State of Colorado

Department of Health Care Policy and Financing

Colorado Medicaid
Community Mental Health Services Program

FY 06–07 Site Review Report

for

Northeast Behavioral Health, LLC

May 2007

HSAG Health Services Advisory Group

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This is the third year that Health Services Advisory Group, Inc. (HSAG) has performed site reviews of the Colorado behavioral health organizations (BHOs). Compliance with federal regulations and contract requirements was evaluated in 10 areas (i.e., delegation; provider issues; practice guidelines; member rights and responsibilities; access and availability; utilization management; continuity-of-care system; quality assessment and performance improvement program; grievances, appeals, and fair hearings; and credentialing). Individual records were reviewed in the areas of grievances, denials, coordination of care for children transitioning from inpatient to outpatient services, and documentation of services to evaluate implementation of select requirements related to the standards. Details of the site review methodology are contained in Appendix D of this report.

This report documents results of the fiscal year (FY) 06–07 site review for **Northeast Behavioral Health, LLC** (**NBH**) related to compliance with requirements in the 10 standard areas and the elements of the record reviews evaluated as part of the site review.

2. Summary of Follow-Up on Prior Year Review

for Northeast Behavioral Health, LLC

As a follow-up to the FY 05–06 site review report, **NBH** was required to submit a corrective action plan (CAP) to the Colorado Department of Health Care Policy & Financing (the Department) addressing all elements for which **NBH** received a score of *Partially Met* or *Not Met*. The plan included interventions to achieve compliance and the timeline. The Department reviewed the CAP and associated documentation, requesting revisions where necessary. **NBH** completed all corrective actions for FY 05–06.

The findings for the FY 06–07 site review were determined from a desk review of the documents submitted by **NBH** to HSAG prior to the on-site portion of the review, interviews with key **NBH** staff members, and a review of records conducted during the site review.

For the review of the 10 standards, the individual elements (i.e., contract requirements) reviewed for each standard were assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable (N/A)*. A summary score was then determined by calculating the percentage of applicable elements found compliant (i.e., *Met*).

Table 3–1 presents the number of elements for each of the 10 standards, the number of applicable elements for each standard, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *N/A*), the overall compliance score for each standard, and the overall compliance score for the review of standards. Details of the review of the 10 standards can be found in Appendix A.

Table 3–1—Summary of Scores for the Standards

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I	Delegation	13	12	8	4	0	1	67%
II	Provider Issues	26	25	21	3	1	1	84%
III	Practice Guidelines	5	5	5	0	0	0	100%
IV	Member Rights and Responsibilities	18	18	16	2	0	0	89%
V	Access and Availability	20	20	20	0	0	0	100%
VI	Utilization Management	8	8	8	0	0	0	100%
VII	Continuity-of-Care System	15	15	15	0	0	0	100%
VIII	Quality Assessment and Performance Improvement Program	12	12	12	0	0	0	100%
IX	Grievances, Appeals, and Fair Hearings	11	11	9	2	0	0	82%
X	Credentialing	32	31	29	1	1	1	94%
	Totals	**160**	**157**	**143**	**12**	**2**	**3**	**91%**

For the review of records for documentation of services, denials, and grievances, elements in each record reviewed were assigned a score of Yes (compliant), No (not compliant), or Not Applicable (N/A). For each of the scored record reviews, a summary score was then determined by calculating the percentage of applicable elements found compliant.

Table 3–2 presents the number of records reviewed, the number of applicable elements, and the number of compliant elements. It also provides an overall compliance score for each record review as well as a combined record review compliance score. Details of each record review can be found in Appendix B. The coordination-of-care record review was not scored. A narrative summary of each record review can be found in Section 4.

Table 3–2—Summary of Scores for the Review of Records

Associated Standard #	Description of Record Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
II	Documentation of Services	10	20	20	100%
VI	Denials	2	6	5	83%
VII	Coordination of Care—Children Transitioning From Inpatient to Outpatient Services	10	Not Scored	Not Scored	Not Scored
IX	Grievances	6	24	23	96%
	Totals	28	50	48	96%

Table 3–3 presents the overall scores (percentage of compliance) for the review of the standards, for the review of records, and for the review of the standards and records combined.

Table 3–3—Overall Compliance Scores

Review of the Standards—Percentage Compliant	91%
Review of Records—Percentage Compliant	96%
Overall Percentage Compliant	92%

This section of the report describes **NBH**'s strengths and required actions related to each of the standards and types of records reviewed. Details of the scores related to the review of the standards can be found in Appendix A and details of the scores related to the review of records can be found in Appendix B.

Standard I—Delegation

Strengths

NBH had delegation agreements with each of its delegates and those agreements contained much of the required content. There was evidence that **NBH** monitored its delegates with respect to quality and data reporting.

Required Actions

While **NBH** had an agreement with each of its network mental health centers that described activities delegated to the mental health centers, the activities specified were either incorrect or incomplete. **NBH** must revise the written agreements with its three mental health centers to clearly specify the activities delegated and the resulting reporting responsibilities of the mental health centers.

Although there was evidence of monitoring the mental health centers and InNET for the performance of delegated administrative functions, **NBH**'s policies did not clearly describe the processes for monitoring delegates. The policies confused processes and requirements for monitoring delegates versus monitoring providers. **NBH** must revise its policies that address monitoring subcontractors to clarify the difference between the requirements of subcontracted delegates and the requirements of subcontracted providers and clearly describe the procedures for monitoring each.

Standard II—Provider Issues

Strengths

NBH had an effective tracking mechanism to ensure that it had an agreement with each provider. Agreements contained all of the required content. The corporate compliance program contained the required content, as did policies and procedures regarding monitoring of providers. There was ample evidence of monitoring the mental health centers in **NBH**'s service area for quality, appropriateness of services provided, member outcomes, requirements for medical records, and requirements for data reporting.

Review of Documentation of Services

A sample of 10 consumer service records was reviewed to assess **NBH**'s compliance with contract requirements related to documentation of services for encounters submitted. **NBH** was compliant with 20 of 20 applicable elements reviewed for a record review score of 100 percent. All 10 records contained documentation of the service provided for the day the encounter was submitted. All 10 records contained documentation that described the service for which the encounter was submitted.

Required Actions

While there was evidence of an active corporate compliance committee, in practice, the committee did not follow through with processes as required by the contract between **NBH** and the Department. Also, there was inconsistency between the corporate compliance plan as written and practice regarding the corporate compliance officer assignment. In addition, a committee member investigated an instance of possible fraud without reporting to the Department until continued community complaints brought the situation to the forefront again, months after **NBH** initially learned of the possible fraud. Communication with the Department occurred only in the second round of activity, not initially, as required. **NBH** must revise the corporate compliance plan to align with practices regarding requirements for designation of a corporate compliance officer and a corporate compliance committee. In addition, all possible instances of fraud must be reported to the Department within 10 business days of receipt of the information, as required.

NBH provided two reports describing studies of member outcomes conducted during 2006. Both studies were conducted on charts from the three mental health centers. There was evidence of other outcomes studies performed, as well; however, none of the studies included consumers served by subcontracted providers. **NBH** must monitor covered services provided under provider agreements for appropriateness of services provided. Monitoring must be representative of the entire network.

The policy that addressed termination of provider subcontracts was inconsistent with the forms attached to the policy regarding the time frame for notice to the Department. **NBH** must revise its policy and other documents to be consistent with each other and address the requirement, as stated in the contract between **NBH** and the Department.

Standard III—Practice Guidelines

Strengths

NBH developed and implemented clinical practice guidelines for the treatment of attention deficit hyperactivity disorder (ADHD) and mood disorders that were based on a compilation of information from various professional organizations, including the American Academy of Pediatrics and the American Psychiatric Association. **NBH** consulted with senior clinical staff within its provider network in the research and development of the practice guidelines and actively considered feedback from consumers and family members when developing final versions of the documents. **NBH** made copies of clinical practice guidelines available to providers, consumers, family members, and other community stakeholders on its Web site.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard IV—Member Rights and Responsibilities

Strengths

NBH had policies and procedures for ensuring consumer rights information was disseminated to new Medicaid enrollees, consumers, staff, and providers. The BHO's process for ensuring rights were taken into account when providing services included training and medical record audits for the community mental health center (CMHC) providers and making consumer representatives and parent family advocates available at each of the CMHCs.

The **NBH** Office of Consumer and Family Affairs (OCFA) functioned to provide a local and BHO-level presence, with key roles in promoting recovery and consumer involvement, providing advocacy services, and processing grievances.

Required Actions

NBH's mechanism for ensuring that the EPN took consumer rights into account was limited to offering training and checking for the presence of posted rights at the providers' sites. The BHO must implement an effective mechanism to ensure that rights are taken into account by the external providers.

The **NBH** Member Rights policy and member handbook listings of consumer responsibilities were inconsistent; therefore, the BHO must ensure that consumer responsibilities are communicated consistently to consumers, staff, and providers.

Standard V—Access and Availability

Strengths

NBH provided evidence of improvements in meeting access-to-care standards over the previous three reporting quarters, as it achieved 100 percent compliance for emergency, urgent, and routine service provision by its network providers. The BHO had policies and processes to ensure consistent measurement and reporting of the access standards across the CMHCs and EPN providers.

NBH provided evidence of policies, procedures, and practices for assessing and ensuring the adequacy of the network composition, considering enrollment, utilization of services, distance, and types of providers. Policies and practices for ensuring service provision to nursing facility residents and dual-eligible consumers were in place. Alternative services were tracked and reported as contractually required.

The BHO and its CMHCs had a process for development of goals and work plans to promote the recovery model. The CMHCs had reported their evaluation of progress in meeting their recovery goals and had numerous initiatives under way that responded to local community needs. The BHO had developed and presented recovery training, published articles and tool kits in provider newsletters, and employed OCFA representatives at the BHO and CMHC levels to promote recovery and consumer empowerment.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard VI—Utilization Management

Strengths

NBH provided a variety of documents to demonstrate that the BHO had a utilization management program that actively monitored access to and appropriate utilization of covered services. **NBH** used several tools, including interrater reliability studies, staff training, and standardized level-of-care (LOC) criteria to help ensure the consistent application of review criteria for authorization decisions. The BHO also demonstrated that it produced and analyzed several reports to help detect underutilization and overutilization of services, and that it actively monitored after-hours authorization decisions for hospital admissions delegated to North Range Behavioral Health.

Review of Denial Records

A sample of two enrollee denial records was reviewed to assess **NBH**'s compliance with contract requirements related to the presence and content of required documentation and the timeliness of decision and documentation. **NBH** was compliant with five of six applicable elements reviewed for an overall score of 83 percent. **NBH** was fully compliant in the following areas: 1) the notice included the reason for the denial, and 2) the decision was made by a qualified clinician. A Notice of Action letter for one case reviewed was not sent in a timely manner to the consumer and provider following a utilization review (UR) denial as required in Exhibit G of the BHO's contract with the Department.

Required Actions

Because not all denial files reviewed met the timeliness standard for issuing a Notice of Action, **NBH** must ensure that a Notice of Action is sent in a timely manner to the consumer and provider following a UR denial decision and request extensions when necessary or appropriate to do so.

Standard VII—Continuity-of-Care System

Strengths

NBH had multiple policies and procedures that described the BHO's requirements and practices for ensuring coordination of care, continuity of care, and for safeguarding consumer confidentiality. **NBH** and its contracted providers worked closely with juvenile and adult probation officers, local judges, developmental disability providers, schools, child welfare, and the vocational rehabilitation system. The BHO also funded several projects that involved the colocation of mental health services at health clinics, medical family practices, pediatrician offices, and federally qualified health centers (FQHCs).

Review of Coordination of Care—Children Transitioning from Inpatient to Outpatient Services

Ten records were reviewed for evidence of care coordination and outpatient follow-up for children following discharge from an inpatient facility. In one case, there was no record of **NBH** involvement in the case because the child was hospitalized in Pueblo and discharged to a Department of Human Services (DHS) placement in Pueblo (as indicated in the hospital discharge summary). In the other nine records, there was evidence of communication between the hospital and either the CMHC or the BHO prior to discharge. In four cases, the discharge plan was for care provided by an organization other than **NBH**. Examples were consumers discharged to residential treatment centers (RTCs) funded by DHS, rehospitalization prior to the scheduled follow-up, or discharge to police custody. In the five cases where **NBH** or its contracted providers were responsible for aftercare, there were progress notes documenting that the follow-up appointment was scheduled prior to discharge and documentation of the consumer attending the follow-up appointment. In four of these cases, the appointment occurred within a week of discharge. In the fifth case, progress notes described multiple "no shows" on the part of the consumer and CMHC efforts to reschedule, with an eventual appointment having taken place.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard VIII—Quality Assessment and Performance Improvement Program

Strengths

As part of its quality assessment and performance improvement (QAPI) program, **NBH** actively collected, analyzed, and reported data from multiple sources, including quality indicators, grievance and appeal data, focus studies, member satisfaction surveys, utilization management measures, and performance improvement projects (PIPs). **NBH** conducted a formal evaluation of the impact and effectiveness of its QAPI program and initiated corrective action plans with network mental health centers, as appropriate, to address problems in performance related to the Mental Health Statistics Improvement Program (MHSIP) survey and other quality studies.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard IX—Grievances, Appeals, and Fair Hearings

Strengths

The OCFA director had produced an operational procedures manual for the delegates at the CMHCs (consumer representatives and parent family advocates) who processed grievances. While the manual had some issues requiring correction, it was an excellent model for ensuring compliance with the BHO's expectations and included tips for interacting with consumers and for writing grievance letters that were responsive and sensitive. The OCFA director also had procedures for effective oversight of grievance processing by the CMHCs.

Review of Grievance Records

Six grievance records were reviewed for timeliness of acknowledgment and decision letters, decisions made by qualified clinicians (for clinical and quality-of-care grievances), and responsiveness to the consumer's grievance issue. All records were clear, complete, and well-documented. The personalized decision letters to consumers were an example of a best practice in their presentation and style. All six records were compliant with elements reviewed, with one exception. One record did not contain evidence that a qualified clinician reviewed and decided the grievance issue.

Required Actions

Due to inconsistencies and unclear and misleading language in the standardized grievance and appeal forms and other grievance policy attachments, the BHO must ensure all documents describing the grievance process are clear, consistent, and accurate.

NBH must ensure that the requirement to provide consumers the opportunity to present appeal evidence in person is implemented. This information was not present in the consumer handbook or appeals policy.

NBH reported a relatively low number of grievances in the categories requested for the review period, as compared to the other BHOs, and stated that a separate process was in place for investigating consumer quality-of-care concerns that were not filed as grievances. The BHO must process all expressions of dissatisfaction as grievances according to the Balanced Budget Act and State contract, and include this information in reporting and trending for quality improvement purposes.

