COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2016–2017 Site Review Report

for

Behavioral Healthcare, Inc.

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), with revisions published May 2016, 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 2016–2017 site review activities for the review period of January 1, 2016, through December 31, 2016. 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 three standard areas reviewed this year. Section 2 contains graphical representation of results for all standards reviewed over the past two three-year cycles. Section 3 describes the background and methodology used for the 2016–2017 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2015–2016 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials record reviews. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the BHO will be required to complete for FY 2016–2017 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 assigned required actions to any requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score. Recommendations for requirements scored as *Met* did not represent noncompliance with contract requirements or federal healthcare regulations.

Table 1-1 presents the scores for **Behavioral Healthcare, Inc.** (**BHI**) for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Coverage and Authorization of Services	31	31	27	4	0	0	87%
II. Access and Availability	10	10	10	0	0	0	100%
Totals	**41**	**41**	**37**	**4**	**0**	**0**	**90%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

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

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	65	61	4	35	94%
Totals	**100**	**65**	**61**	**4**	**35**	**94%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

BHI Utilization Management (UM) policies and procedures stated that **BHI** provides all medically necessary services based on a determination of medical necessity using established criteria and/or confirmation of a BHO-covered diagnosis or benefit. UM policies included the definition of medical necessity criteria per the State Medicaid program as well as service-level specific criteria for initial and continuing authorization of higher levels of service—inpatient, subacute, intensive outpatient, in-home treatment, partial hospitalization, residential, day treatment, psychological testing, and other specialty care services. Emergency services do not require prior authorization. UM decisions considered clinical judgement, recent evaluations, treating provider's recommendations, and member's response to prior treatments. **BHI** referred all decisions to deny authorization to a licensed behavioral health clinician with oversight by **BHI**'s chief medical officer, a board-certified psychiatrist. UM staff consulted with the requesting provider as needed to obtain more information appropriate to the authorization decision and offered peer-to-peer consultation to providers who disagree with the UM Department decision. **BHI** conducted inter-rater reliability (IRR) assessments for all levels of service at least annually—with participation of all UM staff members and medical directors—and staff members stated that UM staff conducted weekly team IRR huddle sessions, case studies, and review of alternative treatment recommendations to improve consistency in decisions among the team. Policies and procedures addressed time frames for making all types of authorization decisions per requirements. In addition, polices required that requests for higher levels of care—i.e., inpatient admission following an emergency room (ER) visit—be processed within one hour of receipt and considered all continued stay authorizations as urgent (expedited) requests. **BHI** monitored timeliness of authorization decisions through monthly and annual internal audits. **BHI** sent a written notice of action (NOA) to the member, with a copy to the provider, for each denied service. NOAs included a custom description of the reason for the denial and suggested alternative treatments available. NOAs included all required content and were available in English and Spanish or other languages upon request. **BHI**'s contracted interpreter service translated NOAs into non-English languages, including the customized reason for the denial and suggested alternative treatments. In addition, staff members stated that **BHI** provided in-house staff training and used other resources to ensure that staff communicates with members in plain language. **BHI** staff members stated and denial record reviews confirmed that, effective September 16, 2016, **BHI** changed the content of the NOA to reflect the change to 60 days for requesting a State fair hearing. The notice of extension letter to the member also included required content.

On-site denials record review confirmed the following:

- Denials record reviews included nine new requests (six standard time frame, two expedited time frame, and one retrospective) and one termination of previously authorized services. **BHI** extended the decision time frame for one case.
- HSAG found that in all cases reviewed a qualified clinician made the decision; the decision was based on established criteria; the NOA was sent to the member and provider; and the NOA included required content.

- **BHI** sent NOAs within the required time frame in nine of 10 cases.
- HSAG found that eight of 10 NOAs to the member were easy to understand.
- For cases in which the member was EPSDT-eligible, **BHI** told the member how to obtain covered fee-for-service or wrap-around services.

Policies and procedures, the provider manual, and the member handbook accurately defined "emergency medical condition," including the prudent layperson definition. Policies and procedures and the member handbook stated that **BHI** pays emergency claims without prior authorization—in or out of network—and the member handbook informed members that they are never liable for payment of emergency services or post-stabilization services. The Emergency and Post-Stabilization Services policy included all requirements for provision and payment for emergency and post-stabilization services as outlined in the requirements. Staff members stated that **BHI** pays all emergency claims without any review. In addition, **BHI** has operationalized the Emergency and Post-Stabilization Services policy related to financial responsibility for post-stabilization services by having a UM authorization request call line available to providers from 8 a.m. until 10 p.m. and reviewed authorizations requested after 10 p.m. immediately the following morning. Staff members stated that **BHI** authorizes all post-stabilization services provided up to the point when a UM determination review can be made.

Summary of Findings Resulting in Opportunities for Improvement

While **BHI** defined "medical necessity" equivalent to the medical necessity definition outlined in the State Medicaid Plan, the definition of medical necessity outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 and 8.706.1.8.1 (effective August 30, 2016)—included the addition of EPSDT-specific criteria. Therefore, **BHI** is advised to immediately update the definition of medical necessity in UM and EPSDT policies accordingly.

The UM Decision Timeframes policy and the NOA policy addressed time frames for mailing the NOA per the requirements. However, information in each policy was incomplete, inconsistent, and/or referenced the opposite policy, requiring that both policies be used together to address all time frame requirements. HSAG recommends that **BHI** consolidate time frames for mailing the NOA into one policy or ensure that each policy includes complete and consistent information.

HSAG observed that some NOAs included terminology or acronyms commonly used in the behavioral health environment and suggested that **BHI** carefully review the "reasons for denial" or "treatment alternatives" sections of each NOA and ensure members will understand the terminology used.

While the information in the NOA accurately defined the processes for a member to file an appeal, the NOA policy stated that if a member is dissatisfied with the action decision, he/she may file a "grievance." HSAG recommends that **BHI** clarify the NOA policy to specify that members dissatisfied with a *decision* may file an appeal. Members dissatisfied with the *process* may file a grievance.

Some of the language in the Emergency and Post-Stabilization policy and the member handbook appeared too confusing for either staff or members to clearly understand emergency and post-stabilization services a follows:

- While the Emergency and Post-Stabilization policy included the definition of emergency services as defined in federal language, it also added, "An Emergency Medical Condition can also be a self-defined emergency." Staff members explained that this is intended to address the definition of emergency as applicable to crisis stabilization units, which includes anything that causes the member extreme distress—such as not having enough food or domestic issues within the family. This extends the definition of emergency medical condition and related requirements for handling an emergency medical condition beyond that intended by the federal definition.
- While the member handbook specifies that members can go to any ER for services when they have an emergency, the emergency section of the handbook also refers members to crisis intervention lines, nurse advice line, and substance abuse and urgent care locations, which obscures the information directing members to seek services from any provider qualified to furnish emergency services to stabilize an emergency medical condition (as defined by federal regulation). Staff members explained that this information is intended to convey that members have alternatives in the community for obtaining "crisis services." However, HSAG advised that crisis services do not equate to emergency services per the federal definition.
- The member handbook also describes inpatient services, subacute services, and detoxification services as examples of "emergency services." These services are post-stabilization—not emergency—services. As such, they may require authorization, whereas emergency services require no prior authorization.

HSAG recommends that **BHI** review and clarify its policies and member handbook communications regarding emergency and post-stabilization services to ensure that additional information does not obscure or confuse the correct federal definitions and requirements. **BHI** may want to consider including a separate section in policies and/or the member handbook to address crisis services.

Summary of Findings Resulting in Required Actions

Although HSAG observed during on-site record reviews that UM staff contacted requesting providers to obtain additional information needed during the authorization process, the Utilization Review Decisions policy, NOA policy, and provider manual also stated that providers may request a peer-to-peer consultation with the UM medical director after a denial is issued. The NOA policy stated that if an NOA is issued due to lack of information, "**BHI** may overturn the denial based on new information received and *this is not considered a part of the appeal process*." This statement is out of compliance with federal and State appeal regulations. HSAG advised **BHI** staff members that once an NOA is issued, any peer-to-peer consultation or decision to overturn a denial decision is part of the appeal process and must be treated as such. **BHI** should ensure that it consults with the provider *prior to* issuing a denial NOA and provides ample opportunity—within the required decision time frames—for the provider to request peer-to-peer consultation. **BHI** must review and revise UM policies and procedures and the provider manual to (1) ensure that **BHI** initiates a peer-to-peer consultation or request for more

information prior to issuing an NOA, and (2) to clarify that a peer-to-peer consultation conducted after an NOA has been issued is considered part of the appeal process and must be treated as such.

The UM Decision Timeframes policy and the NOA policy addressed time frames for mailing the NOA per the requirements. However, neither policy specified that when **BHI** extends the time frame, the NOA must be mailed "no later than the date the extension expires." **BHI** must revise policies and procedures to specify that the time frame for mailing the NOA when the decision time frame is extended is no later than the date the extension expires.

During on-site record reviews, HSAG noted one case in which **BHI** extended the time frame for making a decision. **BHI** sent the written notice of extension only to the provider, not to the member. **BHI** must ensure that it provides the member written notice of extension of the time frame for making an authorization decision.

During on-site record reviews, HSAG identified that **BHI** mailed the NOA for termination of previously authorized services outside of the required time frame—10 days prior to the date of the intended action. **BHI** must ensure that it provides notice of termination of previously authorized services at least 10 days before the date of the intended action.

HSAG noted in on-site denial record reviews that NOAs were written in language that was easy for the member to understand. However, two cases included information that appeared to be inappropriate for the member and were therefore scored as "not easy to understand." **BHI** must implement a process to ensure that the information included in individual member NOAs is appropriate and not confusing to the member.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

BHI's Network Adequacy policy stated **BHI**'s intention to maintain a network of appropriate numbers and types of providers to ensure timely provision to all covered services. The policy described the mechanism **BHI** uses to measure the adequacy of its network and stated that **BHI** would consider anticipated enrollment, expected use of services, geographic locations of providers and members, numbers of single case agreements (SCAs), member surveys, and grievances related to access and availability of providers. **BHI**'s *Annual Network Adequacy and Needs Assessment Report* dated May 31, 2016, reported a need for additional providers and facilities specializing in treatment of substance use disorder (SUD). During the on-site interview, staff members stated that **BHI** contracted with about eight new SUD providers since June 2016. Staff members reported that while **BHI** is confident that its network of providers is sufficient to meet the needs of its membership, it maintains an open network and continues to welcome new providers—especially providers specifically requested by members and those who reflect the cultural diversity of its membership.

BHI's Psychiatric Consultations Second Opinions policy described **BHI**'s process for providing members with second opinions in or out of network free of charge. **BHI**'s Out of Network Providers—Single Case Agreements policy described **BHI**'s processes for using SCAs when medically necessary services cannot be provided by **BHI**'s existing network. SCA contract templates included language that prohibited providers from charging members for covered services.

BHI publishes 24-hour crisis telephone numbers for three of its community mental health centers (CMHCs) as well as State and national crisis hotlines prominently on its website, in its member handbook, and in quarterly member newsletters. While not advertised as being available 24/7, staff members stated that **BHI**'s main telephone number is answered by a live person 24 hours a day, 7 days a week. **BHI** requires that its providers adhere to the appointment standards for emergency, urgent, and routine services and publishes the appointment standards in the provider manual, member handbook, and on its website. **BHI** requires that its CMHCs submit access-to-care data quarterly, conducts provider site visits that include review of appointment standards, and monitors member grievances regarding access.

BHI's service area encompasses some of the most culturally diverse areas in Colorado, and **BHI** prides itself on its willingness and ability to provide services in a manner that respect and address the cultural needs of all members. **BHI** had a cultural competency plan that outlined goals for ensuring the provision of culturally competent services, and staff members provided evidence of having conducted annual self-assessments that measured progress towards meeting the goals. In addition to annual cultural compliance training required of **BHI** staff members, **BHI** hired a consultant in 2016 to provide staff members with an additional, intensive four-hour cultural competency training. **BHI** offers cultural competency training to all providers and helps sponsor educational sessions—open to providers, members, and the community—offered by the CMHCs. Recent sessions addressed cultural issues related to the lesbian, gay, bisexual, transgender, and queer and/or questioning (LGBTQ) community, the homeless community, and Spanish and Vietnamese communities.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no findings resulting in opportunities for improvement related to access and availability.

