Colorado Medicaid
Community Mental Health Services Program

FY 07–08 Site Review Report

for

Northeast Behavioral Health, LLC

May 2008

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

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Overview of FY 07–08 Compliance Monitoring Activities

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct an annual evaluation of their managed care organizations and prepaid inpatient health plans (PIHPs) to determine compliance with regulations, contractual requirements and the state's quality strategy. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for the Colorado behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the fourth year that HSAG has performed compliance monitoring reviews of the BHOs. For the fiscal year (FY) 07–08 site review process the Department requested a focused review of five areas of performance. HSAG developed a review strategy consisting of five components for review, which corresponded with the five areas identified by the Department. These are: Access to Care (Component 1), Coordination of Care (Component 2), Oversight and Monitoring of Providers (Component 3), Member Information (Component 4), and Review of Corrective Action Plans and Supporting Documentation (Component 5). Compliance with federal regulations and contract requirements was evaluated through review of the five components. This report documents results of the FY 07–08 site review activities. Details of the site review methodology and summaries of the findings, strengths, opportunities for improvement, and required actions for each component are contained within the section of the report that addresses each component. Template data collection tools for Components 1, 3, and 4, as well as completed documents for Components 2 and 5, are found in the appendices.

In developing the data collection tools and in reviewing the five components, HSAG used the BHOs' contract requirements and regulations specified by the BBA with revisions that were issued on June 14, 2002, and effective on August 13, 2002. The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services final protocol *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)* (see Appendix H).

Objective of the Site Review

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

- The BHO's compliance with federal regulations and contract requirements in the five areas of review.
- The quality, timeliness, and access to mental health care furnished by the BHO, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of the area reviewed.
- Activities to sustain and enhance performance processes.

To accomplish these tasks, HSAG:

- Collaborated with the Department to determine the review and scoring methodologies for each component of the review, data collection methods, the schedule, the agenda, and other issues as needed.
- Collected and reviewed documents before and during the on-site portion of the review.
- Analyzed the data and information collected.
- Prepared a report of findings (2007–2008 Site Review Report) for each BHO.

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

Summary of Results

Each component of the review was assigned an overall score of *In Compliance*, *In Partial Compliance*, or *Not In Compliance* based on conclusions drawn from the review activities. Required actions were assigned to any component receiving a score of *In Partial Compliance* or *Not In Compliance.* As appropriate, opportunities for improvement were also identified for some components regardless of the score. While recommendations for enhancement of BHO processes were provided based on these identified opportunities for improvement, these recommendations do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **Northeast Behavioral Health, LLC** (**NBH**) for each of the components. Details of the findings for each component follow in subsequent sections of this report.

Table 1-1—Results

Component	Overall Score
Component 1—Access to Care	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 2—Coordination of Care	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 3—Oversight and Monitoring of Providers	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 4—Member Information	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 5—Review of FY 06–07 CAPs	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*

Methodology

HSAG conducted member interviews and telephone assessments of **NBH**'s access processes and compared the results with the BHO's policies and published practices and with information obtained from interviews with key BHO staff members.

HSAG reviewed for compliance with the following contract requirements:

- *Exhibit C.1:* "The Contractor shall assess the need for services."
- *II.F.1.a.5*: "The Contractor shall meet the standards for timeliness of service for routine, urgent, and emergency care."
- *II.F.1.f:* "The Contractor shall allow, to the extent possible and appropriate, each Member to choose his or her health professional."

Member Interviews

The Department provided HSAG with a sample of 10 Medicaid members (with an oversample of 41 Medicaid members) who received or attempted to receive services between the dates of January 1, 2007, and December 31, 2007. The intended sample mix for each BHO was as follows: three Medicaid members who received only an intake visit during the review period, three Medicaid members who received an intake and subsequent services during the review period, and four Medicaid members who were identified by various stakeholder groups.[2-1] HSAG interviewed four adult Medicaid members, two of whom reported that they had subsequent treatment following the intake assessment, and six individuals whose children were Medicaid members who received an intake assessment, with four receiving subsequent services. There were no Medicaid members identified by the stakeholder groups who met the selection criteria for the sample (members who experienced an issue accessing services between the dates of July 1, 2006, and December 31, 2007, and had not had the matter investigated by either the Medicaid ombudsman or the Department). HSAG developed a short questionnaire that was conducted via telephone. Members were asked to describe their experience of obtaining an individual, confidential assessment for entry into services. Interview questions were designed to obtain members' perceptions related to the ease of gaining access to services provided by the BHO and information provided to them during initial and subsequent contact with the BHO.

[2-1] Stakeholder groups are the Mental Health Planning and Advisory Council, the Mental Health Advisory Committee, and the Office of the Ombudsman for Medicaid Managed Care.

Telephone Assessment of BHO Access Processes

HSAG conducted five calls per BHO to assess the processes and practices at each BHO for providing access or intake services to Medicaid members in the BHO's service area. The HSAG caller identified him/herself as an HSAG representative calling on behalf of the Department. The caller then asked a series of situational and standard questions about policies and processes for providing access to services. Answers were recorded by each caller and are summarized in the findings section below. The call worksheets (see Appendix B) included scripts with a set of situations to present to the BHO intake worker. The situations presented to the BHO intake worker were different for each of the four calls. The caller worksheets also included a set of policy or process questions, which were standard questions to be asked during each call. Each scripted call was made to each BHO simultaneously. That is, Call Script 1 was made to each BHO on Tuesday, January 8, 2008, at 2 p.m.; Call Script 2 was made to each BHO on Saturday, January 12, 2008, at 3 p.m. and repeated on Monday, January 28, 2008, at 12:30 p.m.; Call Script 3 was made to each BHO on Wednesday, January 23, 2008, at 9:30 a.m.; and Call Script 4 was made to each BHO on Tuesday, January 29, 2008, at 4 p.m.

Summary of Findings

The **NBH** Access to Services section of the provider manual and the policy and procedure manual stated that each clinical intake appointment includes an assessment of the member's need for services. The Chart Audit Report, the Review of Provider Centers Internal Chart Audits, the Outpatient IPN Authorization Validity Study, and the Inpatient Authorization Validity Study provided evidence that **NBH** monitored both the independent provider network (IPN) and the community mental health centers (CMHCs) for the presence and completeness of assessments of members seeking behavioral health services. During each call the HSAG reviewer made to the **NBH** access line or to **NBH** contractors, the clinician indicated that the Medicaid member described in the scenario would be scheduled for an intake assessment, or in the case of an emergency, may be urged to go to the nearest emergency room.

The Access to Services section of the provider manual and the policy and procedure manual included the requirements for timely access to services as specified by the Department. Online provider training (accessed by both CMHC and independent network providers) provided evidence that providers were informed of the access standards by more than one method.