Standard X—Credentialing

Strengths

NBH had clear policies and procedures and mechanisms to document the credentialing and recredentialing of practitioners and the assessment of organizational providers. The credentialing and recredentialing policies included the majority of the requirements. There was evidence that **NBH** followed the credentialing and recredentialing policies and procedures.

Required Actions

Although **NBH**'s credentialing policy addressed how applicants were informed of their rights under the credentialing program, the process described in the policy regarding informing applicants of their rights to an appeal process was not the process used by **NBH**. **NBH** must revise its policy that specifies how applicants are informed of their rights to an appeal process under the credentialing program to ensure that policies and practices are aligned.

The **NBH** credentialing policy did not address the procedure for ongoing monitoring of sanctions, complaints, and adverse events. In addition, **NBH** staff reported that there was no monitoring of federal sanctions between recredentialing cycles. **NBH** must revise its policies to include the procedure for ongoing monitoring of sanctions, complaints, and adverse events and include each National Committee for Quality Assurance (NCQA) monitoring requirement.

General Observations and Recommendations About NBH's Preparation for the Site Review

General Observations

NBH representatives attended the site review technical assistance presentation conducted by HSAG in fall 2006 in preparation for submission of documents and for participation in the site review interviews scheduled for January 2007. HSAG received **NBH**'s timely submission of desk review documents; however, the organization and completeness of the documents submitted were not effective in portraying **NBH**'s compliance with the BHO contract and the PIHP managed care regulations as follows:

- The desk review documentation form did not contribute much additional information about the operations or practices of the BHO. Instead, the form often repeated the standard/element statement as derived from contract or regulation. The purpose of this form was to provide the reviewers with information about specific BHO practices as illustrated through the related documents that were to be submitted for each standard/element (policies, procedures, reports, etc.).
- **NBH** did not identify the documents in a clear, consistent, and organized manner (e.g., documents were labeled with the standard and element number instead of being labeled with information about the document's content). While this process could have been effective if used consistently, documents that were submitted to respond to more than one standard/element were not always clearly linked to the additional standards/elements.
- Some documents submitted contained information from outside of the defined document review period (e.g., reports of clinical chart reviews performed in 2005 were submitted; however, the review period was 2006).
- **NBH** submitted a set of provider manual policies as well as BHO policies. It was unclear to the reviewers how the policies differed or how each set of policies applied to the independent providers vs. mental health center providers vs. the BHO staff. No explanation of the applicability or differences was included in the desk review submission, which required discussion and clarification during the opening session of the site review.
- During the interview portion of the site review, it became clear that numerous relevant documents were present at the BHO but had not been submitted with the desk review material requested. **NBH** produced numerous reports, policies, and other documents as evidence of compliance during the on-site portion of the site review that could have been reviewed by the site review team prior to developing interview questions. As a result, post-on-site review by HSAG was extensive, and the BHO's closing summation session did not include preliminary findings for some review areas.

Recommendations

As a result of this experience, HSAG recommends that key **NBH** management staff work with the Department or dialogue with other BHOs to establish an effective method of preparing for future

site reviews. This method should ensure completeness of documentation submitted for the desk audit, relevance to the time period for review, clear and consistent labeling and organization of documents provided as evidence of compliance, responsiveness in terms of detailed information as requested, and use of content area experts in the preparation of materials for the site review process.

NBH is required to submit to the Department a CAP for all elements within the standards scored as *Partially Met* or *Not Met* and for all elements within the record reviews scored as *No*. The CAP must be submitted within 30 days of receipt of the final version of this report. For each element that requires corrective action, the BHO must identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. After the Department has approved the CAP, **NBH** will be required to submit documents identified as evidence of compliance.

Table 5-1 describes activities required for the CAP process.

Table 5-1—Corrective Action Plan Process	
Step 1:	**Corrective action plans are submitted.**
	Each BHO will submit a CAP to the Department within 30 calendar days of receipt of the final external quality review site review report. CAPs will be submitted via HSAG's file transfer protocol (FTP) site and the BHO will e-mail notification to the Department and HSAG. For each of the elements within the standards receiving a score of *Partially Met* or *Not Met*, and for each element within the record reviews receiving a *No*, the CAP must address the planned intervention(s) to achieve compliance and the timeline(s) for the intervention(s).
Step 2:	**Plans are reviewed and approved.**
	HSAG and the Department will review the CAPs. The Department will notify each BHO as to the adequacy of its plan. If the Department determines that a CAP is adequate to bring the BHO into full compliance with the applicable contract requirements, the Department will notify the BHO in writing that the plan is approved. If the Department determines that a CAP is not adequate to bring the BHO into full compliance with one or more contract requirements, the Department will require the BHO to submit a revised CAP. Following the review of the revised plan, the Department will notify the BHO in writing of its decision to approve the plan or to require further revisions.
Step 3:	**Progress reports may be required.**
	Based on the nature and seriousness of the noncompliance, the Department may require the BHO to submit regular reports to the Department detailing progress made on one or more elements in the CAP.

Table 5-1—Corrective Action Plan Process	
Step 4:	**Corrective actions are implemented.**
	Each BHO is expected to implement all corrective actions and achieve full compliance with the applicable contract requirements within 60 calendar days of the Department's written notification of having approved the BHO's CAP. The Department may extend the time frame for implementation of one or more of the corrective actions if requested by a BHO in writing and with cause.
Step 5:	**Substantiating documentation is submitted.**
	When all Department-approved corrective actions have been implemented, the BHO will submit documentation to the Department substantiating the completion of all required corrective actions and compliance with the related contract requirements.
Step 6:	**Documentation substantiating implementation of the plans is reviewed and approved.**
	Following a review of the documentation, the Department will inform the BHO as to whether: (1) the documentation is adequate to demonstrate completion of all required actions and compliance with the related contract requirements, or (2) the BHO must take additional actions and/or submit additional documentation. The Department will inform each BHO in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the BHO into full compliance with all the applicable contract requirements.

Table 5-2 can be used by the BHO to document its planned interventions for any required actions that are listed.

Table 5-2—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard I: Delegation				
3. Content of Agreement The written agreement: A. Specifies the activities delegated to the subcontractor.	NBH must revise its written agreements with the three network mental health centers to clearly specify the activities delegated to the subcontractor and ensure that various sections and attachments to the agreements are consistent with each other.			
B. Specifies the reporting responsibilities delegated to the subcontractor.	NBH must revise its agreement with NRBH to specify NRBH's reporting responsibilities regarding the delegated responsibility of inpatient service authorization.			
4. Policies and Procedures The Contractor has written procedures for monitoring the performance of subcontracts: A. On an ongoing basis	NBH must revise policies that address monitoring subcontractors to clarify the difference between monitoring the performance of subcontracted delegates and of subcontracted providers.			
B. Through formal review	NBH must revise its policies/procedures related to monitoring delegates to align with its practices and to reflect accurate information.			
Standard II: Provider Issues				
2. Program Integrity A. The Contractor has a mandatory compliance plan and administrative and management arrangements or	NBH must revise the compliance plan to align with practices regarding the requirements for designation of a compliance officer.			

Table 5-2—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
procedures that are designed to guard against fraud and abuse, and that include: 2. Designation of a compliance officer and compliance committee that is accountable to senior management.				
B. The Contractor reports possible instances of Medicaid fraud to the Department within ten (10) business days of receipt of information. The Referrals include specific background information, the name of the Provider and a description of how the Contractor became knowledgeable about the occurrence.	NBH must report all possible instances of fraud to the Department, as required.			
6. Monitoring of Providers The Contractor monitors covered services provided under provider agreements for: C. Member Outcomes	NBH must monitor covered services provided under provider agreements for member outcomes. Monitoring must be representative of the entire network.			

Table 5-2—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
8. Termination of Provider Agreements The Contractor notifies the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area and provides the notice at least ninety (90) days prior to termination of the services unless the termination is based on quality or performance issues.	NBH must revise policies and other documents to be consistent with each other and address the requirement that NBH notify the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area. The policy and the process must include the provision that notice be given at least 90 days prior to termination of the services unless the termination is based on quality or performance issues.			
Standard IV: Member Rights and Responsibilities				
2. Takes Rights into Account A. The Contractor ensures that its staff and affiliated providers take these rights into account when furnishing services to members.	NBH must implement a mechanism to ensure that external provider network (EPN) providers take rights into account when providing services.			
3. Member Responsibilities The Contractor has written requirements for member participation and responsibilities in receiving covered services.	NBH must ensure that consumer responsibilities and expectations for participation in receiving covered services are communicated to consumers, staff, and providers in a consistent manner.			

Table 5-2—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard IX: Grievances, Appeals, and Fair Hearings				
1. Grievance and Appeal Records The Contractor maintains a record of grievances and appeals.	NBH must ensure that the standardized forms it uses for communicating with consumers and for processing grievances and appeals are accurate, consistent, and clear, that only applicable forms are included in the respective policies and procedures (related to the grievance or appeal processes), and that the language in the grievance policy attachment accurately describes the responsibilities of the BHO and the CMHCs. In addition to clarifying these identified issues in policies, the BHO must ensure that any operational manuals, training, or other communication to staff and providers about the grievance and appeal processes are clear, accurate, and consistent with the requirements and with each other. Because the Balanced Budget Act (BBA) and State contract definition for a grievance is "any expression of dissatisfaction about any matter other than an action," the BHO must ensure that all complaints and consumer quality-of-care concerns are processed according to the grievance requirements and that data are reported to the Department and used for trending and quality improvement purposes.			

Table 5-2—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
6. Appeals Process A. The Contractor provides the member an opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and informs the member of the limited time available in the case of expedited resolution.	NBH must ensure that it communicates the requirement to allow the consumer the opportunity to present evidence in person when filing an appeal.			
Standard X: Credentialing				
3. Content of Policies and Procedures P. How the applicant is notified of these rights and of the appeal process.	NBH must revise its policy that specifies how applicants are notified of their rights under the credentialing program, including the right to an appeal process, to ensure that policies and practices are aligned.			
Q. The procedure for ongoing monitoring of sanctions, complaints and adverse events (for high-volume providers).	NBH must revise its policies to include the procedure for ongoing monitoring of sanctions, complaints, and adverse events, and include each NCQA monitoring requirement.			

Table 5-2—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Recommendations About NBH's Preparation for the Site Review				
	HSAG recommends that key NBH management staff work with the Department or dialogue with other BHOs to establish an effective method of preparing for future site reviews. This method should ensure completeness of documentation submitted for the desk audit, relevance to the time period for review, clear and consistent labeling and organization of documents provided as evidence of compliance, responsiveness in terms of detailed information as requested, and use of content area experts in the preparation of materials for the site review process.			

The review of the standards follows this cover page.

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
1. Pre-delegation Assessment	Prior to entering into subcontracts, the Contractor evaluates the proposed subcontractor's ability to perform the activities to be delegated.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The Subcontracting policy included procedures for predelegation assessment. Northeast Behavioral Health (NBH) staff reported that no new delegation subcontracts were entered into during the review period. While the contract language delegating the processing of grievances to the mental health centers was newly developed during the review period, the relationship between NBH and the mental health centers was not new. The requirement to evaluate the mental health centers' ability to perform the delegated function of grievance processing was not applicable because NBH had knowledge of this ability based on the existing relationship.	
II.C.1	**Required Actions** None	
2. Written Agreements	The Contractor has a written agreement with each subcontractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH delegated submission of encounter and Colorado Client Assessment Record (CCAR) data to InNET; prior authorization for after-hours inpatient hospitalizations to North Range Behavioral Health, and grievance processing to North Range Behavioral Health, Centennial Mental Health Center, and Larimer Center for Mental Health. NBH had current agreements with InNET and each of the three mental health centers.	
II.C.2	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement	The written agreement: A. Specifies the activities delegated to the subcontractor.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The agreement with InNET specified that submission of encounter and CCAR data was performed by InNET. The agreement with North Range Behavioral Health (NRBH) indicated that NRBH authorized inpatient services; however, the agreement did not specify the limitation that NRBH only authorized inpatient services after normal business hours (evenings and weekends). Each of the three mental health center agreements contained language inconsistent with the delegation of after-hours authorization to NRBH and stated that no authorization of inpatient hospitalization was required for hospitalizations up to 72 hours. On-site, NBH staff confirmed that authorization for inpatient hospitalization was, in fact, required at all times. Each of the three mental health center agreements stated, in Attachment G, that each center would receive, investigate, resolve, track, and report grievances to NBH; however, Attachment G also indicated that appeals would be received and processed by the mental health centers. Appeals were not delegated to the mental health centers. Attachment F to the agreement, which indicated what delegation oversight NBH would perform, only described the mental health centers' responsibilities as maintaining policies and procedures for grievances.	
	Required Actions NBH must revise its written agreements with the three network mental health centers to clearly specify the activities delegated to the subcontractor and ensure that various sections and attachments to the agreements are consistent with each other.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement	B. Specifies the reporting responsibilities delegated to the subcontractor.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The InNET agreement specified the reporting responsibilities of InNET related to the delegated activities of data submission. The three mental health center agreements specified the reporting responsibilities related to processing of grievances. The NRBH agreement did not specify NRBH's reporting responsibilities related to the delegated function of service authorization.	
	Required Actions NBH must revise its agreement with NRBH to specify NRBH's reporting responsibilities regarding the delegated responsibility of inpatient service authorization.	
	C. Includes provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article III of the three mental health center agreements included provisions for revoking delegation or imposing other sanctions in the case of inadequate performance. The InNET agreement included provisions for imposing sanctions, including suspension of a specific delegated activity.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement II.C.2	D. Specifies that the subcontractor shall comply with the standards specified in the contract between the BHO and the Department for any responsibilities delegated to the subcontractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each agreement contained language that specified that the subcontractor would comply with the standards specified in the contract between NBH and the Department.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
4. Policies and Procedures	The Contractor has written procedures for monitoring the performance of subcontracts: A. On an ongoing basis	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Subcontracting policy stated that delegates would be subject to ongoing monitoring and formal review; however, the policy stated that delegates were responsible for types of information related to service provision rather than delegated activities and did not clearly describe the procedures for ongoing monitoring of delegated activities.	
	Required Actions NBH must revise policies that address monitoring subcontractors to clarify the difference between monitoring the performance of subcontracted delegates and of subcontracted providers.	
	B. Through formal review	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Subcontracting policy included written procedures for monitoring delegates. The written procedures indicated that semiannual audits would be performed. While there was evidence that monitoring occurred during the review period, there was not evidence of semiannual audits. In addition, the policy stated, "where the delegate's functions are accredited by NCQA or another recognized accrediting body, documentation of current accreditation will serve as a proxy for oversight by NBH." This statement is only accurate if the delegated function is credentialing and the accrediting agency is NCQA. At the time of the site visit, NBH did not delegate any credentialing tasks.	
	Required Actions NBH must revise its policies/procedures related to monitoring delegates to align with its practices and to reflect accurate information.	
II.C.4		

