COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2017–2018 Site Review Report

for

Behavioral Healthcare, Inc.

April 2018

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Code of Federal Regulations, Title 42—federal Medicaid managed care regulations, with revisions published May 6, 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 and Financing (the Department) has elected to complete this requirement for Colorado's behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to allow for implementation of new federal managed care regulations published May 2016, the Department determined that the review period for FY 2017–2018 was July 1, 2017, through December 31, 2017. This report documents results of the FY 2017–2018 site review activities for **Behavioral Healthcare, Inc.** (**BHI**). This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the four standard areas reviewed this year. Section 2 describes the background and methodology used for the 2017–2018 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2016–2017 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 appeals and grievances 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 2017–2018 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 **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)
V. Member Information	12	11	8	3	0	1	73%
VI. Grievance System	27	27	19	8	0	0	70%
VII. Provider Participation and Program Integrity	13	13	11	2	0	0	85%
IX. Subcontracts and Delegation	4	4	2	2	0	0	50%
Totals	**56**	**55**	**40**	**15**	**0**	**1**	**73%**

*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 record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals	54	45	35	10	9	78%
Grievances	60	54	53	0	6	98%
Totals	**114**	**99**	**88**	**10**	**15**	**89%**

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

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

BHI's policies and procedures described the processes used to ensure that written member materials use easily understood language and format; are available in alternative formats and prevalent non-English languages; and include taglines in large print and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation. **BHI** had written contracts with organizations to provide oral interpretation and written translation. Subcontracts for written translation services included options for expedited translation (within 24 hours).

BHI mailed to members a welcome letter within 30 days of enrollment and an annual letter. These two letters introduced **BHI**'s program and included instructions for finding a provider; what to do in case of a mental health crisis; how to file a complaint; and where to get more information about available services, events, and ways to get involved. The letter included information about the Child Mental Health Treatment Act (CMHTA) and links to community resources for housing, substance abuse, care management, and more.

Summary of Findings Resulting in Opportunities for Improvement

HSAG reviewed various member material available in portable document format (PDF). While the font appeared to be in an acceptable range, HSAG was unable to directly confirm the font size due to the PDF format. HSAG recommends that **BHI** review all member documents to ensure that the general text of PDF versions of member materials is made available to members in at least a 12-point font.

During the on-site member information interview, staff members stated that **BHI** primarily communicates with members using the United States Postal Service; however, during the grievance and appeal interview, different **BHI** staff members referenced use of email to communicate with members during the appeals process. HSAG recommends that **BHI** develop a policy that delineates the appropriate use of email communications with members and that identifies processes to ensure security of protected health information.

Summary of Required Actions

HSAG found that many appeal resolution letters reviewed as part of the record reviews included inappropriate and confusing information, such as a technical description of the appeal determination process and continued benefits information for a new service request. **BHI** must ensure that all member information is written using appropriate and easy-to-understand language.

BHI's online advanced practitioner search allowed members to search for providers by name, location, clinical specialty, language spoken, ethnicity, office hours, license type, whether a provider has completed cultural competency training, whether the location is accessible for persons with physical

disabilities, and more. However, the PDF version of the provider manual failed to designate which providers have completed cultural competency training and which locations are accessible for persons with physical disabilities. Furthermore, neither the online version nor the print version included website uniform resource locators (URLs). **BHI** must update the print version of its provider manual to identify providers who have completed cultural competency training and locations accessible for persons with physical disabilities. **BHI** must also update both the print version and online provider search to include providers' website URLs (if available).

HSAG used the Adobe Acrobat Pro accessibility checker to test the provider directory and the fall newsletter. The Adobe checker noted minor accessibility errors related to each document. Additionally, WAVE Web Accessibility Tool identified issues with the **BHI** website. **BHI** must develop a process to ensure that all information available on its website is readily accessible (i.e., complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines).

Standard VI—Grievance System

Summary of Strengths and Findings as Evidence of Compliance

BHI's Grievance Procedure policy and Appeal Process policy thoroughly addressed requirements related to grievances and appeals, including accurate time frames for filing grievances, appeals, or requests for State fair hearings (SFHs); time frames for providing written notices to members; content of resolution notices to members; provision of assistance to members in filing processes; and procedures for reviewing grievances and appeals. Staff members stated that most appeals are generated by providers and expedited. Record reviews demonstrated that both grievances and appeals were consistently handled in accordance with requirements, including acknowledgement to the member through investigation and resolution and timely notices of resolution to members. **BHI**'s grievance and appeals documentation and tracking system was thorough, easy to access, and captured detailed information about each step in the process of handling grievances and appeals. The system also generated an ongoing tracking report for staff to monitor the processing of grievances and appeals. Staff members demonstrated a commitment to handling member grievances and appeals thoroughly and expeditiously. **BHI**'s provider manual thoroughly informed providers of all required components of information related to the grievance, appeal, and SFH system.

Summary of Findings Resulting in Opportunities for Improvement

The member welcome letter described examples of a grievance to include "if you believe your services were denied unfairly." Such a complaint would technically be an appeal of adverse benefit determination (ABD); therefore, HSAG recommends that this example be modified or removed from the welcome letter.

BHI should consider the following improvements in the Appeal Process policy:

- The policy states that the member may present information "which occurred prior to the date of denial." **BHI** should clarify that the member may present, and **BHI** will consider, all such comments, documents, or information.
- The policy states that the member may file an appeal within 60 days from *effective* date of the ABD. To avoid confusion, **BHI** should remove the word "effective"—i.e., the member may file an appeal within 60 days of the date on the ABD notice.
- The policy does not specifically state that the resolution time frame on an extended appeal is "no later than the date the extension expires."
- The policy does not differentiate that SFH and continued benefit information should be included in content of letter only *when the appeal is not resolved in favor of the member.*

Summary of Required Actions

BHI had not implemented a mechanism to verify that a provider had the member's written consent to file a grievance or appeal on behalf of that member. **BHI** must implement a mechanism to ensure that a provider has the member's written permission to file.

The Grievance Procedures policy stated that staff "will request permission from the member to take steps necessary to investigate and work to resolve the grievance." **BHI** must modify procedures to ensure that all grievances are processed regardless of whether or not remedial action is requested.

BHI must revise the Appeal Process policy to correctly outline the criteria for provision of continued benefits during an appeal or SFH, including that the member must (1) request continuation of benefits (not file the appeal) according to the "timely filing" parameters, and (2) file the appeal within 60 calendar days of the ABD notice.

BHI must modify its appeals policies and procedures to remove the criterion "the time period or service limits of a previously authorized service have been met" from the definition of how long benefits will continue during an appeal or SFH.

BHI must review and modify the appeal resolution letter *template* to ensure that the information included is necessary and is written in language that may be easily understood by the member and that the template includes the accurate time frame for requesting an SFH.

Based on appeals record reviews, HSAG identified the following required actions:

- **BHI** must modify procedures and/or monitoring processes to ensure that written notice of grievance resolution is provided to the member within the required time frame.
- **BHI** must ensure that continued benefit information is included only in appeal resolution letters that apply to an appeal of termination or reduction of previously authorized services.

Consistent with the detailed findings noted in individual requirements of the related standard, the **BHI** provider manual includes inaccuracies in some grievance and appeal information. **BHI** must ensure that all corrective actions implemented in response to recommendations or required actions in this standard are similarly applied to the grievance and appeal information in the provider manual.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

BHI had policies and procedures and implemented processes for selection and retention of providers. These included credentialing and recredentialing using National Committee for Quality Assurance (NCQA) standards, anti-discrimination attestations and monitoring of credentialing committee decisions, and notices to providers declined network participation informing of the reasons for having declined participation and the right to appeal.

BHI had numerous policies and procedures related to the compliance program and related to monitoring for fraud, waste, and abuse. The corporate compliance plan was comprehensive, thoroughly addressing all required components of the program, and was supported by detailed policies and procedures. **BHI** provided annual training and education of staff, board members, and providers through well-defined compliance program training modules; and all detailed policies were available on the **BHI** website. **BHI** documented open lines of communication, requirements to report per the False Claims Act, and follow-up investigation of potential compliance issues. The corporate compliance officer demonstrated thorough knowledge of compliance requirements and oversight of the corporatewide compliance program. **BHI** provided evidence of pre-employment/pre-contracting and monthly screening of all employees and contracted entities against the System for Award Management (SAM) and the Office of Inspector General (OIG) databases of excluded individuals. **BHI**'s claims processing delegate screened claims for potential fraud, waste, or abuse. Additionally, **BHI** conducted in-depth on-site audits of providers to identify potential compliance or fraud issues and implement corrective actions as appropriate. **BHI** had implemented mechanisms to identify and recover any overpayments made to providers or capitation payments made to the BHO.

Summary of Findings Resulting in Opportunities for Improvement

HSAG recommends that **BHI** strengthen the language in its policies and procedures, as follows:

- Include in the Recovery of Payment from Providers policy that when a provider reports an overpayment to **BHI** the provider should specify *the reason for the overpayment.*
- The Termination from Provider Network policy stated that **BHI** would report to the Department any provider termination "where such termination will cause services to be inadequate in any area." **BHI** should clarify that it will report to the Department any circumstances that will affect the provider's eligibility to participate in the managed care program (whether or not it will cause services to be inadequate in any area).

- Staff members described that *prompt response* to identified compliance issues meant "as soon as possible" as determined by the compliance officer and according to the perceived severity of the issue. **BHI** should more explicitly address in written procedures the expected time frames for "prompt response" to compliance issues.

While **BHI**'s delegate, Colorado Access, regularly screens provider claims for potential fraud, waste, and abuse, **BHI** has been unable to reliably obtain regular reports from Colorado Access on its screening results. HSAG encourages **BHI** to continue to pursue regular reporting by Colorado Access of claims screening results to enable **BHI** to do more specific follow-up monitoring of potential provider fraud, waste, and abuse.

Summary of Required Actions

BHI did not include, in any of its compliance policies, policy statements regarding reporting to the Department as specified in federal and State requirements. **BHI** must include policy statements (within an existing applicable policy) stating that **BHI** will:

- Identify to the Department and return to the Department within 60 calendar days any overpayments of capitation amounts received by **BHI**.
- Report to the Department any prohibited affiliation within five business days of discovery.
- Report to the Department any change in ownership within 35 days after the change.

Standard IX—Subcontracts and Delegation

Summary of Strengths and Findings as Evidence of Compliance

BHI's Sub-contractual Relationships and Delegation policy and procedure described the process for conducting pre-delegation evaluations, delineated the required contents of the contract consistent with regulations, required ongoing and annual performance reviews, and required that the subcontractor submit corrective action plans to address any identified performance deficiencies. **BHI** submitted evidence that it monitored its delegates, as described in each contract.

BHI's written contracts included the delegated activities, related reporting responsibilities, and provision for revocation. Three of **BHI**'s four written contracts also included the contractor's agreement to comply with Medicaid laws and the right to audit provisions found at 42 CFR 438.230.