Summary of Findings Resulting in Required Actions

HSAG identified no required corrective actions for this standard.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

Summary of Strengths and Findings as Evidence of Compliance

The Preventive Health Services policy defined EPSDT services and provided a high-level description of mechanisms for informing members about EPSDT services, incorporating EPSDT medical necessity definition into UM procedures, referring members to **BHI** care coordinators and Healthy Communities, and monitoring providers for compliance with EPSDT-related requirements. Staff members stated that the Preventive Health Services policy was intended to be the umbrella policy that describes EPSDT program components, with corresponding procedures defined in individual department or provider communications. The Coordination of Care policy described general care coordination for all members, with expectations that providers make referrals for needed services and share mental health information with medical providers. Policies adequately outlined processes for **BHI** care coordinators to assist members eligible for EPSDT services with obtaining needed referrals or services. The **BHI** member handbook described all the benefits of EPSDT preventive services and identified Healthy Communities as a resource to assist members with obtaining services. The provider manual stated that providers must refer members who need EPSDT screening to their primary care providers (PCPs). **BHI** required that providers conduct a comprehensive intake assessment of member needs for all members and create a corresponding treatment plan. The provider manual stated that providers should obtain and consider results of the screenings in service planning. **BHI** UM policies and procedures incorporated the EPSDT definition of medical necessity and criteria for approval of EPSDT services into authorization decisions. As noted in member NOAs, EPSDT-eligible members are referred to the **BHI** care managers or the Department's Office of Clinical Services for assistance with obtaining medically necessary services not covered by the BHO. Care coordination policies and the provider manual stated that if the provider is not licensed or equipped to render necessary treatment or further diagnosis, the provider or **BHI** care manager will refer the individual to an appropriate practitioner or facility or to Healthy Communities for assistance. The Preventive Health Services policy outlined many of the community agencies and providers of EPSDT-related services. Staff stated that care coordinators have experience, contacts, and resources for coordinating with outside agencies that may offer EPSDT-related services. **BHI** identified a member of its care management staff as an EPSDT specialist. The provider manual referenced EPSDT services in several sections and provider trainings, and while limited, provided a link to the Health First Colorado website to obtain more information on EPSDT services.

Despite the opportunities for improvement and recommendations outlined below, **BHI** made significant efforts over the past year to implement processes to address BHO responsibilities related to EPSDT. All components of EPSDT requirements were at least partially met.

Summary of Findings Resulting in Opportunities for Improvement

At the time of on-site review, the member handbook was **BHI**'s only adequate source of informing members about the benefits of EPSDT, including services available under the EPSDT program and

where and how to obtain those services. HSAG encourages **BHI** to expand both oral and written mechanisms for communicating information on EPSDT services to members and to consider including EPSDT communications with members at the provider point of service, as well as ongoing and periodic—not just enrollment—mechanisms.

While **BHI** demonstrated that it has care coordination processes and resources capable of assisting members with obtaining EPSDT services not covered by the BHO, including coordination with outside agencies, both the written care coordination procedures and the provider manual indicated that providers or **BHI** care coordinators would refer members to Healthy Communities for assistance with EPSDT services. HSAG recommends that **BHI** ensure its care coordinators are actively involved in coordinating services for members and not routinely deferring to Healthy Communities. HSAG also recommends that **BHI** clarify to providers that **BHI** care coordinators are available to assist members and providers with necessary referrals.

Staff members stated that **BHI** obtained most of the resources used to support the EPSDT requirements from the Health First Colorado website and that the resources are sometimes vague or lack clarity regarding expectations for implementation. Staff members stated that they would appreciate any further resources to guide procedures for effective implementation. HSAG recommends that **BHI** work directly with the Department's EPSDT staff resource—Gina Robinson—and also consider working with the corresponding Regional Care Collaborative Organization (RCCO) in the region to integrate BHO and primary care objectives and resources for delivery of EPSDT services.

BHI's Quality Audit Tool reviewed for documentation of: (1) "EPSDT present"; (2) problem and negative findings that are identified and noted; and (3) referrals made based on findings. HSAG recommends that **BHI** clarify in the tool or in auditor instructions whether the reviewer is monitoring for documentation of BHO provider screenings or screenings obtained from PCPs, the *types* of referrals made, and what is intended by "EPSDT present." In addition, HSAG recommends expanding the tool to monitor for requirements delineated in the **BHI** provider manual.

The provider manual referenced EPSDT services in several sections—i.e., Medical Care Benefits, Frequently Asked Questions (FAQs), and EPSDT Screening Form. These references to EPSDT are isolated and obscure. HSAG recommends **BHI** consider consolidating all EPSDT-related information and provider expectations into a clearly defined EPSDT section of the provider manual.

NOA letters to members (families) under age 20 refer the member to **BHI**'s care management team or the Department's Office of Clinical Services. The Department advised that NOA letters should refer members to **BHI** care coordinators—not directly to the Department's Office of Clinical Services. In the record reviews, one NOA for a member who was eligible for EPSDT services omitted information to refer the member for assistance in obtaining services, and one NOA for an adult who was not eligible for EPSDT included this clause. HSAG recommends that **BHI** reviews individual NOAs to ensure that appropriate information is included in each letter.

Summary of Findings Resulting in Recommendations

Staff members described that the Preventive Health Services policy was intended to be the umbrella policy to describe EPSDT program components, with specific procedures intended to be defined in individual department or provider communications. The Coordination of Care policy described general care coordination for all members, with little reference to EPSDT services. Neither policy detailed procedures for implementing the components of the policy or referenced other organizational procedures related to EPSDT processes. Neither policy defined the specific components of the EPSDT periodicity schedule or addressed mechanisms for facilitating members with obtaining EPSDT screenings, providing treatment and diagnostic services to EPSDT beneficiaries, or arranging wrap-around services or other EPSDT-related referral and care coordination services. HSAG recommends that **BHI** revise existing policies or develop new policies to address all requirements of the EPSDT program and define more detailed procedures for providers or organizational staff members to implement the components of the EPSDT program. These procedures should be linked to or identified within the EPSDT policies.

The **BHI** member handbook described all the benefits of EPSDT preventive services and described Healthy Communities as a mechanism to assist members with obtaining services. The member handbook did not describe that services could be obtained through the PCP or offer assistance of **BHI** staff with obtaining a PCP referral. The annual enrollee letter described EPSDT services at a very high level and did not inform members of the components of periodic health screenings or how to access EPSDT services. Similarly, the member and family newsletter informed members about Healthy Communities but did not describe the types of EPSDT services available. At the time of review, only the member handbook was considered an adequate source of informing members about the benefits of EPSDT. HSAG recommends that **BHI** enhance its member communications regarding EPSDT to ensure that members thoroughly understand the EPSDT benefits and services available and how to access them.

While it appeared that **BHI** defined a mechanism in the provider manual for providers to assist members with obtaining EPSDT screenings, **BHI** provided limited evidence (e.g., policies, audit tools, or provider training) that it has developed effective mechanisms to "ensure the provision of all applicable components of periodic health screens (assessments) to EPSDT beneficiaries." HSAG recommends that **BHI** enhance or clarify internal documents and procedures and provider communications and trainings to ensure the provision of all EPSDT periodic health screens to EPSDT beneficiaries.

BHI omitted the following from the EPSDT definition of medical necessity: "The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living." HSAG recommends that **BHI** update its definition of medical necessity for EPSDT services in applicable policies and procedures to include the following: "The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living." HSAG strongly recommends that **BHI**'s UM policies incorporate the definition of medical necessity as outlined in the Findings section of Standard I, element 4, of the compliance monitoring tool.

BHI has developed a Quality Audit Tool for monitoring provider medical records which appeared to monitor for documentation of screenings and exams with the components outlined in the requirement. However, neither the provider manual nor other identified provider materials/trainings communicated

these documentation standards to providers. HSAG recommends that **BHI** incorporate the documentation requirements related to EPSDT screenings and exams into provider communications.

The Preventive Health Services policy required that **BHI** share member protected health information (PHI) with Healthy Communities without special member permission but did not specify procedures or responsibilities for implementing this requirement. Neither the Coordination of Care policy nor the provider manual included this information. Because both the provider and the **BHI** care coordinators are responsible for coordinating with Healthy Communities, it is unclear how the statements in the Preventive Health Services policy would be operationalized. HSAG recommends that **BHI** implement procedures and/or provider and staff communications to ensure that the requirement to share PHI with Healthy Communities without requiring releases from members is included in operational processes. Procedures should include the responsibility of the providers or care coordinators to obtain all needed documents for access to non-covered services.

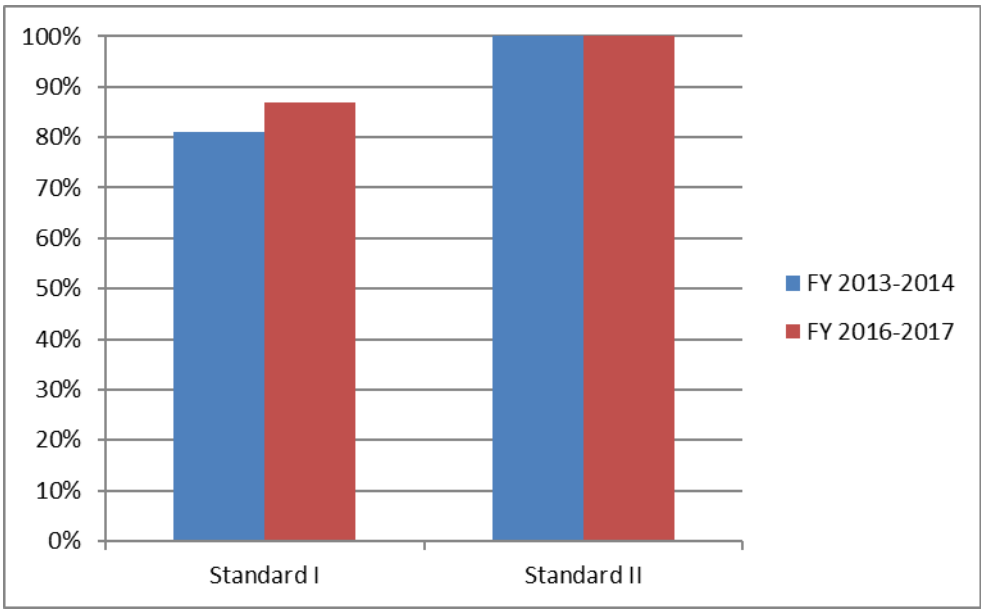
The provider manual did not inform providers of all EPSDT benefits and services and did not adequately outline expectations of providers related to the EPSDT program. The Provider Bulletin briefly described the EPSDT benefit with a link to the Health First Colorado website that outlines components of the EPSDT program but did not specify what the provider is expected to do with this information. The EPSDT Presentation Provider Forum PowerPoint provided a general description of the purpose of EPSDT services but incompletely addressed the components of EPSDT screening services, did not communicate expectations of BHO providers regarding EPSDT services, and provided a link to the Health First Colorado website if providers "wanted to know more." While these documents represented attempts to communicate with providers regarding EPSDT services, they were individually and collectively inadequate in communicating the Department's EPSDT requirements. HSAG recommends that **BHI** develop effective "systematic" communications with network providers regarding the Department's EPSDT requirements and facilitating provision of periodic health screens. "Systematic" communications include regular and periodic mechanisms to communicate with providers.

Comparison of Results

Comparison of FY 2013–2014 Results to FY 2016–2017 Results

Figure 2-1 shows the scores from the FY 2013–2014 site review (when Standard I and Standard II were previously reviewed) compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **BHI**'s contract with the State may have changed, and may have contributed to performance changes.