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
5. Monitoring of Delegates	The Contractor monitors services provided through subcontracts for: A. Quality	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There was evidence of monitoring NRBH for the quality of the service authorizations performed by NRBH and of monitoring each of the network mental health centers for the quality of the grievance processing performed by them. There was evidence of monitoring InNET for quality of data submission performed by InNET on behalf of NBH.	
	Required Actions None	
	B. Data reporting	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There was evidence that each delegate was monitored regarding data reporting related to the specific delegated function.	
	Required Actions None	
II.C.3		

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
6. Corrective Action II.C.5	If the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor take corrective action.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There was evidence that NBH required corrective action through specific communication with NRBH related to the performance of service authorization.	
	Required Actions None	
7. Termination of Subcontracts II.C.9	The Contractor notifies the Department in writing of its decision to terminate any existing subcontract applicable to the performance of services under the Contract.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH provided a contract cover sheet which contained BHO Medicaid contract language regarding notification to the department of subcontract terminations 60 days prior to the termination (unless such termination is related to quality issues). The cover sheet contained both the delegation requirement and the provider requirement. During the interview, NBH staff reported that each agreement (delegation or provider) was issued with a cover sheet that would be used in the event of subcontract termination, and that NBH management staff would complete the applicable section at the time of contract termination. Staff reported that there had been no delegation subcontracts terminated during the review period.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
8. Access to Records II.C.8	All subcontracts provide for access to all records by the Secretary of the U.S. Department of Health and Human Services, for 3 years following disposition of property or equipment. **Findings** All agreements with delegates included the provision for access to records by the secretary of the U.S. Department of Health and Human Services for a period of three years following disposition of property or equipment. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Results for Standard I					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
8	4	0	1	12	67%

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
1. Provider Discrimination II.H.4.a	A. The Contractor does not discriminate with respect to 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.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Network policy included language prohibiting discrimination. During the interview, staff reported that the credentialing policies and procedures were applied to all applicant providers uniformly.	
	Required Actions None	
	B. If the Contractor declines to include individual or groups of providers in its network, it gives the affected providers written notice of the reason for its decision.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy stated that providers were given the reason they were declined participation in the Network. A template letter was reviewed on-site.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity	A. The Contractor has a mandatory compliance plan and administrative and management arrangements or procedures that are designed to guard against fraud and abuse, and that include: 1. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state requirements.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Compliance policy articulated NBH's commitment to comply with all applicable federal and State requirements.	
	Required Actions None	
	2. Designation of a compliance officer and compliance committee that is accountable to senior management.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Compliance policy described the designation of a compliance officer and a compliance committee. The policy indicated that the chief financial officer was the compliance officer. During the interview, staff reported information that was inconsistent with the policy. There were minutes of the compliance committee meetings that demonstrated that the committee was active during the review period.	
	Required Actions NBH must revise the compliance plan to align with practices regarding the requirements for designation of a compliance officer.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity	3. Training and education for the compliance officer and the Contractor's employees.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Compliance policy described training at new employee orientation. During the interview, staff confirmed that employees were trained about the corporate compliance plan at new employee orientation. Staff reported that it was not NBH's policy to retrain employees regarding the compliance plan. The policy stated, and staff confirmed, that the compliance plan would be "reaffirmed" at the annual performance evaluation. This reaffirmation consisted of a signature page requiring the employee to sign a statement indicating that he or she was aware of and agreed to adhere to the NBH compliance policy and all applicable laws and regulations.	
	Required Actions None	
	4. Provisions for internal monitoring and auditing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Compliance policy described provisions for auditing and monitoring. There were a variety of audits conducted that provided evidence that monitoring occurred.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity II.G.5.c.1-7 II.H.5.d	5. Provisions for prompt response to detected offenses and for development of corrective action initiatives.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Compliance policy included provisions for a response to detected offenses and the development of corrective action initiatives.	
	Required Actions None	
	B. The Contractor reports possible instances of Medicaid fraud to the Department within ten (10) business days of receipt of information. The Referrals include specific background information, the name of the Provider and a description of how the Contractor became knowledgeable about the occurrence.	☐ **Met** ☐ **Partially Met** ☑ **Not Met** ☐ **N/A**
	Findings The Program Integrity policy described reporting of possible instances of Medicaid fraud within the required 10 business days and the content of the report. The corporate compliance committee meeting minutes contained a report of possible fraud that was not reported to the Department by NBH within 10 days of the original report. The corporate compliance meeting minutes indicated that a compliance committee staff member performed a chart review and determined that the incident was not fraud; therefore, the Department was not notified. The minutes also reflected that months later, the Department only became aware of the situation through another source and at that point there was communication between NBH and the Department regarding the situation.	
	Required Actions NBH must report all possible instances of fraud to the Department, as required.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
3. Provider Agreements II.H.10.a.2	The Contractor has a written agreement with each provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had an effective tracking system to ensure that NBH had an agreement with each provider. A sample of provider files were reviewed on-site and contained current agreements.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
4. Content of Agreement	The written agreement: A. Specifies the activities of the provider	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each provider agreement specified the covered services to be provided.	
	Required Actions None	
	B. Specifies the reporting responsibilities of the provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each provider agreement specified the reporting responsibilities required of the provider.	
	Required Actions None	
	C. Includes provisions for revoking the agreement or imposing other sanctions if the provider's performance is inadequate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each provider agreement included provisions for revoking the agreement or imposing other sanctions if the provider's performance became inadequate.	
	Required Actions None	
II.H.10.a.2		

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
5. Liability for Payment	The Contractor provides that its Medicaid members are not held liable for: A. The Contractor's debts in the event of the Contractor's insolvency.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each provider agreement included the provision that Medicaid members were not held liable for NBH's debts in the event of NBH's insolvency.	
	Required Actions None	
	B. Covered services provided to the member for whom the Department does not pay the Contractor, or the Department or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each provider agreement included the provision that Medicaid members were not held liable in the event of nonpayment by NBH.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
5. Liability for Payment II.H.11.a	C. 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.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each provider agreement included the provision that the subcontractor may not bill, charge, collect deposits from, or seek compensation from covered persons.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	The Contractor monitors covered services provided under provider agreements for: A. Quality	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH's chart audit template form included a review for several quality indicators. Summaries of chart audits at each of the internal CMHCs and an external chart audit summary all performed during the review period, demonstrated monitoring services provided for quality.	
	Required Actions None	
	B. Appropriateness	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH's chart audit template form included an assessment of appropriateness of services provided. Summaries of chart audits at each of the internal CMHCs and an external chart audit summary all performed during the review period, demonstrated monitoring for appropriateness of services provided.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	C. Member outcomes	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH provided two reports describing studies of member outcomes conducted during 2006. Both studies were conducted on charts from the three mental health centers. There was evidence of other outcomes studies performed as well; however, none of the studies included consumers served by subcontracted providers.	
	Required Actions NBH must monitor covered services provided under provider agreements for member outcomes. Monitoring must be representative of the entire network.	
	D. Requirements for medical records	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH's chart audit template form included a review for compliance with Medical record requirements. Summaries of chart audits at each of the internal CMHCs and an external chart audit summary all performed during the review period, demonstrated monitoring for medical record requirements.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers II.H.10.a.3	E. Requirements for data reporting **Findings** There was evidence that NBH monitored whether encounter and CCAR data was sent to InNET and the Division of Mental Health (DMH), as appropriate, by the mental health centers. The review of the statistically valid sample of encounter records included a review for completeness of data and included both mental health center and subcontracted providers. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
7. Policies and Procedures II.H.10.a.4	The Contractor has written procedures for monitoring the performance of providers on an ongoing basis. **Findings** The Quality Assessment and Performance Improvement policy and plan included procedures for monitoring the performance of providers on an ongoing basis. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
8. Termination of Provider Agreements II.H.10.d	The Contractor notifies the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area and provides the notice at least ninety (90) days prior to termination of the services unless the termination is based on quality or performance issues.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Subcontracting policy addressed termination of providers. The attached contract cover sheet correctly stated that notice would occur 90 days prior to termination; however, The policy stated that notice would be given to the Department 60 days prior to the termination	
	Required Actions NBH must revise policies and other documents to be consistent with each other and address the requirement that NBH notify the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area. The policy and the process must include the provision that notice be given at least 90 days prior to termination of the services unless the termination is based on quality or performance issues.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
9. Prohibited Affiliations II.H.6.a	The Contractor does not knowingly have a relationship of the type described below with the following: An individual or an affiliate of an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Network policy included the provision prohibiting NBH relationships with providers who have been disbarred from federal health care programs, and referred to Title XI of the Social Security Act, Sections 1128 and 1128A. The policy did not expand the prohibited relationships to affiliates of debarred individuals or to procurement and nonprocurement activities under Executive Order No. 12549; however, staff confirmed during the interview that NBH did not knowingly have relationships with individuals who were debarred from federal programs for any reason.	
	Required Actions None	
10. Marketing II.H.8	The Contractor adheres to all contract requirements related to marketing.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings NBH staff reported that, during the review period, NBH did not engage in marketing activities as marketing is defined in the BHO contract with the Department.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
11. Department Approved Member Handbook II.H.8.a	The BHO's Member Handbook was submitted to and approved by the Department prior to distribution.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH provided letters from the Department dated May 19, 2005, and October 4, 2006, approving the NBH member handbook. NBH staff reported that the handbook approved in October 2006 was the handbook being distributed at the time of the site review.	
	Required Actions None	
12. Statistically Valid Sampling II.J.6.c.3.c	The BHO reviews compliance with criteria for submission of encounter claims data each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH reviewed a statistically valid sample (411) of encounter records for compliance with contract criteria. The report NBH submitted indicated that NBH reviewed for accuracy and completeness of data, the presence of both paid and denied claims, and for the presence of documentation in the medical record. The report also indicated that the sample included data from each of the three network mental health centers, as well as subcontracted providers, and represented the array of services provided by NBH.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
13. Record Review: Documentation of Services	Presence, timeliness, and accuracy of documentation to support encounter claims.	
	Findings A sample of 10 consumer service records was reviewed to assess NBH's compliance with contract requirements related to documentation of services for encounters submitted. NBH was compliant with 20 of 20 applicable elements reviewed for a record review score of 100 percent. All 10 records contained documentation of the service provided for the day the encounter was submitted. All 10 records contained documentation that described the service for which the encounter was submitted.	
	Required Actions None.	

Results for Standard II					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
21	3	1	1	25	84%

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	Any practice guidelines adopted by the Contractor will: A. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the field.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Northeast Behavioral Health (NBH) Development of Practice Guidelines policy stated that the BHO adopted practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals. This review period, NBH adopted clinical practice guidelines for the treatment of ADHD and mood disorders, including major depression, bipolar disorder, dysthymia, and cyclothymia. The guidelines were developed by the BHO based on a compilation of information from several professional organizations, including the American Academy of Pediatrics and the American Psychiatric Association.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	B. Consider the needs of the members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Information regarding clinical practice guidelines included in the appendix of the provider manual stated that NBH made a decision to develop practice guidelines for ADHD and mood disorders based on available information regarding the most commonly occurring diagnoses among children and adults served by the BHO. During the interview, NBH staff also indicated that the development of a practice guideline for ADHD had assisted BHO providers in making differential diagnoses for youth and adults with histories of methamphetamine abuse. Minutes of a Quality Improvement Committee (QIC) meeting held on June 21, 2006, documented that the committee discussed and adopted practice guidelines for the treatment of ADHD and mood disorders, and that several consumers and family members attended the meeting. NBH also provided a document that described numerous meetings with consumer groups at North Range Behavioral Health, Larimer Center for Mental Health, and the Centennial Mental Health Center to solicit consumer feedback regarding draft practice guidelines.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	C. Be adopted in consultation with contracting health care professionals.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The appendix of the NBH Provider Manual stated that practice guidelines were adopted by the BHO in consultation with its network mental health centers, independent providers, and other clinical experts in the field. At the time of the interview, BHO staff stated that the NBH clinical director and a network mental health center medical director with extensive experience in the treatment of ADHD and mood disorders took a leadership role in the research and development of the practice guidelines. Minutes for NBH Practice Guideline Committee meetings held on July 25, 2006, and August 18, 2006, indicated that the meetings were attended by the medical directors from the network mental health centers and other senior clinical staff from NBH and the provider network.	
	Required Actions None	
	D. Be reviewed and updated periodically as appropriate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Practice Guidelines policy stated that the BHO reviewed and updated clinical practice guidelines at least once every two years. During the interview, NBH staff indicated that any significant change in the professional literature would trigger the need for a more frequent review and revision of the guidelines. Since NBH adopted its first set of clinical practice guidelines in June of 2006, a review of the guidelines was not yet required.	
	Required Actions None	
II.I.2.a.1		

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
2. Dissemination II.I.2.a.2	The Contractor disseminates practice guidelines to all affected providers and, upon request, to members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Practice guidelines adopted by the BHO were posted on the NBH Web site and were included in the appendix of the provider manual. The NBH Practice Guidelines policy stated that the guidelines were given to providers and, upon request, to consumers, their advocates, and the public at large. In the summer of 2006, NBH sent a provider newsletter to notify providers regarding newly adopted practice guidelines for the treatment of ADHD and mood disorders.	
	Required Actions None	