Each of the Medicaid members interviewed (or the parent/guardian of the member) reported that he or she had attended an intake assessment appointment. None of the individuals interviewed reported difficulty obtaining an appointment for the intake assessment. Ten individuals were interviewed, including four adult members and six parents of child members. One interview was conducted in Spanish at the request of the parent. Two of the four adult members reported that they returned for therapy following the intake assessment. Four of the parents reported that the child had subsequent treatment following the intake assessment, and one indicated that a subsequent appointment was scheduled, but had not yet occurred. Seven of the individuals interviewed reported that they received services at one of the CMHCs. Two were uncertain if the services were received at a CMHC or from a private therapist. One parent reported that the therapy occurred on-site at the child's day care center.

Nine of the 10 individuals interviewed responded positively when asked how they felt about the first appointment and whether they were satisfied. All responses regarding satisfaction with the first appointment were related to how the members felt they were treated by the therapists. In addition, 1 member indicated that the positive response was also related to the effectiveness and efficiency of the staff at the CMHC. Although only 1 individual responded negatively when asked about satisfaction with the first appointment, 2 additional individuals, when specifically asked, responded that something did bother them about the appointment. Two of these 3 individuals expressed dissatisfaction with the therapy provided at the first visit, and 1 individual reported dissatisfaction with the length of time it took to develop the treatment plan. None of these 3 individuals reported that they had complained to anyone at the time of the visit. In response to what bothered them, 2 members reported that they either did not return for additional sessions or did not continue therapy past the first few sessions. None of the individuals who did not return for therapy after the first visit reported that they had been denied therapy by the BHO.

Seven of the 10 individuals interviewed indicated that they were very pleased with the therapy and outcomes. One parent expressed that the therapy was "alright," and 2 of the adult members expressed overall dissatisfaction with the therapy experience.

During each telephone assessment call, the HSAG reviewer was offered an appointment within the required time frame appropriate to the situation (See Appendix B). The FY 2007 Access to Services Report indicated that **NBH** was 100 percent in compliance with the timeliness standards for urgent and emergency services. During one quarter, **NBH** was 99.99 percent compliant for routine services. **NBH** required the one provider that was not compliant to submit a corrective action plan, which brought the **NBH**'s compliance to 100 percent as reported in the quarterly FY 2007 Access to Services Report.

The consumer handbook, the provider manual, the online provider training, and the annual member handbook demonstrated that both members and providers were informed of the member's right to choose his or her provider.

Summary of Strengths and Opportunities for Improvement

NBH had a variety of processes in place to ensure that members were assessed during the intake appointment and that the intake appointment was provided within the required time frames. These processes included monitoring, the use of corrective action plans, provider training, and tracking which providers participated in online training.

Ninety percent of the individuals interviewed expressed satisfaction with the intake assessment. Eighty percent expressed overall satisfaction with the therapy experience. One hundred percent of individuals interviewed attributed the feeling of satisfaction or dissatisfaction to the relationship between the consumer and the therapist. Two individuals who were unsatisfied with therapy indicated that they chose to discontinue therapy rather than complain or speak to anyone about their dissatisfaction, although one of these individuals stated that she was aware of the complaint process.

No trends could be identified regarding the reason for negative responses regarding satisfaction (type of issue, center, etc.). Two members expressed frustration with the Social Services foster care system and the length of time it took to arrange for that agency's services.

Although **NBH** policies clearly indicated that members may choose to receive services from the IPN, the HSAG assessment calls were routinely transferred or referred to the area CMHCs. Only one of the five CMHC staff members that the HSAG caller spoke to indicated that Medicaid members could choose an independent provider, and offered the caller a provider list. **NBH** may want to evaluate how that aspect of its policy is operationalized.

Summary of Required Actions

There are no corrective actions required at this time, as **NBH** was found to be in compliance with this component.

Methodology

Care coordination (as defined in the FY 07–08 BHO contract) means the process of identifying, screening, and assessing members' needs; identification of and referral to appropriate services; and coordinating and monitoring an individualized treatment plan. This treatment plan should also include a strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment. The focus of the FY 07–08 Coordination of Care record review was to use the clinical record to identify and assess the BHO's and providers' practices related to care coordination with primary care physicians and parents or guardians of children receiving services, specifically with respect to medication management. The Department provided HSAG with a sample of 10 Medicaid members (with an oversample of 5) who were children (0–17 years of age) and who received a medication management visit between January 2007 and September 2007. A reference period of 45 days prior to, and 45 days following, the medication management encounter date was used for review of each record. The purpose of the record review was to identify instances of care coordination between mental health provider(s) and the family (parent or guardian) and between mental health provider(s) and the primary care physician (PCP) related to medication management. Mental health providers may include the prescriber or the therapist.

HSAG reviewed for compliance with the following contract requirements:

- *II.F.1.g.3:* "The Contractor shall coordinate with the Member's medical health providers to facilitate the delivery of health services, as appropriate."
- *II.G.1.c:* "The Member has the right to participate in decisions regarding his or her health care."
- *II.G.5:* "The Contractor shall encourage involvement of the Member, family members, and advocates in service planning."

Summary of Findings

The **NBH** Coordination of Care policy described coordination between behavioral health and medical care services as an essential component of successful treatment and stated that **NBH** coordinates services with medical care providers. The Participation of Consumers and Family Members or Advocates in Service Planning policy stated that involvement of family members in the assessment of need and development of goals for children and adolescents is mandatory. Mandatory online training for CMHC and independent providers included policies and procedures regarding coordinating with medical providers and the involvement of members and their families in service provision as well as member rights.

During the interview, **NBH** staff members described chart audits conducted by the BHO for both the IPN and the CMHCs that were used to monitor for evidence of care coordination. The Outpatient Provider Audit form indicated that the reviewer determines whether the treatment plan was completed

by the provider and signed by an adult member or the parent or guardian of a child. The form also included a section for the reviewer to determine whether progress notes contained documentation of coordination with the family and/or medical provider. Other quality improvement activities related to coordination-of-care topics included the continuation of a performance improvement project (PIP) measuring follow-up after an inpatient hospital admission, a current PIP with the goal of increasing caregiver involvement in the treatment of children and adolescents, and a current PIP involving coordination of care between the mental health practitioner and the PCP. The intervention for the coordination-of-care PIP required the primary therapist (care coordinator) to send a notification letter to the PCP following an intake assessment. The notification letter contained information about the services planned for the member, including a list of medications, as appropriate.

HSAG reviewed 10 records. No records from the oversample were reviewed. A reference period of 45 days prior to, and 45 days following, the medication management encounter date was used for review of each record. Two of the 10 records included documentation of discussions between the primary therapist and the parent regarding the effectiveness of medications. A total of 7 records included documentation of discussions between the primary therapist and the parent regarding the child's current status, progress, and/or goals and treatment strategies. Only 1 record documented a discussion between the prescriber and the parent, outside of the medication management visit, regarding medications. There were no records that indicated discussions between the prescriber and the primary therapist about medications or progress. There were 3 records indicating that the only contact with family was during the medication management visit. One of those cases was identified as a "medication only" case. The other two cases showed no therapy sessions during the 90-day reference period; therefore, no coordination with the family was indicated. While only 1 record contained communication (a letter) with the PCP during the reference period, 2 other records contained similar letters outside of the reference period.