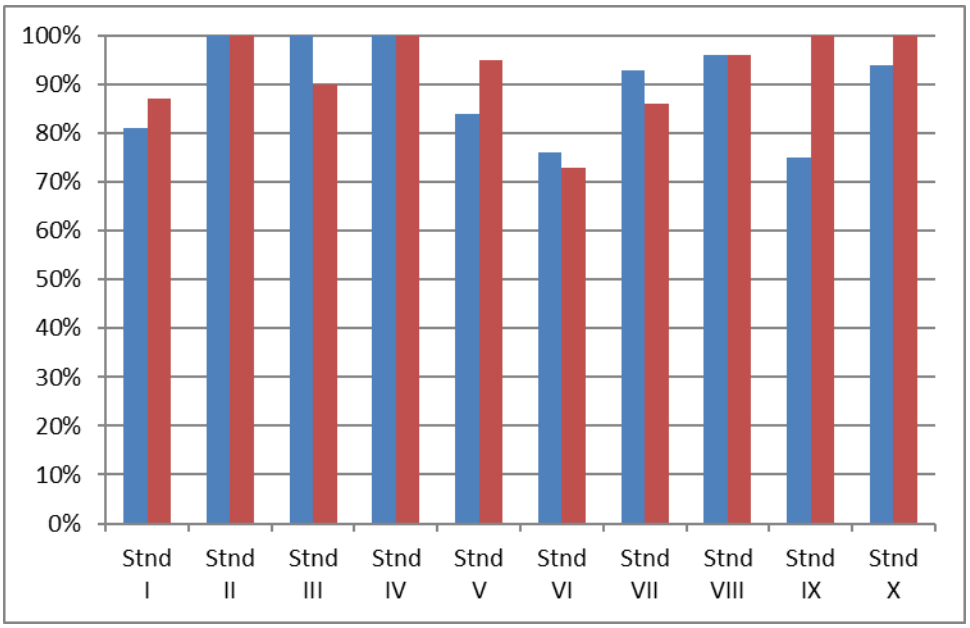
Figure 2-1—Comparison of FY 2013–2014 Results to FY 2016–2017 Results



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—Behavioral Healthcare, Inc.'s Compliance Scores for All Standards



Note: Results shown in blue are from FY 2011–2012, FY 2012–2013, and FY 2013–2014. Results shown in red are from FY 2014–2015, FY 2015–2016, and FY 2016–2017.

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

Table 2-1—List of Standards by Review Year

Standard	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17
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	
XI—EPSDT Services						X

3. Overview and Background

Overview of FY 2016–2017 Compliance Monitoring Activities

For the fiscal year (FY) 2016–2017 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability.

HSAG reviewed an additional EPSDT standard for all BHOs during the FY 2016–2017 compliance site reviews. This standard was developed collaboratively by HSAG and the Department using federal EPSDT regulations and guidance in addition to State statutes that address EPSDT. The FY 2016–2017 findings for this standard can be found in Appendix A. A narrative summary of findings for this standard is also presented in the Executive Summary. During the on-site reviews, the Department identified that, while the BHO contracts require BHOs to comply with "all federal and State EPSDT regulations," the BHO contracts did not include the specificity delineated in the compliance monitoring tool. Therefore, the EPSDT findings will be used only to inform the development and implementation of EPSDT contracting provisions for the Regional Accountable Entities (RAEs) that will assume the capitated behavioral health contracts beginning in FY 2018–2019. No corrective actions are required based on this compliance monitoring review. The State's EQRO vendor will review the EPSDT standard again in FY 2019–2020.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued May 6, 2016. HSAG conducted a desk review of materials submitted prior to the on-site review activities: a review of records, documents, and materials provided on-site; and on-site interviews of key BHO personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to BHO service and claims denials.

A sample of the BHO's administrative records related to Medicaid service and claims denials was reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid service and claims denials that occurred between January 1, 2016, and December 31, 2016. For the record review, the BHO received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each required element. Results of

record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[3-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The three standards chosen for the FY 2016–2017 site reviews represent a portion of the Medicaid managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Aug 24, 2016.

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

FY 2015–2016 Corrective Action Methodology

As a follow-up to the FY 2015–2016 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 2015–2016 compliance monitoring site review.

Summary of FY 2015–2016 Required Actions

As a result of the FY 2015–2016 site review of Standard III—Coordination and Continuity of Care, **BHI** was required to ensure that each member accessing services receives an individual assessment that addresses developmental needs. For Standard VIII—Credentialing and Recredentialing, **BHI** was required to develop a mechanism to ensure that it recredentials both individual and organizational providers every 36 months.

Summary of Corrective Action/Document Review

BHI submitted its proposed plan to HSAG and the Department in May 2016 and began submitting documents to demonstrate implementation of the plan in June 2016. After requesting that **BHI** submit additional information, HSAG and the Department determined that **BHI** successfully addressed all required actions.

Summary of Continued Required Actions

BHI had no required actions continued from FY 2015–2016.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Compliance Monitoring Tool
for Behavioral Healthcare, Inc.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor must ensure that the services provided are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished. • No less than the amount, duration, and scope furnished under fee-for-service Medicaid. *42 CFR 438.210(a)(3)(i)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.2.8, 2.2.7	**Documents Submitted:** UM 801 Access and Availability (pg. 1-2, section 4) UM 809 Medical Necessity Criteria (whole document) UM 809aa Medical Necessity Criteria (whole document) UM 810 Notice of Action (NOA) (pg. 1, section C; pg. 2, section 4) Utilization Management Program Description (pgs. 1-5) **Process Description:** BHI ensures that enrollees consistently receive the appropriate type and amount of all medically necessary covered service that are the most effective and the least restrictive possible in supporting recovery. The UM Program is overseen by the Chief Medical Officer (CMO) of BHI as outlined in the Utilization Management Program Description. Services are authorized in sufficient amount, duration, or scope to achieve identified treatment objectives. All authorization decisions are based solely on the appropriateness of the care for the member based on defined Medical Necessity Criteria as referenced in UM 809 Medical Necessity Criteria policy. The BHI UM Program supports member recovery by ensuring consistent access to the most effective and least restrictive medically necessary behavioral health services as discussed in policies UM 801 Access and Availability and UM 810 Notice of Action (NOA).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Amendment 6, Exhibit A-2—2.2.9	**Documents Submitted:** UM 810 Notice of Action (NOA) (pgs. 2-3) UM 809 Medical Necessity Criteria (whole document) UM 809aa Medical Necessity Criteria (whole document) Utilization Management Program Description (pgs. 1-5) **Process Description:** BHI has established Utilization Management/Medical Necessity Criteria that serve as a basis for all clinical authorization decisions. These criteria are outlined in the UM 809 Medical Necessity Criteria policy and attachment UM 809 aa. It also serves as a guideline that promotes consistent, clinically appropriate decision-making, and efficient utilization of available resources; which is discussed in the Utilization Management Program Description. The UM Medical Necessity Criteria consider individual needs and the local delivery system. BHI does not arbitrarily deny or reduce the amount, duration, or scope of required services solely based on diagnosis, type of illness, or condition of the member. Denials are described in policy UM 810 Notice of Action (NOA).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor may place appropriate limits on a service: • Based on criteria applied under the State plan (medical necessity). • For utilization control, provided the services furnished can reasonably be expected to achieve their purposes. *42 CFR 438.210(a)(4)(i) and (ii)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.2.10	**Documents Submitted:** UM 809 Medical Necessity Criteria (whole document) UM 809aa Medical Necessity Criteria (whole document) UM 824 Utilization Review Decisions (whole document) UM 810 Notice of Action (NOA) (pgs. 2-3) Provider Manual FY17 (pgs. 14-15) **Process Description:** BHI requires that services meet established Medical Necessity Criteria for authorization, which are outlined in UM 809 Medical Necessity Criteria policy. This ensures consistency and appropriateness in clinical decision making across the BHI system. A covered service is deemed medically necessary if it is found to be an equally effective treatment among other treatment options; and if the services might be reasonably expected to prevent, reduce, assist, and correct the symptoms of an illness. Or if the service will or is reasonably expected to maintain a member's highest level of independent functioning; as outlined in policy UM 824 Utilization Review Decisions policy and the Provider Manual FY17. UM Reviewers utilize BHI's Medical Necessity Criteria when rendering authorization and denial decisions. They utilize clinical information received from facilities to issue coverage determinations.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. The Contractor specifies what constitutes "medically necessary services" in a manner that: • Is no more restrictive than that used in the State Medicaid program. – Is in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care. – Is reasonably necessary for the diagnosis or treatment of a covered behavioral health disorder or to improve, stabilize, or prevent deterioration of functioning resulting from such a disorder. – Is clinically appropriate in terms of type, frequency, extent, site, and duration. – Is furnished in the most appropriate and least restrictive setting where services can be safely provided. – Cannot be omitted without adversely affecting the member's behavioral health and/or physical health conditions associated with the member's covered behavioral health diagnosis or the quality of care rendered. • Addresses the extent to which the Contractor is responsible for covering services related to the following: – The prevention, diagnosis, and treatment of health impairments.	**Documents Submitted:** UM 809 Medical Necessity Criteria (whole document) UM 809aa Medical Necessity Criteria (whole document) Provider Manual FY17 (pgs. 14-15), Utilization Management Program Description (pgs. 2-3) Medical Necessity Criteria BHI screenshot (pg. 1) CLIN 213 Preventive Health Services (whole document) **Process Description:** BHI reviews service authorization requests based on BHI Medical Necessity Criteria, which is outlined in the UM 809 Medical Necessity Policy and attachment (UM 809aa). Medical necessity is determined through the evaluation of several factors, including but not limited to: • Member and family/guardian identification of preferences and goals for recovery; • Ongoing consultation with the provider throughout the episode of care (EOC) to determine the medical necessity of services as established by changes in the member's condition and treatment needs and identified goals; and • Consultation with the member, family, informal supports, and/or person with legal custody about his/her treatment history, to identify unique and/or special client needs (e.g., cultural considerations, communications needs, and special clinical circumstances that may necessitate a unique approach to treatment). The above factors are enumerated in the Utilization Management Program Description. Providers are notified of the Medical Necessity Criteria through the Provider Manual. Providers are	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– The ability to achieve age-appropriate growth and development. – The ability to attain, maintain, or regain functional capacity. *42 CFR 438.210(a)(5)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—1.1.1.34	informed of any updates to Medical Necessity Criteria via the annually published Provider Manual. BHI Medical Necessity criteria are also available to providers, members, family members, advocates, and interested others through the BHI website or by calling the UM Department. Furthermore, policy CLIN 213 Preventive Health Services describes how BHI maintains a comprehensive program of preventive health services for all members and through Care Coordination efforts, members could be identified, screened, assessed and assisted.	

Findings:
While BHI defined "medical necessity" equivalent to the medical necessity definition outlined in this requirement, the definition of medical necessity outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—included the addition of EPSDT-specific criteria. Therefore, BHI is advised to immediately update the definition of medical necessity accordingly. Please reference 10-CCR 2505-10 8.076.1.8 (a-g) and 8.7016.1.8.1 for guidance:

8.076.1.8. Medical necessity means a Medical Assistance program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.
b. Is provided in accordance with generally accepted professional standards for health care in the United States.
c. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
e. Is delivered in the most appropriate setting(s) required by the client's condition.
f. Is not experimental or investigational.
g. Is not more costly than other equally effective treatment options.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8.076.1.8.1 For EPSDT-specific criteria, see 10 C.C.R. 2505-10, Section 8.280.4.E. "For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living; and meets the criteria set forth in Section 8.076.1.8(b-g)."		
5. The Contractor has in place written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.9	**Documents Submitted:** UM 824 Utilization Review Decisions (whole document) UM 815 Utilization Management Decision Timeframes (whole document) Utilization Management Program Description (pgs. 4-5) Provider Manual FY17 (pgs. 12-13) **Process Description:** Per the UM 824 Utilization Review Decisions policy, BHI requires pre-authorization for behavioral health services for inpatient, subacute, intensive outpatient, in-home treatment, partial hospitalization, residential, day treatment, psychological testing, and other specialty care services. Services requiring pre-authorization are outlined in the Utilization Management Program Description and are made available to providers via the Provider Manual. BHI does not require pre-authorization for emergency services. Prior service authorizations are based on a thorough review of complete and current clinical information. If the documentation is incomplete, BHI UM staff members follow up with a verbal request to the provider for the missing clinical information. All prior service authorization decisions are made in compliance with regulatory, NCQA, and contractually required timelines and documentation standards, as outlined in policy UM 815 Utilization Management Decision Timeframes.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
6. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure consistent application of review for authorizing decisions. *42 CFR 438.210(b)(2)(i)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.15	**Documents Submitted:** UM 824 Utilization Review Decisions (whole document) UM 815 Utilization Management Decision Timeframes (whole document) Utilization Management Program Description (pgs. 2-5) 09-2016 Quality Monitoring Report (pgs. 5-7) **Process Description:** BHI maintains policies and procedures to ensure BHI Medical Necessity Criteria are consistently applied across the network and all levels of care (LOC), as outlined in the UM 824 Utilization Review Decisions and UM 815 Utilization Management Decisions Timeframes policies. Weekly inter-rater reliability studies are conducted by BHI and the results are discussed across the team. These are reported in the monthly Quality Monitoring Report. The BHI UM Department identifies and examines utilization patterns outside of established criteria ranges through examination of performance data and over/under-utilization measures. Any significant variance and/or pattern of variance is reviewed in more detail (e.g., individual case reviews) and the UM Director is responsible for oversight of any corrective action plans (CAPs) that are implemented. These standards are outlined in the Utilization Management Program Description.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *4 2CFR 438.210(b)(2)(ii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.16	**Documents Submitted:** UM 824 Utilization Review Decisions (whole document), Provider Manual FY17 (pg. 15) **Process Description:** BHI UM staff engages in ongoing consultation with the provider throughout the episode of care (EOC) to determine the medical necessity of behavioral health services as established by changes in the member's condition and treatment needs. A "Doctor to Doctor" may be requested by the provider (attending physician) and BHI's Physicians for a review of authorization or denial decisions. These elements are described in policy UM 824 Utilization Review Decisions. In addition, when a notice of action is sent to a provider, the provider is notified that they can contact a member of the UM Department to discuss the denial decision. Providers are also made aware of this option in the Provider Manual.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The provider manual stated that if a member does not meet medical necessity criteria, the UM Department will discuss the member's needs with the provider and work to agree on appropriate alternative treatments. On-site denial record reviews demonstrated three cases in which UM staff contacted the requesting provider to obtain additional information during the authorization process. The Utilization Review Decisions policy, Notice of Action (NOA) policy, and provider manual also stated that the provider may request a peer-to-peer consultation with the UM medical director after a denial is issued. The NOA policy stated that if an NOA is issued due to lack of information, "BHI may overturn the denial based on new information received and *this is not considered a part of the appeal process*." This statement is out of compliance with federal and State appeal regulations. HSAG advised staff that once an NOA is issued, any peer-to-peer consultation or decision to overturn a denial decision is part of the appeal process and must be treated as such. BHI should ensure that it consults with the provider to obtain more information as needed *prior* to issuing an NOA.