Results for Standard III					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
5	0	0	0	5	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	The Contractor has written policies and procedures for treating members in a manner that is consistent with the member's right to: A. Receive information about his/her rights.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Member Rights, listed all the required rights statements, and the Member Information policy contained NBH's procedures for ensuring new enrollees and consumers received the consumer informational materials in a timely manner. Both NBH and its providers (community mental health centers [CMHCs] and other providers) had responsibilities for distribution of consumer handbooks and other materials, which were developed by the BHO and included a listing of consumer rights and responsibilities. Additional means of distributing this information included posters at provider and CMHC sites, and the BHO provided documentation of its mechanism for oversight and monitoring that the providers posted the rights and ombudsman posters as required.	
	Required Actions None	
	B. Be treated with respect and with due consideration for his/her dignity and privacy.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Member Rights, and the consumer handbook contained the consumer's right to be treated with respect and due consideration for dignity and privacy.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	C. Participate in decisions regarding his/her health care, including the right to refuse treatment except as provided by law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Member Rights, and the consumer handbook contained the consumer's right to participate in treatment decisions and the right to refuse treatment.	
	Required Actions None	
	D. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Member Rights, and the consumer handbook contained the consumer's right to receive information on treatment options in a manner that is easily understood.	
	Required Actions None	
	E. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Member Rights, and the consumer handbook contained the consumer's right to be free from restraint and seclusion as a means of coercion, discipline, convenience, or retaliation.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	F. Request and receive a copy of his/her medical records and to request that they be amended or corrected.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Member Rights, and the consumer handbook contained the consumer's right to request and receive a copy of his or her medical record or to request a correction. The rights listing also included the consumer's right to receive a notice of privacy practices from providers.	
	Required Actions None	
	G. Be furnished health care services in accordance with 42 C.F.R. Sections 438.206 through 438.210.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Member Rights, and the consumer handbook contained the consumer's right to receive appropriate, accessible, medically necessary services. NBH had additional policies containing requirements for coordination of care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights II.G.3	H. Be free to exercise his/her rights without it affecting the way the Contractor and its providers treat the member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Member Rights, and the consumer handbook contained the consumer's right to complain or express an opinion without retaliation or affects on how the consumer is treated.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	A. The Contractor ensures that its staff and affiliated providers take these rights into account when furnishing services to members.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH provided evidence of training on consumer rights that was required to be held by the community mental health centers (CMHCs) annually and as part of new employee orientation. Evidence of chart audits conducted and reported by the CMHCs and audits conducted by the BHO on the CMHCs included some elements to measure whether consumer preferences were addressed, whether documentation showed consumer participation and the consumer's signature in the treatment plan, whether care was coordinated with medical providers, and whether privacy was protected through use of signed releases of information as applicable. In the interview, staff also stated that the presence of local consumer representatives and parent/family advocates at the CMHCs provides awareness of the need to take rights into account. There was no evidence of audits in the review period or other means to ensure that providers in the independent network took rights into account when providing services.	
	Required Actions NBH must implement a mechanism to ensure that external provider network (EPN) providers take rights into account when providing services.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	B. The BHO has a process to ensure the member's right to an independent advocate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH's policy, Member Rights, and the consumer handbook contained the consumer's right to an independent advocate. While the BHO reported that few consumers request this assistance, the Office of Consumer and Family Affairs had numerous resources (information and brochures) that it used to refer consumers to local advocacy groups as needed.	
	Required Actions None	
	C. The BHO has processes to follow-up on all member complaints about a staff person or provider and to ensure that the staff/providers do not retaliate against the member for expressing a concern.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Grievance Process policy documented the process that the BHO used to follow up on any consumer complaints about staff or providers. In the grievance record review, examples of such complaints demonstrated that NBH followed its process for investigation and resolution of these incidents. NBH used letters to acknowledge complaints. The acknowledgment letters reinforced that retaliation or being treated differently as a result of complaining would not be tolerated, and provided the consumer numbers to call with such concerns. The right to complain without resulting retaliation was also listed on all rights statements that consumers received.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account II.G.3-4	D. The BHO furnishes to each of its Members information about the assistance available through the Medicaid Managed Care Ombudsman Program and how to access Ombudsman Program Services. **Findings** Information about the availability of the Medicaid Managed Care Ombudsman Program was included in consumer rights information (the consumer handbook) as well as on posters that were required by NBH to be posted at all CMHC and EPN provider sites. The BHO had documented evidence of its monitoring process to ensure that the posters were available at provider sites. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
3. Member Responsibilities II.G.2	The Contractor has written requirements for member participation and responsibilities in receiving covered services. **Findings** NBH had a policy, Member Responsibilities, and addressed responsibilities in the consumer handbook. However, the policy included an additional listing of four consumer responsibilities for "recipients of Medicaid" that were not communcated to the consumers in the handbook. **Required Actions** NBH must ensure that consumer responsibilities and expectations for participation in receiving covered services are communicated to consumers, staff, and providers in a consistent manner.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
4. Consumer and Family Affairs II.G.5	The Contractor has an Office of Consumer and Family Affairs to work with members and families.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a director of its Office of Consumer and Family Affairs (OCFA) and had delegated the responsibilities for advocacy and grievance processing to consumer representatives and parent/famiy advocates who were employed by each of the network community mental health centers. The OCFA functioned to provide advocacy services to consumers and their families/representatives throughout the service delivery process as needed. OCFA also functioned to provide a consumer voice in various levels of committee involvement and decision-making and to process grievances at the NBH and local CMHC levels. Appeals processing was performed by the director of OCFA at the BHO level only.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
5. Advance Directives	A. The Contractor has written policies and procedures for Advance Directives.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had an advance directive policy and procedure contained within the Member Rights policy that met the requirements at 42 Code of Federal Regulations (CFR) 422.128 for addressing compliance with the State law. The policy addressed ensuring adult consumers received the policy information on advance directives, a description of the law, a description of the documentation requirements of advance directives in the medical record, an explanation that services are not conditioned on whether or not the consumer has an advance directive, and provisions for staff and provider education about the requirements for advance directives.	
	Required Actions None	
	B. The Contractor provides all adult members with written information on Advance Directives policies, which includes: 1. A description of the applicable state law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a consumer handbook section and a separate brochure that were provided to all new enrollees and adult consumers. The information included a description of the State law.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
5. Advance Directives	2. The member's rights under the law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a consumer handbook section and a separate brochure that were provided to all new enrollees and adult consumers. The information included the consumer's rights under the law.	
	Required Actions None	
	3. The fact that complaints concerning non-compliance with the Advance Directive requirements may be filed with the State Department of Public Health and Environment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a consumer handbook section and a separate brochure that were provided to all new enrollees and adult consumers. The information included the fact that complaints about noncompliance with advance directives could be filed with the State and provided the phone number for filing complaints.	
	Required Actions None	
II.H.7		

Results for Standard IV					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
16	2	0	0	18	89%

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
1. On-site Nursing Facilities II.F.2-3	The Contractor: - Provides medically necessary mental health services on-site in nursing facilities for members who are residents of nursing facilities and who cannot reasonably travel to a service delivery site for their services. - Considers the ability of the resident to travel when determining the service delivery site (i.e., BHO site or nursing facility).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a policy, Nursing Facility Residents, and a section in the consumer handbook that addressed the provision of services to nursing facility (NF) residents on-site if the resident was unable to travel. During the interview, BHO staff stated that its practice was to use community mental health centers (CMHCs) to respond to service needs in NFs within the region. The CMHCs were required to report to NBH the number of consumers and NF sites. NBH provided evidence of this report, which indicated that the three CMHCs delivered services on-site at 16 regional NFs during 2006.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
2. Dual Medicare/Medicaid Eligible	A. The Contractor makes an effort to identify and include providers in the Contractor's network that are capable of billing Medicare for dual Medicare and Medicaid eligible members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a policy, Dual Medicare/Medicaid Eligibility, and a section in the consumer handbook that addressed its requirements for identifying and referring dually-eligible consumers to Medicare providers. Several staff within the CMHCs were eligible to bill Medicare, and the BHO reported that these providers were used for delivery of services to dually-eligible consumers to the extent possible. During the site visit, NBH provided a listing of individuals at two of the CMHCs who could bill Medicare.	
	Required Actions None	
	B. If qualified Medicare providers cannot be identified, the Contractor provides the medically necessary mental health services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a policy, Dual Medicare/Medicaid Eligibility, and a section in the consumer handbook that addressed its requirements for providing services to dually-eligible individuals if a qualified Medicare provider could not be identified.	
	Required Actions None	
II.F.4		

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	A. The Contractor monitors providers to determine compliance with standards for timely access.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a policy on access to services that contained requirements for the timely provision of services. Staff, during the interview, described the BHO's requirement that the CMHCs and the EPN providers furnish to NBH a description of how each provider collected and reported its data on access-to-care standards. The BHO quality improvement staff had undertaken an intensive review of the procedures used by the providers, approved them, and had developed a detailed policy with measurement specifications for use by the providers. Oversight of the process and outcome of measuring the access-to-care standards was accomplished through reporting to the quality committee and was reflected in the minutes of meetings in April and August, 2006. Access data were compiled for both the CMHCs and the EPN and reported quarterly to the Department.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	B. The Contractor meets standards for timeliness of service including the following: 1. Emergency services are available - By phone within 15 minutes of the initial contact. - In person within one hour of contact in urban and suburban areas. - In person within two hours of contact in rural and frontier areas.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO reported that the EPN providers were required by contract to have an emergency services plan in place for consumers consisting of either the provider being on call or ensuring emergency and after-hours coverage. The three mental health centers were the BHO's "backup system" for emergency service provision weekdays from 8 a.m. to 5 p.m., and the acute treatment unit (ATU) at North Range Behavioral Health provided after-hours emergency services for all consumers, including face-to-face assessments as needed. The BHO reported that hospitals in the region did not report emergency contacts because they had their own mental health assessment teams; therefore, emergency room data were not included in the quarterly access-to-care reports.	
	Required Actions None	
	2. Urgent care is available within 24 hours.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Similar to the procedures for providing and measuring access to emergency services, the BHO required the EPN and CMHCs to ensure timely urgent care appointments and to measure and report to the BHO on a regular basis. The data for urgent appointments provided by the EPN and CMHC providers was reported to the Department in the quarterly access-to-care reports.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	3. Routine services are available within seven calendar days.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH process for monitoring routine appointment data for the EPN included an automated utilization management database that was used to record a provider's response to a referral/request for a routine appointment. The CMHCs collected and reported data on the provision of routine appointments within the standard for timely access. Quarterly reports to the Department contained evidence of monitoring routine access for both CMHC and EPN providers.	
	Required Actions None	
	C. The Contractor takes corrective action if there is a failure to comply with standards for timely access.	
	Findings This element was not reviewed or scored.	
	Required Actions	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services II.F.1.a.7 II.F.1.a.4.a-e II.F.1.a.8 Exhibit C.III.C	D. The authorization process takes into consideration other factors, such as the need for services and supports to assist a Member to gain new skills or regain lost skills that support or maintain functioning and promote recovery.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had in its policies for utilization management specific criteria for the provision of home-based, respite, and more traditional services. The UM policy also addressed the use of clinical guidelines for decision-making, and that other factors were to be considered, including the consumer's needs for services and supports to assist in skill-building, functional improvement, and recovery. The BHO had processes for quality improvement reviews of service provision by providers, and in the interview, described involvement in staffings when an issue arose concerning consumers' care and services not meeting their recovery needs. NBH staff also stated that it focused on recovery plans and the use of alternative services in trainings and when attending staffings on consumers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	In establishing and maintaining the provider network, the Contractor considers: A. Including both Essential Community Providers and other providers.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Adequate Capacity and Services, required that the BHO take into consideration the use of essential community providers and other providers. The quarterly network adequacy reports provided during the site review demonstrated that the BHO had contracts during the review period with a federally qualified health center, hospitals, other organizational providers, and several individual practitioners.	
	Required Actions None	
	B. The anticipated Medicaid enrollment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Adequate Capacity and Services, required that the BHO take into consideration the anticipated Medicaid enrollment. The quarterly network adequacy reports provided during the site review demonstrated that the BHO had processes to use historical enrollment data, by county, in determining the adequacy of its network.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	C. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the enrolled population.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Adequate Capacity and Services, required that the BHO take into consideration the service utilization patterns by analyzing prior fiscal years. The quarterly network adequacy reports provided during the site review stated that the BHO had considered this information when reviewing the network for adequacy. Information was reported by county, by number of prescribers, by licensed and unlicensed practitioners, and by facility type.	
	Required Actions None	
	D. The numbers and types (training/experience) of providers required to furnish the contracted Medicaid services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Adequate Capacity and Services, required that the BHO take into consideration the types of providers required to furnish services. The quarterly network adequacy reports provided during the site review stated that the BHO had considered this information when reviewing the network for adequacy. Information reported included the number of prescribers, licensed and unlicensed practitioners, and case managers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	E. The numbers of network providers who are not accepting new Medicaid patients.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Adequate Capacity and Services, required that the BHO take into consideration the number of providers not accepting new patients. The quarterly network adequacy reports provided during the site review included the number of providers by type and by county that were not accepting new patients.	
II.F.1.c	**Required Actions** None	
5. Out-of-Network Providers	If the Contractor is unable to provide covered services to a particular member, the Contractor provides the covered services out of network at no cost to the member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Provider Network, stated that if the BHO is unable to provide a service in the network, the BHO would provide the service out of network at no cost to the consumer. The quarterly network adequacy reports provided during the site review included evidence that the BHO had contracts with out-of-network/out-of-region providers, as well as single-case agreements to meet individual needs.	
II.F.1.d	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
6. Geographic Access	A. The Contractor has arrangements to ensure proximity of participating providers to the residences of members so as not to result in unreasonable barriers to access and to promote continuity of care taking into account the usual means of transportation ordinarily used by members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Adequate Capacity and Services, contained the requirements for ensuring the geographic proximity of providers to consumers' residences. The BHO had arrangements with its contractor InNET to assess the geographic locations of consumers and providers using the enrollment report zip codes. The quarterly network adequacy reports provided during the site review had evidence of the procedure to assess provider proximity greater than 30 miles. In the site review opening session, the BHO also provided evidence of geomapping of its service sites and consumers as a means of assessing provider proximity.	
	Required Actions None	
	B. The Contractor ensures that providers are located throughout the Contractor's service area, within 30 miles or 30 minutes travel time, to the extent such services are available.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Adequate Capacity and Services, contained the requirements for ensuring the geographic proximity of providers to consumers' residences, with the goal of 30 miles or 30 minutes. The BHO had arrangements with its contractor InNET to assess the geographic locations of consumers and providers using the enrollment report zip codes. The quarterly network adequacy reports provided during the site review had evidence of the procedure to assess provider proximity greater than 30 miles. In the site review opening session, the BHO also provided evidence of geomapping of its service sites and consumers as a means of assessing provider proximity.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
II.F.1.e II.1.a.5		
7. Selection of Providers	The Contractor allows each member to choose, to the extent possible and appropriate, his or her health professional.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH policy, Member Rights, and the consumer handbook described that the BHO allowed consumers to choose a provider from the contracted network and to request that a provider be added to the network. The quarterly network adequacy reports provided during the site review contained evidence of single-case agreements with nonnetwork providers to respond to consumer needs or choice.	
II.F.1.f	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
8. Recovery Model Exhibit C.II	The Contractor will demonstrate commitment to the recovery model.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH provided evidence of recovery training that was offered to staff and providers, and of recovery articles and resources for "toolkits" that were published in provider newsletters in spring and winter 2006. As a mechanism for ensuring that recovery efforts were emphasized at the CMHCs, the BHO required each CMHC to develop a recovery model plan with specific goals and time frames for completion and to submit an evaluation annually of progress toward meeting the stated goals. Evidence of these reports was reviewed and demonstrated that several initiatives by each CMHC were well under way or had been completed. Recovery-focused reports and updates were presented to the quality improvement committee by the OCFA director, and recovery language was present in the consumer handbook, including emphasis on consumer involvement at the BHO and an invitation to join committees and advocacy groups.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
9. Medication Management Exhibit C.IV.I	The BHO provides or arranges for the monitoring of medications prescribed, and consultation provided to Members by a physician as necessary.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH's consumer handbook and the policy on covered services described the provision of medication management services. The policy contained standards for minimum frequency for the provision of medication services (every three months). The BHO stated that services are adequate and timely due to the number of psychiatrists and the use of nurse practitioners as prescribers at the CMHCs. It was reported that the BHO's challenge was securing out-of-network psychiatrists as needed, and that the BHO had successfully contracted with private psychiatrists in two of its geographic areas.	
	Required Actions None	
10. Alternative Services Exhibit K.III.A-I	The BHO has sufficient capacity to provide alternative services as described in Exhibit K of the Contract with the Department (effective 3/31/06). These services are available to serve the specified number of Members, and at the specified locations.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH report on alternative services provided in the fourth quarter of FY 05-06 documented, for each service, the contracted capacity and number of locations, and the number of unique clients, encounters, and the cost for each service. The BHO stated that there were no waiting lists for the services, most of which were in a “ramping-up” process. At the request of the BHO, the Department had amended the contract requirements in November 2006 to add services, including respite services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		

