence Services (whole document) CLIN-209 State Plan and Waiver Services (whole document) CLIN-210 Coordination of Care (whole document) CLIN-211 Continuity of Care (whole document) CLIN-212 Coordination of Care for Special Populations FY16 (whole document) ADM-106 Coordination of Medicaid and Medicare Benefits ADMHN Care Coordination Agreement	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Members transitioning from Colorado Mental Health Institutes (Ft. Logan and Pueblo) and hospitals. ◆ Members receiving wraparound services under an HCBS waiver. Contract: Exhibit A—2.4.2.4.1; 2.4.2.4.2; 2.4.2.2.1.1	AuMHC Care Coordination Agreement CRC Care Coordination Agreement Transition Specialist Program Description Transition Coordinator Job Description (pgs. 1 - 3) BHI Care Management plan (whole document) **Description of Process:** **BHI's clinical policies** CLIN-203 DDMI and TBIMI Practice Standards, CLIN-207 Nursing Home Services CLIN-209 State Plan and Waiver Services and CLIN-212 Coordination of Care for Special Populations policies demonstrate how BHI addresses the delivery of covered services to its members, service accessibility, and the attention to individual needs for members considered part of a specialized population and or have complex needs. BHI CLIN-210 Coordination of Care and CLIN-211 Continuity of Care polices addresses the coordination and continuity of care to promote the maintenance of health for all members, including those considered part of a specialized population and or have complex needs. BHI also has specialized programs that work specifically to ensure that coordination of care and continuity of care for those members that need specialized services or have complex needs are assisted in accessing those services. Those programs are: **The BHI Transition Coordinator** (TC) and **Transition Specialist Programs'** primary responsibility is to coordinate the continuity of care for Members needing behavioral health services as they transition between service delivery systems and from hospitalization to less restrictive alternatives and into community resources. **BHI CM Management Program:** BHI's Care Management (CM) and Complex Case Management (CCM) program have been designed in	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	collaboration with the local Regional Care Collaborative Organization (RCCO) to support and foster the mission of BHI; our CM program promotes behavioral wellness by addressing, stabilizing, and preventing decline in its members' behavioral health as well as their physical health. In addition, BHI has Care Coordination agreements with the Mental Health Centers to support the coordination of care and determine if members are engaged in treatment, support members with complex needs, determine medical needs and linking members with necessary services.	
Findings: BHI's Care Management Program Description and policies and procedures adequately described BHI's efforts to identify and provide care management to the identified special populations. BHI had policies that described care coordination specifically for members with developmental disabilities or traumatic brain injury, for members residing in nursing facilities, for members who are dually diagnosed or involved with multiple treatment systems, for coordination with State waiver programs, and for coordination during transitions. During the on-site interview, BHI's transition coordinator presented a case regarding a member who transitioned from the Colorado Mental Health Institute in Pueblo to the Jefferson County Detention Center. BHI worked with the Jefferson Center for Mental Health (a CMHC in another BHO region) to perform assessment of the member prior to discharge from the detention center. The case presentation demonstrated assisting the member in receiving transportation vouchers and coordination with other providers, the detention center staff, the public defender's office, and the Arapahoe-Douglas Mental Health Center where the member would be receiving services upon discharge. The transition coordinator followed the member for four months post discharge.		
2.D. The Contractor ensures that providers (primarily Community Mental Health Centers) communicate with and coordinate services with the Single Entry Point (SEP) care manager for each member who participates in the Waiver for Persons with Mental Illness (HCBS-MI) or Waiver for the Elderly, Blind, or Disabled (HCBS-EBD). The Contractor also coordinates with assisted living residences (ALRs) or other supported community living arrangements in which HCBS waiver recipients live.	**Documents Submitted:** 2D CMHC Service Coordination CCTS Contract Exhibit A-Statement of Work (whole document) **Description of Process:** Each of the three community mental health centers have a process in place to ensure the coordination of services with the single entry point (SEP for each member who participate in the Waiver for Persons with Mental Illness or Waiver for the Elderly, Blind, or Disabled). The attached document called 2D CMHC Service Coordination contains the detail of how each mental health center ensures this standard is met.	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
Contract: Exhibit A— 2.4.2.2.1.2	BHI's community Mental Health Centers and contracted programs coordinate with Alternative Care Residences and group homes as appropriate to ensure the adequate placement level for all members.	
Findings: Each of BHI's in-network CMHCs had a process to ensure that an individual is designated to communicate with the SEP or home and community-based services (HCBS) care manager. In most cases the process of coordinating with these agencies was not different from the processes applied when members not enrolled in specialized Medicaid waiver programs needed the day-to-day coordination with other systems or providers. BHI's audit tool did not include a field to evaluate whether the therapist had identified whether the member was receiving services from another system of care or waiver program. BHI may want to consider adding this to this or another monitoring process. If a member is in the complex care management program, the care manager will assess the member's service plan to determine if waiver services are needed and assist the member with application. The SEP in the BHI service area is Colorado Access, BHI's delegate for complex care management. BHI has a business associate agreement with Colorado Access to allow for release of information.		
2.E. The Contractor coordinates with county departments of human/social services in regard to children and youth in out-of-home placements (including kinship care, foster care, and subsidized adoptions) to: ◆ Ensure that children who have had a positive screen for trauma receive a formal follow-up trauma assessment and trauma-informed covered services (if indicated). ◆ Coordinate behavioral health referrals and services with county case workers, and initiate/maintain contact with case workers on an ongoing basis regarding child/adolescent members as well as adult members who have child welfare-involved children in their care. ◆ Ensure that therapists and case managers coordinate with county case workers regarding significant events which include, but are not limited to, discharge from treatment, significant clinical decompensation, and no-shows. The provider network includes clinical staff who are familiar with the unique needs of child welfare members, are able to	**Documents Submitted:** Job Description Transition Coordinator (pgs.1 and 3) CLIN-212 Coordination of Care for Special Populations FY16 (whole document) Resiliency Center Application (pg.10) Foster_Adoption Experienced Providers Search Trauma_Foster Provider List_11182015 (whole document) **Description of Process:** BHI and its providers, in cooperation with our catchments counties Department of Human Services (DHS) offices have several programs in place to help facilitate the specialized needs of children and youth in out of-home placement. BHI providers in two counties participate in Title IV-E initiative which screens children involved with the Department of Human Services (DHS) for trauma. If the screen indicates a need for further assessment or services, a referral is sent to a BHI provider and the provider outreaches the identified family, as shown in the Resiliency Center Application document.	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
provide psycho-educational as well as practical therapeutic interventions, and know of and refer families to community resources. The Contractor identifies a person within its organization who can serve as a main point of contact for the county departments of human/social services. Contract: Exhibit A—2.5.11.5; 2.4.2.4.2.7.1	BHI providers in Adams county are co-locate at the DHS office. This provider is notified whenever a child enters placement, and is immediately available to accept referrals, to personally connect with the DHS caseworker for information, and then to flexibly schedule and complete assessments with each child. BHI's Transition Coordinator (TC) has been identified as the point of contact for departments of human/social services. The TC also provides trainings annually to each county DHS office on the Medicaid systems in Colorado, how to access services and the authorized process for inpatient, homebased and intensive services. DHS is encouraged to contact the TC with significant service needs related to behavioral health, including care management, for any BHI members. The TC is also the point of contact to ensure that therapists are coordinating with DHS case managers regarding moving between levels of care and/or discharge from services.	
Findings: BHI staff members reported that the transition coordinator is the point of contact for DHS. Staff members reported that BHI has provided one training to DHS case workers. Training included explanation of how medical necessity is determined and description of services available. BHI is planning to provide trainings quarterly. BHI has providers in the network with experience treating children in the foster system and maintains a list of providers with such experience. In addition, foster care experience may be entered as a search parameter in the provider search feature on BHI's website. BHI has been participating in a seven-county initiative to provide trauma assessment when a case is opened with DHS. BHI provides an initial screen to determine the appropriate trauma assessment. BHI staff members also described a collaborative project with DHS to provide multidisciplinary therapy services to children with autism and using FFS billing.		
2.F. The Contractor collaborates with agencies responsible for the administration of jails, prisons, and juvenile detention facilities to coordinate the discharge and transition of incarcerated adult and child/youth members. The Contractor: ◆ Ensures members receive medically necessary initial services after release from correctional facilities and	**Documents Submitted:** Transition Coordinator Job Description (pgs. 1 – 3) BHO to CMHC transitions meeting invite CLIN-212 Coordination of Care for Special Populations FY16 (whole document) **Description of Process:** A collaboration between all BHO's has been established with the goal	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
provides the continuation of medication management and other behavioral healthcare services prior to community reentry and continually thereafter. ◆ Designates a staff person as the single point of contact for working with correctional facilities that may release incarcerated or detained members into the Contractor's service area. ◆ Collaborates with correctional facilities to obtain medical records or information for members who are released into the region, as necessary for treatment of behavioral health conditions. ◆ Works with the Department on initiatives, including Medicaid eligibility issues, related to members involved or previously involved with the State correctional system. ◆ Proposes (to the Department) innovative strategies, such as the use of technology, communication protocols, and coordination techniques with the courts, parole officers, police officers, correctional facilities, and other individuals needed to meet these requirements. Contract: Exhibit A—2.4.2.4.2.5	of coordinating one process for the continuity of care for criminally involved members with behavioral health needs from correctional facilities. This collaborative group has designated a single point of contact within each BHO to collaborate with correctional facilities. This single point of contact is working with correctional facility representative to develop a process to identify prior to release those members with medical necessary behavioral health needs, to classify these member into correct services area and to ensure that pertinent medical information is communicated with the appropriate community mental health program. This BHO, HCPF and correctional facilities collaboration is working on developing innovative ways to address several identified barriers in moving a process forward to ensure continuity of care. This barriers include but are limited to: • Compliance with HIPPA with any data exchange • Ensuring members have been attributed to the correct BHO and/or RCCO. • Development of a universal referral form used to identify and transmit pertinent medical information between facilities and BHOs. BHI continues to work with the other BHO's to find alternative and creative ways to connect care management services to these members prior to release, with the goal of helping establish a medical home and avoid any interruption in needed behavioral health treatment and medications.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Independently of this collaboration BHI has met with BHI providers to establish a process to enroll these members into the appropriate programs and services prior to release.	
Findings: BHI's transition coordinator is the point of contact for working with the Department of Corrections (DOC) and with jails to ensure that members receive appropriate services following release. The BHOs have developed a collaboration group and have had numerous meetings with the DOC to develop a process for referral. Staff members reported the most important change that has occurred in this process is that State regulations now allow members to apply for Medicaid 41 days prior to release. The DOC has case managers, and the transition coordinator works with these case managers when possible to ensure application for Medicaid and referral to the appropriate CMHC. The transition coordinator also identifies a parole officer to coordinate with once the member has been released. One barrier encountered was the change of vendor for case management services for the DOC. The BHO group has had some difficulty coordinating with the new vendor on a system level. Timely release of medical records remains a barrier. The BHO group is working with the DOC to develop a business associate agreement that would allow release of pertinent records for the purpose of care coordination. BHI's transition coordinator has identified re-entry specialists at the county jails. The transition coordinator has also been working with county sheriffs to coordinate payment for hospitalizations longer than 24 hours. BHI staff members reported that outreach occurs to all counties in the metro area, stating, "Members do not necessarily get arrested in the same county where they live."		
2.G. The Contractor provides outreach, a delivery system, and support to nursing facilities and assisted living residences in its service area, including: ◆ Provision of medically necessary, covered behavioral health services on-site in nursing facilities and assisted living residences for members who cannot reasonably travel to a service delivery site. (Residents able to travel may be required to receive their behavioral health services at a delivery site.) The Contractor will work collaboratively with the facilities to determine which residents are and are not able to travel. ◆ Monthly outreach and coordination for the provision of mental health and substance use disorder services for members in nursing facilities and assisted living residences.	**Documents Submitted:** CLIN-207 Nursing Home Services (whole document) CLIN-210 Coordination of Care (whole document) ADM-106 Coordination of Medicaid and Medicare Benefits (whole document) CLIN-212 Coordination of Care for Special Populations FY16 (whole document) Transition Coordinator Job Description (pgs 1 and 2) CMHC services in Nursing Facilities – screenshots FW Behavioral Health Transitions Collaborative (email) **Description of Process:** All policies referenced above describe how BHI and its providers partner with Skilled Nursing Facilities in our catchment to provide behavioral health and psychiatric services to residents who are diagnosed with a major mental illness. These programs focus on	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Assigning a primary contact from the BHO to each nursing facility and assisted living residence, who will ensure members are receiving necessary behavioral health services and help problem solve any related member issues. ◆ Establishing an ongoing quarterly meeting with all nursing facilities and assisted living residences to address outstanding issues. ◆ Providing Preadmission Screening and Resident Review (PASRR) Level II requirements and services to members entering nursing facilities, and providing any specialized behavioral health services identified on the assessment. Contract: Exhibit A—2.4.2.4.2.1	providing multidisciplinary services, within a wraparound model, in order to help consumers and families stabilize and engage in recovery. BHI's Transition Coordinator has outreach to Skilled Nursing Facilities (SNF) and other long-term care (LTC) facilities to identify service barriers and other concerns regarding behavioral health services offered to our Medicaid and dually eligible Medicaid and Medicare members residing in nursing facilities. BHI in collaboration with HCPF has begun a collaboration aimed at establishing a group dedicated professional working in and with SNF and LTC facilities in effort to address issues related to the continued institutionalization of individuals with behavioral health disabilities. BHI providers monitor Pre-admission and Resident Review (PASRR) level II requirements and services by providing trained Level II evaluators to assess the behavioral health needs of residents who will be entering nursing homes. This includes working with the nursing home facilities to increase their knowledge of these requirements and how to better address the needs of residents. Each of BHI CMHC center have an older adult program that provides PSARR Level II evaluation for all members who have major mental illness and are being referred to SNF or assisted living facility. These PSARR evaluators are licensed clinicians who assess for appropriate level of care and SNF placement in accordance with OBRA federal regulations. BHI providers also provide therapeutic and case management services to Members who reside in SNFs and LTC facilities. In collaboration with a PASRR evaluator and facilities, BHI providers identify service needs of Medicaid members.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: BHI staff members reported that thus far the CMHCs have been responsible for working directly with the nursing facilities where their members reside. BHI policies require that the CMHC providers have monthly contact with their members residing in nursing or assisted living facilities. BHI staff members reported believing that the CMHCs have done a good job working with the nursing facilities. Staff members reported that BHI has begun reaching out to some nursing facilities in the service area with only moderate success. Staff reported that staff members have attempted to meet quarterly with the nursing facilities to discuss system issues (such as substance use), while the CMHCs' work is member-specific. BHI staff indicated that more work needs to be done with the nursing facilities at the BHO level.		
2.H. The Contractor works closely and collaboratively with the Regional Care Collaborative Organizations (RCCOs) on care coordination activities. Contract: Exhibit A— 2.4.2.2.3	**Documents Submitted:** BHI CM Program Description (whole document) BHI Enrollee Desktop Procedure (whole document) MOU BHI RCCO (whole document) **Description of Process:** **BHI CM Program Description**-this document details how BHI Care Managers work closely and collaboratively with the Regional Care Collaborative Organizations (RCCOs). Our care managers assist members to connect with physical health providers to facilitate integrated care. **BHI Enrollee Desktop procedure –**describes the processes to identify members who could benefit from care management services and outline procedures for member outreach, goals and objectives of care management, health needs assessments and care management interventions. **MOU BHI RCCO -** Is the Memorandum of Understanding agreement between BHI and Colorado Access that outlines the care management scope of work and compensation to ensure that members are connected with RCCOs	Information Only
Findings: BHI has a memorandum of understanding with Colorado Access, the RCCO in BHI's service area. BHI has been outreaching some of the RCCO's smaller providers to encourage partnering with BHI for behavioral health service provision and for helping some clinics with care integration. One of BHI's in-network		