Summary of Findings Resulting in Opportunities for Improvement

All opportunities for improvement related to subcontracts and delegation resulted in required actions.

Summary of Required Actions

BHI's written agreement with CyraCom used a CyraCom template that failed to include subcontractor's agreement to comply with applicable Medicaid laws and regulations. This agreement also failed to include the right to audit provisions. **BHI** must amend its contract with CyraCom to include CyraCom's agreement to comply with Medicaid laws and the right to audit provisions outlined in 42 CFR 438.230.

2. Overview and Background

Overview of FY 2017–2018 Compliance Monitoring Activities

For the fiscal year (FY) 2017–2018 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the BHO's contract requirements and regulations specified by federal Medicaid managed care regulations published May 6, 2016. The Department determined that the Health First Colorado member handbook, as published and distributed by the Department, was the source of member handbook information and that BHOs were not accountable for compliance with member handbook federal requirements in 42 CFR 438.10(g). 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 appeals and grievances.

HSAG also reviewed a sample of the BHO's administrative records related to Medicaid appeals and grievances to evaluate implementation of federal healthcare regulations and managed care contract requirements as specified in 42 CFR 438 Subpart F and 10 CCR 2505-10, Section 8.209. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed). Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid appeals and grievances that occurred between July 1, 2017, and December 31, 2017. For the record review, the BHO received a score of *M* (met), *NM* (not met), or *NA* (not applicable) for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance System. HSAG also separately calculated a grievances record review score, an appeals record review score, and an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2017–2018 site reviews represent a portion of the Medicaid managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

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

[2-1] 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. https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2017.

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

FY 2016–2017 Corrective Action Methodology

As a follow-up to the FY 2016–2017 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 2016–2017 compliance monitoring site review.

Summary of FY 2016–2017 Required Actions

For the FY 2016–2017, HSAG reviewed Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. HSAG found **BHI** 100 percent compliant with the requirements in the access and availability standard; however, to address issues related to coverage and authorization of services, **BHI** was required to develop a plan including the following activities and goals:

- Review and revise utilization management (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 a notice of action (NOA), and (2) 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.
- Revise policies and procedures to specify that, when the decision time frame is extended, the time frame for mailing the NOA is no later than the date the extension expires.
- Ensure that **BHI** provides the member written notice of extension of the time frame for making any authorization decision
- Ensure that **BHI** provides notice of termination of previously authorized services at least 10 days before the date of the intended action.

Summary of Corrective Action/Document Review

BHI submitted a proposed plan of corrective action in May 2017 and evidence of having implemented its plan in July 2017. HSAG and the Department requested and reviewed additional clarification in August 2017 and determined in October 2017 that **BHI** had addressed all required actions.