Results for Standard V					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
20	0	0	0	20	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program	A. The Contractor has a Utilization Management (UM) Program to monitor the access to and appropriate utilization of covered services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH provided a variety of documents to demonstrate that the BHO had a utilization management (UM) program that actively monitored access to and appropriate utilization of covered services. The NBH FY 06-07 Quality Improvement (QI) Plan included several access-to-care indicators as well as numerous UM measures used by the BHO to monitor service utilization. The BHO also had UM-related policies and procedures and ensured the consistency of authorization decisions through the use of standardized level-of-care (LOC) criteria and interrater reliability studies.	
	Required Actions None	
	B. The UM program includes written policies and procedures.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had numerous policies and procedures and other written documents that described the UM program. The BHO's UM-related policies described processes and requirements for: 1) the monitoring of service utilization; 2) the service authorization process; 3) the handling of utilization review (UR) denials, including Notice of Action requirements; and 4) activities including training and interrater reliability studies used by the BHO to ensure the consistency of service authorization decisions.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program II.J.1	C. The Contractor has a mechanism in effect to ensure consistent application of the review criteria for authorization decisions and, as applicable, consultation with the requesting provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings To ensure the consistent application of review criteria for authorization decisions, NBH included copies of standardized LOC criteria as part of the Utilization Management policy. The policy stated that the BHO conducted interrater reliability studies on the UM authorization process and described the availability of a peer-to-peer consultation process to discuss BHO utilization review recommendations. During the interview, NBH staff clarified that authorization decisions for all services requiring prior authorization during business hours were made by the BHO directly. Staff also reported that NBH delegated responsibility for making after-hours authorization decisions for hospital admissions to North Range Behavioral Health. NBH provided copies of the materials used by the BHO to train North Range Behavioral Health staff regarding the use of the NBH standardized LOC criteria.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
2. Over-/Under-Utilization II.I.2.e	The Contractor has in effect mechanisms to detect both under-utilization and over-utilization of services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO's FY 06-07 Quality Improvement Plan and Mechanism to Detect Over- and Under-Utilization policy described various methods used by NBH to detect under- and overutilization of services. Measures used by the BHO included penetration rates, missed appointments by consumers diagnosed with a major mental illness at intake, the 100 highest utilizers, high utilizers of emergency room services, and consumers exceeding inpatient and outpatient benefit limitations. During the interview, NBH staff indicated that utilization reports with trended data for each network mental health center were frequently produced by the BHO and shared with the mental health centers. Minutes from a Quality Improvement Administrative Subcommittee (QIAS) meeting dated June 6, 2006, documented a discussion regarding key measures used by the BHO to evaluate over- and underutilization.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
3. Evaluation of UM Program II.J.I.e	The Contractor has mechanisms to evaluate the effects of the UM program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH used several methods to evaluate the overall effectiveness of its UM program. Summary data and a written analysis of findings for UM-related measures was included in the BHO's Program Impact Analysis and Annual Report Fiscal Year 2005-2006. The BHO also conducted a Practitioner Satisfaction Survey that solicited feedback regarding several aspects of the BHO's UM process, including customer service, timely authorizations, and availablilty of training.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
4. Clinical Expertise II.J.1.g	The Contractor ensures that any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope, that is less than requested, is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Service Authorization policy required that any decision to deny a requested service for clinical reasons must be made by the NBH director, medical director, or by an appropriate practitioner reviewer. The policy stated that only the medical director was authorized to deny a request for inpatient care. During the interview, NBH staff clarified that UR denials for routine outpatient levels of care were made by master's degree level or PhD-level clinicians and that any denials for hospital care, day treatment, partial care, or residential services were made by physicians. Findings from the denial record review indicated that NBH's practice was consistent with policy and that 100 percent of the UR denials included in the sample had been reviewed by a qualified health care professional with appropriate clinical expertise in treating the member's mental health disorder.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
5. Co-occurring MI/DD II.E.1	The Contractor has written criteria for determining whether the need for mental health services for a member with co-occurring mental illness and developmental disabilities is a result of the individual's mental illness, or a result of the individual's developmental disability, or developmental delay (if the member is under age 5).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a Co-Occurring Mental Illness and Developmental Disabilities policy that stated that the BHO was responsible for providing medically necessary services to treat any psychiatric diagnosis regardless of whether the mental health diagnosis was primary or secondary. The policy addressed the handling of both routine and urgent referrals for consumers with co-occuring disorders and described the BHO's processes for assessment, diagnosis, and service authorization. During the interview, NBH staff indicated that they had participated in ongoing meetings hosted by the Department to refine practice standards for the evaluation and treatment of persons with co-occuring mental illness and developmental disabilities.	
	Required Actions None	
6. Compensation for Conducting UM Activities II.F.1.g	The Contractor does not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO's Utilization Management policy stated that NBH's method of compensating individuals or entities conducting utilization reviews did not incentivize the individual or entity to deny, limit, or discontinue medically necessary services to Medicaid consumers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
7. Record Review—Denials	Presence and timeliness of required documentation and decisions by qualified clinician.	
	Findings A sample of two enrollee denial records was reviewed to assess NBH's compliance with contract requirements related to the presence and content of required documentation, and the timeliness of decisions and documentation. NBH was compliant with 5 of 6 of the total applicable elements reviewed for an overall score of 83 percent. NBH was fully compliant in the following areas: 1) the notice included the reason for the denial, and 2) the decision was made by a qualified clinician. A Notice of Action for one case reviewed was not sent in a timely manner to the consumer and provider following a UR denial as required in Exhibit G of the BHO's contract with the Department.	
	Required Actions NBH must ensure that a Notice of Action is sent timely to the consumer and provider following a UR denial decision.	

Results for Standard VI					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
8	0	0	0	8	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
1. Written Policies and Procedures II.F.1.h.1	The Contractor has written policies and procedures that ensure coordination of the provision of covered services to its members, and that address expectations for timely coordination of care.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a Care Coordination and Continuity of Care policy that described the role of the care coordinator or primary therapist in identifying, providing, arranging for, and/or coordinating with other agencies to ensure that each consumer receives needed health care and other supportive services in the community. The policy described required procedures related to the care coordination process and provided general guidance to staff regarding expectations about the timeliness of providing and documenting coordination-of-care activities.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	The written policies and procedures address: A. Service accessibility	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Care Coordination and Continuity of Care policy described assisting consumers in accessing needed medical care, mental health services, and other supportive services in the community as a key role of the care coordinator or primary therapist.	
	Required Actions None	
	B. Attention to individual needs	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Care Coordination and Continuity of Care policy indicated that the types and intensity of supports provided were to be based on each consumer's strengths and needs. The NBH Medical Records policy also required that a service plan be developed for each consumer and that the plan include individualized strategies to assist consumers in their recovery.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	C. Continuity of care	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO's Care Coordination and Continuity of Care policy described the importance of providing adequate support to consumers in situations that required individuals to move between levels of care and/or between service providers within the network. The policy also included an expectation that consumers, family members, and/or persons with legal custody play as active a role as possible in the transition planning process.	
	Required Actions None	
	D. Maintenance of health	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Medical Records policy stated that a key principle in the development of service plans was to incorporate goals and objectives that emphasized recovery and supported the consumer's mental health. The BHO's Care Coordination and Continuity of Care policy also included a list of strategies to promote consumer wellness, including distributing brochures to consumers regarding preventive behavioral health programs such as clubhouses.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	E. Independent living	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Care Coordination and Continuity of Care policy stated that, as clinically appropriate, consumers were assisted in remaining in their community and supported in living in the most independent living situation possible. During the interview, NBH staff reported that the BHO and its contracted providers used standardized level-of-care (LOC) criteria and various independent living skill assessment tools to make determinations about the most appropriate living situation for each consumer.	
	Required Actions None	
	F. Coordination with other medical and behavioral health plans	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO's Care Coordination and Continuity of Care policy identified the coordination of care with other medical and mental health care providers as an essential component to consumer recovery. The policy required that consumers who were unable to obtain medical and/or behavioral health care services independently be provided the necessary supports to assist them in accessing appropriate primary medical and behavioral health care services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	G. Confidentiality and privacy consistent with 45 CFR parts 160 and 164 (HIPAA)	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a Confidentiality policy that addressed expectations regarding maintaining consumer privacy and confidentiality and that described requirements regarding the release of protected health information consistent with 45 Code of Federal Regulations (CFR), Parts 160 and 164 the Health Insurance Portability and Accountability Act of 1996 (HIPAA). NBH also had a HIPAA Regulations policy that addressed the issue of staff access to protected health information on a need-to-know basis and that described procedures to ensure system security for electronic medical records.	
II.F.1.h.1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
3. Care Coordination	A. The Contractor provides for care coordination, which addresses the member's need for integration of mental health and other services. This includes identifying, providing, arranging for and/or coordinating with other agencies to ensure that the member receives the health care and supportive services that allow the member to remain in her/his community.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had a Care Coordination and Continuity of Care policy that described the role of the care coordinator or primary therapist in ensuring the integration of mental health and other community services. The NBH Member Handbook also included a brief description of the role and responsibilities of the care coordinator. During the interview, NBH staff stated that they collaborated closely with juvenile and adult probation officers, judges, developmental disability providers, local schools, child welfare, and vocational rehabilitation experts. Staff members from the BHO also indicated that two of their network mental health centers had staff colocated at juvenile detention centers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
3. Care Coordination II.F.1.h Exhibit C.III.B	B. The BHO, in consultation with the service provider, Member, family, and/or person with legal custody, shall determine the medical and/or clinical necessity of the covered service.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Medical Records policy required that service plans be developed in partnership with the consumer and that services be tailored to the needs of consumers and families. The BHO's Service Authorization policy stated that service authorization decisions were to be made in consultation with the provider, consumer, and family or person with legal custody. During the interview, NBH staff stated that intensive service care coordinators employed by the network mental health centers frequently sought consumer and family input regarding the past effectiveness of treatment interventions when making service authorization decisions. NBH also provided an example of a chart audit tool used by North Range Behavioral Health, one of the BHO's network mental health centers. The audit tool included an indicator regarding consumer and family/guardian involvement in the service planning process.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
4. Coordination with Medical Care Services	A. The Contractor assists members in obtaining necessary medical treatment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Care Coordination and Continuity of Care policy included a requirement that the care coordinator or primary therapist provide support to consumers on an as-needed basis to assist members in accessing needed medical treatment. NBH monitored performance in communicating with medical providers through a performance improvement project (PIP) that measured the percentage of network mental health center charts that included documentation of communication with the consumer's medical provider.	
	Required Actions None	
	B. If a member is unable to arrange for supportive services to obtain medical care due to his/her mental illness, these supportive services will be arranged for by the Contractor or another person who has an existing relationship with the member whenever possible.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Care Coordination and Continuity of Care policy identified that coordination with medical providers was an essential component of successful treatment. The policy required that in the event the consumer was unable to access health care services independently, the care coordinator or another person who had an existing relationship with the consumer was responsible for providing support services to assist the member in obtaining needed medical care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
4. Coordination with Medical Care Services II.F.1.h	C. The Contractor coordinates with the member's medical health providers to facilitate the delivery of health care services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO provided evidence of monitoring activities to evaluate the level of communication and coordination between mental health providers and medical practitioners. Information regarding a PIP on communication/coordination with primary care physicians indicated that mental health center performance in documenting communication with medical providers had increased from 2 percent in December 2005 to 66 percent in July 2006. During the interview, NBH staff stated that its network mental health centers had several projects in place that involved the colocation of mental health services at health clinics, medical family practices, pediatrician offices, and federally qualified health centers (FQHCs).	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
5. School-Based Services	Mental health services are provided to school-aged children and adolescents on site in their schools, with the cooperation of the schools.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings School based services are listed as a covered service in both the NBH Provider Manual and the NBH Member Handbook. The BHO provided a listing of schools served by each of the network mental health centers throughout the review period and a description of specialty services offered, including the use of multisystemic therapy (MST) for youth at risk of suspension. During the interview, BHO staff reported that services provided to schools included individual, group, and family counseling, as well as day treatment and behavior management services.	
Exhibit C.IV.I	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
6. EPSDT II.E.1	The Contractor provides services identified under the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings General information regarding the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program was available to consumers and family members in the NBH Member Handbook and in the BHO's EPSDT Medicaid Well Child Checkups brochure. The NBH Benefit Limits policy clarified that inpatient and outpatient benefit limitations did not apply to consumers who were eligible for services under the EPSDT Program. At the time of the interview, BHO staff reported that they monitored benefit limitation reports produced by InNET on a monthly basis to ensure that contracted providers were not inappropriately denying mental health services for youth and young adults under the EPSDT Program.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
7. Record Review—Coordination of Care: Inpatient to Outpatient Transition (children). Exhibit C.I	There is evidence of coordination of care provided for children transitioning from an inpatient facility to outpatient services.	
	Findings Ten records were reviewed for evidence of care coordination and outpatient follow-up for children following discharge from an inpatient facility. In one case, there was no record of NBH involvement because the child was hospitalized in Pueblo and discharged to a DHS placement in Pueblo following discharge (as indicated in the hospital discharge summary). In the other nine records, there was evidence of communication between the hospital and either the CMHC or the BHO prior to discharge. In four cases, the discharge plan was for care provided by an organization other than NBH. Examples were consumers discharged to RTCs funded by DHS, rehospitalization prior to the scheduled follow-up, or discharge to police custody. In the five cases where NBH or its contracted providers were responsible for aftercare, there were progress notes documenting that the follow-up appointment was scheduled prior to discharge and there was documentation of the consumer attending the follow-up appointment. In four of these cases, the appointment occurred within one week of discharge. In the fifth case, progress notes described multiple "no shows" on the part of the consumer and CMHC efforts to reschedule, with an eventual appointment having taken place.	
	Required Actions	