Summary of Strengths and Opportunities for Improvement

While the PIP involving communication with the PCP represents an effort to improve coordination of care with the PCP, this project had significant limitations. The project required that a letter be sent to the PCP only following an intake assessment, which meant that changes to medications may not have been communicated to the PCP, and that members who had been receiving ongoing therapy that began prior to the start of the PIP were not receiving the coordination-of-care intervention. **NBH** staff members reported that there were no initiatives to improve ongoing communication between the mental health practitioner and the PCP, or to include members whose intake was prior to the start of the PIP. As a result, the record review indicated that only one record contained evidence that communication with the PCP occurred within the 90-day reference period. While **NBH** followed its policies and procedures regarding communication with PCPs, **NBH** may want to consider developing additional criteria or guidelines to ensure that coordination and communication occurs at other appropriate times during the member's treatment.

Summary of Required Actions

There are no corrective actions required at this time, as **NBH** was found to be in compliance with this component.

Methodology

HSAG conducted a desk review of policies and an on-site review of documentation with an interview of key BHO personnel. This component of the compliance monitoring review was designed to examine the BHO's processes for directly monitoring independently contracted providers, and to examine the BHO's processes for monitoring the community mental health centers' (CMHCs) supervision and training of their providers. Specific attention was paid to the BHO's practices related to identifying and responding to issues during its monitoring of the CMHCs. The review period for this component of the review was January 1 through December 31, 2007.

HSAG reviewed for compliance with the following contract requirements:

- *II.F:* "The Contractor shall ensure that required and alternative services are provided through a well-organized service delivery system. The service delivery system shall include mechanisms for ensuring access to quality, specialized care from a comprehensive provider network."
- *II.G.4.h.3:* "Additional Member rights include the right to have an independent advocate, request that a provider be considered for inclusion in the network, and receive culturally appropriate and competent services from participating providers."
- *II.H.10.a.1:* "The Contractor shall be responsible for all work performed under this Contract, but may enter into Provider agreements for the performance of work required under this Contract. No provider agreements, which the Contractor enters into with respect to performance under the Contract, shall in any way relieve the Contractor of any responsibility for the performance of duties required under this Contract."
- *II.H.10.a.3:* "The Contractor shall monitor Covered Services rendered by provider agreements for quality, appropriateness, and patient outcomes. In addition, the Contractor shall monitor for compliance with requirements for Medical Records, data reporting and other applicable provisions of this Contract."

Summary of Findings

The **NBH** Network Adequacy Report, the Quality Improvement and Utilization Management Performance Indicators Report, and the Alternative Services Expenditures Report demonstrated that **NBH** monitored services and the service delivery system by monitoring Medicaid enrollment, penetration rates, alternative services expenditures, and a variety of utilization management (UM) indicators, including over- and underutilization, hospital admissions, and hospital recidivism rates. The Mental Health Statistical Improvement Project (MHSIP) Results Report and the Youth Services Survey for Families (YSS-F) Results Report included an analysis of consumer satisfaction results regarding access to care indicators. The Adult Consumer Report Card Survey was an internal consumer satisfaction survey that measured items in addition to the MHSIP. The quality assessment and performance improvement (QAPI) plan, as well as QAPI program meeting minutes, described the review and analysis of grievances, appeals, and critical incidents.

During the on-site interview, **NBH** management staff members reported that they routinely tracked whether CMHCs and independent providers completed mandatory training online, which included a description of member rights and provider responsibilities related to taking member rights into account. The QAPI plan, the QAPI policy, and the Provider Records Audit policy included detailed descriptions of monitoring and reviewing the services provided, consumer satisfaction surveys, grievances, appeals, and chart audits. The Chart Audit Report and the Review of the Center Chart Audits included an evaluation of medical records for the quality and appropriateness of services provided.

NBH management staff indicated that regular CMHC documentation reviewed by the **NBH** QAPI program staff included UM plans (including training goals and progress toward achieving the prior year's training goals), recovery plans, QAPI plans, cultural competency plans, access reports, grievance reports, human resources reports (including the number of prescribers and licensed and nonlicensed staff), reports of encounters, and benefit limit reports. In addition, **NBH** staff reported reviewing annual training and new employee orientation outlines and attendance records for training provided by the CMHCs, as well as policies and procedures pertaining to Medicaid contract compliance.

Summary of Strengths and Opportunities for Improvement

NBH had a variety of methods to monitor the services provided by its contractors. The collaboration between the utilization management and the quality management departments resulted in development of training for providers. The internal consumer satisfaction survey (Adult Consumer Report Card) had 500 respondents among the three CMHCs. During the on-site interview, **NBH** management staff members also indicated that they reviewed results of the consumer satisfaction surveys for English-speaking and Spanish-speaking consumers separately in order to compare the results and determine if there were significant differences in responses between the two groups. **NBH** management staff members indicated that they determined there was no significant difference in the responses between the two groups.

Summary of Required Actions

There are no corrective actions required at this time, as **NBH** was found to be in compliance with this component.

Methodology

HSAG compared results of the member interviews and the telephone assessments to BHO policies and to documentation provided to members in writing. This component assessed the accuracy of information provided verbally during the intake process at the BHO and at facilities designated by the BHO to perform the intake function on behalf of the BHO.

HSAG reviewed for compliance with the following contract requirements:

- *II.G.4.b:* "The Contractor shall have in place a mechanism to help Members and potential Members understand the requirements and benefits of the plan."
- *II.G.1.d:* "The Contractor shall establish and maintain written policies and procedures for treating all Members in a manner that is consistent with the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand."

Summary of Findings

The **NBH** member handbook contained a complete description of services available through **NBH** and how to access those services. A cover letter was used as an enclosure to the annual member handbook mailing. The letter was an easy-to-read outline of the information that could be found in the handbook. The handbook also described other benefits available under the Medicaid State plan as well as member rights. In addition, **NBH** provided documentation of several community forums where Medicaid benefits and specific programs were discussed, allowing participants to ask questions of the **NBH** management staff and program directors.

The Member Information policy included the procedures for informing members of all rights, including the right to receive information about alternative treatment options. Mandatory online training for providers included detailed information about services, benefits, and member rights so that providers could understand, and help members understand, the Medicaid benefits.

During the member interviews, six individuals remembered receiving a member handbook or other written materials. Three of these individuals remembered something about the content of the information they received.

Summary of Strengths and Opportunities for Improvement

NBH had a variety of mechanisms in place to help members understand the requirements and benefits of the State Medicaid plan. Through the use of chart audits, **NBH** tracked whether providers distributed the member handbook and member rights. The chart audit form included a check for the presence of the signature form signed by the member indicating receipt of the handbook and rights. Completion of provider training was tracked by **NBH** management staff through the online training mechanism.

NBH management staff reported that **NBH** required providers to discuss and explain member rights and the member handbook at each intake assessment. However, the Provider Responsibilities policy stated only that providers "should be prepared" to discuss rights and other content of the member handbook. The online PowerPoint presentation, Member Rights and Responsibilities, also was unclear regarding provider requirements during the intake assessment. The online training addressed responsibilities of the care coordinator; however, the training was unclear that this referred to the primary therapist and did not clearly delineate between the primary therapist/care coordinator and **NBH** specialized care coordinators as described in the Coordination and Continuity of Care policy. **NBH** may want to review its policies regarding care coordination and clarify roles for the independent provider network as indicated.