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CMHCs has an embedded pediatric PCMP. Some barriers encountered have been sharing of medical records with incompatible electronic medical record systems and understanding billing codes. BHI staff members also described coordination work between the RCCO care manager and BHI's care manager. In some cases, the Colorado Access care manager is identified as both; however, in some instances, the CMHC and the RCCO must work together to identify a primary care manager and determine how to ensure that duplicative work does not occur.		
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary (behavioral health) care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. *42CFR438.208(b)(1)* Contract: Exhibit A— 2.5.1; 2.5.5.3; 2.5.5.4	**Documents Submitted:** CLIN-209 State Plan and Waiver Services (whole document) CLIN-210 Coordination of Care (whole document) CLIN-211 Continuity of Care ADM-106 Coordination of Medicaid and Medicare Benefits (whole document) UM-811 Procedure on BHO to BHO Treatment (whole document) BHI CM Program Description ADMHN Care Coordination Agreement (whole document) AuMHC Care Coordination Agreement(whole document) CRC Care Coordination Agreement (whole document) Provider search and Contact BHI information screenshots Transition Coordinator job (whole document) Amendment Facility Service Agreement-Care Coordination (pgs. 3 and 4) **Description of Process:** All policies referenced above describe the mechanism that BHI has in place to ensure that members have access to services and assistance in determining the member's appropriate needs. BHI Provider network database, which is accessible to members via the internet or by calling BHI Member Call Line, has the ability to sort by demographic area, ethnicity, religion, language, treatment modalities and clinical specialties. The BHI Member Call Line is available to assist members in navigating and understanding his/her behavioral health benefits, rights	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
	and responsibilities, and filing grievances as needed, as well as accessing other community resources. Also the Amendment Facility Service Agreement-Care Coordination document shows how the contracted facilities agree on providing care coordination to BHI members to ensure that each member has an ongoing source of primary (behavioral health) care appropriate to his or her needs. BHI in collaboration with Co Access provides members with the option of enrolling specialized Care Management Services. Care Managers are responsible for assisting in identification of Members who may require additional care coordination with medical and other services. They can also assist Members in becoming attributed through the RCCO to the primary care medical provider (PCMP) of their choice. Care coordination responsibility encompasses working directly with Members, families, and providers over time to assist in arranging and managing a complex set of resources required to maintain the health and functioning of BHI Members. BHI's Transition coordinator acts as clinical liaison between BHI and a variety of providers to ensure continuity of care for Members transitioning levels of care. These transitions include the following: • Criminal justice populations to outpatient treatment providers • Inpatient levels of care to outpatient levels of care • Inpatient care to day treatment, in-home, or residential levels of care for children and adolescents • Emergency Department to home • Outpatient to Primary Care Physician (PCP) • Intensive outpatient to outpatient • Day treatment, in-home, or residential to outpatient and home	

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	Furthermore, the TC has been designated as a point person for these referral sources to assist members in the coordination of covered services by connecting members with community mental health centers, BHI's Care Managers, network providers or other appropriate community resources.	
4. The Contractor ensures that each member accessing services receives an individual intake and assessment for the level of care needed, performed by a qualified clinician. The intake and assessment process addresses: ◆ Developmental needs. ◆ Cultural and linguistic needs. ◆ Screening for mental illness, substance use, and trauma disorders. *42CFR438.208(c)(2)* Contract: Exhibit A—2.5.10.1	**Documents Submitted:** UM-823 Treatment Record Content (pg. 2) Screenshot of BHI Website- UM-823 Treatment Record Content Clinical Quality Review Audit Tool CMHC Intake Assessment Peer Review or Templates **Description of Process:** BHI's UM-823 Treatment Record Content Policy outlines the specific requirements of an intake/assessment. This policy is available to providers via the BHI website. BHI trains providers on the required elements of an intake/assessment. BHI received peer-review audit tools from the Community Mental Health Centers (CMHCs) in its catchment area and other providers to determine if providers were capturing the requirements of intakes/assessment and or monitoring the content of intakes/assessments internally via peer review process. The CMHC Intake Assessment Peer Review or Intake Templates document gives an example of how the requirement is met. In addition, through BHI's Provider Monitoring and Auditing process, a clinical quality audit is conducted on treatment records. The audit consists of reviewing intakes/assessments to ensure providers are addressing developmental needs, cultural and linguistic needs of members, and screening for mental health, substance use, and trauma. The Clinical Quality Audit Tool shows the elements reviewed an audit specific to intake/assessment.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: Each member is assessed prior to receiving services from either a CMHC or a contracted provider. BHI ensures that assessments and treatment plans address all required components by using a chart audit process. The chart audit process uses a sampling methodology which ensures that both CMHC and contracted providers are audited for completeness and quality of documentation. BHI's audit form included fields for evaluating whether the assessment addressed cultural and linguistic needs and screening for history of mental illness, substance use, and trauma disorders. The form did not evaluate whether the assessment addressed developmental needs. Therefore, while members who are involved in complex case management receive a comprehensive health needs assessment that addresses developmental needs, BHI did not have a mechanism to ensure that each member accessing services receives an individual assessment that addresses developmental needs.		
Required Actions: BHI must ensure that each member accessing services receives an individual assessment that addresses developmental needs.		
5. The Contractor shares with all health plans, RCCOs, and providers serving each member with special healthcare needs the results of its identification and assessment of the member's needs to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: Exhibit A—2.4.2.4.2.4.1	**Documents Submitted:** ADM-104 Coordination of Benefits CLIN-210 Coordination of Care (whole document) CLIN-211 Continuity of Care (whole document) ADMHN Care Coordination Agreement (whole document) AuMHC Care Coordination Agreement(whole document) CRC Care Coordination Agreement (whole document) CLIN-203 DDMI and TBIMI Practice Guidelines (whole document) Care Management Delegation Agreement (whole document) UM-811 Procedure on BHO to BHO Treatment BHI Care Management plan (whole document) **Process Description:** All policy referenced above describe how BHI providers work with members with special health care needs who are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. BHI for providers and encourages coordination of care with allied agencies to prevent duplication of services. **The Care Management Delegation Agreement**-outlines the policies and procedures that address the scope of care between BHI and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
	Colorado Access to ensure that the coordination and provision of covered services is completed in conjunction with other entities including but not limited to ◆ Any other MCO or PIHP. ◆ Other behavioral healthcare providers. ◆ Physical healthcare providers. ◆ Long-term care providers. ◆ Waiver services providers. ◆ Pharmacists. ◆ County and State agencies. ◆ Public health agencies. Each BHI CMHC has a care coordination agreement which describes how BHI facilitates the appropriate delivery of health care services for those transitioning from hospitals into community based services. BHI's providers are co-located in services medical clinics within the catchment area to help facilitate services. These clinician's collaborate with the physical health care provider s to assess members treatment needs. BHI's is also in production with community medical clinics to develop a e-referral program which is designed to help facilitate access to care and sharing of pertinent member information.	
6. The Contractor utilizes the information gathered in the member's intake and assessment to build an individualized, culturally sensitive comprehensive service plan that includes: ◆ Measurable goals. ◆ Strategies to achieve the stated goals. ◆ A mechanism for monitoring and revising the service plan as appropriate. The service plan is developed by the member, the member's	**Documents Submitted:** BHI Outpatient Integrated Service Plan (pg.2, 4) UM-823 Treatment Record Content (pg. 3) Treatment Plan Peer Review Process Examples (whole document) Clinical Quality Audit tool (whole document) **Description of the Process:** For BHI providers, development of the plan is a collaborative effort among members, the parents or legal guardians of child and adolescent members, informal caregivers, family members or other important	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
designated client representative (DCR), and the provider/treatment team, and is signed by the member and the reviewing professional. (If a member chooses not to sign his/her service plan, documentation shall be provided in the member's medical record stating the member's reason for not signing the plan.) Service planning shall take place annually or if there is a change in the member's level of functioning and care needs. *42CFR438.208(c)(3)* Contract: Exhibit A—2.5.11.1–2.5.11.4	persons selected by the member and/or parents/guardians. The treatment plans are reflective of the person's needs, wishes, and specific issues that have been identified in the assessment process. BHI encourages providers to use the BHI Outpatient Integrated Service Plan template to document measureable goals and objectives/strategies to achieve the developed goals. The BHI UM-823 Treatment Record Content policy indicates what is required in a treatment plan. BHI Providers have access to this policy via the BHI website. Both the member and the reviewing professional sign each treatment plan and any changes to it. If for any reason the member who participated in crafting the Individualized Service Plan does not wish to sign the plan, it is noted on the treatment plan and the reasoning is documented in the medical record. BHI received information from several providers indicating a Treatment Plan peer review process and examples are noted in the Treatment Plan Peer Review Process Examples document. As part of BHI's Ongoing Provider Monitoring process, BHI incorporates an audit of member treatment plans and reviews the elements noted in the Clinical Quality Audit Tool to ensure that providers are creating measureable, specific goals and objectives/strategies to achieve those goals. BHI reviews treatment plans to ensure that all signatures are acquired and if the member refused to sign a treatment plan, BHI ensures documentation of the reasoning for not signing is included. Finally, as part of the quality audits BHI checks to make sure treatment plans are updated at least annually, or updated if there is a change in care needs or functioning of the member.	

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Requirement	**Evidence as Submitted by BHO**	**Score**
7. The Contractor must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or approved number of visits) as appropriate for the member's condition. *42CFR438.208(c)(4)*	**Documents Submitted:** Member and Family Handbook (pg. 15) UM-808 Electroconvulsive Therapy ppFY16 (whole document) UM-808 aa BHI ECT Authorization Request Form (whole document) UM-809ab Medical Necessity Criteria – SUD Disorders (whole document) UM-809ac Medical Necessity Criteria – Eating Disorders (whole document) **Description of the Process:** The Member and Family Handbook notifies members how to access a specialist, if needed for care. Members can call the BHI Member Services line and speak with a representative about accessing specialty care. The authorization of specialty care such as Electroconvulsive Therapy (ECT), Eating Disorder treatment, and Substance Use Disorder (SUD) services depends on medical necessity. BHI policies including UM-808 Electroconvulsive Therapy ppFY16, UM-808aa BHI ECT Authorization Request Form, UM-809ab Medical Necessity Criteria – SUD Disorders, and UM-809ac Medical Necessity Criteria – Eating disorders provide information on specialty care. Providers or members can work with the UM Department to request an authorization for specialty care for a member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor shall adequately and timely provide the covered services out of network at no cost to the member. *42CFR206.(b)(4)* Contract: Exhibit A—2.5.9.5	**Documents Submitted:** BHI Single Case Agreement Contract (whole document) Member and Family Handbook (pg. 15) **Description of the Process:** The member has the right to find a provider outside of BHI's contracted network as seen in the Member and Family Handbook on page 15. Members can contact providers outside the network to request	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
	services. If the provider agrees to offer the services, it is the responsibility of the provider to contact BHI's Provider Relations Director to set up a Single Case Agreement (see Template) for the Medicaid covered services.	
9. The Contractor must arrange for the provision of all *medically necessary services** identified under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, 42 CFR Sections 441.50 to 441.62, including: ◆ Referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. (Referral assistance must include giving the family or beneficiary the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.) ▪ At a minimum, the Contractor must assure that the medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action. ◆ Making appropriate use of State health agencies, State vocational rehabilitation agencies, Title V grantees (Maternal and Child Health/Crippled Children's Services), and other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC). ◆ Offering the family or beneficiary necessary assistance with transportation and necessary assistance with scheduling appointments for EPSDT services.	**Documents Submitted:** Member and Family Handbook (pgs. 9 and 10) CLIN-213 Preventive Health Services ppFY16(whole document**)** Provider Manual FY16 (pgs. 12 and 13) NOA Letter (pg. 1) **Description of the Process:** Utilization Management Department: The Utilization Management Department includes EPSDT medical necessity criteria in their review when making authorization decisions for any member that qualifies under the EPSDT requirements. If the services requested are determined to not be medically necessary, the Notice of Action (NOA) letter includes information on why medical necessity was not met and information on appeal rights. For those medically necessary services which are not covered, members are directed to work with the BHI Member Services Call Line and/or to contact the Client and Clinical Care Office at HCPF to assist with a referral to the Healthy Communities Program. Office of Member and Family Affairs: Member Service Program educates and informs members about Preventive Services initiatives through the following processes: a. Member and Family handbook b. BHI website c. Member newsletters d. Educational outreach events e. Member Call Line	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
Medical necessity for EPSDT—* Medical Necessity means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it: ◆ Is found to be an equally effective treatment among other less conservative or more costly treatment options, and ◆ Meets at least one of the following criteria: ▪ The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability. ▪ The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability. ▪ The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability. ▪ The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living. Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.	The BHI Member and Handbook states that members can access Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. The BHI Member Call Line is available to assist members in navigating and understanding his/her behavioral health benefits and locating providers. Additionally, the member call line assists EPSDT qualified members with connecting to the Healthy Communities program and getting set up with a Family Health Coordinator. Provider Relations Department: BHI contracted providers are also required to share preventative health information to members and are educated about these services and initiatives through the following processes: a. Provider Bulletins b. Provider Manual c. BHI website	