Required Actions:
BHI must review and revise UM policies and procedures and the provider manual to ensure that BHI initiates a peer-to-peer consultation or request for more information *prior* to issuing an NOA. BHI must correct written policies and procedures and internal processes to clarify that peer-to-peer consultation conducted after an NOA has been issued is considered part of the appeal process and must be treated as such.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor's UM program ensures that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease. *42 CFR 438.210(b)(3)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.15.3	**Documents Submitted:** Utilization Management Program Description (pgs. 1-2) UM 810 Notice of Action (NOA) (pgs. 2-3, section 4) UM 824 Utilization Review Decisions ppFY16 (pg. 2, section D) **Process Description:** BHI UM functions and goals are directly overseen by the BHI UM Department and include activities performed by BHI UM staff and is ultimately overseen by the BHI Chief Medical Officer (CMO). The UM Department has qualified staff members, including registered nurses and licensed clinicians, to review and authorize or deny along a continuum of behavioral health care services; as outlined in UM 824 Utilization Review Decisions. The Utilization Management Program Description outlines the position of BHI Chief Medical Officer (CMO), a Colorado-licensed, board-certified psychiatrist. The CMO is involved in all aspects of the UM program; including, but not limited to: Notice of Action and appeal decisions, medical necessity criteria development, dissemination and training of clinical practice guidelines, new technology reviews, doctor-to-doctor consultations with attending physicians to determine appropriate level of care, oversight of denied claims as it relates to medical necessity and covered diagnoses, identifying barriers to admission, discharge, and disposition, and oversight of clinical decision making. Denials and Notice of Actions are described in UM 810 Notice of Action (NOA) policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor has in place processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42 CFR 438.210(c)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.1 10 CCR 2505-10 8.209.4.A	**Documents Submitted:** UM 810 Notice of Action (NOA) (pgs. 3-6) Provider Manual FY17 (pg. 15) Notice of Action Example (whole document) Spanish Notice of Action Form (whole document) **Process Description:** Pre-service and concurrent authorization decisions are communicated to members and providers in compliance with Medicaid regulations regarding timelines and notice content, as described in UM 810 Notice of Action (NOA). BHI provides timely notification to members and providers regarding any denial, reduction, suspension, termination, or limited authorization of a requested type or level of service in accordance with Federal and State regulations. BHI provides notice to the member, guardian, or the Designated Client Representative (DCR) via certified mail. BHI notifies the requesting provider verbally then via fax or email of any decision to deny or reduce a service authorization request. Examples of these notices are referenced in the Notice of Action Example and the Spanish Notice of Action Form. Providers are made aware of these notices in the Provider Manual.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The Contractor provides notice of standard authorization decisions as expeditiously as the member's health condition requires and not to exceed 10 calendar days from receipt of the request for service. *42 CFR 438.210(d)(1)* Contract: Amendment 6, Exhibit A-2—2.5.15.1 10CCR2505—10, Sec 8.209.4.A.3.c	**Documents Submitted:** UM 815 Utilization Management Decision Timeframes (whole document) UM 810 Notice of Action (NOA) (pg. 4, section D) Provider Manual FY17 (pg. 14) 06-2016 Internal UM Monitoring Report (pg. 1) **Process Description:** Pre-service authorization decisions are communicated to BHI members and providers in compliance with Medicaid regulations regarding timelines and notice content; which is further discussed in the Provider Manual. BHI monitors the timeliness of UM decision-making by tracking the date services are initially requested, the date on which the authorization decision is made, and whether this timeframe is within authorization response time requirements. BHI acts to improve performance if authorization response standards are not met. BHI also conducts monthly and annual audits of UM timelines for service authorizations and denials; which is reported monthly in the Internal UM Monitoring Report. Policies and procedures require adherence to the timeframes for which prior service authorization, concurrent, and retrospective UM decisions are made; as outlined in UM 815 Utilization Management Decision Timeframes policy. Standard service authorization decisions are made and communicated to the member and provider within 10 calendar days following the receipt of the request. An expedited UR process is used when BHI determines that the standard authorization timeline could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. These UR decisions are made and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	communicated to the member and provider as expeditiously as the member's condition requires and no later than three (3) working days after the receipt of the request for service authorization. Denial timeframes are outlined in UM 810 Notice of Action (NOA) policy.	
11. For cases in which a provider indicates, or the Contractor determines, that the standard authorization time frame could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not to exceed 3 working days from receipt of the request for service. *42 CFR 438.210(d)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.15.2	**Documents Submitted:** UM 814 Utilization Management Decision Timeframes (pgs. 1 and 3) 06-2016 Internal UM Monitoring Report (pg. 1) **Process Description:** BHI responds to service authorization requests from members and providers in a timely manner to accommodate the clinical urgency of the request and in compliance with timeframes set forth by Medicaid regulations. Decisions for requests for services in which the application of the standard timeframes could seriously jeopardize the member's life, health, or safety or the ability to attain, maintain, or regain maximum function are made and communicated to the member and/or provider no later than three business days following the receipt of the request for service. Policies and procedures require adherence to these timeframes. BHI monitors the timeliness of decision making by tracking the date services are initially requested, whether an expedited decision is needed, the date on which the authorization decision is made, and whether this timeframe is within authorization response time requirements. Procedurally, all requests for expedited decisions are managed by the "Acute" UM team which operates 24/7. Information on timeless of decision making is tracked in Altruista and audited and reported to BHI's Quality Improvement	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Committee at least monthly by the Utilization Review Manager and/or Director as shown in the 06-2016 Internal UM Monitoring Report.	
12. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days if the member requests an extension or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(2)* Contract: Amendment 6, Exhibit A-2—2.5.15.1 and 2.5.15.2.1	**Documents Submitted:** UM-815 Utilization Management Decision Timeframes (pg. 2 Sec IV A) 06-2016 Internal UM Monitoring Report (pg. 1) UM Spreadsheet (whole document) **Process Description:** Pre-service authorization decisions are communicated to BHI's members and providers in compliance with Medicaid regulations regarding timelines and notice content. Service authorization decisions for standard and expedited requests may be extended up to 14 calendar days if the member or provider requests an extension and/or if BHI needs additional clinical information to decide and can justify that the extension in in the member's best interest. This information is tracked in a spreadsheet by Utilization Review staff and audited and reported to BHI's Quality Improvement Committee at least monthly by the Utilization Review Manager and/or Director as shown in the 06-2016 Internal UM Monitoring Report.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
13. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.6.5.5 10CCR2505—10, Sec 8.209.4.A.1	**Documents Submitted:** UM-810 Notice of Action (NOA) (pg. 4, section 2) Spanish Notice of Action Form 8-5-2016 (whole document) Notice of Action (whole document) **Process Description:** BHI's Notice of Action letters are written at a 6th grade reading level wherever possible and are available in Spanish, which is the prevalent non-English language for BHI's service area.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: HSAG noted during on-site denial record reviews that NOAs were written in language that was easy for the member to understand. However, two cases included information that appeared to be inappropriate for the member and were therefore scored as not easy to understand.		
Required Actions: BHI must implement a process to ensure that the information included in individual member NOAs is appropriate and not confusing for the member.		
14. Notices of action must contain: • The action the Contractor (or its delegate) has taken or intends to take. • The reasons for the action. • The member's or provider's (on behalf of the member) right to file an appeal and procedures for filing. • The date the appeal is due. • The member's right to request a State fair hearing. • The procedures for exercising the right to a State fair hearing.	**Documents Submitted:** UM-810 Notice of Action (NOA) (whole document) Notice of Action Example (whole document) **Process Description:** BHI's Notices of Action meet all requirements set forth by the Department as evidenced by policy and example.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• The circumstances under which expedited resolution is available and how to request it. • The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. • The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). *42 CFR 438.404(b)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.6		
15. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except: – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that	**Documents Submitted:** UM-810 Notice of Action (NOA) (pg. 3 Section C and pg. 4 Section D) UM-815 Utilization Management Decision Timeframes (whole document) Provider Manual FY17 (pg. 16) **Process Description:** BHI's Notices of Action are mailed within the timeframes set forth by the Department as evidenced by policy UM-810 Notice of Action (NOA) and UM-815 Utilization Management Decision. This information is tracked in a spreadsheet by Utilization Review staff and audited at least monthly by the Utilization Review Manager and/or Director. This is also explained in the Provider Manual	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
requires termination or reduction and indicates that the member understands that service termination or reduction will occur. o The member has been admitted to an institution in which the member is ineligible for Medicaid services. o The member's address is determined unknown based on returned mail with no forwarding address. o The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. o A change in the level of medical care is prescribed by the member's physician. o The notice involves an adverse determination regarding preadmission screening requirements. o The transfer or discharge from a facility will occur in an expedited fashion. • For denial of payment, at the time of any action affecting the claim. • For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. • For expedited service authorization decisions, as expeditiously as the member's health condition		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
requires but within 3 working days after receipt of the request for services. • For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the time frame, as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.210 (d)* *42 CFR 438.404(c)* *42 CFR 431.211,431.213, and 431.214* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5 10CCR2505—10, Sec 8.209.4.A (3) (a-c)		
Findings: The UM Decision Timeframes policy and the NOA policy addressed time frames for mailing the NOA per the requirements. However, the information in each policy is either incomplete, inconsistent, and/or refers to the opposite policy, requiring that both policies be used together to address all time frame requirements. Neither policy specifies that when BHI extends the time frame, it must mail the NOA "no later than the date the extension expires." (However, the extension letter to the member documents the new decision date based on the calculated 14-day extension.) During the on-site record reviews, HSAG found one NOA to the member for termination of previously authorized services was not sent within the required time frame—10 days prior to the date of the intended action.		
Required Actions: BHI must ensure that it provides notice of termination of previously authorized services at least 10 days before the date of the intended action. BHI must also revise policies and procedures to specify that the time frame for mailing the NOA when the decision time frame was extended is no later than the date the extension expires.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
16. If the Contractor extends the time frame for making a service authorization decision, it: • Provides the member written notice of the reason for the decision to extend the time frame. • Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. *42 CFR 438.404(c)(4)(i)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5.5.2 10CCR2505—10, Section 8.209.4.A.3.c (i)	**Documents Submitted:** UM 815 Utilization Management Decision Timeframes (Sections A3b, B3b, C3b) **Process Description:** BHI's Utilization Management Decision Timeframes policy outlines the process and procedures for making a service authorization decision; that the member will be informed in writing of any decision to extend timeframes; and of the members' right to file a grievance if they disagree with the extension decision.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: During on-site record reviews, HSAG noted one case in which BHI extended the time frame for making a decision. BHI sent the written notice of extension only to the provider, not to the member.		
Required Actions: BHI must ensure that it provides the member written notice of extension of the time frame for making an authorization decision.		
17. The Contractor provides that compensation to individuals or entities that conduct utilization management (UM) activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Amendment 6, Exhibit A-2—2.5.15.4	**Documents Submitted:** Member and Family Handbook 8-26-2016 (pg. 26) Provider Manual FY17 (pg. 17) Affirmative Statement (pg. 1) Utilization Management Program Description (pg. 5) **Process Description:** BHI does not offer incentives of any kind for individuals or entities conducting UM functions to limit, discontinue, or deny medically necessary services to any member. This notification is provided to Members in the Member and Family Handbook, to providers in the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Provider Manual, and is described in the Utilization Management Program Description. Additionally, all new UM employees sign an Affirmative Statement regarding incentives.	
18. The Contractor defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.20	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 1 III. A) Member and Family Handbook 8-26-16 (pg. 17) Provider Manual FY17 (pg. 24) **Process Description:** BHI appropriately and accurately defines emergency medical condition in policy UM-818 Emergency and Post Stabilization Services as well as in the Member and Family Handbook and in the Provider Manual.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. The Contractor defines "emergency services" as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.21	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 1 III. B) Member and Family Handbook 8-26-16 (pg. 19) **Process Description:** BHI appropriately and accurately defines emergency services in policy UM-818 Emergency and Post Stabilization Services as well as in the Member and Family Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
20. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.1	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 2, IV. A) Member and Family Handbook 8-26-16 (pg. 12) **Process Description:** BHI's policy UM-818 Emergency and Post Stabilization Services policy ensures payment of medically necessary emergency services, regardless of whether the provider has a contract with BHI. In addition, members are notified of this requirement via the Member and Family Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor informs members that prior authorization is not required for emergency services. *42 CFR 438.10(f)(6)(viii)(B)* Contract: Amendment 6, Exhibit A-2—2.6.11.1.13.4	**Documents Submitted:** UM 818 Emergency and Post Stabilization Services (pg. 3, IV. C. 1) Provider Manual FY17 (pg. 12) Member and Family Handbook 8-26-16 (pg.19) **Process Description:** As shown in policy UM-818 Emergency and Post Stabilization Services, BHI's contracts with hospitals and other emergency services providers clearly state that prior authorization is not required for coverage and payment for emergency services. The BHI Member and Family Handbook provides members with information regarding prior authorization not being required for emergency services and the BHI provider Manual give providers the same information.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
22. The Contractor may not deny payment for treatment obtained under the following circumstances: • A member had an emergency medical condition, as defined in 42 CFR 438.114(a) (see #18 above). • Situations which a prudent layperson who possesses an average knowledge of health and medicine would perceive as an emergency medical condition but the absence of immediate medical attention would not have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. – Serious impairment to bodily functions. – Serious dysfunction of any bodily organ or part. • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.1, 2.2.4.3.4.2	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 3, IV, C. 1 -5) BHI Member and Family Handbook 8-26-16 (pgs. 4 – 7, 13 – 16) **Process Description:** Policy UM-818 Emergency and Post Stabilization Services reflects how BHI does not deny payment for treatment obtained by members under the specific circumstances defined in this requirement. Additionally, BHI Member and Family Handbook describes the services and benefits to members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
23. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor, or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42 CFR 438.114(d)(1)(i) and (ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.3	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 3,IV, C.1) **Process Description:** BHI's policy UM-818 Emergency and Post Stabilization Services prohibit the restriction of emergency medical conditions based on a list of diagnosis and symptoms.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. The Contractor will be responsible for emergency services: • When the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. • For *practitioner* emergency room claims for members with a primary substance use or mental health disorder diagnosis. (The Contractor is not financially responsible for outpatient emergency room services for members with a primary substance use disorder diagnosis or when the primary diagnosis is medical in nature.) Contract: Amendment 6, Exhibit A-2—2.2.4.3.11, 2.2.4.3.12, 2.2.4.3.13	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 3,IV, C.2) **Process Description:** BHI's policy UM-818 Emergency and Post Stabilization Services describes how BHI is responsible for Emergency Services (including practitioner emergency room claims), when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures that treat a secondary medical diagnosis.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
25. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.5	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 3,V, A) BHI Member and Family Handbook 8-26-16 (pgs. 4 – 7, 13 – 16) **Process Description:** BHI's policy UM-818 Emergency and Post Stabilization Services includes a description of how BHI members are not billed for Emergency and/or Post-Stabilization Care Services. In addition, BHI Member and Family Handbook informs members that Emergency Services are free of charge to them.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
26. The Contractor allows the attending emergency physician or the provider actually treating the member to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor, who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.6	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 3, V, A) **Process Description:** BHI defers to the attending emergency physician or treating provider in determining when the member is stabilized for transfer or discharge, pursuant to 42 CFR 438.114 (d) (3). The process of emergency evaluation of a Medicaid member is a collaboration between the member, emergency services clinician, Emergency Department (ED) attending physician, family and other collateral contacts involved in emergency response. This process includes a thorough review of the member's condition, safety needs, preferences of the member and/or family, availability of community based resources that can safely and effectively meet the member's immediate needs for treatment and stabilization, and medical necessity criteria for level of care. Ultimately, the decision about post-stabilization care is the responsibility of the emergency room physician and provider, but is conducted with a thoughtful review of all available, relevant information from involved informants.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
27. The Contractor defines "poststabilization care services" as covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.47	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pgs. 3 and 4 Sec V) Member and Family Handbook 8-26-16 (pg. 15) **Process Description:** BHI's definition of Post-Stabilization Care Services is consistent with the language found in 42 CFR 438.114 (a). The Emergency Services clinician evaluates Members' progress through clinical interview, which includes risk assessment, and mental status examinations to ensure no suicidal or homicidal ideation, plan or intent exist and that consumer does not meet criteria for grave disability. Emergency Services clinicians consult with the Emergency Department (ED) attending physician and nurse regarding clinical impressions and recommendations based on their assessment. As stated above the attending physician or treating provider shall make the final determinations of when member is stabilized for transfer or discharge.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
28. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.7	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 4 Sec C) **Process Description:** BHI is responsible for payment of post-stabilization services when BHI has authorized such services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
29. The Contractor is financially responsible for post stabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition under the following circumstances: • Within 1 hour of a request to the organization for pre-approval of further post stabilization care services. • The Contractor does not respond to a request for pre-approval within 1 hour. • The Contractor cannot be contacted. • The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care, and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician; and the treating physician may continue with care of the patient until a plan physician is reached or the Contractor's financial responsibility for post stabilization care services it has not pre-approved ends. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii) and (iii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.8, 2.2.4.3.8.1, 2.2.4.3.8.2, 2.2.4.3.8.3	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 3 -4,V, B& C) **Process Description:** BHI's policy UM-818 Emergency and Post Stabilization Services clearly defines the contractor's responsibility for financial obligation for post-stabilization care services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
30. The Contractor's financial responsibility for post stabilization care services it ***has not*** pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care. • A plan physician assumes responsibility for the member's care through transfer. • A plan representative and the treating physician reach an agreement concerning the member's care. • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.9	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 4,V, C,2) **Process Description:** BHI's policy UM-818 Emergency and Post Stabilization Services defines when BHI responsibility for post-stabilization care services that have not been pre-approved end. All the described decisions are reached in collaboration between the member, ED attending physician, emergency services clinician, and others involved in the emergency response.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
31. The Contractor must limit charges to members for post stabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.8.4	**Documents Submitted:** UM-818 Emergency and Post Stabilization Services (pg. 3, V.A) **Process Description:** As described in policy UM-818 Emergency and Post Stabilization Services, BHI does not charge members for post-stabilization care services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	27	X	1.00	=	27
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	27