During the HSAG assessment calls to the intake staff, one of the five intake workers was aware that Medicaid members could request therapists outside of the CMHCs. **NBH** may want to evaluate training of CMHC staff regarding access policies and requirements and revise training as indicated.

Summary of Required Actions

There are no corrective actions required at this time, as **NBH** was found to be in compliance with this component.

6. Component 5—Corrective Action Plan and Document Review

for Northeast Behavioral Health, LLC

Methodology

As a follow-up to the FY 06–07 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all elements for which it received a score of *Partially Met* or *Not Met*. The plan was to include interventions to achieve compliance and the timeline. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with the BHO until HSAG and the Department determined that the BHO completed each of the required actions from the FY 06–07 compliance monitoring site review, or until the time of the on-site portion of the BHO's review.

Summary of Findings

NBH submitted all documentation, as required, in a timely manner. All corrective actions in Standard I—Delegation; Standard IV—Member Rights and Responsibilities; Standard IX—Grievances, Appeals and Fair Hearings; and Standard X—Credentialing have been completed.

Summary of Strengths and Opportunities for Improvement

There was evidence that all corrective actions in Standard II, except for Element 2B—Program Integrity, were completed. **NBH** had implemented revised policies and procedures. During the on-site portion of the follow-up review, **NBH** management staff reported that the revised service and provider agreements with the CMHCs were scheduled to be sent out for signature in March 2008. A review of Compliance Committee meeting minutes indicated that there were at least two instances of possible fraud that were not reported to the Department.

Summary of Required Actions

NBH must (1) report all instances of possible Medicaid fraud to the Department within 10 days of receipt of the information, (2) submit quarterly reports to the Department's Quality Improvement section summarizing compliance committee meetings, (3) develop a corrective action plan designed to implement a mechanism to ensure reporting of all instances of possible Medicaid fraud, and (4) work with the Department to obtain technical assistance regarding expectations and the definition of possible Medicaid fraud.

Appendix A. Member Interview Worksheet
for Northeast Behavioral Health, LLC

The member interview worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Member Interview Worksheet

Interviewer Name: Barbara McConnell Hector Cariello (Spanish-Speaking) Rachel Henrichs	BHO Name: Northeast Behavioral Health
Member ID: _____ *(not to appear in the report)*	Member Name: _____

Introduce Yourself and Describe (Briefly) HSAG

The State of Colorado has asked us to interview a few Medicaid members to ask about their recent experiences at _____ (name the provider or make a general reference to services if the provider agency is unknown). Do you have a few minutes to talk about your experiences?

Members: (If child, parent was interviewed)

Member #1: Adult
Member #2: Child
Member #3: Child
Member #4: Adult
Member #5: Child
Member #6: Child
Member #7: Adult
Member #8: Adult
Member #9: Child
Member: #10: Child

Where services were received:

Member #1: Larimer County—Mental Health Center
Member #2: Dr. X.—unsure if facility or private
Member #3: Larimer County—Mental Health Center
Member #4: North Range Mental Health Center
Member #5: North Range Mental Health Center
Member #6: Weld County—Mental Health Center
Member #7: Unknown
Member #8: Larimer County Mental Health—Loveland
Member #9: On-site at day care
Member #10: Akron Mental Health Center

1. *How did you feel about your first appointment at _____? Were you satisfied with your experience during your first appointment at _____?*

How did you feel?

Member #1: "I liked it."
Member #2: "Very satisfied."
Member #3: "It was good."
Member #4: "I had previous therapy that I thought went well. This time (in the past year) I wasn't happy."
Member #5: "I was frustrated by the time we got there because we had to go through Social Services and it took forever to get it set up."
Member #6: "I didn't go to the first appointment. Social Services took her. I took her after that."
Member #7: "Fine."
Member #8: "Not too bad."
Member #9: "Alright."
Member #10: "Great."

Were you satisfied?

Member #1: "Yes."
Member #2: "Yes."
Member #3: "Yes."
Member #4: "With my previous therapy, yes. This year, no."
Member #5: "It would have been better if I could have set it up myself, but yes."
Member #6: N/A
Member #7: "Probably not satisfied in the long term. The first few times were ok."
Member #8: "Yes."
Member #9: "Yes."
Member #10: "Completely satisfied."

2. *Can you tell me why you felt that way? Describe why you were/were not satisfied.*

Member #1: "The way she (the counselor) was, the way she interacted."
Member #2: "Dr. X. gave me good advice on how to relate/interact and/or modify my daughter's behavior. The advice worked and there has been a positive outcome. The doctor and medical staff treated us well."
Member #3: "They were prompt and courteous and concerned. They were willing to answer questions."
Member #4: "Before I thought they were knowledgeable, but not this last time. I had a different person. I had a woman before. I wasn't comfortable with the man this time and his kind of therapy."
Member #5: "I felt positive about the counselor (J) and the group therapy (D).
Member #6: "It helped a lot. They did a good job. It helped work out our problems."
Member #7: "We never really got into anything. The therapist kept telling me I was OK even though I knew I needed help.

Member #8: "I was satisfied at first, but I don't think anything ever came of it."
Member #9: "I went with her one time, but mostly she had play therapy at the day care. I couldn't see what they were doing it for, but it was alright."
Member #10: "The therapist helped me find medication to help me manage my son's behavior."

3. Was there anything that bothered you about the appointment or the person you talked to?

Member #1: "No."
Member #2: "No."
Member #3: "No."
Member #4: "I don't think religious stuff should be part of therapy."
Member #5: "It took longer than I thought it would to develop the treatment plan and get started. It had already taken two years to get there because of Social Services."
Member #6: "No, I was surprised how good it was."
Member #7: "I don't think my problems were as severe as others they see. I felt like they downplayed my problems. I still had things I needed to work through."
Member #8: "No."
Member #9: "No."
Member #10: "No."

4. If so, did you ever talk to anyone about it, or do anything about it?

Member #1: N/A
Member #2: N/A
Member #3: N/A
Member #4: "No."
Member #5: "No."
Member #6: N/A
Member #7: "No, I just quit going."
Member #8: N/A
Member #9: N/A
Member #10: N/A

5. If yes, did you receive anything in the mail about your complaint?

Member #1: N/A
Member #2: N/A
Member #3: N/A
Member #4: N/A
Member #5: N/A
Member #6: N/A
Member #7: N/A
Member #8: N/A
Member #9: N/A
Member #10: N/A

6. *Were you ever told what you can do if you are unhappy about the help you are getting from your counselor? Did you ever get something about this in the mail?*

Member #1: "No."
Member #2: "Yes, the doctor told me that I could change doctors or facilities."
Member #3: "Yes."
Member #4: "I don't remember."
Member #5: "No, but I didn't ask. I didn't see my issue as North Range's problem."
Member #6: "No."
Member #7: "Yes."
Member #8: "No."
Member #9: "I can't remember, but I know I can complain if I want."
Member #10: "Yes."