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Requirement	**Evidence as Submitted by BHO**	**Score**
42 CFR 441.61 (a) and (b); *42 CFR 441.62* Contract: Amendment 3— 6.A.2.2.1 10 CCR 2505-10—8.280.8.C and D.5 10 CCR 2505-10—8.280.1		
10. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. In all other operations, as well, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Contract: 10.B; Exhibit A—2.4.2.1.1.6	**Documents Submitted:** PRIV-508 – Disclosure of Protected Health Information PRIV-505 – Business Associate Agreement Procedures BHI Individual Provider Contract template p. 6 section 3.12 and 3.13 Business Associate Agreement Template - whole document Annual BHI HIPPA training 2015 2015 HIPPA Questions/test **Description of the Process:** BHI has policies and procedures in place that ensure that in the process of coordinating care, each member's privacy is protected in accordance with the requirements in 45 CFR parts 160 and 164, subparts A and E. PRIV 508 outlines the process and the purposes for disclosing PHI; PRIV 505 outlines the Business Associate's role with protecting the privacy of BHI members. The Business Associate Agreement template is evidence of exact terms and privacy protections are in place with subcontractors. In order to ensure that BHI uses an discloses identifiable health information in accordance to federal and state laws, BHI trains all staff annually on HIPAA and privacy standards, The training and post-test have been attached as evidence.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor shall form relationships with community partners and government agencies that provide services to members. Agencies include: ◆ Colorado Department of Health Care Policy and Financing, Division of Development Disabilities. ◆ Colorado Department of Human Services, Child Welfare. ◆ Colorado Department of Human Services, Office of	**Documents Submitted:** Community Partners and Agencies Description **Description of the Process:** BHI's has established relationships with community partners and government agencies to offer Members the opportunity to receive behavioral health services in an integrated and coordinated setting,	Information Only

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Requirement	**Evidence as Submitted by BHO**	**Score**
Behavioral Health. ◆ Colorado Department of Public Health and Environment, STD/HIV Section. ◆ Colorado Department of Public Health and Environment. ◆ Colorado Department of Corrections. ◆ Colorado Prevention Services Division. Contract: Exhibit A—2.4.2.5; 2.4.5.6	strengthen the ability of families to protect and care for their own children, and minimize harm to children and youth. BHI incorporates trauma informed care in all services and embraced the implementation of the Crisis Stabilization Units and related statewide crisis hotline to assist members in receiving the right service at the right place at the right time. Within other collaborations, BHI works with the Office of Behavioral Health on different programs and projects placing peer specialists at the Colorado Mental Health Institutes at Ft. Logan and Pueblo to address recovery needs, and transition back to the community. Furthermore, BHI is aligned with OBH and the Colorado Department of Corrections in offering services to offenders and psychiatric services, transitional housing and vocational training, and supports the Division of Youth Corrections contracting providers to conduct emergency evaluations, providing co-located mental health services, and training judicial staff on trauma and a variety of behavioral health issues. Along with the CDPHE, and other stakeholders; BHI is working in the development of programs working on post-partum depression and wellness programs. Lastly, BHI has a long-standing relationship with the Colorado Department of Health Care Policy and Financing and this relationship has become stronger through timely reporting, data collection, open channels of communication and a shared commitment to quality of care.	

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Findings:

BHI submitted comprehensive documentation describing strong relationships with partners and agencies including:

- **Colorado Department of Human Services (CDHS) Division of Developmental Disabilities (DDD):** BHI collaborates with case managers to obtain and support specialized placements for members with developmental disabilities and provides mental health assessments for members to determine if their symptoms are due to a covered mental health diagnosis or if services should be provided under the Developmental Disabilities (DD) waiver. When appropriate, BHI and its CMHCs provide services for individuals also served by the DDD. These services are designed to coordinate with and complement DDD services. One of BHI's CMHCs has an embedded pediatric clinic providing specialty therapy services to children with developmental disabilities.
- **CDHS Division of Child Welfare:** BHI providers offer services within the home environment. BHI is represented on the Title IV-E Waiver (including trauma-informed care practices) and participates in a work group dedicated to developing optimal behavioral health services for children and families involved with the child welfare system. The goal of the group is to create a vision for behavioral health care for the child welfare system in Colorado. BHI works with youth involved in both the criminal justice and child welfare systems, offers training to BHI providers and partners on trauma-informed care, and collaborates with CDHS on issues involving adult protective services. BHI has provided training to DHS workers on the definition of "medical necessity" and services covered under the Medicaid managed care contract.
- **CDHS Office of Behavioral Health (OBH):** BHI routinely collaborates with OBH. Examples include working with OBH to develop critical incident reporting policy, OBH awarding BHI a grant for "Modernizing Treatment Through Trauma-Informed Care and Peer Support Services at the Mental Health Institutes," and BHI's CMHCs working closely with OBH (meeting all requirements of the Child Mental Health Treatment Act by evaluating needs and by providing/coordinating care and transitions for children at risk for out-of-home placement and with no other funding source for these services). OBH also awarded BHI the Continuity of Care with Transition Specialists (CTCS) contract.
- **CDHS Division of Youth Corrections (DYC):** BHI collaborates and supports the DYC by contracting with providers to conduct emergency mental health evaluations for members and providing co-located mental health services at the Foote Detention Center and Adams Youth Services Center. BHI provides training to judicial staff on trauma, residential care for youth, and a variety of behavioral health issues.
- **Colorado Department of Public Health and Environment (CDPHE):** BHI joins the Department in addressing "The Winnable Battles" of postpartum depression and substance abuse. BHI aligns its health promotion programs with the priorities of the Department and uses resources provided by CDPHE to provide wellness-focused services. BHI participates with the Office of Suicide Prevention in its community programs and advisory committee.
- **Colorado Department of Corrections (DOC):** BHI's CHMCs provide outreach and community-based treatment and psychiatric services for offenders. As part of its collaboration with DOC, these providers use telepsychiatry to engage with inmates who, once released, will become BHI members to ensure successful reintegration into their communities.

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Requirement	**Evidence as Submitted by BHO**	**Score**
12. The Contractor shall ensure that behavioral health services are provided to dual or multi- eligible members and assist members in finding qualified Medicare providers who are willing to provide covered services. If qualified Medicare providers cannot be identified or accessed, the Contractor shall provide medically necessary covered behavioral health services. Contract: Exhibit A—2.4.2.4.2.2.1.	**Documents Submitted:** CLIN-212 Coordination of Care for Special Populations FY16 (whole document) ADM-106 Coordination of Medicaid and Medicare Benefits (whole document) CLIN-203 DDMI and TBIMI Practice Standards (whole document) CLIN-210 Coordination of Care (whole document) Care Management Delegation Agreement **Process Description:** BHI has policies and procedures in place that ensure that in the process of coordinating care for dual or mutli-eligible members. BHI providers work closely with Colorado Access (CoA) as the Regional Care Collaborative Organization (RCCO) for Region 3 to establish communication and plan care coordination activities. Care coordination includes education about benefits under both plans, assistance with finding new providers if desired, and access to specialty providers when needed. If a dually-eligible Member is not associated with a primary care medical provider through the RCCO, BHI providers will help them connect to and enroll with one.	Information Only
Findings: BHI staff members reported that each of BHI's CMHCs is capable of providing services under Medicare. In addition, BHI identifies, in its network, providers qualified to provide services under Medicare. BHI's website provider search feature has a field to mark Medicare provider as a search parameter.		
13. For members with a behavioral health covered diagnosis and a co-occurring noncovered diagnosis, including autism, traumatic brain injury, and developmental disability, the Contractor will assess members using Department-approved criteria and provide medically necessary covered services for the behavioral health diagnosis. ◆ The Contractor has a mechanism for working with developmental disability services, Community Centered Boards (CCBs), Single Entry Point agencies (SEPs), or	**Documents Submitted:** CLIN-203 DDMI and TBIMI Practice Standards (whole document) CLIN-203aa Evaluation and Treatment of Covered MI People with TBI (whole document) CLIN-203ab Evaluation and Treatment of Covered MI with DD (whole Document) CLIN-210 Coordination of Care (whole document) CLIN-211 Continuity of Care (whole document) Transition Specialist Program Description (whole document)	Information Only

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Requirement	**Evidence as Submitted by BHO**	**Score**
other appropriate agencies/healthcare providers to secure agreement regarding the medical necessity of behavioral services. ◆ The Contractor provides care coordination to members, including appointment setting, assistance with paperwork, and follow-up to ensure linkage with the appropriate agency. If the Contractor determines that the member does not have a covered behavioral health diagnosis, the Contractor informs the member about how services may be obtained, and refers them to the appropriate providers (e.g., RCCOs, CCBs, and SEPs). Contract: Exhibit A—2.4.2.4.2.3.2–3; 2.5.10.2.2–3	Care Management Program Description (whole document) BHI Enrollees Desktop Procedure (whole document) Provider List_DD Autism TBI_1102201 (whole document) **Description of the Process:** **The Transition Specialist Program Description** outlines the mechanism in place for working with the Person Centered Planning Board to provide wrap around services for members that Medicaid and other payer sources cannot pay for. BHI's policies including : **CLIN-203 DDMI and TBIMI Practice Standards** details the procedures to ensure that the appropriate and effective assessment and service provisions for those members who have both DD and or TBI diagnoses. **CLIN-210 Coordination of Care** outlines the coordination of care for members to ensure collaborative treatment activities with other medical and behavioral health services to ensure continuity of care to promote maintenance of health and maximize independent living skills for our members. **CLIN-211 Continuity of Care** outlines and details the BHO's policy for continuity of care to ensure that when members transition from one setting to another that members have continued access to services during these times, including provider termination from the network and alternative care if services are unavailable. The BHI enrollee and procedure document and Care Management Program Description outlines how BHI provides care coordination to members including appointment setting, assistance with paperwork and follow up to ensure linkage with the appropriate agencies.	

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Requirement	**Evidence as Submitted by BHO**	**Score**
	BHI also has a list of contracted providers within its network to provide medically necessary covered services for the behavioral health diagnosis for members with a behavioral health covered diagnosis and a co-occurring non-covered diagnosis.	
Findings: BHI had adequate policies and procedures for treating members with development disabilities and traumatic brain injury. BHI staff members reported that BHI collaborated with the Department's Client and Clinical Care Program Office to meet with providers to discuss the populations of members with DD and autism and to problem solve treatment and payment strategies. Staff reported that Community Reach Center (CRC) has an embedded clinic that provides behavioral health and other therapy service (such as occupational therapy) and is able to bill FFS for these services.		
14. The Contractor maintains policies, procedures, and strategies for helping to transition members from Mental Health Institutes (Institutes) located at Ft. Logan and Pueblo to safe and alternative environments. The Contractor also: ◆ Care coordinates with the Institutes to have plans in place to provide medically necessary covered services once the member has been discharged from the Institute. ◆ Works with local counties and hospitals in its region in order to transition children from hospitals to safe and alternative step-down environments (e.g., home, residential). ◆ Meets with local counties and hospitals to develop transition protocols and procedures to ensure continuity of care and continuation of services for members. ◆ Works with the Institutes to execute communication and transition plans for members. ◆ Assigns a liaison to serve as a regular point of contact with Institute staff and members who will return to or enter the Contractor's geographic service area. ◆ Is responsible for ongoing treatment, case management, and other behavioral health services once the member is discharged from an Institute.	**Documents Submitted:** Care Management Program Description (whole document) CCTS Contract Exhibit A-Statement of Work (whole document) CLIN-212 Coordination of Care for Special Populations FY16 (whole document) Transition Coordinator Job Description (page 2) Transition Specialists Program Description (whole document) **Description of the Process:** BHI's strategies for helping to transition members from the Mental Health Institutes located at CMHI-FL and CMHIP (Pueblo) include doing so through the Care Management Program, The Transition Specialist Program and through the Transition Coordinator. These avenues are briefly outlined below: **Care Management program -** The CM program serves adult Medicaid recipients and their families. The majority of these members have a severe persistent mental illness that limits their ability to function in daily life. As a result, they do not receive treatment for long periods of time, resulting in multiple emergency department (ED) visits, inpatient hospital stays, and often a decline in their mental health. The program is an evidence-based practice founded by the National	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Participates on the Institute's Person Centered Planning Board. Contract: Exhibit A—2.4.2.4.2.8	Council on Community Behavioral Healthcare's (NCCBH's) Four Quadrant Clinical Integration Model[1] which identifies target populations and corresponding integration approaches for the provision of services as describe in the document called: CM Program Description. **Transition Specialist Program Description-** This program assists clients and communities statewide in managing the transition from hospitalization to less restrictive alternatives, employing a wraparound services approach. The Transition Specialists will facilitate community reintegration and manage funds for wraparound services which are not otherwise supported with insurance or other funding sources for persons transitioning from the two state mental health institutes. **BHI Transition Coordinator** is working in collaboration with other BHOs to develop a process for those Medicaid Members that are not releasing directly to the community from the Mental Health Institutes. These members are most likely forensic clients sent to the institutes for competency evaluations and will be returning back to county jails. BHI and the BHO have met with representatives from CMHIP and Ft. Logan and develop a process in which the Institutes refer members directly to a BHO point contact, that contact is responsible to connecting the Member to services in the facility they are returning too and to connect community mental health services once released. Population Served: • The priority for the service will be for individuals who have been hospitalized at either the Colorado Mental Health Institute at	

[1] Behavioral Health/Primary Care Integration. Retrieved December 10, 2014 developed by National Council for Community Behavioral Health as an environmental assessment tool. http://www.integration.samhsa.gov/clinical-practice/four_quadrant_model.pdf

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Pueblo or the Colorado Mental Health Institute at Fort Logan. The service will mainly focus on individuals on the discharge barrier wait list, but will also provide a service for any clients at the Institutes that meet the following criteria: • Individuals who have been hospitalized in the Institutes for one year or more. • Individuals who have a demonstrated past history of significant barriers which have prohibited them from a successful transition into their home community. • Individuals who have had 3 or more inpatient psychiatric readmissions at any hospital within the previous 12 months • Defendants pleading not guilty by reason of insanity (NGRI The Transition Specialists begin working with the clients prior to discharge and then follow the client's out of the institutes up the 60-90 days based on the individual needs of the client, longer if necessary for a successful transition.	