Summary of Continued Required Actions

No required actions were continued from the FY 2016–2017 site review activities.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood **and is readily accessible by members.** *(Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.)* *42 CFR 438.10(b)(1)* Contract Amendment 7: Exhibit A3—2.6.5.13.1	**Documents Submitted:** ADM-119 Communication with Persons with Limited English Proficiency (whole document) OMFA-606 Member Information (pg. 1) BHI Welcome Letter (pgs. 3 and 4) **Process Description:** BHI provides all member materials is a manner that is understood. This is outlined in the OMFA-606 Member Information Policy. In addition, BHI contracts with an organization, InPraxis Communications, which specializes in re-formatting content to 6th grade language. Upon Medicaid enrollment, members also receive a Welcome Letter that list their rights to receive information in alternate formats.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. **For consistency in the information provided to members, the Contractor uses the following as developed by the State:** • **Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization,**	**Documents Submitted:** Health First Colorado Handbook (whole document) UM-801 Access and Availability (pg. 1) UM-804 Appeal Process (pgs. 1, 2) UM-809 Medical Necessity Criteria (pg. 1) UM-818 Emergency and Post Stabilization Services (pg. 1) OMFA-603 Grievance Procedure (pg. 1) QI-704 Network Adequacy (pg. 1) BHI website screenshot member information **Process Description:** The Health First Colorado Handbook and BHI's website include information on the terms listed in this standard. Definitions of these terms are also listed in BHI policies. The policies include	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • **Model member handbooks and member notices.** *42 CFR 438.10(c)(4)* Contract Amendment 7: Exhibit A3—2.2.6, 2.3.2, 3.1.7	UM-801 Access and Availability, UM-804 Appeal Process, UM-809 Medical Necessity, UM-818 Emergency and Post Stabilization Services, OMFA-603 Grievance Procedure, QI-704 Network Adequacy.	
Findings: HSAG is aware and the Department acknowledges that, for the 2017–2018 compliance review period, the State has neither developed nor communicated to health plan contractors a consensus list of managed care definitions to be used in information provided to members. HSAG has therefore scored this element *Not Applicable.* HSAG recommends that all contractors maintain awareness of this requirement and, when received, incorporate State-defined managed care definitions into all applicable member communications, as directed by the Department.		
3. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** • **All written materials for members must:** – Use easily understood language and format.	**Documents Submitted:** ADM-119 Communication with Persons with Limited English Proficiency (whole document) OMFA-606 Member Information (whole document) BHI Welcome Letter (English and Spanish) (pgs.3-4) FY18 Annual Enrollee Letter (English and Spanish) (whole documents) **Process Description:** BHI makes all written information available in prevalent non-English languages. The materials are also available in alternative	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– **Use a font size no smaller than 12 point.** – Be available in alternative formats **and through provision of auxiliary aids and services** that take into consideration the special needs of members **with disabilities** or limited English proficiency. – **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.** – Be available for immediate dissemination in that language. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit A3—2.6.5.13.1–3, 2.6.5.13.6.1–3, 2.6.5.13.7, 2.6.5.13.10.1–4	formats. This is outlined in the OMFA-606 Member Information and ADM-119 Communication with Persons with Limited English Proficiency policies. Members also receive a Welcome Letter upon enrollment and an Annual Enrollee letter which lists the availability of the documents in alternate formats and prevalent non-English languages.	
Findings: BHI's policies and procedures described the processes used to ensure that written member materials use easily understood language and format; were available in alternative formats and prevalent non-English languages; and included taglines in large print and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation. However, HSAG found that many appeal resolution letters reviewed as part of the record reviews included inappropriate and confusing information, such as a technical description of the appeal determination process and continued benefits information for a new service request.		
Required Actions: BHI must ensure that all member information is appropriate and written using easy-to-understand language.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. **If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:** • **The format is readily accessible (see definition of readily accessible above).** • **The information is placed in a Web site location that is prominent and readily accessible.** • **The information can be electronically retained and printed.** • **The information complies with content and language requirements.** • **The member is informed that the information is available in paper form without charge upon request, and is provided within five (5) business days.** *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit A3—2.6.5.3.6–8	**Documents Submitted:** OMFA-606 Member Information (pgs. 4 and 5) BHI Welcome Letter (pg. 3) FY18 Annual Enrollee Letter (pg. 2) Pediatric Letter (pgs. 2 and 3) BHI website screenshot member information **Process Description:** BHI makes member information available electronically through our website bhicares.org. The information is readily accessible and allows members to print the information. This is listed in OMFA-606 policy as well as on the Welcome Letter.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: HSAG used the Adobe Acrobat Pro accessibility checker to test the provider directory and the fall newsletter. The Adobe checker noted minor accessibility errors related to each document. Additionally, WAVE Web Accessibility Tool identified issues with the BHI website.		
Required Actions: BHI must develop a process to ensure that all information available on its website is readily accessible (i.e., complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines).		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • **This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.** • The Contractor notifies members that **auxiliary aids and services are available upon request and at no cost for members with disabilities**, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)* Contract Amendment 7: Exhibit A3—2.6.5.13.7–9	**Documents Submitted:** BHI Welcome Letter (pg. 3) FY18 Annual Enrollee Letter (pg. 2) **Process Description:** BHI ensures that interpretation services are available to all non-English speaking members free of charge. The Welcome Letter and Annual Enrollee Letter notifies members on how to access those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from or was seen on a regular basis by the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 7: Exhibit A3—2.6.10.1	**Documents Submitted:** CLIN-211 Continuity of Care (whole document) CRED-404 Termination from Provider Network (whole document) Member Notification Letter of Provider Term (whole document) **Process Description:** BHI gives written notice of termination of a network provider within 15 days of receipt of the termination notice to each member who received his/her care from the provider within the last 12 months.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	BHI gives notice to members within 15 days after receipt of a provider termination. BHI sends letter to the members who received his/her care from the provider within the last 12 months; as well as outreach calls to assist members find a new provider. This is listed in Clin-211 Continuity of Care and Cred-404 Termination from Provider Network.	
7. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals**, pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:** • The provider's name and **group affiliation**, street address(es), telephone number(s), **Web site URL, specialty (as appropriate),** and whether the providers will accept new members. • **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.** • **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and*	**Documents Submitted:** ADM-129 Practitioner and Provider Directories (whole document) Provider Network Directory Provider Network Screenshot **Process Description:** BHI makes available the following information of the Contacted Provider Network at http://www.bhicares.org/members/find-a-provider/ . BHI ensures that updates/new records pertaining to providers are loaded no later than 30 days of receiving the final executed contract. BHI makes edits weekly as requested changes come in. BHI updates the paper Provider Directory monthly. Electronic Format: • Facility/Organization Information – All locations available on BHI's webpage accept new members and have attended a cultural competency class/training within their organization and have the appropriate accommodations for people with physical disabilities. Other details included are: o Facility Detail o Address o Phone	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.) *42 CFR 438.10(h)(1-3)* Contract Amendment 7: Exhibit A3—2.6.5.8.1–3	○ Accreditation Type ○ Substance Use Only (Yes/No) ○ Office Hours ○ Additional Languages Spoken • Individual Provider Information – ○ Group Name ○ Office Address ○ Phone ○ Fax ○ Email Contact ○ License Type ○ Board Certification (○ Contract Type ○ Office Hours ○ Accepting New Patients (Yes/No) ○ Clinical Specialties ○ Treatment Modalities ○ Cultural Competency Training (Yes/No) ○ Age Group Provider Sees ○ Disability Access/Public Transportation to location available **BHI makes available to the public the option to search for specifics related to the information above.** http://www.bhicares.org/members/advanced-provider-search/	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: BHI's online advanced practitioner search allowed members to search for providers by name, location, clinical specialty, language spoken, ethnicity, office hours, license type, whether a provider has completed cultural competency training, whether the location is accessible for persons with physical disabilities, and more. However, the PDF version of the provider manual failed to designate which providers have completed cultural competency training and which locations are accessible for persons with physical disabilities. Furthermore, neither the online version nor the print version included website URLs.		
Required Actions: BHI must update the print version of its provider manual to identify providers who have completed cultural competency training and locations that are accessible for persons with physical disabilities. BHI must also update both the print version and online provider search to include providers' website URLs (if available).		
8. **Provider directories are made available on the Contractor's Web site in a machine-readable file and format.** *42 CFR 438.10(h)(4)* Contract Amendment 7: Exhibit A3—2.6.5.8.4	**Documents Submitted:** ADM-129 Practitioner and Provider Directories (whole document) Provider Network Directory **Process Description:** Paper Provider Directories are provided in English and Spanish – Directories are available in a PDF format and are updated monthly. The directory is available for download on the website or BHI's Member Services team can email or mail to members at their request. The PDF Directory includes the following information for Facilities/Organizations and Practitioners. • City • Provider Type • Provider Name • License (License types defined) • Non-English Languages Spoken • Address	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	• Age Group Seen • Phone Number	
9. The Contractor provides other necessary information to members, including: • The Child Mental Health Treatment Act (CMHTA). • Community resources. Contract Amendment 7: Exhibit A3—2.6.7.3.1 and 2.6.7.3.3	**Documents Submitted:** BHI Welcome Letter (pg. 2) FY18 Annual Enrollee Letter (pg. 2) **Process Description:** The Welcome Letter and Annual Enrollee Letter contains information to help members understand CMHTA as well as find community resources.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. For any information provided to members by the Contractor, the Contractor ensures that information is consistent with federal requirements in 42 CFR 438.10. *42 CFR 438.10 (b)*	**Documents Submitted:** OMFA-606 Member Information (whole document) **Process Description:** BHI abides by 42 CFR 428.10 when providing all member information. This is listed in OMFA-606 Policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. **The Contractor provides member information by any of:** • **Mailing a printed copy of the information to the member's mailing address.** • **Providing the information by email after obtaining the member's agreement to receive the information by email.** • **Posting the information on the Contractor's Web site and advising the member in paper or electronic form that the information is available on the Internet and including the applicable Internet address, provided that**	**Documents Submitted:** OMFA-606 Member Information (whole document) BHI website screenshots member information **Process Description:** BHI provides member information in paper format or via email depending on the member's request. Member information is posted on BHI's website in prominent location and printable version.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • **Providing the information by any other method that can reasonably be expected to result in the member receiving that information.** *42 CFR 438.10(g)(3)*		
12. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)*	**Documents Submitted:** OMFA-606 Member Information (pg. 2) BHI Welcome Letter (pg. 2) FY18 Annual Enrollee Letter (pg. 1) **Process Description:** BHI does not provide physician incentive plans. This is listed in the Welcome Letter and Annual Enrollee Letter. This is also listed in the OMFA-606 Policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard V—Member Information							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	8
				Total Score ÷ Total Applicable		=	73%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. **The Contractor has established internal grievance procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The contractor must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them.** • **The Contractor may have only one level of appeal for members (or providers acting on their behalf).** • **A member may request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination has been upheld.** • **If the Contractor fails to adhere to required time frames for processing appeals, the member is deemed to have exhausted the Contractor's appeal process and the member may initiate a State fair hearing.** *42 CFR 438.400(a)(3)* *42 CFR 438.402(a-c)* *42 CFR 438.400(b)* Contract Amendment 7: Exhibit A3—2.6.4.1, 2.6.4.9.1, 2.6.4.9.3 10 CCR 2505-10—8.209.3.A, 8.209.4.A.2.c, 8.208.4.N, and 8.209.4.O	**Documents Submitted:** OMFA-603 Grievance Procedure (whole document) UM -804 Appeal Process (pgs. 2 and 5) FY 18 Appeal Tracking (whole document) **Process Description:** BHI has an internal grievance procedures in place that is outlined in the OMFA-603 Grievance Procedure Policy. Grievances are tracked in a grievance database and reviewed by the Member Advisory Board, Quality Improvement Committee, and Credentialing Committee. A grievance report is also submitted to Healthcare Policy and Financing quarterly. BHI also has an established grievance and appeal system in place to handle appeals of adverse benefit determinations. In this system, BHI only has one level of appeal for members (or providers acting on their behalf) (see Policy UM 804 Appeal Process Section IV A, pg. 2). The appeal system allows for members to request a State Fair Hearing after receiving an appeal resolution from BHI that the adverse benefit determination has been upheld and/or when BHI fails to adhere to required time frames for processing appeals (see Policy UM 804 Appeal Process Section IV B 1 a&b, pg. 5). BHI collects and tracks information about appeals in a spreadsheet maintained by the Utilization Management team. The Director and Manager of Utilization Management, regularly monitor appeals and audit the appeal tracking spreadsheet regularly. Please see the spreadsheet title, "FY 18 Appeal Tracking".	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. The Contractor defines "adverse benefit determination" as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • **The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).** • For a resident of a rural area with only one managed care plan, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network.	**Documents Submitted:** UM-810 Adverse Benefit Determination (pgs. 1 – 2) **Process Description:** BHI defines "Adverse Benefit Determination" in accordance with 10 CCR 2505-10—8.209.2.A and 42 CFR 438.400(b) and 42 CFR 438.52 (b)(2)(ii) as evidence in Policy UM 810 Adverse Benefit Determinations Section III A, pgs. 1-2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– The provider is not part of the network but is the main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider. o If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* Contract Amendment 7: Exhibit A3—1.1.1.3 10 CCR 2505-10—8.209.2.A		
3. The Contractor defines "Appeal" as "a review by the Contractor of an **adverse benefit determination**." *42 CFR 438.400(b)* Contract Amendment 7: Exhibit A3—1.1.1.4 10 CCR 2505-10—8.209.2.B	**Documents Submitted:** UM -804 Appeal Process (pg. 1) **Process Description:** BHI follows its contract by defining "appeal" as a review of an adverse benefit determination. Please see Policy UM 804 Appeal Process Section III B, pg. 1).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. The Contractor defines "grievance" as "an expression of dissatisfaction about any matter other than an **adverse benefit determination**." Grievances may include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the member's rights **regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.** *42 CFR 438.400(b)* Contract Amendment 7: Exhibit A3—1.1.1.27, 2.6.4.5.8.1.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	**Documents Submitted:** OMFA-603 Grievance Procedure (pg. 1) **Process Description:** BHI defines a grievance as listed in this standard. The grievance definition is listed in OMFA-603 policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *42 CFR 438.402(c)* Contract Amendment 7: Exhibit A3—2.6.4.4.1, 2.6.4.4.4, 2.6.4.6.3, 1.1.1.17 10 CCR 2505-10—8.209.3.B.1, 8.209.3.B.2, 8.209.2.C	**Documents Submitted:** OMFA-603 Grievance Procedure (pg. 2) UM 804 Appeal Process (pgs.1, 2 and 5) **Process Description:** BHI has provisions for who may file grievances and appeals. Members may file grievances and BHI appeals and may request State Fair Hearings. If a member gives their written consent, a provider or authorized representative may file for the above on the member's behalf (see policies OMFA-603 Grievance Procedure and UM 804 Appeal Process.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: While both the Grievance Procedures and Appeals Process policies accurately defined who may file a grievance or appeal and providers were allowed to file on behalf of members, BHI had not implemented a mechanism to verify that a provider had the member's written consent to file.		
Required Actions: BHI must implement a mechanism to ensure that a provider has the member's written permission to file on behalf of that member.		
6. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.D	**Documents Submitted:** OMFA-603 Grievance Procedure (pg. 2) **Process Description:** BHI accepts orally and written grievances as described in the OMFA-603 Grievance Procedure Policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.A	**Documents Submitted:** OMFA-603 Grievance Procedure (pg. 2) BHI Welcome Letter (pg. 1) **Process Description:** BHI allows member to file a grievance at any time. There is no timeframe to file a grievance. This requirement is listed in the OMFA-603 Grievance Procedure Policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.B	**Documents Submitted:** OMFA-603 Grievance Procedure (pg. 2) **Process Description:** BHI sends the member a written acknowledgement of the grievance within two working days of receiving it. This requirement is listed in OMFA-603 Grievance Procedure Policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and **within 15 working days of when the member files the grievance.** • Notice to the member must be in writing in the format established by the Department. • **Notice to the member must be in a format and language that may be easily understood by the member.** *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract Amendment 7: Exhibit A3—2.6.4.5.5, 2.6.4.5.5.1, 2.6.5.13.1 10 CCR 2505-10—8.209.5.D.1, 8.209.5.F	**Documents Submitted:** OMFA-603 Grievance Procedure (pg. 3) **Process Description:** BHI resolves grievances within 15 working days or as expeditiously as the member's health condition requires. This timeline is listed in OMFA-603 policy. The notice to the member is also in a format and language that is easily understood by the member.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Grievance Procedure policy accurately specified the time frame for providing to the member written notice of grievance resolution. However, the policy also stated that staff "will request permission from the member to take steps necessary to investigate and work to resolve the grievance." HSAG noted that the member's permission is not required to resolve a grievance and that this process is out of compliance with new regulations defining "grievance" as any expression of dissatisfaction "…*regardless of whether remedial action is requested*." In addition, grievance record reviews identified one case in which the grievance was resolved through a case conference with the member, but a written resolution notice was not sent within the required time frame.		
Required Actions: BHI must modify procedures and/or monitoring processes to ensure that all grievances are processed regardless of whether or not remedial action is requested and that written notice of resolution is provided to the member within the required time frame.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract Amendment 7: Exhibit A3—2.6.4.5.5.2 10 CCR 2505-10—8.209.5.G	**Documents Submitted:** OMFA-603 Grievance Procedure (pg. 3) Grievance Resolution Letter Template **Process Description:** BHI's grievance resolution letters includes outcome of grievance and date the grievance was completed. The grievance letter template and OMFA-603 policy shows these requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, **auxiliary aids and services upon request**, as well as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* Contract Amendment 7: Exhibit A3—2.6.4.3 10 CCR 2505-10—8.209.4.C	**Documents Submitted:** OMFA-603 Grievance Procedure (pg. 2) Grievance Resolution Letter Template UM-804 Appeal Process (pgs. 2 – 3) **Process Description:** BHI provides reasonable assistance to members in completing any forms and taking other procedural steps related to a grievance. OMFA-603 and UM 804 policies state this requirement. Members are notified of this assistance via the grievance acknowledgement and resolution letters.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's	**Documents Submitted:** OMFA-603 Grievance Procedure (pg. 2) UM-804 Appeal Process (pg. 3) **Process Description:** BHI ensures that individuals who make decisions on grievances and/or appeals were not involved in any previous level of review or decision-making, nor a subordinate of any	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. • **Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.** *42 CFR 438.406(b)(2)* Contract Amendment 7: Exhibit A3—2.6.4.5.4, 2.6.4.6.10, 2.6.4.6.6.1, 2.6.4.7.1.1, 2.6.4.7.1.2 10 CCR 2505-10—8.209.5.C, 8.209.4.E	such individual. BHI ensures that individuals who make appeal decisions have the appropriate clinical expertise in treating the member's condition or disease. Please see Policy UM 804 Appeal Process and OMFA 603 Grievance Procedure. BHI provides members and DCRs with the opportunity to present evidence, in the form of oral testimony, written comments or documents which will be taken into account in the appeal review without regard to whether such information was submitted or considered in the initial adverse benefit determination. Please see Policy UM 804 Appeal Process Section IV A 7 c, pg. 3).	
13. A member may file an appeal with the Contractor **within 60 calendar days** from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* Contract Amendment 7: Exhibit A3—2.6.4.6.3.1 10 CCR 2505-10—8.209.4.B	**Documents Submitted:** UM-804 Appeal Process (pg. 2) **Process Description:** BHI is in compliance with 42 CFR 438.402 (c)(2)(ii) in allowing members to file appeals within 60 calendar days from the date on the adverse benefit determination notice. Please see Policy UM 804 Appeal Process Section IV A 5, pg. 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
14. The member may file an appeal either orally or in writing and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406(b)(3)* Contract Amendment 7: Exhibit A3—2.6.4.6.3.2 10 CCR 2505-10—8.209.4.F	**Documents Submitted:** UM-804 Appeal Process (pg. 2) **Process Description:** BHI allows members to file appeals either orally or in writing. If a member files an oral request, the request must be followed with a written request (unless the request is for expedited resolution). Please see Policy UM 804 Appeal Process Section IV A 2, pg. 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor sends the member written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract Amendment 7: Exhibit A3—2.6.4.1 10 CCR 2505-10—8.209.4.D	**Documents Submitted:** UM-804 Appeal Process (pg. 3) **Process Description:** In compliance with 10 CCR 2505-10—8.209.4.D and 42 CFR 438.406(b)(1), BHI send members written acknowledgement of their appeal requests within two (2) working days, unless the member or DCR requests an expedited appeal. Please see Policy UM 804 Appeal Process Section IV A 7 a), pg. 3.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date), and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request.	**Documents Submitted:** UM-804 Appeal Process (pg. 3) **Process Description:** BHI's appeal process is in compliance with 10 CCR 2505-10—8.209.4.F, 8.209.4.G, 8.209.4.H, 8.209.4.I and 42 CFR *438.406(b)(3-5)*. Please see Policy UM 804 Appeal Process Section IV A 7 parts a-e, pg. 3.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• The member a reasonable opportunity, in person and in writing, to present evidence **and testimony** and make legal and factual arguments. **(The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.)** • The member and his or her representative the member's case file, including medical records, other documents and records, and **any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame.** • That included, as parties to the appeal, are: – The member and his or her representative. – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3-5)* Contract Amendment 7: Exhibit A3—2.6.4.6.4, 2.6.4.6.5, 2.6.4.6.7, 2.6.4.6.8, 2.6.4.6.9 10 CCR 2505-10—8.209.4.F, 8.209.4.G, 8.209.4.H, 8.209.4.I		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
17. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • For expedited resolution of an appeal and notice to affected parties, **within 72 hours** after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)&(3)&(d)(2)* *42 CFR 438.10* Contract Amendment 7: Exhibit A3—2.6.4.7.1, 2.6.4.7.3.2, 2.6.4.7.3.5, 2.6.5.13.1 10 CCR 2505-10—8.209.4.J, 8.209.4.L	**Documents Submitted:** UM-804 Appeal Process (pgs. 4 - 6) **Process Description:** BHI resolves appeals and provides written notice of the appeal decision as expeditiously as the member's health condition requires. For standard resolutions, appeals are resolved within 10 working days. For expedited resolutions, appeals are resolved within 72 hours and BHI makes reasonable efforts to provide oral notice of the resolution. Written notices of appeal resolutions are in a language that may be easily understood by the member. Please see Policy UM 804 Appeal Process Section IV A 9 a) i. pg. 4-5 and Section IV A 9 b) i and ii pg. 5-6.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The appeal resolution letter template included extensive information that was not necessary to communicate to the member. In addition, some template language was written in regulatory language (e.g., criteria for requesting continued benefits during a SFH) and not easy for the member to understand. Template issues are global; therefore, HSAG did not consider this information in the scoring of "resolution letter easy to understand" in individual appeal record reviews. However, BHI should review and modify the appeal resolution letter template to ensure that the information included is necessary and is written in language that may be easily understood by the member. In five of nine appeal record reviews, HSAG noted that the appeal resolution letter included the member's right to continue benefits during the SFH when the appeal related to a request for new services—i.e., was *not* related to termination or reduction of previously authorized services. HSAG determined that this information was both confusing and misleading to the member. Additionally, one letter to the member included a technical description of the appeal determination process, which likely was not easy for the member to understand.		
Required Actions: BHI must implement processes to ensure that the appeal resolution notice to the member is written in language that may be easily understood by the member. BHI must also ensure that continued benefit information is included only in appeal resolution letters that apply to appeals of previously authorized services, to avoid confusion for members.		
18. The contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days: • If the member requests the extension; or • If the Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. • If the Contractor extends the time frames, it must—for any extension not requested by the member: – Make reasonable efforts to give the member prompt oral noice of the delay. – **Within two (2) calendar days**, give the member written notice of the reason for the	**Documents Submitted:** OMFA-603 Grievance Procedure (pg. 3) Extension Letter Template UM-804 Appeal Process (pgs. 3 - 5) **Process Description:** BHI follows 10 CCR 2505-10—8.209.4. J, 8.209.4.O and 42 CFR 438.408(c) regarding time frame extensions for the resolution of grievances and appeals. Please see Policy UM 804 Appeal Process Section IV A 9 a i and ii, pg. 3-4 and Section IV B 1 b pg. 5. And policy OMFA-603 Grievance Procedure). The investigating representative or member may request a 14-calendar day extension to resolve the grievance. If the timeframe is extended, the BHI representative will send the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
delay and inform the member of the right to file a grievance if he or she disagrees with that decision. – Resolve the appeal as expeditiously as the member's health condition requires and no later than the date that the extension expires. • **If the Contractor fails to adhere to the notice and timing requirements for extension of the appeal resoultion time frame, the member may initiate a State fair hearing**. *42 CFR 438.408(c)* Contract Amendment 7: Exhibit A3—2.6.4.7.2, 2.6.4.7.2.1, 2.6.4.7.8, 2.6.4.7.3.3, 2.6.4.5.8.1.2, 2.6.4.9.3, 2.6.4.6.2.5.2.3 10 CCR 2505-10—8.209.4.J, 8.209.4.O	member a written notice within 2 calendar days detailing the extension. The extension letter template is an example of the member notification.	
19. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. o That the member may be held liable for the cost of these benefits if the hearing	**Documents Submitted:** UM-804 Appeal Process (pg.7) **Process Description:** BHI's written notice of appeal resolution is in compliance with the requirements under 10 CCR 2505-10—8.209.4.M and 42 CFR 438.408(e). Please see Policy UM 804 Appeal Process Section IV A 9 b pg. 4, Section D 1 pg. 6 and Section D 3 pg. 7.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract Amendment 7: Exhibit A3—2.6.4.7.4, 2.6.4.7.5 10 CCR 2505-10—8.209.4.M		
Findings: In five of nine appeal record reviews, HSAG noted that the appeal resolution letter included the member's right to continue benefits during the SFH when the appeal was related to a request for new services—i.e., *not* related to termination or reduction of previously authorized services.		
Required Actions: BHI must develop a process to ensure that the appeal resolution letter informs the member of the right to request that benefits/services continue while the hearing is pending *only* when the appeal relates to termination or reduction of previously authorized services.		
20. **The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.** • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. • The parties to the State fair hearing include the Contractor as well as the member and his or her	**Documents Submitted:** UM-804 Appeal Process (pgs.5 -6) **Process Description:** BHI follows contractual requirements related to State Fair Hearings. Please see Policy UM 804 Appeal Process Section IV B parts 1 – 6, pg. 5-6.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
representative or the representative of a deceased member's estate. • The Contractor shall participate in all State fair hearings regarding appeals. *42 CFR 438.408(f)(1) and (2) and (3)* Contract Amendment 7: Exhibit A3—2.6.4.9.1, 2.6.4.9.3, 2.6.4.9.2, 2.6.4.9.5 10 CCR 2505-10—8.209.4.N, 8.209.4.O, 8.209.4.H		
Findings: The Appeal Process policy accurately addressed all circumstances related to SFHs, as defined in the requirement. However, the appeal resolution letter template included an inaccurate time frame for requesting an SFH during the review period. Template issues are global; therefore, HSAG did not consider the inaccurate time frame in scoring the required content of letters in individual appeal record reviews.		
Required Actions: BHI must ensure that the appeal resolution letter template includes the accurate time frame for requesting an SFH.		
21. The Contractor maintains an expedited review process for appeals for when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the Contractor denies a request for expedited resolution of an appeal, it must:	**Documents Submitted:** UM-804 Appeal Process (pg.2) **Process Description:** BHI maintains an expedited review process for appeals that is in compliance with 10 CCR 2505-10—8.209.4.Q, 8.209.4.R, 8.29.4.S and 42 CRF 438.410. Please see Policy UM 804 Appeal Process Section IV A 4 a & b pg. 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– Transfer the appeal to the time frame for standard resolution. – **Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision.** *42 CFR 438.410* Contract Amendment 7: Exhibit A3—2.6.4.7.3, 2.6.4.7.3.1, 2.10.17.2 10 CCR 2505-10—8.209.4.Q, 8.209.4.R, 8.29.4.S		
22. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.	**Documents Submitted:** UM-804 Appeal Process (pg. 6) **Process Description:** BHI provides for the continuation of benefits/services while appeals and State Fair Hearings are pending as stated in 10 CCR 2505-10—8.209.4.T and 42 CFR 438.420(a) and (b). Please see Policy UM 804 Appeal Process Section IV D 1 pg. 6.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 calendar days of the notice of adverse benefit determination. **This definition of "timely filing" only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* Contract Amendment 7: Exhibit A3—2.6.4.8.1 10 CCR 2505-10—8.209.4.T		
Findings: The Appeal Process policy accurately describes most criteria for providing continuation of benefits during an appeal or SFH. However, the criteria inaccurately state that the member must *file the appeal* within 10 days of the date of the adverse benefit determination or the intended effective date of the adverse benefit determination. Similarly, the policy does not specify that the member must file the appeal within 60 calendar days of the notice of ABD. The accurate criteria for providing continued benefits are that the member must (1) request continuation of benefits (not file the appeal) according to the "timely filing" parameters, and (2) file the appeal within 60 calendar days of the ABD notice.		
Required Actions: BHI must correct the Appeals Process policy to correctly outline the criteria for provision of continued benefits during an appeal or SFH.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
23. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract Amendment 7: Exhibit A3—2.6.4.8.2 10 CCR 2505-10—8.209.4.U	**Documents Submitted:** UM-804 Appeal Process (pgs. 6-7) **Process Description:** BHI is in compliance with 10 CCR 2505-10—8.209.4.U and 42 CFR 438.420(c) as evidenced in Policy UM 804 Appeal Process Section IV D 2 pgs. 6-7.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Appeal Process policy outlined the parameters, per the requirement, for how long requested benefits will continue pending outcome of an appeal or SFH, but also added a criterion, "the time period or service limits of a previously authorized service have been met." This criterion does not apply to how long benefits will continue pending the outcome of an appeal or SFH.		
Required Actions: BHI must modify its policies and procedures to remove the criterion "the time period or service limits of a previously authorized service have been met" from the definition of how long benefits will continue during an appeal or SFH.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
24. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* Contract Amendment 7: Exhibit A3—2.6.4.8.3 10 CCR 2505-10—8.209.4.V	**Documents Submitted:** UM-804 Appeal Process (pgs.7) **Process Description:** BHI is in compliance with 10 CCR 2505-10—8.209.4.V and 42 CFR 438.420(d) as evidenced in Policy UM 804 Appeal Process Section IV D 3, pg. 7.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than **72 hours** from the date it receives notice reversing the determination. • If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services, unless State policy and regulations provide for the State to cover the cost of such services.	**Documents Submitted:** UM-804 Appeal Process (pg.7) **Process Description:** BHI is in compliance with 10 CCR 2505-10—8.209.4.V, 8.209.W and 42 CRF 438.424 as evidenced in Policy UM 804 Appeal Process Section IV D 4&5, pg. 7.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
42 CFR 438.424 Contract Amendment 7: Exhibit A3—2.6.4.8.4, 2.6.4.8.5 10 CCR 2505-10—8.209.4.V, 8.209.W		
26. The Contractor maintains records of all grievances and appeals. **The records must be accurately maintained in a manner accessible to the State and available on request to CMS. The record of each grievance and appeal must contain, at a minimum, all of the following information:** • **A general description of the reason for the grievance or appeal.** • **The date received.** • **The date of each review or, if applicable, review meeting.** • **Resolution at each level of the appeal or grievance.** • **Date of resolution at each level, if applicable.** • **Name of the person for whom the appeal or grievance was filed.** *42 CFR 438.416* Contract Amendment 7: Exhibit A3—2.9.6.2 10 CCR 2505-10—8.209.3.C	**Documents Submitted:** OMFA-603 Grievance Procedure (pg. 4) Grievance Report Template UM-804 Appeal Process (pg.7) **Process Description:** BHI maintains records of all grievances in a grievance database. The information collected with each grievance is detailed in the grievance report template and in OMFA-603 Policy. BHI also maintains records of all appeals in accordance with 10 CCR 2505-10—8.209.3.C and 42 CFR 438.416. Please see Policy UM 804 Appeal Process Section IV E, pg. 7.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
27. The Contractor provides the information about the grievance appeal and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member, including how members obtain a hearing, and the representation rules at a hearing. • The availability of assistance in the filing processes. • The toll-free number to file orally. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. • Appeals process available under the Child Mental Health Treatment Act (CMHTA), if residential services are denied.	**Documents Submitted:** Provider Manual FY18 (pgs. 16, 17, 34 and 35) **Process Description:** The Provider Manual contains information regarding grievances, appeals, State Fair Hearings, how a member or provider can access assistance with the filing process, toll-free numbers the member can use. It also specifies that benefits will continue if the appeal or request for State Fair Hearing is filed within the timeframe and if benefits continue during the process the member may be required to pay the cost of services while the appeal or State Fair Hearing process is pending, if the final decision is adverse to the member. The Provider Manual is given to new providers upon contracting.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Any State-determined provider's appeal rights to challenge the failure of the organization to cover a service. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract Amendment 7: Exhibit A3—2.6.4.4 10 CCR 2505-10—8.209.3.B		
Findings: The BHI Provider Manual included information on all components of the grievance and appeal system described in the requirement. However, the provider manual included in some information provided inaccuracies consistent with the detailed findings noted in individual requirements of this standard.		
Required Actions: BHI must ensure that all corrective actions implemented in response to recommendations or required actions in this standard are similarly applied to the grievance and appeal information in the provider manual.		