7. *Did you ever get any written information about the BHO (either when you went there or in the mail)?*

Member #1: "No."
Member #2: "Yes."
Member #3: "Yes."
Member #4: "Yes, I got a pamphlet."
Member #5: "It's possible. I don't remember."
Member #6: "No, but she was in foster care when she started. The foster parents may have."
Member #7: "I don't think so."
Member #8: "I think so during the first appointment."
Member #9: "Yes."
Member #10: "Yes, they give you all that stuff when you first go in."

8. *(If yes): What do you remember about the information?*

Member #1: N/A
Member #2: "The interpreter explained the handouts and what I could do if I was unhappy."
Member #3: "Rights, who to contact if I had complaints. I probably have them."
Member #4: "I don't remember if I read them."
Member #5: N/A
Member #6: N/A
Member #7: N/A
Member #8: "Nothing, really."
Member #9: "It was a book."
Member #10: "I've been in the system long enough. I know my rights and where to go and what to expect. It was all that stuff."

9. Where were you told you could get counseling? Were you given more than one place to go?

Member #1: No. I went through them because of the welfare. That's where I called to go to.
Member #2: "The interpreter recommended other facilities, but the other facilities did not speak Spanish."
Member #3: "I was given three mental health centers to choose from."
Member #4: "No."
Member #5: "No, but I really wanted to go to North Range. I specifically asked for the therapist I had before."
Member #6: "Social Services told us where to go."
Member #7: "No, I thought that was the only place I could go because of the Medicaid."
Member #8: "No."
Member #9: N/A. "The therapist came to the day care."
Member #10: "There was a certain psychologist that I needed to treat my son. His services were offered at several locations and several dates."

10. Did you go back for counseling after your first appointment?

Member #1: "No."
Member #2: "No."
Member #3: "Yes, two or three times."
Member #4: "No."
Member #5: "Yes, I went for about a month."
Member #6: "Yes."
Member #7: "Yes, three or four times."
Member #8: "Yes a couple of times."
Member #9: "She had more than one session, but it was always at the day care."
Member #10: "No."

11. (If no): Do you mind telling me why?

Member #1: "Because I found out that the Medicaid didn't go through then. I have Medicaid now, so I'm going to go back."
Member #2: "Not yet. My daughter's behavior improved due to the doctor's advice. We have another appointment in two or three weeks"
Member #3: N/A
Member #4: "I don't think religion should be part of therapy."
Member #5: N/A
Member #6: N/A
Member #7: N/A
Member #8: N/A
Member #9: N/A
Member #10: "We didn't need to. The psychologist helped us get medicine for my son. It's perfect and the pediatrician is monitoring it for us."

If the Member Was Denied Services (or Told He or She Didn't Qualify)

12. Did you get a letter explaining why they couldn't help you?

Member #1: "I got a notice in the mail from the State that I didn't get Medicaid."
Member #2: N/A
Member #3: N/A
Member #4: N/A
Member #5: N/A
Member #6: N/A
Member #7: N/A
Member #8: N/A
Member #9: N/A
Member #10: N/A

13. (If yes): Did it explain anything else you could do to get help if you didn't agree with the letter?

Member #1: N/A
Member #2: N/A
Member #3: N/A
Member #4: N/A
Member #5: N/A
Member #6: N/A
Member #7: N/A
Member #8: N/A
Member #9: N/A
Member #10: N/A

14. Is there anything else you would like to tell me about the Medicaid mental health services you have received?

Member #1: "I'll go back when I'm able to."
Member #2: "It went well. I worked out issues and felt better. They did a job. I felt good about it."
Member #3: "I was very pleased with the doctor and medical care received at the facility."
Member #4: "I also went to group and didn't like it. Before it was very relaxed and I had a good experience with the woman that I saw, but not this time. I ended up leaving therapy."
Member #5: "No."
Member #6: "I was very happy. They did a good job."
Member #7: "It wasn't a bad experience; I just didn't get what I wanted out of it."
Member #8: "No."
Member #9: "It was very helpful. They could see what I couldn't see."
Member #10: "We have been dealing with Medicaid behavioral health services for my son since he was 18 months old (now 10 years old). This was just the most recent event."

Appendix B. Telephone Assessment Worksheet for Northeast Behavioral Health, LLC

The telephone assessment worksheet follows this cover page.

Telephone Assessment Worksheet 1

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Northeast Behavioral Health Telephone number called: 1-888-296-5827

Date of call: Tuesday, January 8, 2008 Time of call: 2 p.m.

Caller: Rachel Henrichs

Name of person answering the phone: T

Offered name: X Had to ask name: _____

Notes:

T said she was new and needed to ask someone what to do with my call. She put the call on hold for a short time, then transferred the call to North Range.

The woman who answered immediately transferred the call to "scheduling."

Person assigned to help or transferred to: J

Offered name: X Had to ask name: _____

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

All

Specific questions for the first call:

1. *How would someone (perhaps a parent) obtain services for a child with Asperger's syndrome who has additional symptoms (i.e., if the parent describes symptoms of psychosis or depression)?*

   J asked how old the child was (the HSAG caller said 8) and asked if the parent had custody (the HSAG caller said yes). She said that NorthRange would treat the depression and psychosis and they would refer the caller to a person or organization that could treat the Asperger's. J had the ability to schedule an appointment immediately.

2. *How would you (the BHO) respond to a nursing home calling to obtain services for a resident (for depression)?*

   J said that NBH offers on-site services for nursing home residents.

   (If the BHO indicates that the resident would have to travel to a CMHC or provider office, ask how transportation could be arranged or services could be provided at the nursing home.)

General questions asked during each call:

3. *What is your next availability for a routine appointment?*

   Call 1: J had appointments available the next day and on Monday (6 days out).

   Call 2 (Sat): J did not have access to routine appointments, but offered that walk-in appointments are available at all CMHCs between 8 and 5.

   Call 2 (repeated—call placed at 12:30 p.m. on Monday, January 28): Monday, February 4 was the next routine appointment, but they offer phone assessments for urgent and emergent care.

   Call 3 (call placed at 9:30 a.m. on Wednesday, January 23): Intake appointments are available anytime between 8 and 5, on a walk-in basis.

   Call 4 (call placed at 4 p.m. on Tuesday, January 29): L said intake appointments were available the next day. The HSAG caller asked if these appointments were walk-in and she said no.

   3.a. *Are callers always directed to a CMHC for services or are they given the choice between a CMHC or a contractor before the appointment is set?*

   Call 1: J said yes. Callers are always scheduled for a CMHC.

   Call 2 (Saturday): Don't know.

   Call 2 (repeated): R only schedules for the CMHC.

   Call 3: B said that all Medicaid members are directed to a CMHC for intake appointments.

   Call 4: L has a list of contractors from which members may choose. She can mail the list to the member or the member can come in and pick it up. L can also review the list over the phone.

3.b. If a member asks if he or she can see someone other than a CMHC provider, what do you tell the member?