Findings:
BHI holds the CTCS contract with OBH for a statewide transition program. In addition, BHI has a transition coordinator who works specifically with BHI's Medicaid members. BHI's transition coordinator's role is to bridge the gap and ensure transition between systems. The transition coordinator receives referrals from the mental health institutes, the corrections system, and nursing facilities. During the on-site interview, staff members reported one system issue being that individuals moving from the institutes to a correctional facility before being released to the community were getting lost in the system. BHI's transition specialist worked with the mental health institutes to ensure coordination of services. One system change that has improved the process is that members are now allowed to apply for Medicaid 41 days prior to release from the institute. On-site, BHI staff presented a case study that demonstrated how BHI coordinated with the Mental Health Institute in Pueblo and the county jail system to successfully integrate the member into the community.

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	9

Total Score ÷ Total Applicable	=	90%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: Exhibit A—2.6.8.1	**Documents Submitted:** OMFA-605 Member Rights and Responsibilities (whole document) OMFA 606 Member Information (pgs. 2 and 3) Member and Family Handbook (pg. 26 and 27) **Description of the Process:** Member rights are outlined in the OMFA-605 Member Rights and Responsibilities policy. Member rights are also listed in the Member and Family Handbook. The OMFA-606 Member Information policy also outlines that all members receive a copy of member rights after enrollment and the member has a right to request a copy in any prevalent language. Copies will be provided to the member at no cost. **Documents reviewed onsite by HSAG:** Online staff training information	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor ensures that its staff and affiliated and network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: Exhibit A—2.6.8.1	**Documents Submitted:** Provider Manual FY16 (pgs. 36 – 39) Screenshot of Website - Members Rights and Responsibilities BHI Provider Contract (Attachment B) Grievance Report (pg. 1) **Description of the Process:** BHI informs providers through the Provider Manual and the BHI Provider Contract of member rights and responsibilities. Member Rights and Responsibilities are also posted on the BHI website for reference. All providers are responsible for posting the member rights at their facility. Members can file a grievance if they believe that their rights are not being taken into account during the course of treatment. The Grievance Report shows categories of grievances, which includes a category for Member Rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
	BHI staff is required to read and understand the Member Rights and Responsibility policy annually. This is tracked through the online training system. All new employees are required to read and understand the policy within two weeks of starting their position and this is also tracked through the online training system. **Documents reviewed onsite by HSAG:** Online staff training information	
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated and network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment, and the right to a second opinion. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Be furnished healthcare services in accordance with requirements for access and quality of services.	**Documents Submitted:** OMFA-605 Member Rights and Responsibilities (pgs 1 - 4) OMFA 606 Member information (whole document) BHI Individual Provider Contract (Attachment B) PRIV-508 Disclosure of Protected Health Information (whole document) Member and Family Handbook (pg. 25 - 27) OMFA 603 Grievance Procedure (whole document) 2016 Annual Enrollee Letter **Description of the Process:** Policy OMFA 605, OMFA 606, and the provider contract include all member rights and the process to notify member of their rights within 30 days of enrollment via the Member and Family Handbook. In addition, both policies outline the expectations of the contracted providers to ensure member rights are taken in to account when furnishing services. Policy OMFA 603 outlines the grievance process. The grievance process allows members to file a grievance related to any issue or concern about their behavioral health services or if any of their rights have been violated.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
42CFR438.100(b)(2) and (3) Contract: Exhibit A—2.6.8.1	Policy number PRIV 508 outlines the member rights related to privacy and confidentiality. The policy outlines the members' right to approve or deny a release of information that includes personal health information. In addition, the policy reviews HIPAA regulations when exchanging treatment Information.	
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. 42CFR438.100(c) Contract: Exhibit A—2.6.8.1	**Documents Submitted:** OMFA 603 – Grievance Policy (pg. 4) BHI Provider Contract (pg. 19) Member and Family Handbook (pgs. 27, 30) **Description of the Process:** The Member and Family Handbook states that a member is free to exercise his or her rights without being adversely affected by the contractor or provider. The OMFA-603 Grievance Policy outlines the process for members to file a grievance. This process is put in place as a method to prevent retaliation. If a member feels they are being retaliated against, they have the right to file a grievance with a client representative at a Community Mental Health Center (CMHC) or with a Member Services and Outreach representative. The BHI Provider Contract states that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the provider treats the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* Contract: Exhibit A—2.6.8.1	**Documents Submitted:** ADM 122 Non Discrimination Policy (whole document) ADM 103 Compliance with Applicable Law (whole document) OMFA-605 Member Rights and Responsibilities (whole document) **Description of the Process:** The ADM-122 Non-Discrimination Policy outlines BHI's commitment to serve all individuals who are eligible for its programs or services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
	without regard to any non-qualifying factor. BHI does not tolerate discrimination by its employees, volunteers, and providers when serving members. The ADM-103 Compliance with Applicable Law policy outlines that BHI complies with all applicable Federal and State Lines including the laws listed in this standard.	
6. The Contractor shall post and distribute member rights to individuals, including: stakeholders, members, providers, member's families, and case workers. Contract: Exhibit A—2.6.8.2	**Documents Submitted:** Screenshot of Website - Members Rights and Responsibilities Provider Manual FY16 (pgs. 36 – 39) **Description of the Process:** The member rights are posted on the BHI website which can be accessed by all employees, stakeholders, providers, and members as needed. Member Rights and Responsibilities are distributed to all providers through the Provider Manual. Providers are expected to post Members Right and Responsibilities at their office locations. Members receive a copy of rights and responsibilities via the Member and Family Handbook within 30 days of enrollment and annually thereafter. Each member has a right to request additional copies of the member rights or request the document in another language, at no cost to the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard IV—Member Rights and Protections							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	N/A
Total Applicable		=	6	**Total Score**		=	6