Total Score ÷ Total Applicable	=	87%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered behavioral health and substance use disorder services. *42 CFR 438.206(b)(1)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.1, 2.5.9	**Documents Submitted:** QI-704 Network Adequacy (whole document) BHI FY16 Annual Quality Report (pgs. 17 – 20) Annual Network Adequacy Report FY16 (whole document) **Process Description:** BHI has an established network of highly qualified behavioral health professionals that provide the full array of state plan services, Alternative/B-3 services as well as substance use disorder services. Inpatient psychiatric care is provided by 10 private and public hospitals. Community-based services for both adults and youth include residential care, individual, group and family therapy, psychiatric services and medication management, emergency services, and cases management. Specialized services for children and families include in-home, school based treatment and welfare involvement. BHI FY16 Annual Quality Report also describes how BHI's network includes providers from a broad range of cultural and ethnic backgrounds, clinical specialties, and experience working with members with complex co-occurring medical, substance use and developmental disability, and other complex diagnoses. In FY16, the BHI Contracted Provider Network (CPN) had 1586 providers serving approximately 308,000 covered lives. As described in policy QI-704 Network Adequacy and Annual Network Adequacy Report FY16, BHI is continuously monitoring and maintaining its network of providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. In establishing and maintaining the network, the Contractor considers: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific Medicaid populations represented in the Contractor's service area. • The numbers, types, and specialties of providers required to furnish the contracted Medicaid services. • The number of network providers accepting/not accepting new Medicaid members. • The geographic location of providers in relationship to where Medicaid members live, considering distance, travel time, and means of transportation used by members. – Members have access to a provider within 30 miles or 30 minutes' travel time, whichever is larger, to the extent such services are available. • Physical access to locations for members with disabilities. *42 CFR 438.206(b)(1)(i) through (v)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.9.1; 2.5.9.2; 2.5.8.1.4	**Documents Submitted:** QI-704 Network Adequacy (whole document) BHI FY16 Annual Quality Report (pgs. 16 – 24) Annual Network Adequacy Report FY16 (whole document) **Process Description:** BHI methodically and regularly evaluates network adequacy and adjusts for needs. BHI evaluates the adequacy of the provider network including geographic distribution, clinical specialties, cultural specialties, the availability of services in languages other than English, and the array of providers that provide services across all contractually required State Plan and Alternative/B-3 services. BHI monitors monthly the number of providers that are accepting and not accepting new Medicaid members. BHI reports on network adequacy, monthly, to the Credentialing Committee and Quality Improvement Committee. This information is discussed and evaluated to determine if there are specific needs or gaps that need to be addressed. BHI evaluates data that comes from several sources, including: Data comes from many sources, including: • Trend analysis of Single Case Agreements • Assessment of access times to ensure providers are able to remain well within standards • Member input through the grievance and appeal process, focus groups, member and provider committees and member comments to providers • Provider feedback • Quarterly analysis of demographic data and trends • Regular tracking of special population needs	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Currently, BHI, has concluded that our provider network is more than sufficient to meet the needs of BHI's Medicaid membership. Recognizing that membership continuously fluctuates due to changes in eligibility requirements and health care reform efforts, BHI continues to keep an open network and monitor and respond to changes in geographic distribution of members and cultural and ethnic mix of our membership. Additionally, BHI's core mental health centers are required, as part of their contract with BHI, to expand capacity whenever necessary to assure adequate access for any BHI member.	
3. The Contractor provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain one outside the network, at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Amendment 6, Exhibit A-2—2.5.8.2	**Documents Submitted:** UM-812 Psychiatric Consultations Second Opinions (whole document) Member and Family Handbook 8-26-16 (pg. 22) **Process Description:** UM-812 Psychiatric Consultations Second Opinions policy, defines the process regarding members obtaining a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network at no cost. The Member and Family Handbook notifies members of their right to a second opinion.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Amendment 6, Exhibit A-2—2.5.9.5	**Documents Submitted:** CRED-401 Out of Network Providers-Single Case Agreements (whole document) **Process Description:** BHI offers single case agreements to out of network providers to provide services to members who are unable to utilize an in-network provider for various reasons. Single case agreements can be offered when medically necessary services cannot be provided by BHI's provider network or if a member identifies a qualified provider of choice that is not a part of BHI's provider network.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor coordinates with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Amendment 6, Exhibit A-2—none	**Documents Submitted:** CRED-401 Out of Network Providers – Single Case Agreements (whole document) BHI Single Case Agreement Contract_01012015 (pgs. 6-8) **Process Description:** All providers under a Single Case Agreement are expected to comply with BHI policies regarding prior authorization, timely filing of claims, corporate compliance requirements, and member rights and responsibilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.9	**Documents Submitted:** UM-801 Access and Availability (pg. 2 Sec C2) Member and Family Handbook 8-26-16 (pg. 28) **Process Description:** The BHI provider network offers emergency services 24 hours a day, 7 days a week, and 365 days a year. A member, family member, provider, or advocate can call BHI or 24 hours a day, 7	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	days a week for emergency or non-emergency situations, clinical assessment, and/or referral to a provider. This information is communicated to members through the Member and Family Handbook.	
7. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid fee-for-service if the provider serves only Medicaid members. • Minimum hours of provider operation shall include service coverage from 8 a.m. to 5 p.m. Mountain Time, Monday through Friday. • Extended hours of operation and service coverage shall be provided at least 2 days per week at clinic treatment sites, which may include additional morning, evening, or weekend hours. • Emergency coverage 24 hours a day, 7 days a week. *42 CFR 438.206(c)(1)(ii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.2, 2.5.8.1.3	**Documents Submitted:** UM-801 Access and Availability (pgs. 1-3) Provider Contract Template (pgs. 4-5 Article III, 3.2) CMHCs Hours of Operation (pgs. 1 – 9) **Process Description:** It is a contractual requirement that all BHI providers maintain hours of operation that are comparable to those offered to Medicaid fee-for-service, Medicare, or other commercial plan members, as outlined in the "Provider Contract Template" and the "UM-801 Access and Availability" policy. In addition, BHI's Community Mental Health Centers have operation hours described in the "CMHCs Hours of Operation". These operation hours cover the minimum hours from 8am to 5pm Monday through Friday, and extended hours of operation covering morning, evenings and weekend hours at least 2 days a week and emergency coverage 24 hours a day, 7 days a week.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services, taking into account the urgency of the need for services: • Emergency services are available: – By phone, including TTY accessibility, within 15 minutes of initial contact.	**Documents Submitted:** UM-801 Access and Availability (pgs. 1-2, IV, B.) Provider Manual FY17 (pg. 24) Provider Site Visit Evaluation Form (pg. 1) Access to Care Standards Screenshots (pg.1) ADMHN Care Coordination Agreement (Attachment F, 1.b.ix) AuMHC Care Coordination Agreement (Attachment F, 1.b.ix) CRC Care Coordination Agreement (Attachment F, 1.b.ix)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– In person within 1 hour of contact in urban and suburban areas. – In person within 2 hours of contact in rural and frontier areas. • Urgently needed services are provided within 24 hours of the initial identification of need. • Routine services are available upon initial request within 7 business days. (Routine services include but are not limited to an initial individual intake and assessment appointment. Placing members on waiting lists for initial routine service requests is not acceptable.) • Routine outpatient appointments following intake/initial assessment shall occur at least 3 times within 45 days. • Outpatient follow-up appointments shall occur within 7 business days after discharge from an inpatient psychiatric hospitalization or residential facility. • Ongoing mental health and substance use disorder services shall be scheduled and continually provided for within 2 weeks from an initial assessment or intake appointment. (Ongoing services include but are not limited to assignment to a therapist and individual/group outpatient therapy.) *42 CFR 438.206(c)(1)(i)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.1—2.5.8.1.11.6	PEO Minutes Q3 FY16 (pg. 3) PEO Minutes Q1 FY17 (pgs. 4-5) **Process Description:** All providers are expected to comply with BHI policies and procedures including access and availability standards. BHI's Access and availability requirements are listed in the BHI's "Provider Manual FY17". Providers are also monitored, and reminded of the standards of access to care during the site visits, through the "Provider Site Visits Evaluation Form" used during BHI standard auditing process. Another mechanism used by BHI to remind providers about access to care standards is through our website as shown in the "Access to Care Standards Screenshots". Furthermore, BHI is now having a quarterly PEO (Program Evaluation and Outcomes) committee meeting to discuss with its high-volume provider's standards such as access to care. During this meeting, providers are presented with segregated data, and discuss barriers and areas that need improvement including possible interventions. Some of the measures discussed during these meetings include the mental health engagement that entails members getting at least 3 outpatient appointments within 45 days after intake/initial assessment, outpatient follow-up appointments within 7 days after discharge and the initiation and engagement of alcohol and other drug dependence treatment. (PEO Minutes Q3 FY16 and PEO Minutes Q1 FY17) Regarding the outpatient, follow-up appointments within 7 days after a hospital discharge, BHI's three CMHCs employed "Hospital Liaisons" to provide care coordination for the transition	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	out of the hospitals. The Liaisons are sent a list of all BHI clients that are in a hospital daily; and their main role is to communicate directly with both the hospital and the member to ensure adequate discharge planning is in place with follow-up services set up. These services are offered through the CMHCs and initial appointments are scheduled within 7 days of the date of discharge. For members that have a Care Manager, the Hospital Liaison also communicates with them so that the Care Manager can ensure the follow-up appointments are in place. The ADMHN, AuMHC and CRC Care Coordination Agreements describe how this service is provided to BHI members.	
9. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access. *42 CFR 438.206(c)(1)(iv) through (vi)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.8	**Documents Submitted:** UM-801 Access and Availability (pg. 3, V.) Access to Care Report FY16Q4 (whole document) BHI Report Card FY16 (whole document) Provider Site Visit Evaluation Form (pg. 1) FY16 Satisfaction Survey Results (whole document) FY16, Q1-Q4 Report Card Data-Grievances (whole document) **Process Description:** BHI has several mechanisms in place to monitor compliance with Access to Care Standards. Each of BHI's core community mental health center submits quarterly aggregate data for each of the Access to Care standards to our Quality Improvement Department. This data is reported to the Department of Health Care Policy and Financing (HCPF), please see "Access to Care Report FY16Q4". Providers also receive feedback through the "BHI Report Card FY16". If a community mental health center falls below identified benchmarks, corrective action plans are required and monitored until compliance is met.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	BHI has also recently changed its auditing process and now a site visit is done, during the site visit standards to access to care are monitored, please reference the "Provider Site Visit Form". BHI also monitors member perception of access to care through analysis of grievances ("FY16, Q1-Q4 Report Card Data-Grievances") and member satisfaction surveys ("2016 Satisfaction Survey Results"), and acts if a pattern of non-compliance emerges.	
10. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (Includes a written cultural competency plan, policies, and training) *42 CFR 438.206(c)(2)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.12.1—2.5.12.3	**Documents Submitted:** ADM-119 Communication with Persons with Limited English Proficiency (whole document) QI-703 Culturally Appropriate and Competent Services (pg. 1) Member and Family Handbook 8-26-16 (pgs. 2, 21,32, 35) FY16, FY17 Cultural Competency Organizational Self-Assessment Annual (whole documents) Provider Manual FY17 (pgs. 5, 31,32) **Process Description:** BHI's policies and procedures, Provider Manual, Member and Family Handbook, and the Cultural Competency Plan detail the organization's committment to promote delivery of services in a culturally competent manner. The Cultural Competency Committee oversees the Cultural Competency Plan (FY16, FY17 Cultural Competency Organizational Self-Assessment Annual) and ensures cultural competency values are integrated throughout the entire organization. The ADM-119 Communication with Persons with Limited English Proficiency policy outlines the procedures for providing written and verbal materials for members with limited English	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	proficiency. The Member and Family Handbook is mailed out to all newly eligible members which offers the handbook in Spanish and large print. The Handbook also directs members on how to access interpretation assistance, provider choice, and how to file a grievance if their cultural needs are not met. The Provider Manual is distributed to all providers in the BHI contracted provider network and outlines the provider expectations to offer language assistance and deliver services in a culturally sensitive way. BHI's Policy QI-703, Culturally Appropriate and Competent Services policy ensures member's have access to culturally appropriate and competent services by contracting with a variety of providers, providing training to BHI staff and BHI providers, evaluating client satisfaction with accessing culturally approrpiate services, and ensuring interpreter services are offered to members in their preferred language.	