Call 1: J said she would have to get more information about scheduling appointments with contractors.

Call 2 (Saturday): Don't know.

Call 2 (repeated): R said she had never been asked this question before. She said that usually people who call the CMHC want appointments with the CMHC. She would offer to take the caller's information and call back with an answer.

Call 3: B was not sure. She said that if a person had other insurance and the need was not urgent, then she could refer the member to a private therapist. She would have to ask about Medicaid.

Call 4: L has a list of contractors from which members may choose. She can mail the list to the member or the member can come in and pick it up. L can also review the list over the phone.

3.c. If a member calls with a request to see a specific private therapist who is not in your network, what do you tell the member?

Call 1: J was not familiar with this process and said she would have to get more information about scheduling appointments with out-of-network contractors.

Call 2 (Saturday): Don't know.

Call 2 (repeated): R said she had never been asked this question before. She said that usually people who call the CMHC want appointments with the CMHC. She would offer to take the caller's information and call back with an answer.

Call 3: B said they would contact the doctor and get him or her enrolled in the program.

Call 4: L was confused by this question. The HSAG caller reworded the question several times before being told that if a member wants to see a private therapist that was not in the network, L would tell the member to call the therapist directly.

4. *What is your next availability for an urgent appointment?*

   Call 1: J said that the first available intake appointment is "tomorrow." However, depending on the urgency, she could work with the member to arrange immediate help. Walk-ins are accepted at the CMHC between 8 and 5 and telephone access is available 24/7.

   Call 2 (Saturday): J said she would get the caller's information and forward it to one of the coordinators.

   Call 2 (repeated): R could offer the caller a phone assessment immediately.

   Call 3: Intake appointments are available anytime between 8 and 5, on a walk-in basis.

   Call 4: L can have a therapist on the phone within 15 minutes.

5. *If I was a Medicaid member calling with an emergency what directions would you give me and how long would it take for me to be seen?*

   Call 1: Members can go to the nearest emergency room for care. Also, emergency appointments are available on a walk-in basis at the CMHC between 8 and 5 and telephone access is available 24/7.

   Call 2 (Saturday): J could counsel the member over the phone, forward the call to another clinician, refer the caller to the nearest emergency department, or send the police or paramedics.

   Call 2 (repeated): R would tell the caller to go to the emergency department and the on-call therapist would meet him or her there. Or she could transfer the caller to the on-call therapist.

   Call 3: B would tell the caller to call 911, go to an emergency room, or B could send the police.

   Call 4: L would direct the caller to go to the nearest emergency room, or she can have a therapist on the phone within 15 minutes. L said she could also send the police.

6. *What is the procedure if a member indicates that he or she has moved from another BHO's catchment area, but the eligibility file does not reflect the change?*

   Call 1: J said this was no problem, that NBH serves everyone. J indicated that eligibility would be sorted out later.

   Call 2 (Saturday): J said they treat everyone.

   Call 2 (repeated): R said it doesn't matter, that they accept everyone.

   Call 3: B said that they serve everyone. She would accept the member and sort out the eligibility part later.

   Call 4: L said that eligibility is statewide, so she feels sure they could work it out.

Telephone Assessment Worksheet 2

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Northeast Behavioral Health Telephone number called: Saturday—First call to 888-296-5827, then to 970-345-2744 (Akron), then to 970-522-4392 (Sterling), then tried 888-296-5827 again.

Date of call: Saturday, January 12, 2008 (recall on Monday, January 28, 2008)
Time of call: 3 p.m. (Saturday), 12:30 p.m. (recall)

Caller: Rachel Henrichs

Name of person answering the phone: J (Saturday) S (recall)

Offered name: X (recall) Had to ask name: X (Saturday)

Notes:

Saturday: For the first call to NBH, the phone rang 14 times before a generic recording invited the caller to "leave a message after the tone." This message did not identify who the caller had contacted. The HSAG caller dialed the number listed for the Akron CMHC and reached a fax machine. The HSAG caller called the Sterling CMHC and spoke to A (had to ask name). A asked that the HSAG caller call again during normal business hours since "this clearly isn't an emergency."

The HSAG caller dialed the main NBH number again and this time, spoke to J. The HSAG caller got the distinct impression that J was a clinician and trained to assist people in crisis situations. She was not familiar with the scheduling, but was able to offer emergency counseling. J said that in the case of an emergency, she could have someone meet the member at the emergency room. If the member refused care and J thought the caller was a danger to himself/herself or others, she could send the police and/or paramedics.

Recall: The HSAG caller introduced herself and asked S, "What would you do with my call if I were calling from Fort Morgan?" She gave the HSAG caller the telephone number for the Fort Morgan CMHC.

Person assigned to help or transferred to: N/A (Saturday) R and J (recall)

Offered name: _____ Had to ask name: __X__

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

Rural and frontier

Specific questions for the second call:

1. *What would you tell an elderly man if he called to request outpatient counseling (for depression) and indicated that he has both Medicare and Medicaid, but cannot find a Medicare provider? (This man is not in a facility. He either lives independently or with family.)*

   Saturday: J would refer this man to the CMHC closest to his home.

   Recall: R asked if the man was suicidal or homicidal. Assuming the call was not urgent, R would schedule an appointment for an intake assessment.

2. *Would the answer given above change if this man was in a wheelchair?*

   Saturday: No.

   Recall: No.

3. *What would a host home provider need to do to obtain services for an adult Down's syndrome resident of a host home who has had behavioral changes recently that staff members of the community-centered board are interpreting as signs of depression?*

   Saturday: J would need to speak with the legal guardian. She would refer the guardian to the closest CMHC.

   Recall: R said she would need to transfer the caller to P (the on-call person) or J (R's supervisor). The HSAG caller asked R to stay on the phone and answer the rest of the questions. After the interview was completed, R asked if the HSAG caller wanted to speak with J. The HSAG caller repeated Question 3 for J. J said they would set up an assessment appointment for the person with Down's syndrome and that person's guardian. J said that every Tuesday morning they have a staff meeting and all assessments are reviewed. The members are assigned to the therapist who is best qualified to meet that person's needs. In the case of depression, J said, "just about anyone could help this person."

Telephone Assessment Worksheet 3

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Northeast Behavioral Health Telephone number called: 888-296-5827

Date of call: Wednesday, January 23, 2008 Time of call: 9:30 a.m.

Caller: Rachel Henrichs

Name of person answering the phone: T

Offered name: X Had to ask name: _____

Notes:

The HSAG caller asked T what she would do with the call if it were from a Medicaid member calling from Fort Collins. She gave the HSAG caller the number for the Larimer County MHC. The HSAG caller dialed 970-494-4200 and was transferred to "Loveland." The person who answered the phone transferred the call to B.

Person assigned to help or transferred to: B

Offered name: X Had to ask name: _____

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

B said, "All of Larimer County"

Specific questions for the third call:

1. *What is the procedure for alternative care facilities (ACFs) to obtain services for their residents?*

   B said that she works with ACFs all the time. The ACF calls B to set up an intake appointment and they go from there. B said, "This center accepts all discharge patients regardless of insurance type."