Total Score ÷ Total Applicable	=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. ◆ The Contractor shall use National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all contracts. Contract: Exhibit A—2.9.7.2.3.1 NCQA CR1	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 (whole document) **Description of Process:** BHI has delegated individual provider credentialing activities to Colorado Access (COA) through its Delegation Agreement. The purpose of this delegation agreement with COA is to streamline provider credentialing for common providers between Access Behavioral Care and BHI. BHI, in conjunction with COA, requires all practitioners to complete the Colorado Health Care Professional Credentials Application. Colorado Access also utilizes the Counsel for Affordable Quality Healthcare (CAQH) to obtain applications as well as the traditional paper copies of applications for credentialing and recredentialing. The practitioner credentialing and recredentialing processes begin with the completion of an application, signed, and dated attestation and submission of requested documentation to either CAQH or Colorado Access. The applications include an attestation by the applicant regarding all required guidelines as outlined by NCQA Standards. Upon request from a provider for network participation, the Director of Provider Relations emails a request to COA to begin credentialing. COA reviews its provider network to determine if the provider has already been credentialed through COA. If the provider has been credentialed and all required information is current and in good standing, COA forwards a Provider Profile, which is a summary of the providers credentialing file to BHI. This summary includes license verification, insurance, and sanction information as well as demographic information. The Director of Provider Relations then compiles the provider credentialing file for review by the Credentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
	Committee. This file includes the information sent by COA, provider's CV or Resume, summary of specialties and populations served and the W9 all of which are provided by the provider to BHI. If the provider has not been credentialed by COA, then the credentialing department at COA sends the Colorado Health Care Professional Credentials Application to the provider. COA also utilizes the Counsel for Affordable Quality Healthcare (CAQH) to obtain applications for credentialing and recredentialing. Once verification of all NCQA required elements has been completed, the Credentialing Program Coordinator at COA reviews the file for completeness and timeliness of the elements as required by the credentialing policy and the file is forwarded to BHI to be presented at the Credentialing Committee for approval of credentialing. BHI's Quality Improvement Committee provides oversight to the Credentialing Committee. The completed credentialing file is then reviewed against BHI Credentialing Criteria. If criteria are met, the application and report is presented to the Credentialing Committee. Based on the decision from the Committee, the practitioner will receive an acceptance or denial letter within thirty (30) days. The denial letter will include the appeal process.	
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include psychiatrists, psychologists, clinical social workers, psychiatric nurse specialists, and or licensed professional counselors). *42CFR438.214(a)* NCQA CR1—Element A1	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 (pgs. 3 and 4) BHI Provider Directory **Description of Process:** BHI's provider network generally consists of, but is not limited to, Doctors of Medicine (MDs), Doctors of Osteopathic Medicine (DOs), PhD, PsyD, LPsy, LCSW, LPC, LMFT, RN NP or CNS or RXN and other licensed independent practitioners with whom it contracts and who render services to members, and who fall within the Contractor's scope of authority and action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.B. The verification sources used. NCQA CR1—Element A2	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 (pgs. 7-10) **Description of Process:** The following elements and sources are researched and/or documentation gathered in support of the credentialing and recredentialing application. ◆ Licensure – Verification of licensure is obtained via the Internet (DORA) along with investigation of restrictions, limitations, or sanctions. Sanction activity is obtained through a query of the National Practitioner Data Bank (NPDB). ◆ DEA (Drug Enforcement Agency) or CDS (Controlled Dangerous Substances) - A copy or fax of the certificate from the practitioner, primary verification from the DEA website (www.deadiversion.usdoj.gov), verification from the American Medical Associate (AMA) Physician profile, or documented visual inspection of the original certificate are all acceptable sources. ◆ Education and Training - Verification of residency training or graduation from a medical school or graduate school is obtained through verification of licensure with the applicable State board. Other acceptable sources of verification may include either verbal or written verification from the institution awarding the degree (graduate school, medical school or residency program), verification received from the American Medical Association (AMA), or American Osteopathic Association (AOA) Master File (Physician Profile). ◆ Board Certification - Board certification is verified using an electronic source (Internet) that utilizes current information from the American Board of Medical Specialties (ABMS) or	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
	the American Medical Association (AMA) or American Osteopathic Association (AOA) Physician Master Files. ◆ Work History - Work history is not primary source verified; however, the practitioner is required to either submit a curriculum vitae or resume, or document a minimum of the past five (5) years of work history, on the credentialing application. Practitioners with work gaps that exceed one (1) year will be requested to provide documentation detailing how the practitioner maintained affiliation with the profession during the work gap. The Credentialing Program Coordinator clarifies either verbally or in writing with the practitioner any gaps in work history that exceed 6 months and document in the file. Verbal communication is documented appropriately in the credentialing file. ◆ Malpractice Insurance Coverage - Malpractice coverage is confirmed through the signed attestation on the application that includes the dates and amounts of the current malpractice insurance coverage or a copy of the insurance face sheet that includes the practitioner's name, dates and amounts of coverage. ◆ Colorado Bureau of Investigation - BHI requires a background investigation of all practitioners. When Colorado Access obtains a criminal history record through the Colorado Bureau of Investigation, the verification also includes a sex offender search. If an offender is a registered sex offender in Colorado, a "Registered Sex Offender" notation will show up on their criminal history.	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 (pgs. 4-5) **Description of Process:** Colorado Access, on behalf of BHI uses primary sources such as the Colorado Department of Regulatory Agencies (DORA) to verify state licenses, the National Practitioner Data Bank (NPDB) and the Federal Office of Inspector General (OIG) database to verify eligibility to participate in federal healthcare programs. The following criteria are used to outline the minimum requirements to be met by an applying network practitioner. ◆ Psychiatrists – Must be MD or DO, board certified or eligible, licensed by the state of CO, and have a valid DEA & CDS certificate ◆ Psychologists - Must be licensed independently as a clinical psychologist and possess a Doctoral Degree in Psychology (PhD, EdD, PsyD) from an accredited college or university ◆ Social Workers - Must possess a Master's Degree in Social Work and be licensed by the state ◆ Psychiatric Nurses/Clinical Specialists (APN/NP/CS/CNS/RXN) - Must possess a Master's degree in psychiatric nursing and be licensed by the state. If RXN, must be licensed by the state of Colorado with prescriptive authority privileges. ◆ Other Clinicians (LMFT, LPC) - Must possess a Master's degree and be licensed by the state. All eligible practitioners must have a minimum of three (3) years post licensure experience in a mental health/substance abuse setting providing direct patient care or otherwise approved by the credentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
	committee. BHI requires practitioners to carry minimum Professional Liability Coverage of $1,000,000 per individual episode; $3,000,000 aggregate and Comprehensive general or Umbrella Liability of $1,000,000 per individual episode; $1,000,000 aggregate. All practitioners must be accessible 24 hours a day, seven days a week or make appropriate arrangements for client care when they are unavailable. In addition, each practitioner must agree to make every effort to be available for appointments as follows: ◆ Emergency evaluation/face to face within 1 hour ◆ Urgent needs met within 48 hours\ ◆ Initial Routine appointments within seven (7) days	
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 pg. 12 Cred Committee Form_100609 Cred Committee Guidelines_100609 **Description of Process:** BHI utilizes a multidisciplinary Credentialing Committee that includes both BHI personnel and providers from the BHI network with experience in all levels of care and behavioral health specialties, including substance use disorders. BHI's Medical Director is a member of the committee and as such participates in all credentialing decisions. The Credentialing Committee meets monthly to review and discuss the complete credentialing files. The committee then approves or declines the credentialing request, and the provider is advised of the result. HI's Medical Director is a member of the Credentialing Committee and as such participates in all credentialing decisions. The Credentialing Committee reviews the credentials of all providers who do not meet the organization's established criteria.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documents Submitted:** CRED-403 Provider Credentialing and RecredentialingppFY16 (pg. 6-10, 15) **Description of Process:** Initially, all credentialing files are completed, reviewed and approved through the Colorado Access Credentialing Committee. This includes medical director sign-off and decision making. The Colorado Access approval date is then the credentialing date of record. The files are then sent to BHI. BHI presents all credentialing files to the Credentialing Committee for review. A current provider profile is maintained through COA for each provider contracted with BHI. The information contained in the file includes but is not limited to the following: ◆ A current application and CV, which includes a five (5) year work history ◆ Current State Professional License to practice ◆ Current DEA license, as applicable ◆ Current Professional Liability Policy face sheet ◆ Evidence of professional medical education including ECFMG, as applicable ◆ Evidence of Board Certification, as applicable ◆ NPDB (National Practitioners Data Bank) query, which includes Medicare and Medicaid sanction activity, as applicable ◆ FSMB (Federation of State Medical Boards) query, as applicable ◆ Evidence of site review, as applicable ◆ Colorado Bureau of Investigation (CBI) Query ◆ Sanctions List BHI presents all credentialing files to the Credentialing Committee for review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 (pg. 1-2) Delegation of Credentialing and Recredentialing with COA CY15 (whole document) **Description of Process:** COA agrees to credential and recredential behavioral health practitioners within its scope who have requested or are participating in BHI's Contracted Provider Network. COA credentialing program complies with the most recent standards and sub-standards set forth by the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), BHI, and any other applicable federal or state regulatory authority and agrees to perform the following credentialing and recredentialing functions in accordance with these NCQA Standards: Initial Credentialing Verification, Application and Attestation, Initial Sanction Information, Verification of Clinical Privileges, Recredentialing Verification, Recredentialing Cycle Length, and Ongoing Sanctions Monitoring. BHI Credentialing Committee BHI retains the right to approve and to terminate individual providers for the Contracted Provider Network.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.G. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes; and that it takes proactive steps to prevent and monitor discriminatory practices).	**Documents Submitted:** Non-discrimination and Confidentiality Attestation CRED-403 Provider Credentialing and Recredentialing ppFY16 (pg. 12, 13) Credentialing Committee Minutes 6-20-14d Credentialing Committee Minutes DRAFT 10-16-2015 **Description of Process:** BHI does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age,	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
NCQA CR1—Element A7	sexual orientation, type of practice, or types of patients the practitioner may specialize in treating. In addition, BHI and its Credentialing Committee do not discriminate against practitioners who serve high-risk populations or who specialize in the treatment of costly conditions. BHI will not discriminate in terms of participation, reimbursement, or indemnification against any healthcare professional that is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. This does not prevent BHI from including practitioners in its network who may meet certain demographic, cultural, or special needs. All participating committee members sign an acknowledgement form stating they do not discriminate when making credentialing and recredentialing decisions. The BHI Credentialing Committee reviews all providers that have been credentialed, re-credentialed and denied credentialing annually. The committee looks for any trends that might indicate possible provider discrimination based on applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes.	
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	**Documents Submitted:** CHCP Credential App10-2011 (pg. 23) CRED-406 Provider Rights FY16 (pg. 2) Provider Manual FY16 (pg. 10) **Description of Process:** When a practitioner has submitted their credentialing application the application is reviewed for completeness. If the application contains information that varies substantially from the information acquired during the credentialing process, the practitioner is given the opportunity to correct the information and/or explain the discrepancy. The provider is notified by any	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
	available means – phone, fax, mail and email. If the provider returns the application with the information corrected or the applicable explanations then the application is entered back into the review process and the new information is verified. If the provider does not respond to the request for additional information the credentialing is request is closed. All the above is completed within the 180 day credentialing cycle. Provider Rights are included in the credentialing application (p. 23) and in the provider manual. **Documents reviewed onsite by HSAG:** Provider contract Attachment D **Other documents reviewed by HSAG:** CRED-403 Provider Credentialing and Recredentialing	
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the credentialing committee's decision. NCQA CR1—Element A9	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 (pg. 11) **Description of Process:** The completed credentialing file is reviewed against BHI Credentialing Criteria. If criteria are met, the application and report is presented to the BHI Credentialing Committee. Based on the decision from the Credentialing Committee, the practitioner will receive an acceptance or denial letter within thirty (30) days. The denial letter will include the appeal process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 (pg. 12) **Description of Process:** BHI's Chief Medical Officer is a member of the Credentialing Committee and as such, participates in all credentialing decisions. Only the BHI Chief Medical Officer has the authority to determine if the file meets the BHI credentialing criteria and to sign off on it as complete, clean, and approved by the Credentialing Committee. Only the BHI Chief Medical Officer has the authority to sign off on all credentialing decisions. That date is considered the effective date for network participation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process. NCQA CR1—Element A11	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 (pg. 13) Provider Manual FY16 (pg. 5) Non-discrimination and Confidentiality Attestation **Description of Process:** Confidential handling includes securing credentialing files and credentialing minutes in locked file cabinets. Access to the credentialing files is granted on a need to know basis under the direction of the credentialing staff. The software used to track credentialing is password protected and access granted only to the credentialing staff. Extraneous materials gathered or generated for Risk and Resource Committee meetings are disposed of in locked shred bins	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Documents Submitted:** Provider Information Form_05122015 (whole document) Delegation of Credentialing and Recredentialing with COA CY15 (pg. 4) CRED-403 Provider Credentialing and Recredentialing ppFY16 (pg. 13 and 14) **Description of Process:** BHI utilizes the Provider Information Form with all its credentialing and recredentialing files. The Provider Information Form is faxed to all providers during credentialing and recredentialing to maintain accurate information regarding education, training, certification and specialty information. This information is used to update the provider directory as well as any other member material. BHI also uses the Provider Info Update Form on the website for providers to submit address, phone, fax, tax id, or other status update information. Any updated provider information obtained through various avenues for BHI or Colorado Access is communicated though emails and provider load files and both entities are updated as necessary. On behalf of BHI, Colorado Access verifies that the information pertaining to credentialed practitioners that is contained in member materials including provider directories is consistent with the information obtained during credentialing by conducting audits, at least annually. Examples of elements audited may include verification of the practitioner's name, education, training, certification, and specialty. Results of the audits are communicated to BHI and corrections are made immediately.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.M. The Contractor notifies practitioners about their rights: ◆ The right to review information submitted to support their credentialing or recredentialing application. NCQA CR1—Element B1	**Documents Submitted:** Provider Manual FY16 (pg. 10) CRED-403 Provider Credentialing and Recredentialing ppFY16 (pg. 1) CRED-406 Provider Rights FY16 (whole document) CHCP Credential App10-2011 (pg. 23) **Description of Process:** BHI Provider Rights are included in the Provider Manual that is available on our website and available in hard copy upon request. Provider Rights are also included in the Colorado Credentialing Application. Included in those rights is the provider's right to review information related to their credentialing application.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.N. The right to correct erroneous information. NCQA CR1—Element B2	**Documents Submitted:** Provider Manual FY16 (pg. 10) CRED-403 Provider Credentialing and Recredentialing ppFY16 (pg. 11) CRED-406 Provider Rights FY16 (whole document) CHCP Credential App10-2011 (pg. 23) **Description of Process:** BHI Provider Rights are included in the Provider Manual that is available on our website and in hard copy upon the provider's request. Included in those rights is the provider's right to correct erroneous information.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.O. The right to receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Documents Submitted:** Provider Manual FY16 (pg. 10) CRED-406 Provider Rights FY16 (whole document) CHCP Credential App10-2011 (pg. 23) **Description of Process:** BHI Provider Rights are included in the Provider Manual that is available on our website and in hard copy upon the provider's request. Provider Rights are also included in the Colorado Credentialing Application. Included in those rights is the provider's right upon request, to receive the status of their application. **Other documents reviewed by HSAG:** CRED-403 Provider Credentialing and Recredentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.P. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints, ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR6—Element A	**Documents Submitted:** CRED-407 Monitoring of Provider Sanctions ppFY16 (whole document) **Description of Process:** Colorado Access conducts ongoing monitoring of practitioners contracted to participate in the BHI network that fall within the scope of credentialing activities. BHI will take appropriate action based on the findings. The ongoing monitoring activities conducted between recredentialing cycles will include monthly review of Medicare and Medicaid sanctions or exclusions and Colorado State licensing sanctions or limitations on licensure. Practitioner-specific member grievances and occurrences of adverse events will be reviewed and investigated by the Quality Improvement Department and presented at the next occurring Quality Improvement Committee meeting. If a practitioner has been disciplined, Colorado Access will retrieve documentation from the applicable issuing agency and forward to BHI	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	for a more detailed investigation. Failure by the practitioner to comply with the corrective action plan as set forth by BHI will be evidenced through ongoing monitoring activities as outlined in appropriate departmental policies including but not limited to the Grievance Procedure and Quality of Care Concern Policy. **Documents reviewed onsite by HSAG:** Monthly COA reports of monitoring actions	
2.Q. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR7—Element A1	**Documents Submitted:** QI-702 Clinical Quality of Care Concerns ppFY16 (whole document) CRED-407 Monitoring of Provider Sanctions ppFY16 (whole document) **Description of Process:** All decisions about altering the practitioner's relationship with BHI include, but are not limited to, issues of quality of care and service, information submitted by the practitioner, as well as objective evidence. Decisions are guided by mental health client care considerations. Corrective action may include suspension of all or part of participation privileges, written warnings, letter of reprimand, probation, requirement of consultation and termination. If action is less severe than reduction of privileges or suspension or termination, the action will take effect immediately.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.R. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR 7—Elements A2 and B	**Documents Submitted:** CRED-407 Monitoring of Provider Sanctions ppFY16 (whole document) **Description of Process:** All physicians and licensed clinicians are subject to reporting of adverse actions to the appropriate State Licensing Board, Healthcare Policy and Finance and the National Practitioner Data Bank.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
2.S. A well-defined appeal process for instances in which the Contractor has taken action against a practitioner for quality reasons, which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR7—Elements A3and C	**Documents Submitted/Location Within Documents:** CRED-409 Provider Appeals ppFY16 (whole document) Provider Manual FY16 (pg. 8) **Description of Process:** The practitioner will be notified of the right to appeal the decision made by the Credentialing Committee within thirty (30) days of receipt of the decision. If the provider wishes to appeal, they have 30 days to provide written notification to the Director of Provider Relations of their intent to appeal. The provider must then provide appeal information in written format within 30 days of their notification to the Director of Provider Relations. They will be given the opportunity to present evidence in person or by phone to the BHI Provider Advisory Council. Corrective actions, which will be reviewed by the Credentialing Committee, with a recommendation for approval or disapproval include: ◆ Termination - the practitioner will be notified in writing of BHI's decision to terminate within seven (7) days of the decision. The BHI Provider Termination Letter Template advises the provider to contact the Director of Provider Relations in writing within thirty (30) days of notification to initiate an appeal. Appropriate tracking systems will be updated to reflect the decision. ◆ The practitioner has the right to appeal the decision to the committee within thirty (30) days of the decision. ◆ Not more than one appellate review will be considered. The Provider Advisory Council will make the final decision. BHI will notify the appropriate authorities for behaviors violating the law or ethical standards or practice.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
	Other documents reviewed by HSAG: Provider_Term_Template_04282015	
2.T. Making the appeal process known to practitioners. NCQA CR7—Elements A4 and C	**Documents Submitted:** Provider__Term_Template_04282015 (whole document) Decline to Include in Network Letter (whole document) Provider Manual FY16 (pg. 11, 14, 15) **Description of Process:** BHI notifies providers of the appeal process in letter format that is mailed via certified mail to the provider within 30 days of the Credentialing Committee's decision. The appeal process is also included in the Provider Manual which is available on our website or a paper copy can be requested by the provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A1	**Documents Submitted:** CRED- 403 Provider Credentialing and Recredentialing ppFY16 (pg. 12) Credentialing Committee Minutes DRAFT 2-20-15 2 (pg. 11) Credentialing Committee Member List FY15 **Description of Process:** BHI utilizes a multidisciplinary Credentialing Committee that includes both BHI personnel and providers from the BHI network with experience in all levels of care and behavioral health specialties, including substance use disorders. Members of the Credentialing Committee represent the following disciplines: Psychiatry, Psychology, Social Work, Nursing, and Professional Counseling.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
4. The credentialing committee: ◆ Reviews credentials for practitioners who do not meet established thresholds. ◆ Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Elements A2 and A3	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 (pg. 12 and 13) **Description of Process:** The Credentialing Committee meets monthly to review and discuss documentation delineating the result of primary source verifications and other pertinent information. The Credentialing Committee receives and reviews credentialing files for all practitioners who have applied for consideration including those who do not meet BHI's established criteria. BHI's Medical Director is a member of the Credentialing Committee and as such participates in all credentialing decisions. Only the BHI Medical Director has the authority to determine if the file meets the BHI credentialing criteria and to sign off on it as complete, clean, and approved by the Credentialing Committee. Only the BHI Medical Director has the authority to sign off on all credentialing decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit is 180 calendar days). ◆ A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 (pg. 7-11) **Description of Process:** BHI presents all credentialing files to the Credentialing Committee for review. A current provider profile is maintained through COA for each provider contracted with BHI. The information contained in the file includes but is not limited to the following: ◆ A current application and CV, which includes a five (5) year work history ◆ Current State Professional License to practice ◆ Current DEA license, as applicable ◆ Current Professional Liability Policy face sheet	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
certification—board certification time limit is 180 calendar days). ◆ Health professional work history—last five years (verification time limit is 365 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit is 180 calendar days). NCQA CR3—Element A	◆ Evidence of professional medical education including ECFMG, as applicable ◆ Evidence of Board Certification, as applicable ◆ NPDB (National Practitioners Data Bank) query, which includes Medicare and Medicaid sanction activity, as applicable ◆ FSMB (Federation of State Medical Boards) query, as applicable ◆ Evidence of site review, as applicable ◆ Colorado Bureau of Investigation (CBI) Query ◆ Sanctions List All information above must be completed within 180 days of signed attestation application date. BHI presents all credentialing files to the Credentialing Committee for review.	
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums= 1/mil/1 mil). ◆ The correctness and completeness of the application. NCQA CR3—Element C Contract: 13.B.(*v*)	**Documents Submitted:** CHCP Credential App10-2011 (pg. 17, 20, 21, 25, 26) **Description of Process:** The practitioner credentialing and recredentialing processes begin with the completion of an application, signed, and dated attestation and submission of requested documentation to either CAQH or Colorado Access. If the signed attestation exceeds 180 calendar days before the credentialing decision, the practitioner must attest only that the information in the application remains correct and complete and does not need to complete another application.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure, or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. NCQA CR3—Element B	**Documents Submitted:** CRED-403 Provider Credentialing and Recredentialing ppFY16 (pg. 2, 7, 11, 16) Ferguson SAM OIG Licensure Sample **Description of Process:** COA reviews the DORA, OIG, and EPLS websites when processing the providers' credentialing file. When the file is received by BHI the Director of Provider Relations also reviews these websites. Results from the provider search from all three those websites are printed and kept on site in the providers credentialing file and are reviewed during the Credentialing Committee meetings.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR5—Element A	RED-408aa Provider Office Site Visit Evaluation Form CRED-408ab Organizational Provider Site Visit Evaluation Tool CRED-408 Provider Office Site Quality ppFY16 **Description of Process:** BHI has developed a site visit tool for both individual providers and organizations that are used for all site visits. Providers are required to meet eighty percent (80%) compliance against the following site visit standards: ◆ Physical accessibility ◆ Physical appearance ◆ Adequacy of waiting and examining room space ◆ Availability of appointments ◆ Adequacy of treatment record keeping, including: ○ Secure, confidential filing system ○ Legible file markers Records are easily located	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
9. The Contractor implements appropriate interventions by: ◆ Continually monitoring member complaints for all practitioner sites. ◆ Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR5—Element B	**Documents Submitted:** OMFA-603 Grievance Procedure ppFY16 (pg. 4) CRED-408 Provider Office Site Quality ppFY16 Credentialing Committee Minutes DRAFT 08-21-15 **Description of Process:** If during a practitioner's participation in BHI's network BHI receives a complaint about the physical office of a provider, a site visit will be conducted. If the provider does not meet the eighty percent (80%) standard on the site visit tool, a follow-up site visit will be conducted within ninety (90) days. If the initial site visit produces any significant concerns, they will be immediately presented to the credentialing committee for review. The provider may be suspended from the network if the office does not meet BHI's standards after the second audit. All documentation for site visits is kept in the provider's on-site credentialing file. The BHI Department of Member and Family Affairs Director reviews all member grievances quarterly as they are completed. The director tracks any trends about specific providers or sites and reviews this information with the Credentialing Committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor formally recredentials its practitioners at least every 36 months. NCQA CR4	**Documents Submitted:** CRED-403 Credentialing and Recredentialing Policy ppFY16 (pg. 14) **Description of Process:** BHI recredentials all providers every three years. Recredentialing applications are obtained by Colorado Access from CAQH for currently contracted and previously credentialed practitioners. A request is generated approximately ninety (90) calendar days prior to the recredentialing due date. The recredentialing process is identical to	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
	the credentialing process except primary source verification does not re-collect educational verification; and provider utilization data, and any complaints and quality information is presented for consideration in the decision making process.	
Findings: BHI delegated credentialing and recredentialing to Colorado Access (COA). During on-site review of recredentialing files, HSAG identified two practitioners recredentialed after the 36-month time period.		
Required Actions: BHI must develop a mechanism to ensure that providers are recredentialed every 36 months. HSAG also recommended that BHI consider developing a process to ensure timely notification from COA of recredentialing files near 36 months and not yet been completed.		
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms—initially and at least every three years— that the provider is in good standing with state and federal regulatory bodies. NCQA CR8—Element A1	**Documents Submitted:** CRED-403 Credentialing and Recredentialing Policy ppFY16 (pg. 15-19) **Description of Process:** BHI has a written policy and procedure for initial and recredentialing of Organizational Providers. BHI confirms that all Organizational providers are in good standing with state and federal regulatory bodies. BHI retains a screen print displaying the query results from the Office of Inspector General (OIG) Federal Program Exclusions Database (Medicaid and Medicare status). www.oig.hhs.gov	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.B. The Contractor confirms—initially and at least every three years—that the provider has been reviewed and approved by an accrediting body. NCQA CR8—Element A2	**Documents Submitted:** Organizational Provider Credentialing Application_03252015 CRED-403 Credentialing and Recredentialing Policy ppFY16 (pg. 18) Centennial Peaks JCAHO Accreditation **Description of Process:** BHI collects and reviews current organization accreditation information from JCAHO, CARF, CHAP, or COA. BHI also collects completed site review reports from CMS, DMH, or ADAD as well as any other requested documentation to ensure the organization complies with BHI standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
11.C. The Contractor conducts—initially and at least every three years—an on-site quality assessment if there is no accreditation status. NCQA CR8—Element A3	**Documents Submitted:** CRED-403 Credentialing and Recredentialing Policy ppFY16 (pg. 18) Wellness Treatment Center Site Visit_05212015 **Description of Process:** Non-accredited organizational provider(s) are subject to an on-site assessment by BHI to confirm that they meet BHI quality standards. BHI will review policies and procedures related to the credentialing of direct care providers and supervisory practices, evidence of criminal background checks and Child Abuse Registry checks, and licensure verifications via the Colorado Department of Regulatory Affairs if applicable. BHI will utilize the CMS site survey conducted by the Colorado Department of Public Health and Environment (CDHPE), the DMH site review conducted on behalf of the Department of Human Services (DHS) or the Alcohol and Drug Abuse Division (ADAD) Site Inspection in lieu of conducting a site visit. In these instances, BHI will require a copy of the reports from the state agency to verify that the assessment complies with BHI standards and to ensure that the organizations credentialing and personnel policies and procedures were reviewed. If the organizational provider has not undergone a site visit by one of the above, or the documentation does not support BHI standards, BHI will perform a site visit.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: BHI's policy described a process to ensure that organizational providers are assessed every three years if not accredited. During on-site review of organization recredentialing files, HSAG identified one organization not accredited and without verification of a State site visit. The organization did not receive an on-site assessment by BHI.		
Required Actions: BHI must develop a mechanism to ensure that organizational providers are reassessed every three years.		