Results for Standard II—Access and Availability							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	10

Total Score ÷ Total Applicable	=	100%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The Contractor must comply with the following requirements based on 42 CFR 441.50 to 441.62 effective October 1, 2015, and Code of Colorado Regulations 10 CCR 2505-10 8.280 effective April 30, 2016. References Contract: Amendment 6, Exhibit A-2—2.5.13.5 The Contractor shall comply with all federal (441.50 to 441.62) and state (10 CCR 2505-10 8.280) EPSDT regulations. Contract: Amendment 6, Exhibit A-2—2.2.1 The Contractor shall provide or arrange for the provision of all medically necessary covered services and diagnoses and procedures, including *services* identified under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, 42 CFR Sections 441.50 to 441.62. (Includes informing, screening, diagnosis, treatment, discretionary services, referral/care coordination, and transportation and scheduling assistance.) Additional Resources State Medicaid Manual/Section 5 offers further detailed instructions and guidance regarding the various components of the EPSDT Program.		
1. The Contractor must have written policies and procedures for providing EPSDT services to members age 20 and under. • The definition of EPSDT services includes informing, screening (assessment), diagnosis, treatment, discretionary services (e.g. medically necessary wrap-around services), referral and care coordination, and transportation and scheduling assistance. 10 CCR 2505-10 8.280.2 and 8.280.8A	**Documents Submitted:** CLIN-213 Preventive Health Services (whole document) CLIN-210 Coordination of Care (whole document) **Process Description:** The policy CLIN-213 Preventive Health Services, describe the policies and procedures BHI has in place for providing EPSDT services to members age 20 and under. This policy also includes the procedures BHI has in place to educate members and providers about these services and the mechanism to assist with Care Coordination as needed. For more detail on the Care Coordination efforts, please reference policy CLIN-210 Coordination of Care.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: During the on-site interview, staff members explained that the Preventive Health Services policy was intended to be the umbrella policy that describes EPSDT program components, with specific procedures defined in individual department or provider communications. The Preventive Health Services policy defined EPSDT services and provided a high-level description of mechanisms for informing members, incorporating the EPSDT medical necessity definition into UM procedures, referring members to BHI care coordinators and Healthy Communities, and monitoring providers for compliance with EPSDT. The Coordination of Care policy described general care coordination for all members, with expectations that providers make referrals for needed services and share mental health information with medical providers. The policy included limited reference to EPSDT services. Neither policy detailed procedures for implementing the components of the policy or referenced other organizational procedures related to EPSDT. Neither policy defined the specific components of the EPSDT periodicity schedule or addressed mechanisms for facilitating members with obtaining EPSDT screenings, providing diagnostic and treatment services to EPSDT beneficiaries, or arranging wrap-around services or other EPSDT-related referral and care coordination services.		
Recommendations: HSAG recommends that BHI revise existing policies or develop new policies to address all requirements of the EPSDT program and define more detailed procedures for providers or organizational staff members to implement the components of the EPSDT program. These procedures should be linked to or identified within the EPSDT policies.		
2. The Contractor must notify members age 20 and under of the benefits and options for children and adolescents under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and is responsible for ensuring that children and their families are able to access the services appropriately. The Contractor must— • Provide a combination of written and oral methods to inform all eligible members (or their families) about the EPSDT program within 60 days of enrollment and annually thereafter. – Member communications must effectively inform those individuals who are blind or deaf	**Documents Submitted:** CLIN-213 Preventive Health Services (whole document) UM-809 Medical Necessity Criteria (pg. 1, Section C) Member Handbook 8-26-16 (pgs. 13-16) FY17 Annual Enrollee Letter (pg. 2) Member and Family Newsletter Issue II, Volume 16 (pg. 3) CLIN-210 Coordination of Care (pgs. Whole document) Provider Manual FY17 (pgs10,11,27) Provider Bulletin – Fall 2016 (pg. 4) Screenshot Member and Family Handbook and Members Newsletters (pg. 1) Screenshot Provider Manual BHI website (pg. 1)	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
or who cannot read or understand the English language. • Using clear and nontechnical language, provide information about the following— – The benefits of preventive healthcare. – The services available under the EPSDT program and where and how to obtain those services; (includes physical, mental, oral and substance abuse, as well as services that may have limits or services not covered in the state plan). – That the services under the EPSDT program are provided without cost to members 20 and under. – That necessary transportation and scheduling assistance for EPSDT services is available to members upon request, and the process to make a request. *42 CFR 441.56 (a)(1)—(4)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.9.1; 2.5.9.2; 2.5.8.1.4	**Process Description:** 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. The medical necessity criteria and procedure is listed in the UM-809 Medical Necessity Criteria policy. 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 that 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. Annual Enrollee Letter c. BHI website d. Member newsletters e. Educational outreach events f. Member Call Line 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	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	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. BHI's care management teams work with both the UM and Member Services departments to assist in the EPSDT referral process and ensures members are receiving all necessary services determined by the screening. This procedure is outlined in policies CLIN-210 Coordination of Care and CLIN-213 Preventive Health Services. 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	