Results for Standard VI—Grievance System							
Total	Met	=	19	X	1.00	=	19
	Partially Met	=	8	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	27	**Total Score**		=	19
				Total Score ÷ Total Applicable		=	70%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* Contract Amendment 7: Exhibit A3—2.9.7.1.1	**Documents Submitted:** CRED-403 Provider Credentialing Recredentialing (pgs. 4 and 5) Provider Information Form (whole document) **Process Description:** The credentialing policy includes the information BHI utilizes for selection and retention of providers. BHI also requires providers to complete a Provider Information Form. This form is presented in their credentialing file detailing the clinical specialties and key trainings that may be helpful in determining network need and participation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the State's policies for credentialing. • The Contractor uses National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all contracts. • The Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. *42 CFR 438.214(b) and (e)* Contract Amendment 7: Exhibit A3—2.9.7.1.1, 2.9.7.2.1.1–2, and 2.9.7.2.3.1	**Documents Submitted:** CRED-403 Provider Credentialing Recredentialing (Whole Document) **Process Description:** The credentialing policy explains process for credentialing and recredentialing providers. BHI ensures that all individual behavioral health practitioners are credentialed in accordance with NCQA standards and guidelines. BHI does not contract with any laboratory-testing sites under this Medicaid contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* Contract Amendment 7: Exhibit A3—2.5.14.1 and 2.9.7.1.3	**Documents Submitted:** CRED-402 Prohibition of Provider Discrimination (whole document) CRED-403 Provider Credentialing Recredentialing (pg. 12) **Process Description:** It is the policy of BHI not to discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification. BHI does not discriminate against particular practitioners that serve high risk populations, or specialize in conditions that require costly treatment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.	**Documents Submitted:** CRED-403 Provider Credentialing Recredentialing (pg. 12) CRED-402 Prohibition of Provider Discrimination (whole document) Decline to Include in Network Template (whole document) **Process Description:** Providers who have been denied credentialing receive a written notice of the reason for the decision. A template letter is attached shows that a reason for including the provider in the network is entered.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* Contract Amendment 7: Exhibit A3—2.5.14.1		
5. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, provider, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participation in federal healthcare programs. • The Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). • The Contractor has procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity. • The Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of its employees and contractors against the HHS-OIG's List of Excluded Individuals (LEIE) to	**Documents Submitted:** CC-309 Sanctions and Exclusions Monitoring Policy (whole document) ADM-115 Subcontractual Relationships and Delegation (page 1) **Process Description:** BHI does not have a director, officer, partner, employee, consultant, subcontractor, provider, or owner who is debarred, suspended, or otherwise excluded from participation in federal healthcare programs. Prior to hire or contracting, and monthly thereafter, BHI screens all of its employees, contractors, and providers against both the HHS-OIG's List of Excluded Individuals (LEIE) and the System for Award Management (SAM) lists. BHI has not had a change in ownership, nor has it found any prohibited affiliation within the review period.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
determine whether they have been excluded from participation in Medicaid. • The Contractor has procedures to provide to the Department written disclosure of any prohibited affiliation within five (5) business days of discovery. *42 CFR 438.214(d)* *42 CFR 438.610(a-c)* *42 CFR 438.608(c)(1-2)* Contract Amendment 7: Exhibit A3—2.9.7.3.3.2, 2.9.7.3.3.7, 2.9.10.9, 2.10.5.2, 2.10.5.3.7.2		
Findings: BHI provided evidence that it monthly screens all required parties against exclusion databases and that no excluded parties had been identified. Staff members verbally stated that BHI would notify the Department in any circumstance that it identified excluded individuals or entities. Similarly, staff members stated that BHI has never had a change in ownership but that they would report any change in ownership to the Department if it occurred. Nevertheless, BHI did not include in any of its compliance policies a policy statement regarding reporting to the Department as specified in State contract requirements. BHI must include in an appropriate policy a policy statement that it will report to the Department any prohibited affiliation within five business days of discovery and any change in ownership within 35 days.		
Required Actions: BHI must include in policy statements (in existing applicable policies) that BHI will report to the Department any prohibited affiliation within five business days of discovery and report to the Department any change in ownership within 35 days after the change.		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
6. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care, or treatment options—including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* Contract Amendment 7: Exhibit A3—2.10.17.1	**Documents Submitted:** Provider Contract Template (pgs. 4,5,17 and 18) **Process Description:** Providers have the right to practice within the lawful scope of their licensure including advising and/or advocating on behalf of members regarding treatments that may be self-administered and the risks, benefits and consequences or treatment or non-treatment. Providers have the right to discuss appropriate treatment alternatives with members, regardless of whether such treatment alternatives are covered services and as well as the member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions. The Member Rights and Responsibilities are included as Attachment B in all provider/practitioner contracts.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment.	**Documents Submitted:** N/A **Process Description:** BHI has not objected to providing any services on moral or religious grounds. BHI will furnish the required notifications to the State and the members if this ever happens.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* Contract Amendment 7: Exhibit A3—2.10.18.1 and 2.10.18.3		
8. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse, and which includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices to ensure compliance with requirements of the contract and who reports directly to the CEO and Board of Directors. • The establishment of a compliance committee of the Board of Directors and at the senior management level, charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract.	**Documents Submitted:** Code of Conduct (whole document) CC-301 Conflict of Interest (whole document) CC-301aa BHI Annual Affirmation (whole document) CC-301ab Conflict of Interest Disclosure Statement (whole document) CC-301ac Supplemental Form (whole document) CC-302 Corporate Compliance and Employee Contractor Relations (whole document) CC-303 Subpoenas (whole document) CC-304 Compliance Monitoring and Auditing (whole document) CC-304aa Compliance Audit Tool (whole document) CC-304ab Full Chart Review Audit Tool (whole document) CC-304ac Template Services Verification Letter (whole document) CC-305 Document Retention CC-306 Compliance with False Claims Act CC-307 Recovery of Payment from Providers (whole document) CC-307aa Compliance Audit Tool (whole document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* Contract Amendment 7: Exhibit A3—2.9.3.1, 2.9.3.1.1.1–2, 2.9.3.1.3–7	CC-307ab Quality (FCR) Audit Tool (whole document) CC-308 Fraud Waste and Abuse (whole document) CC-309 Sanctions and Exclusions Monitoring Policy (whole document) CC-310 Effective Lines of Communication (whole document) CC-311 Monitoring and Auditing (whole document) CC-312 Training and Education on Corporate Compliance (whole document) PRIV-501 Accounting of Disclosures of Protected Health Information (whole document) PRIV-501aa Request for Accounting of Disclosures (whole document) PRIV-501ac Accounting Report (whole document) PRIV-501ad Research Report (whole document) PRIV-502 Alternate Means of Communication (whole document) PRIV-502aa Request to Receive PHI at Alternative Location or by Alternative Means (whole document) PRIV-503 Amendment of Protected Health Information (whole document) PRIV-503aa Request to Amend PHI (whole document) PRIV-503ab Denial of Request to Amend PHI (whole document) PRIV-503ac Approval of Request to Amend PHI (whole document) PRIV-503ad Notice of Amendment to PHI (whole document)	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	PRIV-503ae Rebuttal to Statement of Disagreement (whole document) PRIV-504 Authorizations and Other Release of Information Forms Received by BHI (whole document) PRIV-505 Business Associate Contract Procedures (whole document) PRIV-506 Member Access to Protected Health Information (whole document) PRIV-506aa Request to Access PHI (whole document) PRIV-506ab Notice of Denial of Access to PHI (whole document) PRIV-506ac Request for Review of Denial of Access to PHI (whole document) PRIV-506ad Notice of Determination of Access to PHI (whole document) PRIV-507 Member Request for Restrictions Regarding Use or Disclosure of Protected Health Information (whole document) PRIV-507aa Request for Restriction of Use or Disclosure of PHI (whole document) PRIV-508 Disclosure of Protected Health Information (whole document) PRIV-508aa Authorization for Use and Disclosure Form (whole document) PRIV-508aa Authorization for Use and Disclosure Form_Spa (whole document) PRIV-508ab Authorization for BHI to receive PHI for Use and Disclosure_Spa (whole document)	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	PRIV-509 Minimum Necessary Rule Regarding Disclosure of Protected Health Information (whole document) PRIV-510 Privacy Regulation Training (whole document) PRIV-511 The Notice of Privacy Practices (whole document) PRIV-511aa - Notice of Privacy Practices (whole document) PRIV-512 Privacy Officer (whole document) PRIV-513 Workforce Access to Protected Health Information (whole document) PRIV-513aa Access to Protected Health Information Form (whole document) PRIV-514 Breach Notification (whole document) PRIV-514aa HIPAA Breach Notification Tool (whole document) PRIV-514ab Content of Notice (whole document) PRIV-514ac Mitigation (whole document) PRIV-515 Protected Health Information Off-Site (whole document) PRIV-516 Protection of Oral and Written Information (whole document) PRIV-517 Physical Access Controls (whole document) PRIV-518 Electronic Access Controls (whole document) Corporate Compliance Committee Charter v2 (whole document) **Process Description:** BHI's Compliance Department consists of a Director of Healthcare Compliance, Compliance Specialist, Compliance	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Committee, and a number of operaitng documents. These documents include the Compliance Plan, Code of Conduct, and all Compliance and Privacy Policies and Procedures. These documents articulate BHI's commitment to compliance. The Director of Healthcare Compliance is certified in both healthcare compliance and healthcare privacy compliance and must attend numerous continuing education classes and trainings to maingtain those certifications. BHI employees are trained through our compliance modules in our Learning Management System and participation in BHI's annual Compliance Week. All seven elements of an effective compliance program are contained in the Compliance Policies and Procedures.	
9. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit and any potential fraud to the State Medicaid Fraud Control Unit. Contractor provides to the Department: – Verbal report immediately. – Written report in three (3) business days.	**Documents Submitted:** CC-306 Compliance with False Claims Act (whole document) CC-308 Fraud Waste and Abuse (whole document) **Process Description:** BHI has a written policy that provides information about the False Claims Act and whistleblower protection (CC-306). BHI has a written policy regarding referral of any fraud, waste, and abuse and suspending payments to a network provider if there is a credible allegation of fraud (CC-308).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud. *42 CFR 438.608(a)(6-8)* Contract Amendment 7: Exhibit A3—2.12.1, 2.9.3.2.1–2, 2.9.3.4.1, 2.9.3.4.4		
10. The Contractor's compliance program includes: • Provision for prompt notification to the Department about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. *42 CFR 438.608(a)(3-4)* Contract Amendment 7: Exhibit A3—2.9.3.2.1–2, 2.10.15.2	**Documents Submitted:** CC-308 Fraud Waste and Abuse (page 2) CRED-404 Termination from Provider Network (whole document) **Process Description:** BHI promptly notifies all appropriate agencies for any instance of Member or Provider fraud, waste, or abuse as described on policy CC-308 Fraud Waste and Abuse. BHI also provides notification to the State about changes in a provider's circumstances that may affect the provider's eligibility to participate in the network. These cirmcumstances may include • Furnishing incomplete or inaccurate information on a professional disclosure form • Suffering revocation, termination, suspension, or probation with respect to licensure, certification, Medicare or Medicaid participation status or accreditation Suffering loss of its general of rpofessinal liability insurance coverage.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11. The Contractor's compliance program includes provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • The Contractor screens all provider claims, collectively and individually, for potential fraud, waste, or abuse— including mechanisms to identify overpayments to providers and to report suspected instances of up-coding, unbundling of services, services that were billed for but never rendered, and inflated bills for services and goods provided. • The Contractor has procedures for provision of a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. - The Contractor provides individual notices to all or a sample of members who received services to verify and report whether services billed by providers were actually received by members. • The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment.	**Documents Submitted:** CC-304 Compliance Monitoring and Auditing (whole document) CC-304aa Compliance Audit Tool (whole document) CC-304ab Full Chart Review Audit Tool (whole document) CC-304ac Template Services Verification Letter (whole document) CC-307 Recovery of Payment from Providers (whole document) CC-307aa Compliance Audit Tool (whole document) CC-307ab Quality (FCR) Audit Tool (whole document) **Process Description:** BHI monitors its providers compliance with state and federal rules through audits. BHI's auditor reviews provider's claims and records and initiates overpayment recoveries as necessary (CC-304 and CC-307). BHI also provides individual notices to a sample of members who received services to verify whether services billed by providers were actually received by members (CC-304, page 6). BHI does have a mechanism for network providers to report overpayments and return the overpayments within 60 days (CC-307, page 5). BHI will return any identified overpayments from the state to itself within 60 days as is required in BHI's contract. BHI has not received an overpayment to date. BHI tracks all recoveries of overpayments, but does not report that to the State as this is not required by contract at this time.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• The Contractor has procedures to identify to the Department within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(a)(5), (c)(3), and (d)(2) and (3)* Contract Amendment 7: Exhibit A3—2.9.3.1.8, 2.9.3.1.1.3–9, 2.9.3.2.1–2, and 5.2.1.1,		
Findings: Staff members verbally described that the BHI Chief Financial Officer maintains communication with the Department regarding any capitation payments made to BHI exceeding contracted amounts and stated that BHI had not identified any excess capitation payments to be reported to the Department. Nevertheless, BHI did not include in any of its compliance policies a policy statement regarding reporting to the Department as specified in federal and State requirements.		
Required Actions: BHI must include a policy statement (in an existing applicable policy) stating that BHI will identify to the Department and return to the Department any overpayments of BHI capitation amounts within 60 calendar days of the identified overpayment.		
12. **The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of the State.** *42 CFR 438.608(b)* Contract Amendment 7: Exhibit A3—2.5.9.12	**Documents Submitted:** Provider Manual FY18 (pg. 6) **Process Description:** All practitioners must be credentialed by BHI as well as a Health First Colorado provider prior to providing services to BHI members. All providers are verified through the ATN report provided by HCPF and/or the state provider portal prior to begining the credentialing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Effective March 1, 2017, providers that are not enrolled in the Health First Colorado interchange through the revalidation or enrollment process are not be able to submit claims submissions, verify member eligibility, or provide any services to Medicaid recipients.	
13. The Contractor provides that Medicaid members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the healthcare provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* Contract Amendment 7: Exhibit A3—2.2.3, 2.10.14.2	**Documents Submitted:** Provider Manual FY18 (pg. 19) Provider Contract Template (whole document) **Process Description:** BHI's Provider Manual and Provider Contract Template informs providers that members are not held liable for: BHI's debts in the event of insolvency, covered services provided to the member for which the Department does not pay BHI, covered services provided to the member that are not contractually allowed per the provider contract, and payments for covered services furnished under another arrangement that are in excess of the amount that the member would owe if BHI provided the services directly.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	11
				Total Score ÷ Total Applicable		=	85%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. **Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.** The Contractor must: • Evaluate the prospective subcontractor's ability to perform the activities to be delegated. • Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. • Identify deficiencies or areas for improvement, and ensure that the subcontractor takes corrective action. *42 CFR 438.230(b)(1)* Contract Amendment 7: Exhibit A3—3.1.5, 3.1.5.1, 3.1.5.3–4	Note—This does not apply to provider agreements (unless provider contracted to perform responsibilities other than services to members). **Documents Submitted:** 07-01-17 Colorado Access - Administrative Services Agreement (ASO) FINAL (whole document) 07-05-16 Colorado Access - Administrative Services Agreement (ASO) FINAL (whole document) FY15 COA Audit FINAL (whole document) FY15 COA Delegation Oversight Audit Final Report (whole document) BHI SFY17 Monthly Contract Performance Summary May Final (whole document) COA October Reports FY18 (whole document) **Process Description:** BHI began delegating many activities to Colorado Access many years ago. BHI monitors the subcontractor's performance every month by tracking every report provided by Colorado Access and by requiring Colorado Access to submit a monthly self-report. BHI's last formal audit on Colorado Access was completed in May 2016. Attached is BHI's contract with Colorado Access (07-01-17 Colorado Access – Administrative Services Agreement (ASO) FINAL and 07-05-16 Colorado Access - Administrative Services Agreement (ASO) FINAL), an example of the self-report (BHI SFY17 Monthly Contract Performance Summary May Final), an example of the monthly tracking document (COA October Reports FY18), and BHI's	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	previous formal audit report (FY15 COA Audit FINAL and FY15 COA Delegation Oversight Audit Final Report).	
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities **or obligations** and related reporting responsibilities. • **That the subcontractor agrees to perform the delegated activities and reporting responsibilities** • Provision for revocation of the delegation of activities or obligation or **specify other remedies in instances where the State or Contractor determines** that the subcontractor has not performed satisfactorily. *42 CFR 438.230(b)(2) and (c)(1)* Contract Amendment 7: Exhibit A3—3.1.5.1.2	**Documents Submitted:** 07-01-17 Colorado Access - Administrative Services Agreement (ASO) FINAL (whole document) 07-05-16 Colorado Access - Administrative Services Agreement (ASO) FINAL (whole document) **Process Description:** BHI has a contract with Colorado Access to perform numerous activities. Please see the Administrative Services Agreement for more information.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor's written agreement with any subcontractor includes: • **The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.** *42 CFR 438.230 (c)(2)* Contract Amendment 7: Exhibit A—6.A	**Documents Submitted:** 07-01-17 Colorado Access - Administrative Services Agreement (ASO) FINAL (page 3) 07-05-16 Colorado Access - Administrative Services Agreement (ASO) FINAL (page 3) **Process Description:** Section 4 of the Administrative Services Agreement requires Colorado Access to comply with all applicable Medicaid laws	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	and regulations, including applicable sub-regulatory guidance and contract provisions.	
Findings: BHI had written agreements with four subcontractors. Three of these written agreements used BHI templates that included the required provisions; however, BHI's written agreement with CyraCom used a CyraCom template that failed to include the subcontractor's agreement to comply with applicable Medicaid laws and regulations.		
Required Actions: BHI must ensure that all written agreements with subcontractors include the subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.		
4. The written agreement with the subcontractor includes: • **The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.** – **The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems related to Medicaid members.** – **The right to audit will exist through 10 years from the final date of the contract**	**Documents Submitted:** 07-01-17 Colorado Access - Administrative Services Agreement (ASO) FINAL (page 7) 07-05-16 Colorado Access - Administrative Services Agreement (ASO) FINAL (page 7) **Process Description:** Section 11 of the Administrative Services Agreement states: "BHI shall own and have the right to control all books, records and deliverables, including supporting documents, generated and/or maintained by COA for BHI under this Agreement. Notwithstanding the foregoing, COA shall have the right to retain copies of all books, records, and deliverables for its own records. BHI, and any successor in bankruptcy, shall have the right to access all books, records, and deliverables maintained by COA under this Agreement at any time, including upon the termination of this Agreement, upon reasonable advance notice. BHI agrees that it shall not use any system access or access to books and records maintained by COA for purposes beyond this Agreement. Furthermore, BHI shall not review any records	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
period or from the date of completion of any audit, whichever is later. – **If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.** *42 CFR 438.230(c)(3)* Contract Amendment 7: Exhibit A3—2.9.9.5	of non-BHI members. BHI shall communicate these restrictions to any staff that will or may have access to COA systems and/or records. BHI and COA shall each cooperate and provide access to the other party in the event that the documents maintained by one party are needed by the other party as evidence in legal proceedings involving such party. In accordance with the provisions contained in this Agreement and until the expiration of ten (10) years after the furnishing of services pursuant to this Agreement, COA and BHI shall upon proper written request made, allow the Comptroller General of the United States, the Secretary of Health and Human Services, HCPF, and the Colorado Division of Insurance, or their duly authorized representatives, access to this Agreement and to the books, documents, and records necessary to certify the nature and extent of costs for the purpose of reimbursement to BHI or payable services provided under this agreement, as applicable, and for any other health or financial oversight activities. If COA enters into any subcontract with a related organization, COA and BHI shall require in such subcontract that the subcontractor also agree to such requirements.”	
Findings: BHI’s written agreement with CyraCom failed to include the right to audit provisions.		
Required Actions: BHI must amend its contract with CyraCom to include the right to audit provisions outlined in 42 CFR 438.230.		

Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	2	X	1.00	=	2
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	2
				Total Score ÷ Total Applicable		=	50%

Appendix B. Record Review Tools

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Behavioral Healthcare, Inc.

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	January 30, 2017
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member:	Heather Piernik

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	***	12/29/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	12/29/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was an expedited request that required no acknowledgment letter.											
2	***	12/19/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	12/22/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was an expedited request that required no acknowledgment letter.											
3	***	12/07/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	12/08/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was an expedited request that required no acknowledgment letter.											
4	***	11/29/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	11/30/17	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: This was an expedited request that required no acknowledgment letter. The right to request continued benefits was included in the resolution letter although the appeal involved a new request for services—i.e., no previously authorized services. HSAG considered this information misleading and confusing to the member.											
5	***	11/28/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	11/28/17	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: This was an expedited request that required no acknowledgment letter. The resolution letter included inappropriate and confusing information such as a technical description of the appeal determination process and continued benefits information for a new service request. HSAG considered this information misleading and confusing to the member.											
6	***	11/13/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	11/15/17	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: This was an expedited request that required no acknowledgment letter. The right to request continued benefits was included in the resolution letter although the appeal involved a new request for services—i.e., no previously authorized services. HSAG considered this information misleading and confusing to the member.											
7	***	10/25/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☒ No ☐	10/27/17	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: This was an expedited request that required no acknowledgment letter. The resolution letter included information about continuation of benefits, which HSAG considered inappropriate and confusing as the appeal involved a new request for a higher level of care.											
8	***	10/16/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	10/18/17	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: This was an expedited request that required no acknowledgment letter. The resolution letter included information about continuation of benefits, which HSAG considered inappropriate and confusing as the appeal involved a new request.											
9	***	10/11/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	10/12/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was an expedited request that required no acknowledgment letter.											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Behavioral Healthcare, Inc.

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
10	***	10/02/17	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: The member was discharged from care on 09/29/17, followed by an appeal by the provider for payment of additional days of care provided beyond the end of the previous authorization. Upon further consideration of the circumstances, HSAG determined that this was a new request for authorization rather than an appeal. Therefore, the case was omitted from the record review.											
OS1			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS2			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**0**	**9**	**9**				**9**	**9**	**9**
Column Subtotal of Compliant (M) Elements			**0**	**9**	**9**				**9**	**4**	**4**
Percent Compliant (Divide Compliant by Applicable)			**NA**	**100%**	**100%**				**100%**	**44%**	**44%**

Key: M = Met; N = Not Met
N/A = Not Applicable

Total Applicable Elements	**45**
Total Compliant (M) Elements	**35**
Total Percent Compliant	**78%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Behavioral Healthcare, Inc.

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	January 30, 2018
Reviewer:	Rachel Henrichs
Participating Health Plan Staff Member:	Cara Hebert

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	****	12/27/17	Y ☒ N ☐ N/A ☐	01/10/18	9	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
2	****	12/20/17	Y ☒ N ☐ N/A ☐	01/11/18	15	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
3	****	12/06/17	Y ☒ N ☐ N/A ☐	12/21/17	11	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
4	****	12/05/17	Y ☒ N ☐ N/A ☐	12/15/17	8	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
5	****	11/17/17	Y ☒ N ☐ N/A ☐	12/18/17	19	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: The member requested an extension. On 12/11/17, BHI mailed the member an extension notice that included all required content.										
6	****	11/10/17	Y ☒ N ☐ N/A ☐	12/07/17	17	Y ☐ N ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: BHI resolved this member's grievance during a face-to-face meeting with involved parties on 11/28/17; however, the grievance coordinator failed to mail the resolution notice until after the timeline expired. BHI immediately notified its contract manager at the Department of the oversight.										
7	****	11/06/17	Y ☒ N ☐ N/A ☐	11/17/17	9	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
8	****	10/26/17	Y ☒ N ☐ N/A ☐	11/15/17	14	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
9	****	09/12/17	Y ☒ N ☐ N/A ☐	09/27/17	11	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Behavioral Healthcare, Inc.

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
10	****	09/08/17	Y ☒ N ☐ N/A ☐	09/14/17	4	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: The member left a message for the grievance coordinator on 09/13/17 requesting that the grievance be withdrawn. The grievance coordinator spoke to the member on 09/14/17 and confirmed that the member had resolved the grievance through direct communication with the staff members to whom the grievance was related. After confirming that the member was happy with the resolution, BHI mailed the member a letter confirming that the member withdrew the grievance. The letter invited the member to call if he wanted to further pursue the issue.										
OS 1			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**10**			**10**	**7**	**7**	**10**	**10**
Column Subtotal of Compliant (Yes) Elements			**10**			**9**	**7**	**7**	**10**	**10**
Percent Compliant (Divide Compliant by Applicable)			**100%**			**90%**	**100%**	**100%**	**100%**	**100%**

Key: Y = Yes; N = No
N/A = Not Applicable

Total Applicable Elements	**54**
Total Compliant (Yes) Elements	**53**
Total Percent Compliant	**98%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2017–2018 site review of **BHI**.

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

HSAG Review Team	Title
Katherine Bartilotta, BSN	Associate Director
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
Kijuana Wright	Associate Director
BHI Participants	**Title**
Braden Perks	Member Services and Outreach Representative
Cara Hebert	Office of Member and Family Affairs Director
Clara Cabanis	Quality Improvement Director
Earl L. Della Barca	Director, Compliance and General Counsel
Heather Piernik	Chief Operations Officer, Community Partnerships; Director, UM
Kathy Forrest	Director, Integrated Care
Liz Bullock	Utilization Manager
Pat Steadman	Chief Executive Officer
Teresa Summers	Director, Provider Relations
Department Observers	**Title**
Russ Kennedy	Quality Specialist

Appendix D. Corrective Action Plan Template for FY 2017–2018

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 and HSAG will: • Approve the planned interventions and instruct the BHO to proceed with implementation, or • Instruct the BHO to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the CAP, the BHO will have a time frame of six months to complete proposed actions and submit documents. The BHO will submit documents as evidence of completion one time only on or before the six-month deadline for all required actions in the CAP. (If necessary, the BHO will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the health plan within the intervening time frame.)

Step	Action
Step 5	**Technical assistance**
	HSAG will schedule with the BHO a one-time, interactive, verbal consultation and technical assistance session during the six-month time frame. The session may be scheduled at the health plan's discretion at any time the health plan determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the BHO as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the six-month deadline will result in assignment as a delinquent corrective action that will be continued into the following compliance review year. (HSAG will list delinquent actions in the annual technical report and in the health plan's subsequent year's compliance site review report.)

The CAP template follows.

Table D-2—FY 2017–2018 Corrective Action Plan for BHI

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
3. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** • **All written materials for members must:** – Use easily understood language and format. – **Use a font size no smaller than 12 point.** – Be available in alternative formats **and through provision of auxiliary aids and services** that take into consideration the special needs of members **with disabilities** or limited English proficiency. – **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral**	BHI's policies and procedures described the processes used to ensure that written member materials use easily understood language and format; were available in alternative formats and prevalent non-English languages; and included taglines in large print and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation. However, HSAG found that many appeal resolution letters reviewed as part of the record reviews included inappropriate and confusing information, such as a technical description of the appeal determination process and continued benefits information for a new service request.	BHI must ensure that all member information is appropriate and written using easy-to-understand language.

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. – Be available for immediate dissemination in that language. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit A3—2.6.5.13.1–3, 2.6.5.13.6.1–3, 2.6.5.13.7, 2.6.5.13.10.1–4		
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 V—Member Information		
Requirement	**Findings**	**Required Action**
4. **If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:** • **The format is readily accessible (see definition of readily accessible above).** • **The information is placed in a Web site location that is prominent and readily accessible.** • **The information can be electronically retained and printed.** • **The information complies with content and language requirements.** • **The member is informed that the information is available in paper form without charge upon request, and is provided within five (5) business days.** *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit A3—2.6.5.3.6–8	HSAG used the Adobe Acrobat Pro accessibility checker to test the provider directory and the fall newsletter. The Adobe checker noted minor accessibility errors related to each document. Additionally, WAVE Web Accessibility Tool identified issues with the BHI website.	BHI must develop a process to ensure that all information available on its website is readily accessible (i.e., complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
7. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, **pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:** • The provider's name and **group affiliation**, street address(es), telephone number(s), **Web site URL, specialty (as appropriate)**, and whether the providers will accept new members. • **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.** • **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than*	BHI's online advanced practitioner search allowed members to search for providers by name, location, clinical specialty, language spoken, ethnicity, office hours, license type, whether a provider has completed cultural competency training, whether the location is accessible for persons with physical disabilities, and more. However, the PDF version of the provider manual failed to designate which providers have completed cultural competency training and which locations are accessible for persons with physical disabilities. Furthermore, neither the online version nor the print version included website URLs.	BHI must update the print version of its provider manual to identify providers who have completed cultural competency training and locations that are accessible for persons with physical disabilities. BHI must also update both the print version and online provider search to include providers' website URLs (if available).