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11.D. The Contractor's policies specify the sources used to confirm: ◆ That providers are in good standing with state and federal requirements. ◆ The provider's accreditation status. (Includes applicable state or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider.) NCQA CR8—Element A, Factors 1 and 2	**Documents Submitted:** CRED-403 Credentialing and Recredentialing Policy ppFY16 (pg. 17-19) **Description of Process:** BHI's policy details the specific sources used to ensure that providers are in good standing with state and federal requirements as well as the provider's accreditation status. The organizational provider must provide evidence of one of the following accreditations and have a site visit performed by BHI to be considered for participation or ongoing participation. ◆ JCAHO ◆ COA ◆ CARF ◆ CMS Site Review ◆ DMH Site Review ADAD Site Inspection	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.E. The Contractor's policies and procedures include: ◆ On-site quality assessment criteria for each type of unaccredited organizational provider. ◆ A process for ensuring that that the provider credentials its practitioners. NCQA CR8—Element A, Factor 3	**Documents Submitted:** CRED-408 Provider Office Site Quality ppFY16 CRED-408ab Organizational Provider Site Visit Evaluation Tool **Description of Process:** If the organizational provider is not accredited by an entity recognized by BHI or not subject to site reviews conducted by CMS, DMH, OBH, or BHI will perform a site visit during the credentialing process. The facility site visit will include (but is not limited to): 1. Availability 2. Credentialing/Privileging: Review Policies and Procedures for credentialing or privileging, recredentialing/reappointment and primary source	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
	verification for staff licensing. 3. Clinical Operation: Review evaluation and reporting of Patient Satisfaction and Patient Complaints and Grievances. 4. Safety: Ensure the organization has policies and procedures for emergency coverage, and use of seclusion and/or restraints. 5. Appearance: Ensure that the offices are neat, clean, and professional 6. Treatment Record Practices and Record Keeping: Review the area where patient files are kept to ensure they are maintained in a locked and secure area. 7. Confidentiality: Review patient confidentiality standards with organization. 8. Medication Safety: Ensure all medications are stored in a safe location that is not accessible to patients and records of how medication samples are kept and distributed **Other documents reviewed by HSAG:** CRED-403 Credentialing and Recredentialing Policy	
12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards.	**Documents Submitted:** CRED-403 Credentialing and Recredentialing Policy ppFY16 (pg. 17, 18) Jefferson CMHC_OBH Review_01242013 **Description of Process:** BHI will utilize the CMS site survey conducted by the Colorado Department of Public Health and Environment (CDHPE), the DMH site review conducted on behalf of the Department of Human Services (DHS) or the Office of Behavioral Health (OBH) Site Inspection in lieu of conducting a site visit. In these instances, BHI will require a copy of	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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NCQA CR8—Element A, Factor 3	the reports from the state agency to verify that the assessment complies with BHI standards and to ensure that the organizations credentialing and personnel policies and procedures were reviewed. The CMS or state review must not be greater than three years old at the time of verification. If the organizational provider has not undergone a site visit by one of the above, or the documentation does not support BHI standards, BHI will perform a site visit.	
13. The Contractor's organizational provider assessment policies and process include assessment of at least: ◆ Inpatient facilities. ◆ Residential facilities. ◆ Ambulatory facilities. NCQA CR8—Element B	**Documents Submitted:** CRED-408ab Organizational Provider Site Visit Evaluation Tool **Description of Process:** BHI will assess organizational providers with which it intends to contract. These providers include hospitals, residential care facilities, Community Mental Health Centers, outpatient provider groups, and child placement agencies. BHI's Organization Site Review Tool includes assessments of services provided by Inpatient, Residential, and Ambulatory Facilities. **Other documents reviewed by HSAG:** CRED-403 Credentialing and Recredentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor has documentation that it has assessed contracted behavioral healthcare (organizational) providers. NCQA CR8—Element C	**Documents Submitted:** BHI Organizational Credentialing Checklist Kids Crossing_Site Visit 08112014 **Description of Process:** BHI utilizes the Organizational Credentialing Checklist when credentialing a facility to adequately review and ensure requirements have been established and met. BHI retains copies of the site review tool in the organizational providers credentialing file.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
15. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR9	**Documents Submitted:** Delegation of Credentialing and Recredentialing with COA CY15 (whole document) BHI SFY15 Quarterly Contract Performance Summary Q4 FINAL UPI Delegation Agreement_Executed_03102015 UPI SEMI ANNUAL REPORT Email UPI Semi Annual-Terms 11132015 UPI Semi Annual-Recreds 11132015 UPI Semi Annual-Initials 11132015 **Description of Process:** BHI has a written delegation agreement with COA to provide individual provider credential functions on behalf of BHI. Within the delegation agreement, BHI retains the right to approve, suspend, and terminate individual providers credentialing. On a periodic basis, but not less than annually, BHI will conduct a review or audit of COA's policies, procedures, and records pertaining to the delegated functions. COA's credentialing program will, at a minimum, satisfy all the most recent standards and sub-standards set forth by the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), BHI, and any other applicable federal or state regulatory authority. BHI will monitor the performance of COA by reviewing reports of credentialing activities on a monthly basis. BHI's Credentialing Committee will review annual audit findings, make applicable recommendations for improvement, oversee compliance with reporting, review actions plans, and perform follow-up activities. BHI entered into a delegation agreement for the credentialing and recredentialing function with University Physicians Inc. (UPI) to support their providers included in the outpatient group contract currently in place. UPI is a large outpatient group practice that	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
	credentials all their providers per NCQA requirements through Med Advantage. UPI provides regular reports of credentialed and recredentialed providers as well as terminations or disciplinary actions against any current provider.	
16. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the delegated activities and responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the delegation agreement) if the delegate does not fulfill its obligations. NCQA CR 9—Element A	**Documents Submitted:** Delegation Agreement for Credentialing and Recredentialing with COA CY15 (whole document) BHI SFY15 Quarterly Contract Performance Summary Q4 FINAL UPI Delegation Agreement_Executed_03102015 UPI SEMI ANNUAL REPORT Email UPI Semi Annual-Terms 11132015 UPI Semi Annual-Recreds 11132015 UPI Semi Annual-Initials 11132015 **Description of Process:** BHI has a written delegation agreement with COA to provide individual provider credential functions on behalf of BHI. Within the delegation agreement, BHI retains the right to approve, suspend, and terminate individual providers credentialing. On a periodic basis, but not less than annually, BHI will conduct a review or audit of COA's policies, procedures, and records pertaining to the delegated functions. COA's credentialing program will, at a minimum, satisfy all the most recent standards and sub-standards set forth by the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), BHI, and any other applicable federal or state regulatory authority. BHI will monitor the performance of COA by reviewing reports of credentialing activities on a monthly basis. BHI'S Credentialing Committee will review annual audit findings, make applicable recommendations for improvement, oversee compliance with reporting, review actions plans, and perform follow-up activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
	BHI has a written delegation agreement with UPI to provide individual provider credential functions on behalf of BHI. On a periodic basis, but not less than annually, BHI will conduct a review or audit of UPI's policies, procedures, and records pertaining to the delegated functions. UPI's credentialing program will, at a minimum, satisfy all the most recent standards and sub-standards set forth by the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), BHI, and any other applicable federal or state regulatory authority. BHI will monitor the performance of UPI by reviewing reports of credentialing activities on a monthly basis. BHI'S Credentialing Committee will review annual audit findings, make applicable recommendations for improvement, oversee compliance with reporting, review actions plans, and perform follow-up activities.	
17. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR9—Element B	**Documents Submitted:** Delegation Agreement for Credentialing and Recredentialing with COA CY15 (pg.4) UPI Delegation Agreement_Executed_03102015 (pg. 3) **Description of Process:** The delegation agreement with COA and UPI for credentialing functions do not include any PHI.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
18. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR9—Element C	**Documents Submitted:** Delegation Agreement for Credentialing and Recredentialing with COA CY15 (pg. 5) UPI Delegation Agreement_Executed_03102015 (pg. 3) **Description of Process:** Within the delegation agreement, BHI retains the right to approve, suspend, and terminate individual providers credentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR9—Element D	**Documents Submitted:** Delegation Agreement for Credentialing and Recredentialing with COA CY15 (whole document) UPI Pre delegation Credentialing Audit Tool Score Sheet UPI Pre Delegation Final Letter_02262015 UPI Pre Delegation Audit CAP Request **Description of Process:** The delegations agreement with COA for credentialing functions has been in place since 2009. The delegation agreement with UPI has been in effect for less than 12 months. BHI conducted a pre-delegation audit to evaluate their capacity and ability prior to the delegation agreement being signed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR9—Element E1	**Documents Submitted:** Credentialing Audit Tool Score Sheet 2012 Credentialing Tool for File Review **Description of Process:** BHI has done delegation audits on Colorado Access for FY 12, 13 and 14. BHI is scheduled to perform the next audit for Colorado Access in the Spring of 2016. This will then put both Colorado Access and UPI	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
	on the same calendar year schedule for the required delegation audits. **HSAG Note:** CY2015 standards compliance will be assessed during the CY2016 audit.	
21. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR9—Element E2	**Documents Submitted:** 2012 Credentialing Policies_Activities Audit Tool **Description of Process:** The initial delegation audit for UPI was performed in March of 2015. The Credentialing Delegation Audits for COA and UPI will be scheduled for Spring of 2016. Both audits will be performed annually on a calendar year. **HSAG Note:** CY2015 standards compliance and annual evaluation will be assessed during the CY2016 audit.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR9—Element E3	**Documents Submitted:** BHI SFY15 Quarterly Contract Performance Summary Q4 FINAL UPI SEMI ANNUAL REPORT Email UPI Semi Annual-Terms 11132015 UPI Semi Annual-Recreds 11132015 UPI Semi Annual-Initials 11132015 **Description of Process:** For COA, BHI reviews the quarterly contract performance summaries, which include the number of files that have been credentialed and recredentialed for that quarter. For UPI, BHI reviews the credentialing, recredentialing and termination provider lists as sent by UPI.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
23. The Contractor identified and followed up on opportunities for improvement (at least once in each of the past two years), if applicable. NCQA CR9—Element F	**Documents Submitted:** Credentialing Audit Tool Score Sheet 2012 Credentialing Tool for File Review 2012 Credentialing Policies Activities Audit Tool **Description of Process:** BHI will follow on any opportunities for improvements in the spring of 2016 when the credentialing audits are performed for COA and UPI. **HSAG Note:** There were no opportunities for improvement identified during the 2013 and 2014 audits.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	44	X	1.00	=	44
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	N/A
Total Applicable		=	46	**Total Score**		=	44