2. *How would you (the BHO) respond if a Medicaid member called and said his or her family member (e.g., son, daughter, spouse, etc.) was having the following symptoms:*
   - *Spending more time alone*
   - *Exhibiting agitation and anxiety when he or she is around people*
   - *Crying frequently*
   - *Making statements of feeling worthless*
   - *Making statements that he or she should be punished (either for something specific or nonspecific)*
   - *Not eating or sleeping*
   - *Not doing the things he or she used to do*

   (Note to caller: The above is a list of classic warning signs that a person may be at risk for suicide. The purpose of this question is to determine if the BHO would assess for suicide risk if these symptoms are reported, even if the caller does not specifically mention suicide.)

   B said she would do an assessment for depression and suicide. She would make sure the person of concern is being monitored. If the situation sounded urgent, B would encourage the family member to call 911, go to the nearest emergency room, or bring the family member to the CMHC. Emergent or not, B said she would encourage the family member to bring the person of concern in for an assessment.

Telephone Assessment Worksheet 4

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Northeast Behavioral Health Telephone number called: 888-296-5827

Date of call: Tuesday, January 29, 2008 Time of call: 4 p.m.

Caller: Rachel Henrichs

Name of person answering the phone: S

Offered name: X Had to ask name: _____

Notes:

After the HSAG caller identified herself and the purpose of the call, she asked S, "If I were a Medicaid member calling to ask for services, what would you do?" S said she would forward the caller to the closest CMHC. The HSAG caller asked, "What if I want a private practitioner?" S said she could mail the caller a list of private practitioners, or the caller could pick it up. S said that the list is also available on the Internet. The HSAG caller asked S, "What if the practitioner I want to see is not on the list?" S said she would instruct the member to call the practitioner, let the practitioner know that he or she is on Medicaid and would like the practitioner to provider him or her care, and ask the practitioner to call NBH and sign up. S would make sure the caller understood that it is the provider's choice whether or not to join. The HSAG caller asked S where she would send the caller if he or she lived in Yuma and she said she would refer the caller to 970-848-5412.

Person assigned to help or transferred to: L

Offered name: _____ Had to ask name: X

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

L said, "Rural…Definitely rural!"

Specific questions for the fourth call:

1. *What is the procedure if a Medicaid member calls and urgently requests medication? The member may have been on medication from a private provider or might be from another state, but is new to Medicaid eligibility and has not yet received services from the BHO.*

   L explained that the Yuma clinic has clinicians capable of writing prescriptions three days a month. L would schedule an intake appointment for the caller. Meanwhile, she would encourage the caller to contact his or her PCP and ask for a 30-day refill. If it was an emergency, L would try to schedule an appointment at another CMHC, but said it would be up to the caller to get himself or herself there.

2. *How would a member who was recently released from a psychiatric hospital (and who has not previously received psychiatric services from this BHO) obtain outpatient services?*

   L said the hospital usually contacts the CMHC before the member is released. L would ask that records and a referral be sent to the CMHC as soon as possible. The CMHC also tries to schedule the intake appointment before the member is released from the hospital. If that appointment was not scheduled beforehand, the member would just need to call to set one up.

   The member will need medication within seven days.

   L explained that the Yuma clinic has a clinician available to write prescriptions three days a month. L could try to schedule an appointment for the caller at another CMHC, but said it would be up to the caller to get himself or herself there.

   Can outpatient therapy services and provision of the medication/prescription be handled during the same initial appointment?

   L said no.

Appendix C. Record Review Worksheet
for Northeast Behavioral Health, LLC

The completed record review worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Record Review Worksheet

The goal of this record review is to identify and describe specific documentation that provides evidence of ongoing communication between the psychiatrist or nurse prescriber and the parents, therapist/care coordinator/case manager, and/or the primary care physician (PCP) regarding a child who has received services through the BHO.

Documentation to be reviewed: Therapist and physician/prescriber progress notes, specific forms used for documentation of service planning meetings, or other pertinent documentation regularly used by the BHO to document ongoing communication with family members or the PCP.

Member ID: Sample 1	Encounter Reference Date: 6/26/07
Reviewer Name: Barbara McConnell	Review Date: 3/3/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/16/07	Progress Note	LPC	Grandmother	N/A	Therapy Session	Yes

Content of Documentation (Brief Description):

This progress note indicated that medications were discussed as part of the treatment planning process.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/23/07	General Note	LPC	Grandmother	LPC	Telephone call	No

Content of Documentation (Brief Description):

This note documented an attempted telephone call from the therapist to the grandmother. A message was left for the grandmother to call back.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/24/07	Case Management Note	MA	Grandmother	N/A	Therapy Session	No

Content of Documentation (Brief Description):

This note documented a therapy session and discussion with the grandmother about how the child was doing and the child's recent hospitalization in an inpatient psychiatric facility.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/13/07	Case Management Note	LPC	Grandmother	Grand-mother	Telephone call	Yes

Content of Documentation (Brief Description):

This note indicated that the child's recent behavior and hospitalization were discussed. The grandmother asked about whether some of the medication should be discontinued.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/26/07	Medication Note	MD	Grandmother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The psychiatrist changed medications and discussed the changes with the grandmother.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
8/2/07	Progress Notes	LPC	Grandmother	N/A	Therapy Session	Yes

Content of Documentation (Brief Description):

This note indicated that the grandmother reported that, although the child had been doing well, at the time of this note he was not sleeping or taking the full dose of medications prescribed. The grandmother asked if the medications needed to be evaluated again.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Record Review Worksheet

Member ID: Sample 2	Encounter Reference Date: 4/26/07
Reviewer Name: Barbara McConnell	Review Date: 3/3/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/30/07	Progress Note	LPC	Mother	N/A	Therapy Session	No

Content of Documentation (Brief Description):

This note documented a discussion of how the child was doing, behaviors, and his current stability.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/15/07	Case Management Note	LPC	Mother	LPC	Telephone call	No

Content of Documentation (Brief Description):

This note described discussions with the mother regarding coverage plans for an upcoming leave of absence for the therapist.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/26/07	Psychiatric Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management reference encounter. The psychiatrist discussed the child's current status with reference to current medications.

Member ID: Sample 3	Encounter Reference Date: 2/1/07
Reviewer Name: Barbara McConnell	Review Date: 3/3/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
1/4/07	Medication Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a medication management encounter prior to the medication management encounter referenced. The psychiatrist discussed the child's status and medications with the mother.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
2/1/07	Medication Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced. The psychiatrist discussed the child's behavior and the effect of medications on the behavior.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
12/26/07 – 3/16/07	Weekly Progress Notes	MA	Mother	Not Determined	In-person and Telephone	No

Content of Documentation (Brief Description):

Weekly progress summaries for the MST (multisystemic therapy) program documented in-person and telephone discussions with the mother to discuss the child's behavior, status, and progress. Weekly progress summary dates: 12/26/06, 1/3/07, 1/10/07, 1/17/07, 1/24/07, 2/7/07, 2/14/07, 2/21/07, 2/28/07, 3/7/07, and 3/16/07.