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
30 calendar days after the Contractor receives updated provider information.) *42 CFR 438.10(h)(1-3)* Contract Amendment 7: Exhibit A3—2.6.5.8.1–3		
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *42 CFR 438.402(c)* Contract Amendment 7: Exhibit A3—2.6.4.4.1, 2.6.4.4.4, 2.6.4.6.3, 1.1.1.17 10 CCR 2505-10—8.209.3.B.1, 8.209.3.B.2, 8.209.2.C	While both the Grievance Procedures and Appeals Process policies accurately defined who may file a grievance or appeal and providers were allowed to file on behalf of members, BHI had not implemented a mechanism to verify that a provider had the member's written consent to file.	BHI must implement a mechanism to ensure that a provider has the member's written permission to file on behalf of that 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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
9. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, **and within 15 working days of when the member files the grievance.** • Notice to the member must be in writing in the format established by the Department. • **Notice to the member must be in a format and language that may be easily understood by the member.** *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract Amendment 7: Exhibit A3—2.6.4.5.5, 2.6.4.5.5.1, 2.6.5.13.1 10 CCR 2505-10—8.209.5.D.1, 8.209.5.F	The Grievance Procedure policy accurately specified the time frame for providing to the member written notice of grievance resolution. However, the policy also stated that staff "will request permission from the member to take steps necessary to investigate and work to resolve the grievance." HSAG noted that the member's permission is not required to resolve a grievance and that this process is out of compliance with new regulations defining "grievance" as any expression of dissatisfaction "…*regardless of whether remedial action is requested*." In addition, grievance record reviews identified one case in which the grievance was resolved through a case conference with the member, but a written resolution notice was not sent within the required time frame.	BHI must modify procedures and/or monitoring processes to ensure that all grievances are processed regardless of whether or not remedial action is requested and that written notice of resolution is provided to the member within the required time frame.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
17. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • For expedited resolution of an appeal and notice to affected parties, **within 72 hours** after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member.	The appeal resolution letter template included extensive information that was not necessary to communicate to the member. In addition, some template language was written in regulatory language (e.g., criteria for requesting continued benefits during a SFH) and not easy for the member to understand. Template issues are global; therefore, HSAG did not consider this information in the scoring of "resolution letter easy to understand" in individual appeal record reviews. However, BHI should review and modify the appeal resolution letter template to ensure that the information included is necessary and is written in language that may be easily understood by the member. In five of nine appeal record reviews, HSAG noted that the appeal resolution letter included the member's right to continue benefits during the SFH when the appeal related to a request for new services—i.e., was *not* related to termination or reduction of previously authorized services. HSAG determined that this information was both confusing and misleading to the member. Additionally, one letter to the member included a technical description of the appeal determination process, which likely was not easy for the member to understand.	BHI must implement processes to ensure that the appeal resolution notice to the member is written in language that may be easily understood by the member. BHI must also ensure that continued benefit information is included only in appeal resolution letters that apply to appeals of previously authorized services, to avoid confusion for members.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
42 CFR 438.408(b)(2)&(3)&(d)(2) *42 CFR 438.10* Contract Amendment 7: Exhibit A3—2.6.4.7.1, 2.6.4.7.3.2, 2.6.4.7.3.5, 2.6.5.13.1 10 CCR 2505-10—8.209.4.J, 8.209.4.L		
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
19. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. o That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract Amendment 7: Exhibit A3—2.6.4.7.4, 2.6.4.7.5 10 CCR 2505-10—8.209.4.M	In five of nine appeal record reviews, HSAG noted that the appeal resolution letter included the member's right to continue benefits during the SFH when the appeal was related to a request for new services—i.e., *not* related to termination or reduction of previously authorized services.	BHI must develop a process to ensure that the appeal resolution letter informs the member of the right to request that benefits/services continue while the hearing is pending *only* when the appeal relates to termination or reduction of previously authorized services.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
20. **The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.** • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. • The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. • The Contractor shall participate in all State fair hearings regarding appeals. *42 CFR 438.408(f)(1) and (2) and (3)* Contract Amendment 7: Exhibit A3—2.6.4.9.1, 2.6.4.9.3, 2.6.4.9.2, 2.6.4.9.5 10 CCR 2505-10—8.209.4.N, 8.209.4.O, 8.209.4.H	The Appeal Process policy accurately addressed all circumstances related to SFHs, as defined in the requirement. However, the appeal resolution letter template included an inaccurate time frame for requesting an SFH during the review period. Template issues are global; therefore, HSAG did not consider the inaccurate time frame in scoring the required content of letters in individual appeal record reviews.	BHI must ensure that the appeal resolution letter template includes the accurate time frame for requesting an SFH.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
22. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 calendar days of the notice of adverse benefit determination. **This definition of "timely filing" only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The*	The Appeal Process policy accurately describes most criteria for providing continuation of benefits during an appeal or SFH. However, the criteria inaccurately state that the member must *file the appeal* within 10 days of the date of the adverse benefit determination or the intended effective date of the adverse benefit determination. Similarly, the policy does not specify that the member must file the appeal within 60 calendar days of the notice of ABD. The accurate criteria for providing continued benefits are that the member must (1) request continuation of benefits (not file the appeal) according to the "timely filing" parameters, and (2) file the appeal within 60 calendar days of the ABD notice.	BHI must correct the Appeals Process policy to correctly outline the criteria for provision of continued benefits during an appeal or SFH.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
provider may not request continuation of benefits on behalf of the member.) *42 CFR 438.420(a) and (b)* Contract Amendment 7: Exhibit A3—2.6.4.8.1 10 CCR 2505-10—8.209.4.T		
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
23. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract Amendment 7: Exhibit A3—2.6.4.8.2 10 CCR 2505-10—8.209.4.U	The Appeal Process policy outlined the parameters, per the requirement, for how long requested benefits will continue pending outcome of an appeal or SFH, but also added a criterion, "the time period or service limits of a previously authorized service have been met." This criterion does not apply to how long benefits will continue pending the outcome of an appeal or SFH.	BHI must modify its policies and procedures to remove the criterion "the time period or service limits of a previously authorized service have been met" from the definition of how long benefits will continue during an appeal or SFH.
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 VI—Grievance System		
Requirement	**Findings**	**Required Action**
27. The Contractor provides the information about the grievance appeal and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member, including how members obtain a hearing, and the representation rules at a hearing. • The availability of assistance in the filing processes. • The toll-free number to file orally. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished	The BHI Provider Manual included information on all components of the grievance and appeal system described in the requirement. However, the provider manual included in some information provided inaccuracies consistent with the detailed findings noted in individual requirements of this standard.	BHI must ensure that all corrective actions implemented in response to recommendations or required actions in this standard are similarly applied to the grievance and appeal information in the provider manual.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
while the appeal or State fair hearing is pending, if the final decision is adverse to the member. • Appeals process available under the Child Mental Health Treatment Act (CMHTA), if residential services are denied. • Any State-determined provider's appeal rights to challenge the failure of the organization to cover a service. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract Amendment 7: Exhibit A3—2.6.4.4 10 CCR 2505-10—8.209.3.B		
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 VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
5. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, provider, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participation in federal healthcare programs. • The Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). • The Contractor has procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity. • The Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of its employees and contractors against the HHS-OIG's List of Excluded Individuals (LEIE) to determine whether they have been excluded from participation in Medicaid. • The Contractor has procedures to provide to the Department written	BHI provided evidence that it monthly screens all required parties against exclusion databases and that no excluded parties had been identified. Staff members verbally stated that BHI would notify the Department in any circumstance that it identified excluded individuals or entities. Similarly, staff members stated that BHI has never had a change in ownership but that they would report any change in ownership to the Department if it occurred. Nevertheless, BHI did not include in any of its compliance policies a policy statement regarding reporting to the Department as specified in State contract requirements. BHI must include in an appropriate policy a policy statement that it will report to the Department any prohibited affiliation within five business days of discovery and any change in ownership within 35 days.	BHI must include in policy statements (in existing applicable policies) that BHI will report to the Department any prohibited affiliation within five business days of discovery and report to the Department any change in ownership within 35 days after the change.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
disclosure of any prohibited affiliation within five (5) business days of discovery. *42 CFR 438.214(d)* *42 CFR 438.610(a-c)* *42 CFR 438.608(c)(1-2)* Contract Amendment 7: Exhibit A3—2.9.7.3.3.2, 2.9.7.3.3.7, 2.9.10.9, 2.10.5.2, 2.10.5.3.7.2		
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 VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
11. The Contractor's compliance program includes provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • The Contractor screens all provider claims, collectively and individually, for potential fraud, waste, or abuse—including mechanisms to identify overpayments to providers and to report suspected instances of up-coding, unbundling of services, services that were billed for but never rendered, and inflated bills for services and goods provided. • The Contractor has procedures for provision of a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. - The Contractor provides individual notices to all or a sample of members who received services to verify and report whether services billed by providers were actually received by members. • The Contractor has a mechanism for a network provider to report to the Contractor when it has received an	Staff members verbally described that the BHI Chief Financial Officer maintains communication with the Department regarding any capitation payments made to BHI exceeding contracted amounts and stated that BHI had not identified any excess capitation payments to be reported to the Department. Nevertheless, BHI did not include in any of its compliance policies a policy statement regarding reporting to the Department as specified in federal and State requirements.	BHI must include a policy statement (in an existing applicable policy) stating that BHI will identify to the Department and return to the Department any overpayments of BHI capitation amounts within 60 calendar days of the identified overpayment.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor has procedures to identify to the Department within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(a)(5), (c)(3), and (d)(2) and (3)* Contract Amendment 7: Exhibit A3—2.9.3.1.8, 2.9.3.1.1.3–9, 2.9.3.2.1–2, and 5.2.1.1,		
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 IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
3. The Contractor's written agreement with any subcontractor includes: • **The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions**. *42 CFR 438.230 (c)(2)* Contract Amendment 7: Exhibit A—6.A	BHI had written agreements with four subcontractors. Three of these written agreements used BHI templates that included the required provisions; however, BHI's written agreement with CyraCom used a CyraCom template that failed to include the subcontractor's agreement to comply with applicable Medicaid laws and regulations.	BHI must ensure that all written agreements with subcontractors include the subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.
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 IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
4. The written agreement with the subcontractor includes: • **The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.** – **The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems related to Medicaid members.** – **The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.** – **If the State, CMS, or HHS Inspector General determines that there is a reasonable**	BHI's written agreement with CyraCom failed to include the right to audit provisions.	BHI must amend its contract with CyraCom to include the right to audit provisions outlined in 42 CFR 438.230.

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* Contract Amendment 7: Exhibit A3—2.9.9.5		
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 appeals and grievances that occurred between July 1, 2017, and December 31, 2017. 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 appeals and grievances. • 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 2017–2018 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.