Results for Standard VII					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
15	0	0	0	15	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
1. Internal Quality Assessment and Performance Improvement Program II.I.1	The Contractor has an internal Quality Assessment and Performance Improvement (QAPI) Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH provided numerous documents to support that the BHO had a quality assessment and performance improvement (QAPI) program. NBH had several policies and procedures that related to provider monitoring and the collection, analysis, and reporting of quality improvement data. The NBH FY 06-07 Quality Improvement Plan provided information regarding the BHO's Quality Improvement Committee and Subcommittee structure. The plan also described various quality indicators, performance improvement projects (PIPs), surveys, and other quality improvement activities implemented by the BHO.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program	The scope of the QAPI program includes, but is not limited to: A. A quality assessment and performance improvement plan that: 1. Delineates current and future quality assessment and performance improvement activities.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Quality Improvement Plan described the BHO's current and future quality assessment and performance improvement activities. The plan contained detailed information regarding quality improvement initiatives implemented by the BHO, summaries of past performance for each measure or quality study, and identification of performance goals or benchmarks for quality improvement activities planned for future implementation.	
	Required Actions None	
	2. Integrates findings and opportunities for improvement identified in studies, performance outcome measurements, member satisfaction surveys, and other monitoring and quality activities.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Program Impact Analysis and Annual Report Fiscal Year 2005-2006 included summary data and an analysis of findings for numerous quality measures and studies, including performance improvement projects (PIPs), consumer satisfaction surveys, clinical outcome data, information gleaned from clinical record reviews, and trending and analysis of quality-of-care concerns (QOCC) data. Strategies to improve future performance, including the implementation of corrective action plans, were also included in the report as appropriate.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program II.I.2	B. Processes for addressing quality of care concerns.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Quality of Care Concerns policy described the QOCC reporting and review process, including the fact that reported QOCCs involving physician quality-of-care issues were reviewed by the NBH medical director. A summary of QOCC data was included in the Program Impact Analysis and Annual Report Fiscal Year 2005-2006. During the interview, NBH staff stated that although the BHO received only a small number of QOCCs annually, quality-of-care concern data were periodically analyzed and trended as part of the quality improvement process.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	A. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Program Impact Analysis and Annual Report Fiscal Year 2005-2006 stated that NBH monitored member perceptions of accessibility and adequacy of services through an analysis of grievance and appeal data and through several consumer satisfaction surveys conducted by the BHO. Detailed data related to the Mental Health Statistics Improvement Program (MHSIP) survey, including a comparison of the BHO's performance to the statewide average, were also included in the Program Impact Analysis and Annual Report Fiscal Year 2005-2006.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	B. The Contractor's tools to monitor member satisfaction include: 1. Member Surveys	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Program Impact Analysis and Annual Report Fiscal Year 2005-2006 stated that NBH monitored member satisfaction using data from the MHSIP survey. The MHSIP survey included several items that addressed consumer perceptions of accessibility, including whether service locations were convenient for the consumer and whether the consumer would recommend the agency to a friend or family member. The FY 06-07 Site Review Document Request Form indicated that NBH conducted an Adult Report Card Survey that included accessibility measures. At the interview, staff from the BHO indicated that the Youth Services Survey for Families (YSSF) had also been conducted this review period and that findings from all member satisfaction surveys had been shared with network mental health centers and with other interested community stakeholders.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	2. Anecdotal Information	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings During the interview, NBH staff stated that anecdotal information regarding consumer and family satisfaction with the treatment system was frequently shared at QIC meetings. The FY 06-07 Quality Improvement Plan, which included results information, also indicated that the BHO held open meetings at its three network mental health centers in spring 2006 to solicit community feedback regarding the NBH system of care. Minutes from a QIC meeting on June 21, 2006, indicated that a consumer attending the meeting asked for the committee's assistance in addressing a problem related to medication. The minutes documented the committee's plan to assist the consumer.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	3. Grievance and Appeal data	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Document Request Form stated that NBH monitored grievance and appeal data closely and initiated action appropriate to the grievance. Aggregate grievance data were reported in the Program Impact Analysis and Annual Report Fiscal Year 2005-2006, including the total number of grievances received by the BHO throughout fiscal year 2005-2006 and the percentage of grievances that were satisfactorily resolved within the required time frame. NBH also prepared a Summary Report on Grievances for Fiscal Year 2005-2006. The report identified a trend in grievances at a specific clinic related to consumer problems in getting prescriptions filled. The BHO indicated that training regarding medication tracking procedures was provided to clinic staff and that no further reports of problems were received.	
	Required Actions None	
	C. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaints is detected, or when a serious complaint is reported.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Quality Assessment and Performance Improvement policy included a provision requiring providers to implement a corrective action plan at the request of the BHO to correct any identified problems in performance. NBH provided several examples of having placed network mental health centers on corrective action plans during the review period to address performance problems identified through the MHSIP survey and other quality studies initiated by the BHO.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
II.I.2.d		
4. Health Information System	The Contractor has a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to: A. Utilization	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Site Review Document Request Form indicated that NBH collected, analyzed, and reported utilization data, including: inpatient days utilized, residential days utilized, and penetration rates. During the interview, NBH staff stated that utilization reports were primarily produced through data available in the InNET data warehouse. BHO staff indicated that data from utilization management reports were routinely shared with both the QIC and Board of Managers.	
	Required Actions None	
	B. Grievances and Appeals	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Program Impact Analysis and Annual Report Fiscal Year 2005-2006 included information regarding the number of grievances and appeals received and the percentage of grievances that were resolved in a timely manner. NBH staff stated that grievance and appeal data were maintained in a Microsoft Excel spreadsheet and routinely distributed to members of the QIC.	
	Required Actions None	
II.I.h.2		

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
5. Program Impact Analysis II.I.2.j.1	The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH formally evaluated the impact and effectiveness of the QAPI program through an annual evaluation process described in the BHO's Quality Assessment and Performance Improvement policy. The Program Impact Analysis and Annual Report Fiscal Year 2005-2006 included summary information and an analysis of data from numerous quality improvement initiatives implemented by the BHO. The annual evaluation was reviewed and approved at a QIC meeting on November 15, 2006.	
	Required Actions None	

Results for Standard VIII					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
12	0	0	0	12	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
1. Grievance and Appeal Records	The Contractor maintains a record of grievances and appeals.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings NBH had paper file copies of grievances, appeals, and related correspondence. NBH also maintained an electronic log of grievances and appeals with key dates and data elements for monitoring and tracking purposes. The data compiled and reported by the director of OCFA included all appeals processed by the BHO and all grievances that were processed by both the BHO and the CMHCs. Record-keeping was complete and organized, and the personalized grievance letters written by the BHO and the CMHCs were particularly well-written and sensitive to the experience of the consumer. The standardized forms that were in use by the BHO and the CMHCs to acknowledge grievances or appeals and to communicate extensions and resolutions contained several inconsistencies (grievance forms referred to appeals and vice versa). In addition, there was confusing language about resolution dates on the extension forms, which did not clearly specify the reason for the extension. The Notice of Action and appeal forms were appended to the grievance policy, but the appeal process was not addressed in that policy. The grievance policy also included, as an appendix, a "related form" which was a document titled "Attachment G, Delegated Functions-Consumer Advocates." This document listed in several places that CMHC responsibilities included processing and reporting of appeals; however, in the interview, it was clarified that this was not a delegated function of the CMHCs. During the interview, staff described separate procedures that were in place to handle quality-of-care complaints, especially for consumers who did not want to file a formal grievance. The process did not include written acknowledgments, decision/resolution letters, or reporting the data to the Department with other grievance information.	
	Required Actions NBH must ensure that the standardized forms it uses for communicating with consumers and for processing grievances and appeals are accurate, consistent, and clear, that only applicable forms are included in the respective policies and procedures (related to the grievance or appeal processes), and that	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
Exhibit G: 8.209.3.C	the language in the grievance policy attachment accurately describes the responsibilities of the BHO and the CMHCs. In addition to clarifying these identified issues in policies, the BHO must ensure that any operational manuals, training, or other communication to staff and providers about the grievance and appeal processes are clear, accurate, and consistent with the requirements and with each other. Because the Balanced Budget Act (BBA) and State contract definition for a grievance is "any expression of dissatisfaction about any matter other than an action," the BHO must ensure that all complaints and consumer quality-of-care concerns are processed according to the grievance requirements and that data are reported to the Department and used for trending and quality improvement purposes.	
2. Provider Information Exhibit G: 8.209.3.B	The Contractor provides a Department approved description of the grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the Contractor. **Findings** The NBH provider information on the grievance, appeal, and fair hearing processes was under review by the Department at the time of this site review. The BHO reported that its mechanisms for dissemination of new or revised provider information included posting to the Web site, mailing hardcopies to providers as requested, and using its provider newsletter as a means of communication. In the interview, staff stated that all new providers received the provider manual when they joined the NBH network and signed a contract. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
3. Reasonable Assistance Exhibit G: 8.209.4.C	The Contractor provides members with assistance in completing any forms required by the Contractor, putting oral requests for a state fair hearing into writing, and taking other procedural steps including providing interpretive services and toll-free numbers that have adequate TTY/TTD interpreter capability.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH grievances and appeals policies and the consumer handbook addressed the requirements for and availability of assistance to the consumer, including assistance with filing or filling out forms and interpreter services, including TTY/TTD numbers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
4. Individuals Who Make Decisions	The Contractor ensures that the individuals who make decisions on grievances and appeals are: A. Individuals who were not involved with any previous level of review or decision-making.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Utilization Management policy, which described the appeals process, and the Grievance Process policy required that individuals who made decisions on appeals and grievances were not previously involved in any level of review or decision-making. The record review of grievances provided evidence of this practice. The OCFA director had developed a comprehensive operating procedures manual for the consumer representatives and parent/family advocates to use in processing grievances at the local level. It addressed this requirement, as well as how to handle "conflict of interest" situations in which the consumer filing a grievance was a friend of or known personally by the consumer representative or parent/family advocate.	
	Required Actions None	
	B. Individuals who have the appropriate clinical expertise in treating the member's condition or disease if deciding an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance that involves clinical issues, or an appeal that involves clinical issues.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Utilization Management policy, which described the appeals process, and the Grievance Process policy required that individuals who made decisions on appeals and grievances had the appropriate clinical expertise and qualifications to do so. With one exception, there was evidence of this practice in the review of grievance records.	
Exhibit G: 8.209.4	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
5. Accepts Grievances and Appeals Exhibit G: 8.209.4	The Contractor accepts grievances and appeals orally or in writing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The NBH Utilization Management policy, which described the appeals process, and the Grievance Process policy required that appeals and grievances would be accepted orally (by phone or in person) or in writing. There was evidence of this practice in the review of grievance records. The electronic tracking logs used by the BHO for grievances also had a data field to record how the grievance was received.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process	A. The Contractor provides the member an opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and informs the member of the limited time available in the case of expedited resolution.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Utilization Management policy section on appeals addressed the requirement to allow the consumer an opportunity to present evidence in writing and addressed the limited time in the case of an expedited appeal. There was not a specific requirement to allow the consumer to present evidence in person either in the policy or in the consumer handbook.	
	Required Actions NBH must ensure that it communicates the requirement to allow the consumer the opportunity to present evidence in person when filing an appeal.	
	B. The Contractor provides the member and the designated client representative opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents and records considered during the appeal process.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Utilization Management policy section on appeals addressed the requirement to provide the consumer and his or her representative the opportunity to review records used in the appeal process.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process	C. The Contractor includes as parties to the appeal, the member and, as applicable, the designated client representative or legal representative.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Utilization Management policy section on appeals addressed the requirement to include the consumer and any representative as parties to the appeal.	
	Required Actions None	
	D. The Contractor has an expedited review process for appeals when the contractor determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Utilization Management policy section on appeals addressed the requirement to provide for an expedited appeal process in instances indicated as appropriate by the BHO or provider.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process Exhibit G: 8.209.4	E. The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The provider manual and the NBH Utilization Management policy section on appeals addressed the requirement to ensure that there would not be punitive action against a provider for requesting an expedited appeal resolution or supporting an appeal.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
7. Record Review—Grievance	Presence and timeliness of required documentation, decisions by qualified clinician, and responsiveness of resolution.	
	Findings NBH had a set of six grievance records for review, which was the total number received in the categories requested for the sampling period. This was, notably, a low number. All records were clear, complete, and had evidence of tracking sheets present. Examples of accepting grievances both orally and in writing were present. Personalized decision letters and written summaries of complaints used in acknowledgment letters were very detailed, clear, and used respectful, responsive, and sensitive language. None of the six grievances required an extension of the time for decision/resolution, and all six had timely letters of acknowledgment and timely resolution letters sent. All resolutions were responsive to the grievance issues. All but one resolution contained evidence that appropriately qualified clinical staff reviewed and decided the grievance issues.	
	Required Actions NBH must ensure that grievance decisions on clinical and quality-of-care grievances are made by appropriately qualified clinicians.	

Results for Standard IX					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
9	2	0	0	11	82%