Total Score ÷ Total Applicable	=	96%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. 42CFR438.*240(a)* Contract: Exhibit A—2.8.1	**Documents Submitted** Quality Improvement Program Description FY16 (whole document) Annual Quality Report (whole document) Quality Improvement Committee Minutes 8-21-15 **Description of Process:** BHI's QAPI program identifies processes that serve to ensure that the spectrum of behavioral health care services are identified, prioritized, intervened upon, and tracked for improvement. The Quality Improvement Program Description FY16 provides more detail about the Quality Improvement program at BHI. The Annual Quality Report FY15 details a variety of QI activities, reporting, and interventions. The BHI Quality Improvement Committee (QIC) is responsible for the monitoring, oversight, and intervention design of BHI daily operations. QIC monitors activities from BHI's quality improvement, utilization management, provider relations, and member and family affairs departments, including (but not limited to): audits, quality of care concerns, critical incidents, over and under-utilization of services, Utilization Management decision timeframes, and provider network adequacy. Trends are analyzed and interventions are developed and implemented as necessary. Effectiveness of interventions and follow-up activities are also reviewed. QIC oversees any significant change in policies and operational procedures from each department. QIC reports to the Program Improvement Advisory Committee. QIC has three subcommittees, each of which includes providers from the BHI network. Each subcommittee chair reports activities and progress to QIC: • Program Evaluation and Outcomes Committee (PEO)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	• Standards of Practice Committee (SOP) • Credentialing Committee	
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: Exhibit A—2.8.5.1.1.2	**Documents Submitted:** Quality Improvement Program Description FY16 (pg. 3-4) Utilization Management Program Description FY16 (pg. 3-4) UM Annual Program Evaluation FY15 (pgs. 6 and 7) BHI FY15 Annual Quality Report (pgs. 48-53) BHI Report Card FY15 Q4 (whole document) 07-2015 Internal UM Monitoring Report Quality Improvement Committee Minutes 8-21-15 **Description of Process:** Both BHI's Quality Improvement Program Description FY16 and Utilization Management Program Description FY16 detail mechanisms to detect both under- and overutilization of services. Several mechanisms exist within BHI's systems and departments to detect under- and over utilization. BHI monitors under- and overutilization of services using a variety of data tracking systems. BHI completes both an Annual Quality Report and a Utilization Management Annual Evaluation. The Annual Quality Report details results of the annual performance measures, based on claims and state data. Specifically, BHI monitors penetration rates, inpatient utilization, readmissions, emergency department visits, and average length of stay. All of these measures contribute to the monitoring of under- and overutilization of services. BHI's UM Annual Program Evaluation details information regarding trends in utilization throughout the fiscal year. This trend analysis allows BHI to be able to monitor the increase/decrease in the use of specific services, as compared to the increase/decrease in membership.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Quarterly, BHI's QI Department creates a Report Card. The BHI Report Card FY15 Q4 gives an example of how inpatient utilization, emergency room visits, readmissions, and length of stay is monitored quarterly. The data from the BHI Report Card is based on internal tracking data reports. BHI discusses the Report Card in the Quality Improvement Committee to create interventions if needed. On a monthly basis, the UM Department creates a report that details the numbers of services requested, by type of service, number of authorizations and denials. This report, as seen in Utilization Management Monitoring Report – 09-2015, also provides information about inpatient; sub-acute high and low services, as well as length of stay, number of emergency room department visits, and readmissions. As a part of this report, BHI reviews client level detail about each readmission and reviews length of stay "outliers." This report is discussed in QIC as well as with the Executive Board members. Trends in utilization of services are analyzed monthly and quarterly and interventions are developed in QIC. This report helps BHI to monitor under- and overutilization monthly. The Top 100 Utilizers is a report BHI uses to help identify overutilization of behavioral health services. It is a report of the Top 100 utilizers of behavioral health dollars outside of the capitated mental health centers. Each member has been assigned a care manager to assess their needs, assist them in accessing services, and to coordinate care among their various providers/community supports. In addition, if/when these members present to an emergency department, the UM team attempts to contact their care manager to gather additional collateral information prior to making an authorization decision. As part of the continuous provider monitoring processes, BHI also	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	reinstituted the outpatient benefit limit report and the inpatient days benefit limit reports. BHI recognizes that there are no benefit limits; however these reports are useful in identifying under- and overutilization of services. BHI's Executive Leadership monitors the amounts paid to contracted providers on a weekly basis. This report allows BHI to see patterns and trends in utilization. Once a pattern is identified and a provider is recognized to consistently submit a large volume and/or high cost claims compared to other providers the Utilization Management, Provider Relations, and Quality Department research further to determine the appropriateness of the services offered and billed. If necessary, BHI follows its Provider Monitoring and Auditing policy if it determines that further information is necessary.	
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members. *42CFR438.240(b)(4)* Contract: Exhibit A—2.8.5.1.1.3	**Documents Submitted:** QI-702 Quality Of Care Concerns (whole document) QI-705 Critical Incident Reporting (whole document) CC-304 Provider Audits (whole document) Quality Improvement Program Description FY16 (whole document) Annual Quality Report (pgs. 21 – 24, 82 – 91) Annual Grievance Monitoring Report FY15 (whole document) **Description of the process:** BHI's Quality Improvement Department policies including QI-702 Quality of Care Concerns, QI-705 Critical Incident Reporting, and CC-304 guide how BHI assesses the quality and appropriateness of care furnished to members. BHI aggregates the results of provider audits, as well as other data including the number of critical incidents submitted and number of substantiated quality of care concerns during the recredentialing process for each provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Provider audits are conducted according to a schedule for each fiscal year by provider type. This year BHI's provider audits are focused on outpatient services, substance use facilities, and in-home providers. BHI also assesses member satisfaction with the care they receive every year through a survey. The Office of Member and Family affairs tracks and monitors grievances to ensure that members receive quality and appropriate care.	
4. The Contractor shall monitor its providers' performances on an ongoing basis and hold them accountable to a formal review according to a periodic schedule. Contract: Exhibit A—2.8.2	**Documents Submitted:** CC-304 Provider Audits (whole document) Credentialing Committee Minutes 8-21-2015 Quality Improvement Committee Minutes 8-21-15 On-going Provider Monitoring documents **Description of the process:** BHI's Provider Audit policy provides evidence that BHI monitors it's provider's performance on an ongoing basis and holds them accountable to a formal review according to a periodic schedule. Each fiscal year, BHI develops an audit plan based on data. BHI, through the Quality Improvement Committee, then decides which provider types or specific providers are going to be audited during the fiscal year. Audits are completed based on the schedule for the current fiscal year. The audit includes a compliance audit, a clinical quality review, and an office site evaluation. The compliance audit assures that providers are billing appropriately for services, while the clinical quality audit assures providers are providing excellent care to members and documenting everything necessary in the member's chart. The site evaluation scored to ensure that provider offices are compliant with standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Results of the three audit elements are presented in QIC as completed by provider. Depending on the results of the audits, providers can be asked to complete a corrective action plan, self-monitoring, or a larger scale audit will be conducted. The auditing process and audit tools are described in more detail in the document titled, "Ongoing Provider Monitoring documents."	
5. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual quality report describes: ◆ The Contractor's performance on the standard measures on which it is required to report. ◆ The results of each performance improvement project. ◆ The Contractor's detailed findings of program effectiveness. *42CFR438.240(e)(1) and (2)* Contract: Exhibit A—2.8.5.2; 2.8.6.1; 2.8.14	**Documents Submitted:** Annual Quality Report (pgs.14, 25, 48, 66, 3, 7, 8, 9) **Description of the process:** Annually, BHI evaluates the impact and effectiveness of the QAPI program. The Annual Quality Report (pgs. 14, 25, and 48) show BHI's performance on the standard measures on which it is required to report. On page 66, BHI shows the results of the current performance improvement project related adolescent depression screening and follow-up care in a behavioral health setting. On pages, 3, 7, 8, 9, BHI discusses key metrics and initiative of the quality improvement program for FY16. BHI also includes detailed findings of the QAPI program effectiveness.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting healthcare professionals.	**Documents Submitted:** CLIN-202 Clinical Practice Guidelines Quality Improvement Program Description FY16 Practice Guidelines Tracker **Description of process:** BHI adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of healthcare professional in particular	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Are reviewed and updated periodically as appropriate. *42CFR438.236(b)* Contract: Exhibit A—2.8.4.1	field. BHI's practice guidelines consider the needs of the members, adopted in consultation with contracting healthcare professionals, and are reviewed and updated periodically as appropriate as seen on the practice guideline tracking spreadsheet. The Standards of Practice (SOP) Committee determines which clinical practice guidelines are required. This is mainly due to a specific need to ensure consistent quality of service provision in certain areas, or a mental health diagnosis with a high prevalence. Each year a diagnostic report is run to highlight the number of BHI members with each behavioral health diagnosis and the SOP Committee will then make recommendations for additional guidelines. The Chief Medical Officer reviews the practice guidelines once every 2 years as a minimum, to ensure they are up to date and includes the most recent clinical best practice.	
7. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost. *42CFR438.236(c)* Contract: Exhibit A—2.6.7.9.1; 2.8.4.1	**Documents Submitted:** CLIN-202 – Clinical Practice Guidelines (whole document) Provider Manual (pg, 32) New Provider Letter Provider Bulletin – examples of sending out practice guidelines Member version of practice guidelines – examples (PG-101 Member version- Schizophrenia, PG- 115 Member Version Generalized Anxiety Disorder) Screenshot - Practice Guidelines Screenshot - Member Versions **Description of Process**: BHI's practice guidelines are disseminated according to the Clinical Practice Guideline policy. Practices guidelines are disseminated through the BHI website. Providers are notified via the Provider Manual that the BHI practice guidelines are available via the BHI website. BHI also highlights various practice guidelines throughout the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	year in the Provider Bulletin. BHI will provide members, potential members, and the public copies of the practice guidelines as requested. BHI can have the practice guidelines translated into other languages, upon the member request. Recently, BHI has created member versions of the practice guidelines to aid in member's understanding of the practice guideline. Examples are provided within the documents submitted for this standard. The Member Services and Outreach Team are able to provide these to members as requested.	
8. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: Exhibit A— 2.8.4.1	**Documents Submitted:** CLIN-202 – Clinical Practice Guidelines (whole document) UM-809 Medical Necessity Criteria (whole document) UM-824 Utilization Review Decisions (whole document) CLIN-203 DDMI and TBIMI Practice Standards (whole document) Member version of practice guidelines – examples (PG-101 Member version- Schizophrenia, PG- 115 Member Version Generalized Anxiety Disorder) **Description of process:** BHI's Utilization Management (UM) department maintains a comprehensive and effective process to monitor access and services from the point of entry through discharge for its members based on its policies and procedures, including but not limited to: CLIN-202 – Clinical Practice Guidelines; UM-809 Medical Necessity Criteria; UM-824 Utilization Review Decisions; CLIN-203 DDMI and TBIMI Practice Standards. Utilization review activities are applied across all higher levels of care and contracted providers are required to adhere to utilization management policies and procedures. BHI utilization review comprises	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	a set of formal techniques designed to monitor and evaluate the clinical necessity, appropriateness, efficacy, and efficiency of health care services, referrals, procedures, and settings. BHI reviews the appropriateness of members' use, consumption, level and intensity of care in an objective and consistent manner. The UM program supports member recovery by ensuring consistent access to the most effective and least restrictive medically necessary behavioral health service. The UM department utilizes an electronic health record 2database, Altruista, in conjunction with detailed spreadsheets to track, monitor and trend utilization review decisions, length of stay, level of care, care management activities, timeliness of UM decision making, and compliance with contractual requirements. All the member versions of the practice guidelines are on the BHI website and the Member Services & Outreach Department are aiming to include the guidelines as part of discussions within the recovery & wellness classes at the drop-in centers. Staff will distribute the guidelines at community resource fairs and will present information on the guidelines at the Member Advisory Board on an annual basis and whenever new guidelines are published. Examples of member practice guidelines are included as evidence. Compliance with the practice guidelines is determined through analysis at the end of the fiscal year. The monitoring of the metabolic side effects of atypical antipsychotics is measured through a member survey and analyzing claims data for the number of members prescribed an atypical antipsychotic that then had labs taken. Compliance with the RAD guideline is measured through claims data for the number of children receiving family therapy as well as the number of children on 3 or fewer antipsychotics at any one time. Finally, adherence to the risk assessment guideline is measured through a provider audit. This	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	provides BHI with important information to determine the extent to which the practice guidelines are being adhered to, so that interventions can be implemented within the following fiscal year if required. Results of each of the practice guideline monitoring mechanisms are shared with the PEO Committee and other committees as needed.	
9. The Contractor monitors member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided. Contract: Exhibit A—2.8.9.1	**Documents Submitted:** BHI FY15 Annual Quality Report (pgs. 25-32 and 82-91) **Description of Process:** Each fiscal year, in the Annual Quality Report, BHI addresses member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided through member satisfaction surveys. BHI conducts its own member satisfaction surveys per NCQA standards and evaluates the results. The member satisfaction survey contains questions related to access to care, cultural needs and preferences, as well as adequacy of care. Results are analyzed by category: Services, Accessibility, Availability, and Acceptability and presented in the Annual Quality Report. The results are reviewed in the Program Evaluation and Outcomes (PEO) Committee and interventions to improve satisfaction are developed as needed. The Department of Healthcare Policy and Financing (HCPF) also conducts an annual survey using a modified version of the ECHO. Results are presented to BHI via a report from Health Services Advisory Group (HSAG) and BHI is provided with the data files to conduct further analysis as needed. Last year BHI analyzed the results of each of the ECHO survey questions for both children and adults and presented the results in PEO.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
10. The Contractor investigates, analyzes, tracks, and trends quality of care (QOC) concerns. (Client complaints about care are not quality of care concerns under this section.) When a quality of care concern is raised, the Contractor: ◆ Investigates the QOC issue(s). ◆ Conducts follow-up with the member to determine if the immediate healthcare needs are being met. ◆ Sends a resolution letter to the originator of the QOC concern. ◆ Refers QOC issues to the Contractor's peer review committee, when appropriate. ◆ Refers the QOC issue to the appropriate regulatory agency, or licensing board or agency, when appropriate. ◆ Documents the incident in a QOC file that includes a description of the QOC concern, steps taken in the QOC investigation, corrective action(s) implemented, and any referrals to peer review or a regulatory agency. Contract: Exhibit A—2.8.10.2	**Documents Submitted:** QI-702 – Clinical Quality of Care Concerns – (whole document) QOCC Template Letters (whole document) Annual Quality Report (pgs. 96 – 97) 08-2015 Quality Monitoring Report (whole document) Quality Improvement Committee Minutes 8-21-15 **Description of Process:** QI-702 – Clinical Quality of Care Concerns policy guides the investigation of all quality of care issues. BHI's uses a database to save information on all Quality of Care Concerns (QOCCs) after investigations in order to track and trend data across fiscal years. The database is available for review during the on-site audit. At least annually, all QOCCs are analyzed for patterns and trends and reported in the Annual Quality Report. The BHI Quality Improvement Committee (QIC) also reviews ongoing QOCCs on a monthly basis, as seen in the Quality Monitoring Report 09-2015 and the Quality Improvement Committee Minutes 8-21-2015. The QOCC Template Letters are included for review. Template letters include an Acknowledgement Letter, Resolution Letter, and a Final Report that is signed by the investigator, Director of Quality Improvement, and Chief Medical Officer. The final report, as well as the QOCC database will include a description of the concern, steps taken in the QOCC process, corrective action implemented and any referrals to a regulatory agency. All QOCCs are reviewed monthly in the Quality Improvement Committee as the peer review process. Example QOCC files can be made available if needed during the on-site portion of the audit.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
11. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42CFR438.242(a)* Contract: Exhibit A—2.8.12.1	**Documents Submitted:** QI-707 Health Information Systems FY16 (whole document) QI-707aa Health Information Systems Data Integration Flowchart **Description of Process:** BHI maintains a robust health information system consisting of interconnected databases and applications that act as a repository for our staff to monitor, review, analyze and report on member and provider behaviors and provide the latest available information on which to base decisions regarding care and policy. Colorado Access provides several platforms by which data can be entered, maintained, utilized for care coordination, contractual obligations, and data-driven decision making. This data is then integrated into the existing BHI databases or otherwise made available through secured web interfaces (e.g. Altruista).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor's health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, third party liability, and disenrollments for other than loss of Medicaid eligibility. *42CFR438.242(a)* Contract: Exhibit A—2.8.12.1	**Documents Submitted:** Grievance Database Appeal Tracking Altruista screenshot **Description of the Process:** Third party liability is loaded into Colorado Access' QNXT system via the eligibility file or from denied explanation of benefits (EOBs) sent in with a claim from a provider. Colorado Access, as BHI's Administrative Service Organizations (ASO), verifies with third party insurance and loads the information appropriately. The UM Department has access to third party liability information through Altruista, and uses the information prior to making authorization decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	BHI does not disenroll members. BHI finds out about members who lose their Medicaid eligibility through the eligibility file that is generated from HCPF. BHI tracks grievances and appeals via internal tracking mechanisms. Each quarter a Grievance and Appeal Report is generated from the databases and sent to HCPF. Each month also aggregated quarterly data is reviewed during the Quality Improvement Committee (QIC).	
13. The Contractor collects data on member and provider characteristics and on services furnished to members (through an encounter data system). *42CFR438.242(b)(1)* Contract: Exhibit A—2.9.4.1	**Documents Submitted:** Encounter File Requirements (whole document) Annual Quality Report (pgs. 84, 89, 90) Provider Database screenshot **Description of the Process:** BHI receives monthly encounter files from the capitated Community Mental Health Centers within BHI's catchment area and claims for covered services from contracted providers. Colorado Access, as BHI's Administrative Service Organization, processes encounters and claims data through Qnxt. Colorado Access sends BHI's monthly encounter file to the Department of Health Care Policy and Financing (HCPF). Data collected on members and providers collected through an encounter data system includes the data fields that are required in the encounter files and referenced in Encounter File Requirements document. Both the ECHO survey, completed by HCPF, and BHI's member satisfaction survey collect demographic data on members receiving services. As seen in the Annual Quality Report demographic data on members is reported for both surveys.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	BHI has created a Provider Database (see screenshot) that captures provider characteristics. Providers are not required, as a part of credentialing to report certain demographic data, but it is an option.	
14. The Contractor's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. *42CFR438.242(b)(2)* Contract: Exhibit A—2.9.4.1.2; 2.9.3.7; 2.9.3.8	**Documents Submitted:** BHI SFY16 Quarterly Contract Performance Summary Q1 Final (pgs 8 – 11) Colorado Access/BHI Management Operation Updates (page 7) Monthly Encounter Reconciliation Process FY15 Scope Document v.Final (whole document) Sending Corrections in an 837_email **Description of the Process:** BHI and its Provider Network, including its Community Mental Health Centers, submit data to Colorado Access on a monthly basis. Data is processed by Colorado Access in a timely fashion, within 45 days for paper claims and within 30 days for electronic claims and encounters, with an accuracy rate of 99.3%. Data is submitted in standardized formats (837 and 835 files), scrubbed and screened for accuracy in diagnosis, place of service, proper eligibility and other required fields to ensure completeness and consistency. Data that does not meet the criteria established by all agencies involved is captured in an EVR (Event Validation Reconciliation) report that is distributed ot the CMHCs on a monthly and annual basis. Throughout the year BHI works with Colorado Access to ensure sound logic is being applied to data calculations surrounding performance measures and encounters/claim submissions through contractually obligated and ad hoc audits/checks.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	14