Findings:
The Preventive Health Services policy stated that the member services department would inform members of EPSDT services through a variety of materials but did not outline specific procedures or mechanisms for implementation. The BHI member handbook described all the benefits of EPSDT preventive services and identified Healthy Communities as a resource to assist members with obtaining services. The member handbook did not state that services could be obtained through the PCP or offer assistance with obtaining a PCP referral. The annual enrollee letter described EPSDT services at a very high level and did not include the components of periodic health screenings or how to access EPSDT services. Similarly, the member and family newsletter informed members about Healthy Communities but did not describe the types of EPSDT services available. During the on-site interview, staff members stated that Office of Member and Family Affairs staff members had been trained on EPSDT services. These staff members were instructed to communicate with EPSDT-eligible members who called the member call line about EPSDT services and provide referrals as needed. However, BHI

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
provided no evidence of procedures or guidance for call center staff to do so. At the time of review, the member handbook was BHI's only adequate source of informing members about the benefits of EPSDT, including services available under the EPSDT program and where and how to obtain those services. HSAG encourages BHI to expand both oral and written mechanisms for communicating information on EPSDT services to members and to consider including EPSDT communications with members at the provider point of service, as well as ongoing and periodic—not just enrollment—mechanisms.		
Recommendations: HSAG recommends that BHI enhance its member communications regarding EPSDT to ensure that members thoroughly understand the EPSDT benefits and services available and how to access them.		
3. The Contractor must reasonably ensure the provision of all applicable components of periodic health screens (assessments) to EPSDT beneficiaries who are receiving BHO services or referred to a BHO provider. *42 CFR 441.56 (b), 441.59 (b)* 10 CCR 2505-10 8.280.8.C; 8.280.4.A.3 (d) and (h), and 8.280.4.A (4) Contract: Amendment 6, Exhibit A-2—2.5.13.2.1	**Documents Submitted:** Quality (FCR) Audit Tool (Columns BJ-BL, Row 8) BHI Mental Health Assessment Form (pgs. 9 - 13) CLIN-213 Preventive Health Services (whole document) CLIN-210 Coordination of Care (whole document) **Process Description:** BHI ensures the provision of all applicable components of the periodic health screens to the EPSDT beneficiaries through the process of full chart quality audits, utilizing the "Quality (FCR) Audit Tool" to capture whether or not providers are abiding by these standards. BHI also developed tools to assist providers in documenting and assess our members, those tools include EPSDT components, please see "BHI Mental Health Assessment Form" page 9 for the developmental disabilities screening and page 13 for referrals and/or recommendations as needed. Furthermore, policies CLIN-213 Preventive Health Services and CLIN-210 Coordination of Care describe the procedures BHI has in place to offer the care coordination needed.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Coordination of Care policy described general processes for coordinating mental health services with medical healthcare providers, but the processes were not specifically related to EPSDT screenings. The policy stated that treating clinicians were responsible to assist members with obtaining medical care for the purpose of health maintenance—not specific to EPSDT screenings—and for maintaining communication with the primary care provider regarding the member's mental health condition. The policy included no procedures for operationalizing these processes for EPSDT-eligible beneficiaries. The Preventive Health Services policy, submitted as evidence of compliance, addressed no processes related to provision of EPSDT periodic screenings. The provider manual stated that providers must refer members who need EPSDT screening to their PCPs and obtain and consider results of the screenings in service planning. The manual describes an *EPSDT Screening Form* which requires providers to document that: "The PCP has been contacted to determine if an EPSDT has been completed; the provider has requested the completion of EPSDT by the PCP if the screening has not been completed; the Medicaid enrollment broker has been called if the Member has no PCP." The manual included no education on the components of EPSDT periodic health screenings. BHI provided no evidence that it trained providers regarding these requirements. The Quality Audit Tool for monitoring provider medical records contained three elements related to EPSDT, but it was unclear in the tool or through on-site interviews that these elements monitored for compliance with the (above) requirements outlined in the provider manual. While it appeared that BHI's provider manual required providers to assist members with obtaining EPSDT screenings, BHI provided limited evidence that it has developed effective mechanisms to "ensure the provision of all applicable components of periodic health screens (assessments) to EPSDT beneficiaries."		
Recommendations: HSAG recommends that BHI enhance or clarify internal documents and procedures and provider communications and trainings to ensure the provision of all EPSDT periodic health screens to EPSDT beneficiaries.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. Results of screenings (assessments) and examinations for members receiving BHO services shall be recorded in the child's medical record. Documentation shall include, at a minimum, identified problem and negative findings and further diagnostic studies and/or treatments needed and the date ordered. 10 CCR 8.280.4.A (5)	**Documents Submitted:** Quality (FCR) Audit Tool (Columns BJ-BL, Row 8) Provider Manual FY17 (pgs. 10, 11 and 27) **Process Description:** BHI's Provider Manual is considered an extension of the providers' contract; therefore, they must abide by the conditions set forth in the contract and the Provider Manual. The "Provider Manual FY17" includes a description of the EPSDT program and standards for the required documentation. Furthermore, BHI monitors that the results of those assessments/screenings are recorded within the member's medical record through the audit process using the "Quality (FCR) Audit Tool."	Information Only
Findings: BHI has developed a Quality Audit Tool for monitoring provider medical records, which required documentation of screenings and exams with the components outlined in the requirement. However, neither the provider manual nor other identified provider materials/trainings communicated these documentation standards to providers.		
Recommendations: HSAG recommends that BHI incorporate the documentation requirements related to EPSDT screenings and exams into provider communications.		
5. The Contractor must ensure the delivery of EPSDT Contractor-covered services. 10 CCR 2505-10 8.280.8A	**Documents Submitted:** Quality (FCR) Audit Tool (Columns BJ-BM, Row 8) Provider Manual FY17 (pgs. 10, 11 and 27) BHI Provider Bulletin – Fall 2016 (pg. 4) EPSDT Presentation Provider Forum (whole document) BHI Provider Bulletin email communication (pg. 1)	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Process Description: BHI monitors the providers' compliance with delivery of EPSDT covered services and connecting members to non-covered services accordingly through the established audit process using the "Quality (FCR) Audit Tool." BHI also educates providers on EPSDT standards through Provider Bulletins (BHI Provider Bulletin - Fall 2016"), the "Provider Manual FY17", Provider Forums and documentation trainings (EPSDT Presentation Provider Forum).	
6. The Contractor must ensure that BHO providers provide diagnostic services in addition to treatment of all mental illnesses or conditions (includes substance abuse) discovered by any screening and diagnostic procedure—even if the services are not covered in the plan. *42 CFR 441.56 (c)* 10 CCR 2505-10 8.280.4.A (3) (e); 8.280.4.C (3) Contract: Amendment 6, Exhibit A-2—2.5.13.2.5	**Documents Submitted:** CLIN-213 Preventive Health Services (pg. 2) Quality (FCR) Audit Tool (Columns BJ-BM, Row 8) CLIN-210 Coordination of Care (pgs.1 – 3) **Process Description:** The policy CLIN-213 Preventive Health Services describes the process in place to address those medically necessary services that are not covered by BHI. Additionally policy CLIN-210 Coordination of Care, also describe how BHI manages and coordinates the care of Medicaid members with other providers, agencies and/or organizations to offer services that best meet member's needs. Finally, BHI also monitors the provider's compliance with the provision of diagnostic and treatment services through EPSDT screening/assessment, please refer to "Quality (FCR) Audit Tool.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. If the provider is not licensed or equipped to render necessary treatment or further diagnosis, the provider shall refer the individual to an appropriate practitioner or facility or to the Outreach and Case Management Office (Healthy Communities) for assistance in finding a provider. 10 CCR 2505-10 8.280.4.C.2 Contract: Amendment 6, Exhibit A-2—2.5.13.1.1	**Documents Submitted:** CLIN-213 Preventive Health Services (pgs. 2) CLIN-210 Coordination of Care (pgs.2) Provider Manual FY17 (pg. 10-11) **Process Description:** As described in both the CLIN-210 Coordination of Care and CLIN-213 Preventive Health Services policies if a provider is not licensed or equipped to provide the necessary treatment the case will be referred to BHI's care management team to assist the member with finding an appropriate provider to deliver the appropriate services. BHI's Provider Manual also explains to providers can refer members to BHI or Healthy Communities for assistance.	Information Only
8. The Contractor defines "Medical Necessity for EPSDT Services" as: • A service that is found to be equally effective treatment among other less conservative or more costly treatment options; • Meets one of the following criteria: – The service is expected to prevent or diagnose the onset of an illness, condition, or disability. – The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability.	**Documents Submitted:** UM-809 Medical Necessity Criteria (whole document) UM-809aa Medical Necessity Criteria (whole document) **Process Description:** BHI defines Medical Necessity for EPSDT in policy attachment UM-809 Medical Necessity Criteria and consistently applies these criteria to all applicable utilization review decisions.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability. – The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living. • May be a course of treatment that includes observation or no treatment at all. – The Contractor's UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements: o The service is medically necessary. o The service is in accordance with generally accepted standards of medical practice. o The service is clinically appropriate in terms of type, frequency, extent, and duration. o The service provides a safe environment or situation for the child. o The service is not for the convenience of the caregiver. o The service is not experimental and is generally accepted by the medical community for the purpose stated. *42 CFR 441.57* 10 CCR 2505-10 8.280.1, 8.280.4.D and E		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: BHI defined "medical necessity" equivalent to the EPSDT medical necessity definition and UM approval criteria outlined in this requirement. However, BHI omitted the following from the medical necessity definition: "The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living." HSAG advises that the definition of medical necessity outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—includes the EPSDT-specific criteria per 8.280.4.E.		
Recommendations: HSAG recommends that BHI update its definition of medical necessity for EPSDT services in applicable policies and procedures to include the following: "The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living." HSAG strongly recommends that BHI's UM policies incorporate the definition of medical necessity as outlined in the Findings section of Standard I, element 4, of this tool.		
9. The Contractor must provide referral assistance to members receiving BHO services for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening (assessment) and diagnosis. • The Contractor must coordinate with other programs that may provide EPSDT-related services: State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Health Care Program for Children with Special Needs), 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). – Includes Child Find, Early Intervention Colorado, and the Accountable Care Collaborative.	**Documents Submitted:** CLIN-213 Preventive Health Services (pg. 2) CLIN-210 Coordination of Care (whole document) **Process Description:** BHI's Care Management team and Member Services and Outreach team provide referral assistance for treatment not covered by the Medicaid plan. Both teams collaborate with multiple agencies, including; Healthy Communities Program, State Health agencies, Mental Health Centers, and schools. These procedures are listed in the CLIN-210 Coordination of Care Policy CLIN-210 and CLIN-213 Preventative Health Services Policy.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Contractors are encouraged to refer children and their families to the Healthy Communities program in their area for community services and medical referrals, transportation information, appointment assistance, and administrative case management. – Contractors are encouraged to contact Healthy Communities for assistance in locating families who may have excessively missed appointments. • The Contractor must have a process to ensure that medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action. *42 CFR 441.61 and 441.62* 10 CCR 2505-10 8.280.8.D (5) Contract: Amendment 6, Exhibit A-2—2.5.13.1		
10. The Contractor must share PHI with the Department's EPSDT outreach and case management agencies (Healthy Communities) as allowable under HIPAA for treatment, payment and operations purposes, without requiring any special releases or other permission from the member. • The Contractor shall have either written consent from a member or a qualified service organization (QSO) agreement with a substance abuse organization to share member information regarding substance abuse disorder treatment with	**Documents Submitted:** CLIN-213 Preventive Health Services (pgs. 2- 3) **Process Description:** BHI's ensures PHI is shared without special releases with the EPSDT outreach and case management agencies including the Health Communities Program as allowable under HIPAA for treatment, payment, and operations purposes. This requirement is listed in the CLIN-213 Preventative Health Services Policy.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
the Department's EPSDT outreach and case management agencies (Healthy Communities). Contract: Amendment 6, Exhibit A-2—2.5.13.3, 2.5.13.4		
Findings: The Preventive Health Services policy included the statements defined in this requirement but did not specify procedures or responsibilities for implementing this requirement. Neither the Coordination of Care policy nor the provider manual included this information. Because both the provider and the BHI care coordinators are responsible for coordinating with Healthy Communities, it is unclear how the statements in the Preventive Health Services policy would be operationalized.		
Recommendations: HSAG recommends that BHI implement procedures and/or provider and staff communications to ensure that the requirement to share PHI with Healthy Communities without requiring releases from members is included in operational processes. Procedures should include the responsibility of the providers or care coordinators to obtain all needed documents for access to non-covered services.		
11. The Contractor facilitates provision of components of periodic health screens (assessments) for members receiving BHO services through systematic communication with network providers regarding the Department's EPSDT requirements. 10 CCR 2505-10 8.280.8.D (3) and (4)	**Documents Submitted:** EPSDT Presentation Provider Forum (whole document) BHI Provider Bulletin – Fall 2016 (pg. 4) Provider Manual FY17 (pgs. 10, 11 and 27) Screenshot Provider Manual BHI website (pg.1) BHI Provider Bulletin email communication (pg. 1) **Process Description:** BHI hosts quarterly Provider Forums, also as requested by providers BHI offers on site trainings. As part of the Forums and Trainings, providers are educated on the requirements of conducting EPSDT screenings. Please reference the "EPSDT Presentation Provider Forum" power point used. Providers are also reminded and educated about EPSDT through the feedback provided after regularly scheduled audits and through the quarterly Provider Bulletins; please see "BHI Provider Bulletin – Fall	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	2016". Additionally, our Provider Manual FY17 includes information regarding EPSDT and providers are expected to abide by the standards set forth in it. This Manual is updated every year and posted on BHI's website (see Screenshot Provider Manual BHI website). Also, an email is sent out alerting of the updated documents (BHI Provider Bulletin email communication).	