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
1. Excluded Providers	The Contractor does not employ or contract with providers excluded from participation in federal health care programs under Title XI of the Social Security Act, Sections 1128 and 1128A.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Provider Network policy included the provision prohibiting NBH from contracting with or employing providers excluded from participation in federal health care programs. Credentialing files contained evidence that NBH checked the U.S. Department of Health & Human Services Office of Inspector General database for debarment or exclusion.	
II.H.3.e	**Required Actions** None	
2. Written Policies and Procedures	The Contractor documents the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs, and who render services or authorize services to members, and who fall within the Contractor's scope of authority and action.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy described the mechanism for documenting the credentialing and recredentialing processes. A review of selected practitioner credentialing files demonstrated the implementation of the policies as written with regard to this requirement.	
NCQA CR1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	The written policies and procedures specify: A. The types of practitioners to credential and recredential. At a minimum, this includes all physicians and other licensed and/or certified practitioners who have an independent relationship with the BHO and who see enrollees outside the inpatient hospital setting or outside the facility-based settings.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the type of practitioners to be credentialed and recredentialed.	
	Required Actions None	
	B. The verification sources used.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the verification sources used.	
	Required Actions None	
	C. The criteria for credentialing and recredentialing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the criteria for credentialing and recredentialing.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	D. The process for making credentialing and recredentialing decisions.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the process for making credentialing and recredentialing decisions.	
	Required Actions None	
	E. The process for managing credentialing files that meet the organization's established criteria.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the process for managing credentialing files.	
	Required Actions None	
	F. The process to delegate credentialing or recredentialing.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings Documents reviewed indicated that NBH does not delegate any portion of the credentialing process. Staff confirmed this during the interview.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	G. The process to ensure that credentialing and recredentialing are conducted in a non-discriminatory manner, i.e., the Contractor does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the process to ensure that credentialing and recredentialing was conducted in a nondiscriminatory manner.	
	Required Actions None	
	H. The process for notifying a practitioner about any information obtained during the Contractor's credentialing process that varies substantially from the information provided to the organization by the practitioner.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the process for notifying a practitioner about any information obtained during the credentialing process that varied from information provided by the applicant.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	I. The process to ensure that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision. Note: The organization (BHO) is not required to notify providers of recredentialing approvals.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the process to ensure that practitioners were notified of the credentialing decision within 60 calendar days of the committee's decision.	
	Required Actions None	
	J. The Medical Director or other designated physician's direct responsibility and participation in the credentialing program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the responsibilities of the medical director regarding the credentialing program.	
	Required Actions None	
	K. The process to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the process to ensure the confidentiality of all information obtained during the credentialing process.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	L. The process for ensuring that listings in provider directories and other materials for enrollees are consistent with credentialing data, including education, training, certification, and specialty.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the process for ensuring that listings in provider directories and other materials for enrollees were consistent with data obtained during the credentialing process.	
	Required Actions None	
	M. The right of practitioners to review information submitted to support their credentialing application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the rights of practitioners, including the right to review information submitted to support their application.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	N. The right of practitioners to correct erroneous information.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the rights of practitioners, including the right to correct erroneous information.	
	Required Actions None	
	O. The right of practitioners, upon request, to be informed of the status of their credentialing or recredentialing application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the rights of practitioners, including the right to be informed of the status of their credentialing or recredentialing application, upon request.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	P. How the applicant is notified of these rights and of the appeal process.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy stated that applicants were notified of their rights in the applicant packet addendum; however, the applicant packet addendum informed applicants of all rights except the right to an appeal process. Applicants were informed of the appeal process through the denial letter; however, this fact was not stated in the Credentialing and Recredentialing policy.	
	Required Actions NBH must revise its policy that specifies how applicants are notified of their rights under the credentialing program, including the right to an appeal process, to ensure that policies and practices are aligned.	
	Q. The procedure for ongoing monitoring of sanctions, complaints and adverse events (for high-volume providers).	☐ **Met** ☐ **Partially Met** ☑ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy did not specify the procedures for ongoing monitoring of sanctions, complaints, and adverse events. There was evidence that NBH monitored for ongoing State sanctions and internal adverse events and complaints; however, there was no evidence of monitoring for federal sanctions between recredentialing cycles.	
	Required Actions NBH must revise its policies to include the procedure for ongoing monitoring of sanctions, complaints, and adverse events, and include each NCQA monitoring requirement.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	R. The range of actions available to the Contractor if the provider does not meet the Contractor's standards of quality.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the range of actions available to NBH if providers did not meet NBH's standards of quality.	
	Required Actions None	
	S. Procedures for detection and reporting of incidents of questionable practice, in compliance with Colorado statutes and regulations, the Health Care Quality Improvement Act of 1986, and NCQA standards.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the procedures for detecting and reporting incidents of questionable practice.	
	Required Actions None	
	T. An appeal process for instances in which the BHO chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy included an appeal process for instances in which the BHO alters practitioners' participation in the network based on issues of quality of care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
CR1-Element A and B NCQA CR9 CR10-Element A and C II.H.3.g		
4. Credentialing Committee	The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing decisions.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy described the role of the Credentialing Committee. A review of the Credentialing Committee meeting minutes demonstrated implementation of the peer review process to make recommendations regarding credentialing decisions.	
	Required Actions None	
NCQA CR2		

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
5. Provider Application NCQA CR4-Element A	Providers are required to complete an application for inclusion in the Contractor's provider network that addresses: - The provider's health status, and reasons for any inability to perform the essential functions of the position, with or without accommodation - Lack of present illegal drug use - History of loss of license and felony convictions - History of loss or limitation of privileges or disciplinary activity - Current malpractice insurance coverage - The correctness and completeness of the application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings During the review period, NBH used the Colorado Health Care Professional Credentials Application, which contained all of the required content. A sample of credentialing files contained the completed Colorado application.	
	Required Actions None	
6. High Volume Practitioners NCQA CR6-Element B	The Contractor specifies the method to identify high-volume providers.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy specified the method NBH used to identify high-volume providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
7. Evaluation of High Volume Practitioners NCQA CR6-Element B	For high-volume providers, the Contractor conducts: A. An initial site visit	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A review of a sample of credentialing files demonstrated that NBH conducted initial site visits for high-volume practitioners.	
	Required Actions None	
	B. An initial evaluation of treatment record-keeping practices at each site.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings An evaluation of treatment record-keeping practices was included on the initial site visit form.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
8. Requirements for Credentialing Policies for Organizational Providers NCQA CR11	The Contractor has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy included written policies and procedures for the assessment of organizational providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
9. Policy Content—Organizational Provider Credentialing	The Contractor's written policies and procedures include: A. The Contractor confirms that the organization is in good standing with state and federal regulatory bodies.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy included the process used to confirm that organizational providers were in good standing with State and federal regulatory bodies.	
	Required Actions None	
	B. The Contractor determines whether the provider has been reviewed and approved by an accrediting body.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy included the process used to determine whether organizational providers had been reviewed and approved by an accrediting body.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
9. Policy Content—Organizational Provider Credentialing	C. If there is no accreditation status, the Contractor conducts an on-site quality assessment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy described the criteria used when conducting on-site quality reviews for organizational providers not accredited. The policy also included the process for ensuring that organizational providers credentialed their practitioners. A review of selected organizational provider files demonstrated that NBH followed its procedures. NBH had performed site visits of each of the three network mental health centers.	
	Required Actions None	
	D. At least every three years, the Contractor confirms that the organizational provider remains in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing and Recredentialing policy included the provision that organizational providers were assessed every three years. The assessment included confirmation that the organization remained in good standing with State and federal regulatory bodies, whether the organization was reviewed and approved by an accrediting body, and on-site quality assessments for nonaccredited providers.	
NCQA CR11-Element A	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		

Results for Standard X					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
29	1	1	1	31	94%

Appendix B. Review of the Records for Northeast Behavioral Health, LLC

The review of the records follows this cover page.

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Northeast Behavioral Health, LLC

Type of Record Reviewed	**Documentation of Services**		
Review Period	**January 1, 2006 - June 30, 2006**	**Reviewer**	**Barbara McConnell**
Review Date	**January 11, 2007**	**Participating BHO Staff Member**	**P. Sitzman, L. Goode-Gramick, L. Leffingwell**

Table B-1—Documentation of Services

#	Member ID	Provider ID	Date of Encounter	Doc Date Matches Encounter Date	Service Documentation Within 7 Days of Encounter Date	Procedure Code Submitted	Description of Procedure Code	Documentation Describes Procedure Code Submitted
1	*******	4034047	1/17/2006	Y	NA	90806	PSYTX, OFF, 45-50 MIN	Y
2	*******	4034054	3/28/2006	Y	NA	T1016	CASE MANAGEMENT EACH 15 MINS	Y
3	*******	4033098	3/8/2006	Y	NA	90805	PSYTX, OFF, 20-30 MIN W/E&M	Y
4	*******	81677359	1/24/2006	Y	NA	90806	PSYTX, OFF, 45-50 MIN	Y
5	*******	4033098	1/26/2006	Y	NA	H0038	SELF-HELP/PEER SERVICES PER 15 MIN	Y
6	*******	4034047	1/20/2006	Y	NA	T1016	CASE MANAGEMENT EACH 15 MINS	Y
7	*******	4034054	1/5/2006	Y	NA	90847	FAMILY PSYTX W/PATIENT	Y
8	*******	4034047	1/10/2006	Y	NA	90806	PSYTX, OFF, 45-50 MIN	Y
9	*******	4034047	1/25/2006	Y	NA	90806	PSYTX, OFF, 45-50 MIN	Y
10	*******	4034054	2/24/2006	Y	NA	T1016	CASE MANAGEMENT EACH 15 MINS	Y
			# Applicable Elements	**10**				**10**
			# Compliant Elements	**10**				**10**
			% Compliant Elements	**100%**				**100%**

TOTALS	
Total # Applicable Elements	**20**
Total # Compliant Elements	**20**
Total % Compliant Elements	**100%**

Table Legend: DOS = Date of Service, Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Northeast Behavioral Health, LLC

Type of Record Reviewed	**Coordination of Care Inpatient to Outpatient Transition (Children)**		
Review Period	**October 1, 2005 - June 30, 2006**	**Reviewer**	**Barbara McConnell**
Review Date	**January 11, 2007**	**Participating BHO Staff Member**	**P. Sitzman, K. Thompson, L. Goode-Grasmick**

Table B-2—Coordination of Care Inpatient to Outpatient Transition (Children)

#	Member ID	DOB	Primary Dx	D/C Date From Inpatient Facility	Date of First Follow-up	Documentation of Coordination and follow-up following an inpatient stay	In-Pt. Provider	Out-Pt. Provider
1	*******	*********	BIPOLAR DISORDER, UNSPECIFIED	5/18/2006		Y	CMHI - Ft. Logan	
The hospital discharge summary indicated that the actual admit date was 4/18/2006. The CMHC progress note described communication with the hospital staff prior to discharge. Discussions described the plan to discharge to a DHS RTC placement.								
2	*******	*********	UNSPECIFIED EPISODIC MOOD DISORDER	11/18/2005	11/21/2005	Y	PVHS/Mountain Crest	LCMH
The Larimer Center for Mental Health care coordinator progress note on 11/15/2005 described discussions with hospital staff regarding the consumer. A care coordinator progress note on 11/17/2005 indicated that an appointment was scheduled for 11/18/2005 with a Larimer Center for Mental Health clinician. There was a Larimer Center for Mental Health progress note on 11/21/2005 describing an intake interview.								
3	*******	*********	DEPRESSIVE DISORDER NEC	4/4/2006	4/10/2006	Y	North Colorado Medical Center	NRBH
A progress note dated 4/4/2006 from the North Range Behavioral Health care coordinator indicated that a care coordinator appointment was scheduled for 4/10/2006 and a follow-up doctor appointment was scheduled for 4/18/2006. There was a North Range Behavioral Health progress note describing an intake with the care coordinator 4/10/2006 and a North Range Behavioral Health progress note describing a medical management appointment on 4/13/2006.								
4	*******	*********	DEPRESS PSYCHOSIS-UNSPEC	4/27/2006	5/25/2006	Y	PVHS/Mountain Crest	LCMH
The hospital discharge summary indicated that the plan was for follow-up at Salud clinic and Larimer Center for Mental Health. A 4/26/2006 hospital progress note stated that an intake appointment was scheduled at Larimer for 4/28/2006. Larimer Center for Mental Health documentation indicated that the consumer was a "no show" for the 4/28/2006 appointment. Larimer Center for Mental Health documentation indicated that the consumer's mother called in on 5/8/2006 and scheduled an appointment for 5/15/2006. Larimer Center for Mental Health documentation indicated that the consumer was a "no show" for the appointment on 5/15/2006. A Larimer Center for Mental Health progress note indicated that the consumer was seen on 5/25/2006.								
5	*******	********	BIPOL AFF, MIXED-UNSPEC	6/20/2006		Y	Centennial Peaks Hospital	
The hospital discharge summary indicated that the plan was to discharge the consumer to the guardian with follow-up at North Range Behavioral Health. A 6/15/2006 North Range care coordinator progress note described a phone call with the NBH utilization manager and a phone call with the DHS case worker. Discussion was that the plan was changing to an RTC placement. The consumer was discharged to an RTC (DHS placement).								
6	*******	*********	CONDUCT DISTURBANCE NOS	4/20/2006		Y	North Colorado Medical Center	
Mental health center care coordinator notes described a conversation with hospital staff and the DHS case worker regarding placement plans. The hospital discharge summary indicated that the consumer was ultimately discharged to police custody.								

Table Legend: Y=Yes, N=No

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Northeast Behavioral Health, LLC

Table B-2—Coordination of Care Inpatient to Outpatient Transition (Children)

#	Member ID	DOB	Primary Dx	D/C Date From Inpatient Facility	Date of First Follow-up	Documentation of Coordination and follow-up following an inpatient stay	In-Pt. Provider	Out-Pt. Provider
7	*******	*********	DEPRESS PSYCHOSIS-UNSPEC	10/13/2005		Y	Cedar Springs Behavioral Health Systems, Inc	Centennial MHC
The aftercare plan from the hospital indicated that the plan was for follow-up at Centennial Mental Health Center. Centennial Mental Health Center care coordinator progress notes on 10/6/2005 indicated that the care coordinator was working with the hospital and foster family to plan for discharging the consumer back to the foster family. The hospital discharge summary 10/13/2005 stated that the consumer was discharged to the foster family, with a therapy appointment scheduled at Centennial Mental Health Center on 10/19/2005 and a doctor appointment scheduled on 11/2/2005. Care coordinator progress notes indicated that the consumer was readmitted to an inpatient facility on 10/17/2005.								
8	*******	*********	HYPERKINETIC SYND NOS	4/17/2006	4/20/1006	Y	CMHI - Ft. Logan	LCMH
The hospital discharge summary indicated that the plan was for treatment to continue at Larimer Center for Mental Health and that an appointment was scheduled for 4/20/2006. There was a progress note from Larimer Center for Mental Health describing an intake appointment on 4/20/2006.								
9	*******	*********	DEPRESS PSYCHOSIS-UNSPEC	11/22/2005	11/23/2005	Y	North Colorado Medical Center	NRBH
There were discharge instructions given to the consumer stating that follow-up appointments were scheduled at North Range Behavioral Health with the consumer's regular therapist on 11/23/2005, 11/28/2005, and 11/30/2005. North Range progress notes indicated that the therapist met with the family on 11/22/2005, just prior to discharge, and that there was an individual session on 11/23/2005.								
10	*******	*********	COND DISORDER, CHILDHOOD ONSET TYPE	12/12/2005			CMHI - Pueblo	
Hospital records indicated that the consumer was discharged to a Pueblo RTC (DHS placement).								