Total Score ÷ Total Applicable	=	100%

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

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Credentialing Record Review Tool
for Behavioral Healthcare, Inc.

Review Period:	January 1, 2015–December 31, 2015
Date of Review:	February 11–12, 2016
Reviewer:	Barbara McConnell and Theresa Larsen
Participating Plan Staff Member:	Teresa Summers/Kelsey Byars

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	******	******	******	******	******	******	******	******	******	******
Provider Type (MD, PhD, NP, PA, MSW)		PSYD	PSYD	LCSW	LCSW	LPC	PA	LCSW	LAC	
Application/Attestation Date		04/15/2014	03/28/2014	12/09/2014	09/22/2014	11/08/2014	07/09/2014	09/08/2014	02/14/2014	
Credentialing Date (Committee/Medical Director Approval Date)	12/08/2014	09/11/2014	07/14/2014	01/06/2015	10/03/2014	12/21/2014	09/11/2014	09/19/2014	02/23/2014	07/31/2014
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☐
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Work history	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ History of professional liability claims	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Current malpractice insurance in required amount	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Signed application and attestation	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
# Applicable elements		**8**	**8**	**8**	**8**	**8**	**9**	**8**	**8**	
# Compliant elements		**8**	**8**	**8**	**8**	**8**	**9**	**8**	**8**	
Percentage compliant		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	

OVERSAMPLE	1	2	3	4	5
Provider ID#	*****	******	******	******	******
Provider Type (MD, PhD, NP, PA, MSW)	LCSW	LCSW			
Application/Attestation Date	01/30/2014	04/19/2013			
Credentialing Date (Committee/Medical Director Approval Date)	02/16/2014	08/08/2013	04/28/2014	01/19/2015	10/24/2013
The Contractor, using primary sources, verifies that the following are present:					
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☐	Y☐ N☐ NA☐
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ Work history	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ Current malpractice insurance in required amount	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
# Applicable elements	**8**	**8**			
# Compliant elements	**8**	**8**			
Percentage compliant	**100%**	**100%**			
Total Record Review Score				**Total Applicable: 81**	**Total Compliant: 81** / **Total Percentage: 100%**

Comments: Sample #1 and #10 were erroneously labeled initial credentialing. Both were recredentialing files. These were replaced with two files from the oversample.

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Recredentialing Record Review Tool
for Behavioral Healthcare, Inc.

Review Period:	January 1, 2015–December 31, 2015
Date of Review:	February 11–12, 2016
Reviewer:	Barbara McConnell and Theresa Larsen
Participating Plan Staff Member:	Teresa Summers and Kelsey Byars

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	******	******	******	******	******	******	******	******	******	******
Provider Type (MD, PhD, NP, PA, MSW)	CSW	LPC	LMFT	PHD	LPC	LPC	PHD	PHD	LPC	LMFT
Application/Attestation Date	07/31/2015	05/26/2015	10/07/2013	04/03/2015	11/19/2012	03/20/2013	10/30/2014	08/14/2013	07/10/2013	12/09/2013
Last Credentialing/Recredentialing Date	10/25/2012	07/06/2012	08/03/2011	08/30/2012	04/21/2010	06/30/2010	01/26/2012	01/13/2011	11/11/2010	03/10/2011
Recredentialing Date (Committee/Medical Director Approval Date	11/03/2015	08/03/2015	02/16/2014	08/03/2015	03/28/2013	05/31/2013	01/19/2015	12/22/2013	10/18/2013	03/17/2014
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in the required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☐ N☒	Y☐ N☒	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	**7**	**7**	**7**	**7**	**7**	**7**	**8**	**7**	**7**	**7**
# Compliant elements	**6**	**6**	**7**	**7**	**7**	**7**	**8**	**7**	**7**	**7**
Percentage compliant	**86%**	**86%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

OVERSAMPLE	1	2	3	4	5					
Provider ID#	******	******	******	******	******					
Provider Type (MD, PhD, NP, PA, MSW)										
Application/Attestation Date										
Last Credentialing/Recredentialing Date										
Recredentialing Date (Committee/Medical Director Approval Date)	07/09/2015	04/13/2015	07/07/2014	03/22/2013	09/09/2015					
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐					
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☐	Y☐ N☐ NA☐	Y☐ N☐ NA☐	Y☐ N☐ NA☐	Y☐ N☐ NA☐					
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☐ N☐ NA☐	Y☐ N☐ NA☐	Y☐ N☐ NA☐	Y☐ N☐ NA☐	Y☐ N☐ NA☐					
◆ Malpractice history	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐					
◆ Current malpractice insurance in the required amount	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐					
◆ Verification that the provider has not been excluded from federal participation	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐					
◆ Signed application and attestation	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐					
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐					
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐					
# Applicable elements										
# Compliant elements										
Percentage compliant										
Total Record Review Score					**Total Applicable: 71**		**Total Point Score: 69**		**Total Percentage: 97%**	

Comments: Oversample files were not needed.

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

Table C-1 lists the participants in the FY 2015–2016 site review of **BHI**.

Table C-1—HSAG Reviewers and BHO Participants

HSAG Review Team	Title
Barbara McConnell, MBA, OTR	Executive Director, State & Corporate Services
Theresa Larsen	Associate Director, State & Corporate Services
BHI Participants	**Title**
Cara Hebert	Director, Office of Member and Family Affairs
Clara E. Cabanis	Quality Improvement Director
Earl L. Della Barca	Director, Healthcare Compliance
Haley Foster	Transition Coordinator
Heather Piernik	Director, Utilization Review
Jeff George	Director, Tech Services
Joyce Siow-Yazzie	Provider Relations Representative
Katie Herrmann, LCSW	Senior Manager, Clinical Services
Kelsey Byars	Colorado Access Credentialing Coordinator
Lisa Brody	Chief Operations Officer
Michelle Tomsche	Colorado Access– BHI Program Director
Shelly J. Spalding	Chief Executive Officer
Teresa Summers	Director, Provider Relations
Department Observers	**Title**
Russ Kennedy	Quality Specialist, Quality and Health Improvement Unit

Appendix D. Corrective Action Plan Template for FY 2015–2016 *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

For this step,	HSAG completed the following activities:
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, persons responsible, 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.

For this step,	HSAG completed the following activities:
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 healthcare regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2015–2016 Corrective Action Plan *for* BHI

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
4. The Contractor ensures that each member accessing services receives an individual intake and assessment for the level of care needed, performed by a qualified clinician. The intake and assessment process addresses: ◆ Developmental needs. ◆ Cultural and linguistic needs. ◆ Screening for mental illness, substance use, and trauma disorders.	Each member is assessed prior to receiving services from either a CMHC or a contracted provider. BHI ensures that assessments and treatment plans address all required components by using a chart audit process. BHI's audit form included fields for evaluating whether the assessment addressed cultural and linguistic needs and screening for history of mental illness, substance use, and trauma disorders. The form did not evaluate whether the assessment addressed developmental needs.	BHI must ensure that each member accessing services receives an individual assessment that addresses developmental needs.
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-3—FY 2015–2016 Corrective Action Plan *for* BHI

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
10. The Contractor formally recredentials its practitioners at least every 36 months.	BHI delegated credentialing and recredentialing to Colorado Access (COA). During on-site review of recredentialing files, HSAG identified two practitioners recredentialed after the 36-month time period.	BHI must develop a mechanism to ensure that providers are recredentialed every 36 months. HSAG also recommended that BHI consider developing a process to ensure timely notification from COA of recredentialing files near 36 months and not yet been completed.
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:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
11.C. The Contractor conducts—initially and at least every three years—an on-site quality assessment if there is no accreditation status.	BHI's policy described a process to ensure that organizational providers are assessed every three years if not accredited. During on-site review of organization recredentialing files, HSAG identified one organization not accredited and without verification of a State site visit. The organization did not receive an on-site assessment by BHI.	BHI must develop a mechanism to ensure that organizational providers are reassessed every three years.
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 four 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 lists of all Medicaid credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. 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.

For this step,	HSAG completed the following activities:
	◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to BHO credentialing and recredentialing. ◆ 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 2015–2016 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.