Findings:
The provider manual referenced EPSDT services in several sections—i.e., Medical Care Benefits, Frequently Asked Questions (FAQs), and EPSDT Screening Form. The manual does not inform providers of all EPSDT benefits and services and does not adequately outline provider expectations related to the EPSDT program. The Fall 2016 Provider Bulletin (distributed through the provider website) briefly described the EPSDT benefit with a link to the Health First Colorado website that outlines components of the EPSDT program. The bulletin did not specify what the provider is expected to do with this information. The EPSDT Presentation Provider Forum PowerPoint provided a general description of the purpose of EPSDT services but incompletely addressed the components of EPSDT screening services, did not communicate expectations of BHO providers regarding EPSDT services, and provided a link to the Health First Colorado website if providers "wanted to know more." While these documents represented attempts to communicate with providers regarding EPSDT services, they were individually and collectively inadequate in communicating the Department's EPSDT requirements.

Recommendations:
HSAG recommends that BHI develop effective "systematic" communications with network providers regarding the Department's EPSDT requirements and facilitating provision of periodic health screens. "Systematic" communications include regular and periodic mechanisms to communicate with providers.

Appendix B. Record Review Tool

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Behavioral Healthcare Inc.

Review Period:	January 1, 2016—November 30, 2016
Date of Review:	January 12, 2017
Reviewer:	Kathy Bartilotta and Rachel Henrichs
Participating Plan Staff Member:	Ginny Meredith and Heather Piernik

Requirements	File 1	File 2	File 3	File 4	File 5
Member	BR	GH	JD	LM	NT
Date of initial request	05/17/16	05/10/16	11/16/16	09/08/16	—
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	T
Standard (S), Expedited (E), or Retrospective (R)	S	S	S	S	—
Date notice of action sent	05/27/16	05/19/16	11/18/16	09/08/16	10/27/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	10	9	2	1	—
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	NC
Was authorization decision timeline extended? (Y or N)	Y	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NC	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	C	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	C	NA	NA	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	NC	NC	C	C	C
Total Applicable Elements	**9**	**6**	**6**	**6**	**6**
Total Compliant Elements	**7**	**5**	**6**	**6**	**5**
Score (Number Compliant / Number Applicable) = %	**78%**	**83%**	**100%**	**100%**	**83%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Requirements	File 6	File 7	File 8	File 9	File 10
Member	RD	TK	JV	KB	JP
Date of initial request	11/21/16	01/05/16	10/13/16	05/12/16	11/04/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
Standard (S), Expedited (E), or Retrospective (R)	E	R	E	S	S
Date notice of action sent	11/21/16	01/06/16	10/13/16	05/12/16	11/11/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	1	1	1	1	7
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	C	NA	C	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	**7**	**6**	**7**	**6**	**6**
Total Compliant Elements	**7**	**6**	**7**	**6**	**6**
Score (Number Compliant / Number Applicable) = %	**100%**	**100%**	**100%**	**100%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Total Record Review Score	Total Applicable Elements: 65	Total Compliant Elements: 61	Total Score: 94%

Notes:

File 1 (BR): The member was 10 years old. BHI denied the request for intensive in-home services based on lack of medical necessity. BHI extended the time frame in order to collect additional information from the requesting provider; however, BHI mailed the extension letter to the provider only—not the member. BHI suggested alternative treatment options and told the member to call the number at the Department's Office of Clinical Services for information about EPSDT services. The notice of action included a reason for denial that appeared to be inappropriate (e.g., casting blame on the parents for the child's condition) and was therefore scored as not being easy to understand.

File 2 (GH): The member was 23 years old. BHI denied the request for psychological testing based on lack of medical necessity. BHI suggested alternative treatment options and told the member to call the Department for information about EPSDT services. Because the member was not eligible for EPSDT services, the additional information may have been confusing. For this reason, HSAG scored the letter as being not easy to understand.

File 3 (JD): The member was 17 years old. BHI denied the request for residential services based on lack of medical necessity. BHI suggested 11 alternative treatment options, including specific services available through the EPSDT program as well as suggestions for transitioning the member to adult services. BHI also told the member to call the number at the Department's Office of Clinical Services for information about EPSDT services.

File 4 (LM): The member was 8 years old. BHI denied the request for subacute high intensity services based on lack of medical necessity. The notice of action included no reference for obtaining EPSDT services.

File 5 (NT): This case was a reduction of previously approved services. BHI mistakenly approved the member for six months of intensive outpatient treatment for substance use disorder. The notice of action informed the member that although BHI agrees the services are medically necessary, it will only approve two weeks at a time. The notice of action was sent less than 10 days before the new date of approved services would end.

File 6 (RD): The member was 31 years old. The member was previously discharged from the crisis center and had not taken medications for three days. The member described hearing voices and threatening to shoot someone but presented to ER as calm and organized. Notes indicated a history of alcohol and drug use. The member requested inpatient services because he/she did not want outpatient treatment. BHI denied the request based on lack of medical necessity and referred the member to SUD treatment. The ER physician requested a peer-to-peer consult after which he/she agreed with BHI's decision.

File 7 (TK): The member was 24 years old. BHI denied the retrospective review of continued stay in social detoxification program based on lack of medical necessity. (Initial four days of social detoxification can be approved without authorization.) Member had already been discharged.

File 8 (JV): The member was 34 years old. Member had been transported to ER by ambulance and reported that he/she was suicidal if released. Member had bipolar disorder, was homeless (trying to find host home for member), and had a long history of ER and inpatient visits. BHI denied the ER request for an acute treatment unit based on lack of medical necessity and suggested crisis stabilization unit as alternative. Medical director offered a peer-to-peer consultation, but the ER physician did not respond.

File 9 (KB): The member was 21 years old. Presented as walk-in to CMHC—feeling worthless/depressed; reported two fights with boyfriend. Member had discontinued therapy with outpatient provider. BHI denied the request for partial hospitalization based on lack of medical necessity and suggested intensive outpatient therapy as an alternative.

File 10 (JP): The member was 51 years old. CMHC requested long-term residential treatment for adult with SUD. BHI's medical director reviewed clinical notes to confirm that this was *not a covered benefit.*

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **BHI**.

Table C-1—HSAG Reviewers and BHI and Department Participants

HSAG Review Team	Title
Kathy Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
BHI Participants	**Title**
Cara Hebert	Director, Office of Member and Family Affairs
Clara Cabanis	Director, Quality Improvement
Earl Della Barca	Director, Compliance
Ginny Meredith	Manager, Utilization Review
Heather Piernik	Director, Utilization Review
Jeff George	Director, Technology Services
Katie Herrmann	Director, Clinical Services
Lisa Brody	Chief Operations Officer
Pat Steadman	Interim Chief Executive Officer
Teresa Summers	Director, Provider Relations
Department Observers	**Title**
Gina Robinson	Program Administrator
Michael Lott-Manier (telephonic)	Contract Manager
Russ Kennedy	Quality Unit

Appendix D. Corrective Action Plan Template for FY 2016–2017

If applicable, the BHO is required to submit a CAP to the Department for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each required action, the BHO should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the BHO must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step	Action
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 email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The BHO must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department or HSAG will notify the BHO via email 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 email or the FTP site, with an email 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.

Step	Action
Step 6	**Documentation substantiating implementation of the plan 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 CAP template follows.

Table D-2—FY 2016–2017 Corrective Action Plan for BHI

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
7. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. 4 2CFR 438.210(b)(2)(ii) Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.16	The provider manual stated that if a member does not meet medical necessity criteria, the UM Department will discuss the member's needs with the provider and work to agree on appropriate alternative treatments. On-site denial record reviews demonstrated three cases in which UM staff contacted the requesting provider to obtain additional information during the authorization process. The Utilization Review Decisions policy, Notice of Action (NOA) policy, and provider manual also stated that the provider may request a peer-to-peer consultation with the UM medical director after a denial is issued. The NOA policy stated that if an NOA is issued due to lack of information, "BHI may overturn the denial based on new information received and this is not considered a part of the appeal process." This statement is out of compliance with federal and State appeal regulations. HSAG advised staff that once an NOA is issued, any peer-to-peer consultation or decision to overturn a denial decision is part of the appeal process and must be treated as such. BHI should ensure that it consults with the provider to obtain more information as needed prior to issuing an NOA.	BHI must review and revise UM policies and procedures and the provider manual to ensure that BHI initiates a peer-to-peer consultation or request for more information prior to issuing an NOA. BHI must correct written policies and procedures and internal processes to clarify that peer-to-peer consultation conducted after an NOA has been issued is considered part of the appeal process and must be treated as such.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
13. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.6.5.5 10CCR2505—10, Sec 8.209.4.A.1	HSAG noted during on-site denial record reviews that NOAs were written in language that was easy for the member to understand. However, two cases included information that appeared to be inappropriate for the member and were therefore scored as not easy to understand.	BHI must implement a process to ensure that the information included in individual member NOAs is appropriate and not confusing for the member.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice of action must be mailed at least 10 days before the date of the intended action. *42 CFR 438.210 (d)* *42 CFR 438.404(c)* *42 CFR 431.211,431.213, and 431.214* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5 10CCR2505—10, Sec 8.209.4.A (3) (a-c)	The UM Decision Timeframes policy and the NOA policy addressed time frames for mailing the NOA per the requirements. However, the information in each policy is either incomplete, inconsistent, and/or refers to the opposite policy, requiring that both policies be used together to address all time frame requirements. Neither policy specifies that when BHI extends the time frame, it must mail the NOA "no later than the date the extension expires." (However, the extension letter to the member documents the new decision date based on the calculated 14-day extension.) During the on-site record reviews, HSAG found one NOA to the member for termination of previously authorized services was not sent within the required time frame.	BHI must ensure that it provides notice of termination of previously authorized services at least 10 days before the date of the intended action. BHI must also revise policies and procedures to specify that the time frame for mailing the NOA when the decision time frame was extended is no later than the date the extension expires
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 I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
16. If the Contractor extends the time frame for making a service authorization decision, it: • Provides the member written notice of the reason for the decision to extend the time frame. • Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. *42 CFR 438.404(c)(4)(i)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5.5.2 10CCR2505—10, Section 8.209.4.A.3.c (i)	During on-site record reviews, HSAG noted one case in which BHI extended the time frame for making a decision. BHI sent the written notice of extension only to the provider, not to the member	HI must ensure that it provides the member written notice of extension of the time frame for making an authorization decision.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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 email 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 three standards and on-site activities. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The BHOs also submitted a list of all Medicaid service and claims denials that occurred between January 1, 2016, and December 31, 2016. 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.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to BHO service and claims denials and notices of action. • 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 2016–2017 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 draft 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.