Table Legend: Y=Yes, N=No

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Northeast Behavioral Health, LLC

Type of Record Reviewed	**Grievances**		
Review Period	**January 1, 2006 - September 30, 2006**	**Reviewer**	**Bonnie Marsh**
Review Date	**January 25, 2007**	**Participating BHO Staff Member**	**Carol Staples**

Table B-3—Grievances Record Review

#	Case ID #	Date Grievance Received	Date of Acknowledgement Letter	Acknowledgement Sent Within 2 Working Days	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Resolved and Notice Sent per Requirement	Appropriate Level of Expertise	Resolution Responsive to Member Grievance?
1	*******	12/29/2005	12/29/2005	Y	1/13/2006	10	NA	Y	Y	Y
Father of child client complained about inexperienced therapist working with his child in play therapy. The center vice president (a licensed clinical social worker) was consulted.										
2	*******	5/30/2006	5/31/2006	Y	6/15/2006	12	NA	Y	N	Y
Consumer stated therapist was closing her case due to lateness and no-shows, and was not referred to another service provider. Consumer representative responded to complaint but did not document her consultation with a qualified clinician regarding treatment options that were provided to the client in the letter.										
3	*******	1/19/2006	1/19/2006	Y	1/24/2006	3	NA	Y	Y	Y
Consumer complained about treatment by the therapist, including verbal threats and physical restraint. The investigation and decision was by the county director of the CMHC (master's degree [MA], licensed professional counselor [LPC]). The incident was reported to DORA and investigated by NBH as a quality-of-care concern.										
4	*******	6/15/2006	6/19/2006	Y	7/3/2006	12	NA	Y	Y	Y
Consumer complained about nonresponsive staff and about accessibility of appointments. Had medication reactions and felt she wasn't given a timely appointment. Consumer representative consulted with the medical director for the investigation and decision.										
5	*******	6/19/2006	6/20/2006	Y	6/20/2006	1	NA	Y	Y	Y
Consumer was in jail and was receiving a mental health assessment. Complained of verbal abuse and rude treatment by staff. The incident was referred to the center director (MA, LPC) and handled through the disciplinary action process.										
6	*******	3/7/2006	3/9/2006	Y	3/21/2006	10	NA	Y	Y	Y
Consumer complained about rude treatment by the van driver, who was a CMHC employee. The issue was sent for supervisory review (MA, LPC) and OCFA ensured that there was a training meeting to discuss expectations of drivers and passengers regarding keeping appointments.										
			# Applicable Elements	**6**				**6**	**6**	**6**
			# Compliant Elements	**6**				**6**	**5**	**6**
			% Compliant Elements	**100%**				**100%**	**83%**	**100%**
TOTALS										
			Total # Applicable Elements	**24**						
			Total # Compliant Elements	**23**						
			Total % Compliant Elements	**96%**						

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Northeast Behavioral Health, LLC

Type of Record Reviewed	**Denials**		
Review Period	**January 1, 2006 - September 30, 2006**	**Reviewer**	**Tom Cummins**
Review Date	**January 25, 2006**	**Participating BHO Staff Member**	**Anne Mitchell**

Table B-4—Denials Record Review

#	Member ID	Date of Initial Request	Standard/Expedited Authorization Decision			Termination, Suspension, or Reduction of Previously Authorized Services		Notice Includes Reasons	Decision Made by Qualified Clinician
			Date Notice Sent	# of Days For Decision	Notice Sent per Requirement	Date Notice Sent	Notice Sent per Requirement		
1	*******	1/19/2006	1/20/2006	1	Y			Y	Y
Request was for new authorization for inpatient care. Denial was made since youth no longer met medical necessity criteria for inpatient services. Notice of Action letter signed by NBH Medical Director									
2	*******	2/2/2006	3/13/2006	19	N			Y	Y
Request was for inpatient care for treatment of an eating disorder in an out-of-state facility. Request was received on February 2, 2006, from a Nurse Practitioner at the consumer's health clinic. Denial was made in consultation with the Medical Director at Larimer Center for Mental Health. Case was denied since consumer did not meet medical necessity criteria for inpatient services and was believed to be able to be treated with intensive outpatient services.									
			# Applicable Elements		**2**			**2**	**2**
			# Compliant Elements		**1**			**2**	**2**
			% Compliant Elements		**50%**			**100%**	**100%**

TOTALS	
Total # Applicable Elements	**6**
Total # Compliant Elements	**5**
Total % Compliant Elements	**83%**

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix C. Site Review Participants
for Northeast Behavioral Health, LLC

Review Dates

Dates for HSAG's site review for **NBH**, the period under review, and the contract term are shown in Table C–1 below.

Table C–1—Review Dates	
Dates of On-Site Review	January 25–26, 2007
Period Under Review	January 1, 2006–December 31, 2006
Contract Term	FY 06–07

Participants

Participants in the FY 06–07 site review of **NBH** are listed in Table C–2 below.

Table C–2—HSAG Reviewers and BHO Participants		
HSAG Review Team		**Title**
Team Leader	Barbara McConnell, MBA, OTR	Colorado Project Director
Reviewer	Bonnie Marsh, BSN, MA	Executive Director, EQR Services
Reviewer	Tom Cummins, LCSW	Consultant
NBH Participants		**Title**
Neil Bensen, PhD		Director of Quality Improvement
Libby Goode-Grasmick		Provider Coordinator
Maureen Huff, PhD		Clinical Director
Julie Kellaway, MS		Assistant Director of Quality Improvement
LaRue Leffingwell, BA		Compliance and Contract Coordinator
Anne Mitchell, RN, BSN		Utilization Management
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Ted Sills, MD		Medical Director
Carol Staples, MA		Director, Office of Consumer and Family Affairs
Karen Thompson, RN, MS, CNS		Executive Director
Department Observers		**Title**
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Overview

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine the MCOs' and PIHPs' compliance with contract requirements and federal regulations. The Department has elected to complete this requirement by contracting with an external quality review organization (EQRO). HSAG is the EQRO for the Department. The U.S. Department of Health and Human Services' (DHHS') Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQR.

The site review addressed the BHO's compliance with federal regulations and contract requirements in 10 areas: delegation; provider issues; practice guidelines; member rights and responsibilities; access and availability; utilization management; continuity-of-care system; quality assessment and performance improvement program; grievances, appeals, and fair hearings; and credentialing.

Individual records were reviewed to evaluate implementation of contract requirements for grievances, denials, coordination of care for children transitioning from inpatient to outpatient services, and documentation of services provided.

In developing the monitoring tool, HSAG used the BHO's contract requirements and the regulations specified by the BBA, including revisions that were issued June 14, 2002, and effective August 13, 2002. The site review adhered to the February 11, 2003, CMS final protocol: *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Regulations.*

Methodology and Process

Objective of the Site Review

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

- The BHO's compliance with federal regulations and contract requirements.
- The quality and timeliness of, and access to, mental health care furnished by the BHO.
- Interventions to improve quality.
- Activities to sustain and enhance performance processes.

To accomplish these tasks, HSAG assembled a team to:

- Collaborate with the Department to determine the review and scoring methodology, data collection methods, schedule and agenda, and other issues as requested.
- Collect and review data and documents before and during the on-site portion of the review.
- Analyze the data and information collected.
- Prepare a report of findings and required actions for each BHO.

Site Review Activities

Throughout this process, HSAG worked closely with the Department and the BHO to ensure a coordinated and supportive approach to completing the site review activities.

The following table describes the activities that were performed throughout the site review process.

Table D–1—Site Review Activities Performed

For this step,	HSAG…
Step 1:	**Established the review schedule.**
	Before the site review, HSAG coordinated with the Department and the BHO to set the site review schedule and assign staff to the site review teams.
Step 2:	**Prepared the data collection tools and submitted them to the Department for approval.**
	To ensure that all information was collected, HSAG developed monitoring tools consistent with BBA protocols. To create the monitoring tool standards, HSAG used the requirements as set forth in the contract between the Department and the BHO. HSAG also followed the guidelines specified by the BBA, including revisions that were issued June 14, 2002, and effective August 13, 2002. Additional criteria used in developing the monitoring tools included the NCQA 2006 Standards for the Accreditation of Behavioral Health Organizations and applicable Colorado and federal requirements.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 3:	**Prepared and submitted the Desk Review Form to the Department and the BHO.**
	After review and approval of the monitoring tools by the Department, HSAG forwarded a Desk Review Form to the BHO and requested that the BHO submit specific information and documents to HSAG within 30 days of the request. The Desk Review Form included instructions on how to organize and prepare the documents related to the review of the standards and records.
Step 4:	**Forwarded a BHO Document Request Form to the BHO.**
	HSAG forwarded a BHO Document Request Form to the BHO as an attachment to the Desk Review Form. The BHO Document Request Form contained the same standards and contract requirements as those in the tool used by HSAG to assess the BHO's compliance with contract requirements for each of the 10 standards. The Desk Review Form included instructions for completing the "BHO Information and Associated Documentation" section of this form. This step provided the opportunity for the BHO to identify, for each requirement, the specific BHO documents or other information that provided evidence of compliance, and streamlined the ability of the reviewers to identify all applicable documentation for review.
Step 5:	**Developed a site review agenda and submitted it to the BHO.**
	HSAG developed an agenda to assist BHO staff in planning for participation in the site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective site review, as well as minimizing disruption to the BHO's day-to-day operations. An agenda sets the tone and expectations for the site review so that all participants understand the process and time frames for the review.
Step 6:	**Provided orientation.**
	HSAG staff provided an orientation for the BHO and the Department to preview the site review process and respond to the BHO's and Department's questions. The orientation included identifying the similarities and differences between the FY 05-06 and the FY 06–07 review processes related to the request for information and documentation prior to the on-site portion of the site review, the schedule of review activities, and the process for the review of records.
Step 7:	**Participated in telephone conference calls with the BHO to answer questions and provide any other needed information before the site review.**
	Prior to the site review, HSAG representatives conducted a pre-site review teleconference with the BHO to exchange information, confirm the dates for the site review, and complete other planning activities to ensure that the site review was completed methodically and accurately. HSAG maintained contact with the BHO as needed to answer questions and provide information to key BHO management staff members. This teleconference and subsequent contact gave BHO representatives the opportunity to request clarification and present any questions about the request for documentation for the desk review and the site review processes.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 8:	**Received desk review documents and evaluated information before the on-site review.**
	Reviewers used the documentation received from the BHO to gain insight into the BHO's structure, enrolled population, providers, services, operations, resources, and delegated functions, if applicable, and to begin compiling the information and findings before the on-site portion of the review. During the desk review process, the reviewers: ◆ Documented findings from the review of the materials submitted by the BHO as evidence of compliance with the requirements. ◆ Identified areas and issues requiring further clarification or follow-up during the interviews. ◆ Identified information not found in the desk review documentation to be requested during the on-site portion of the review.
Step 9:	**Received record review listings and posted samples to HSAG's FTP site prepared for each BHO.**
	The Desk Review Form provided the BHO with the purpose, timelines, and instructions for submitting record review lists and for pulling sample records for HSAG's review. HSAG generated four unique record review samples based on data files supplied by the BHO or the Department. These files included the following databases: consumer grievances, consumer denials, consumers who are children and had been discharged from an inpatient facility, and encounters that had been reviewed by the BHO as part of a statically valid sample of encounters. From each of these databases, a random sample of unduplicated records was selected. For each of the record reviews, HSAG selected 10 records for the sample and five additional records for the oversample.
Step 10:	**Conducted the on-site portion of the review.**
	During the site review, BHO staff members were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. Activities completed during the site review included the following: ◆ Conducted interviews with BHO staff. Interviews were used to obtain a complete picture of the BHO's compliance with contract requirements, to explore any issues not fully addressed in the documents, and to increase overall understanding of the BHO's performance. ◆ Reviewed information and documentation. Throughout the desk review and site review processes, reviewers used a standardized monitoring tool to guide the identification of relevant information sources and to document the findings regarding compliance with the 10 standards. This activity included a review of applicable policies and procedures, meeting minutes, quality studies, reports, records, and other documentation. ◆ Received and reviewed records. Reviewers used standardized monitoring tools to review records and to document findings regarding compliance with contract requirements and the BHO's policies and procedures. ◆ Summarized findings at the completion of the site review. As a final step, HSAG reviewers met with BHO staff to provide a high-level summary of the preliminary findings from the site review.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 11:	**Calculated the individual scores and determined the overall compliance score for performance.**
	All of the 10 standards in the monitoring tool were reviewed and the information analyzed to determine the BHO's performance on the individual elements within each standard. For the review of records, each element was reviewed and the BHO's documentation analyzed to determine compliance.
Step 12:	**Prepared a report of findings and required actions.**
	After completing the documentation of findings and scoring for each of the 10 standards and for the reviews of records, HSAG prepared a draft report of the site review findings, scores, and required actions for the BHO. The report was forwarded to the Department and the BHO for their review and comment. After the Department's approval of the draft, a final, individual BHO report was issued to the Department and the BHO.

Evaluation and Scoring Methodology

Standards

The BHO's performance in complying with the elements (i.e., contract requirements) related to each of the 10 standards was evaluated against evidence obtained through a review of the BHO's documents and information provided during interviews with BHO staff. A score was assigned and the review findings and related substantiating evidence were documented in the "Findings" sections of the monitoring tool. The score (*Met, Partially Met*, or *Not Met*) indicated the degree to which the BHO's performance was in compliance with the individual elements in each standard. A score of *Not Applicable* (*N/A*) was used if an individual element did not apply to the BHO. Corrective actions required by the BHO to achieve compliance with the requirements were documented in the "Required Actions" section of the monitoring tool.

Scoring Methodology (Definitions)

The BHO received a score of *Met*, *Partially Met*, *Not Met*, or *N/A* for each element of each standard. This methodology follows the CMS final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*: *A protocol for determining compliance with Medicaid Managed Care Regulations*, February 11, 2003, and is defined below.

Met indicates full compliance, defined as either of the following:

- All documentation listed under a regulatory provision, or component thereof, must be present, or
- BHO staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews, or
- Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

- No documentation is present and staff have little or no knowledge of processes or issues addressed by the regulatory provisions, or
- For provisions with multiple components, key components of a provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for remaining components.

Not Applicable (***N/A***) signifies that the requirement does not apply, because:

- The standard or element was not applicable to the BHO.

To arrive at an overall percentage of compliance score for each standard, the total number of elements receiving a score of *Met* was divided by the total number of applicable elements.

Record Reviews

The evaluation of records to determine compliance with contract requirements was accomplished through the use of a record review tool developed for each of the applicable reviews (grievances, denials, coordination of care, and documentation of services).

Similar to the methodology followed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for determining the sample size required for confidence when evaluating compliance with elements of performance, a sample of 10 records with an oversample of five records was used for record reviews (unless there were 10 or fewer available records, in which case all available records were reviewed). The samples were selected from all applicable BHO records from January 1, 2006, through September 30, 2006 for the review of grievances and denials. For the review of documentation of services, HSAG used a random sample of 10 records with an oversample of five records selected from the 411 records submitted by each BHO for the validation of the BHO's review of a statistically valid sample of encounter data. For the coordination-of-care record review, HSAG used a sample of 10 records with an oversample of five records selected from the Department's encounter data list of children with inpatient stays and discharge dates between October 1, 2005, and June 30, 2006. Each record was reviewed for evidence of BHO compliance with the applicable elements.

For each type of record review except coordination of care, the BHO received a score of *Yes* (compliant), *No* (not compliant) or *N/A* for each of the elements evaluated. Except for the coordination-of-care record review, the BHO received an overall percentage-of-compliance score for each type of record review and for all the scored record reviews combined. The overall record review score was calculated by dividing the total number of elements scored *Yes* by the total number of applicable elements.

Determination of Overall Compliance Percentage Score

The overall compliance percentage score for each BHO was calculated by dividing the total number of elements that were compliant for the standards and the record reviews by the total number of applicable elements.

References

BBA (Balanced Budget Act). Centers for Medicare & Medicaid Services. CMS and Related Laws and Regulations. Available at: http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr438_04.html.

Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPS): A protocol for determining compliance with Medicaid Managed Care Regulations*, Final Protocol, February 11, 2003.

National Committee for Quality Assurance (NCQA) *2006 Standards for the Accreditation of Behavioral Health Organizations (BHOs)*. Washington, DC.