Telephone contacts occurred: 12/18/06, 12/20/16, 12/21/06, 12/29/06, 1/12/07, 1/23/07, 1/25/07, 2/1/07, 2/2/07, 2/6/07, 2/7/07, 2/8/07, 2/9/07, 2/15/07, 2/16/07, 2/19/07, 2/20/07, 2/22/07, 2/28/07, 3/8/07, and 3/16/07.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
2/2/07 – 2/20/07	General Notes	MA	Caseworker	Not determined	Telephone	No

Content of Documentation (Brief Description):

Notes on 2/2/07, 2/7/07, and 2/20/07 documented telephone contacts with the social services caseworker. Content of the phone conversations was documented in the weekly progress summaries.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
2/7/07 – 2/20/07	General Notes	MA	Teacher	Not determined	Telephone	No

Content of Documentation (Brief Description):

Notes on 2/2/07 and 2/20/07 documented telephone contacts with the teacher. Content of the phone conversations was documented in the weekly progress summaries.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/7/07	General Note	MA	N/A	N/A	Meeting	No

Content of Documentation (Brief Description):

This note documented a meeting at the school that had occurred on 2/28/07. The mother, teacher, caseworker, and MST therapist were present. The child's status, behavior, and progress were discussed.

Member ID: Sample 4	Encounter Reference Date: 4/4/07
Reviewer Name: Barbara McConnell	Review Date: 3/3/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/30/07	Letter	N/A	N/A	N/A	Meeting	No

Content of Documentation (Brief Description):

This was a letter from the family court and documented a court proceeding. Goals and conditions for the mother were discussed related to visitation and reunification. No discussion of the child's progress or status was mentioned.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/4/07	Psychiatric Progress Note	MD	Unknown	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced. Status of the child was discussed. It was unclear who attended the medication management visit with the child.

Member ID: Sample 5	Encounter Reference Date: 4/26/07
Reviewer Name: Barbara McConnell	Review Date: 3/3/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/26/07	Psychiatric Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced. Status of the child was discussed, as well as the medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/22/07	Progress Note	LPC	Mother	Mother	Telephone	No

Content of Documentation (Brief Description):

This note documented a phone call from the mother during which she requested that therapy sessions resume.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/5/07	Progress Note	LPC	Mother	LPC	Therapy Session	No

Content of Documentation (Brief Description):

This note documented a case management monitoring session with the mother. They discussed the child's symptoms.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/6/07	Letter	LPC	Family Medicine Center	LPC	Letter	Yes

Content of Documentation (Brief Description):

The letter explained the new NBH policy to send a notification to the PCP explaining treatment the child was receiving at NBH. This notification system was part of the NBH PIP on coordination of care.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Record Review Worksheet

Member ID: Sample 6	Encounter Reference Date: 5/21/07
Reviewer Name: Barbara McConnell	Review Date: 3/3/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/21/07	Physician Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced and discussions with the mother.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Record Review Worksheet

Member ID: Sample 7	Encounter Reference Date: 5/2/07
Reviewer Name: Barbara McConnell	Review Date: 3/3/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/2/07	Psychiatric Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced. The note indicated discussion with the mother regarding the medications and their effectiveness.

Member ID: Sample 8	Encounter Reference Date: 4/12/07
Reviewer Name: Barbara McConnell	Review Date: 3/3/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/6/07	Progress Note	MS	Grandmother	N/A	Therapy Session	No

Content of Documentation (Brief Description):

This note documented a discussion with the grandmother about the child's progress.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/12/07	Medical Note	MD	Grandmother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced. The child's behavior and effectiveness of the medications were discussed.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/27/07	Progress Note	MA	Grandmother	N/A	Therapy Session	No

Content of Documentation (Brief Description):

This note documented a therapy session and discussion with the grandmother about the child's behavior and progress.

Member ID: Sample 9	Encounter Reference Date: 5/3/07
Reviewer Name: Barbara McConnell	Review Date: 3/3/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/2/07	Psychiatric Progress Note	MD	Mother	Mother	Telephone	Yes

Content of Documentation (Brief Description):

This note documented a call from the mother regarding the child's behavior. The psychiatrist agreed to change the medication dosage.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/3/07	Psychiatric Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced. The discussion included information about the child's behavior and effectiveness of the medications.

Member ID: Sample 10	Encounter Reference Date: 5/3/07
Reviewer Name: Barbara McConnell	Review Date: 3/3/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/19/07	Case Management Note	BA	Mother	BA	Telephone	No

Content of Documentation (Brief Description):

This note indicated that the therapist initiated the telephone call because he thought that a session had been missed. They discussed the child's behavior and current status.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/29/07	Case Management Note	BA	Mother	Mother	Telephone	No

Content of Documentation (Brief Description):

This note documented a telephone call placed to the mother as a return call after the mother left a message earlier in the day. They discussed the child's behavior and treatment strategies.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/2/07	Progress Note	BA	Mother	N/A	Therapy Session	No

Content of Documentation (Brief Description):

This note documented a family therapy session and discussion of the child's behavior and progress.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/16/07	Case Management Note	BA	Mother	N/A	Therapy Session	No

Content of Documentation (Brief Description):

This note documented a therapy session and discussion of the child's behavior and progress.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/30/07	Family Therapy Progress Note	BA	Mother	N/A	Service Planning Session	Yes

Content of Documentation (Brief Description):

This note documented a service planning session. The child's behavior, current status, and progress were discussed, as well as treatment strategies, which included medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/3/07	Psychiatric Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced and discussion with the mother.

Appendix D. Oversight and Monitoring of Providers Worksheet
for Northeast Behavioral Health, LLC

The oversight and monitoring of providers worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Oversight and Monitoring of Providers Worksheet

The following questions were used to prompt discussion during the on-site portion of the review:

Does the BHO use member satisfaction data to improve the quality of services provided by community mental health centers (CMHCs) and the independent provider network (IPN)? If so, how?

Is member satisfaction information used by the BHO's CMHCs to identify staff training needs?

How does the BHO know whether mental health center staff receives appropriate: (a) supervision, (b) training, and (c) professional development/continuing education?

How does the BHO know that its CMHC providers have a culturally appropriate work force?

How does the BHO know that its provider network (CMHC and IPN) is adequately prepared (in training, skills, and competence) to work with the BHO's members (in terms of member diagnosis, age, etc.)?

Review of the CMHC's policies/procedures for training content to determine if CMHC policies are compliant with BHO policies (intake, grievance system, provider-member communication, advance directives, second opinion, etc.)?

Review of agendas or orientation curriculum and attendance records of the CMHC for compliance with BHO policies?

Review/audit of credentialing records to determine compliance with BHO policies?

Review of policies/procedures for clinical supervision?

Review of forms/tools used for provider supervision?

Provider profiling (reports or data)?

Review of data provided by the CMHC?

Data kept regarding cultural or linguistic competencies?

Review of percentage of Spanish-speaking members at each CMHC?

Utilization data per individual provider?

Trending grievance data?

Other?

How does the BHO ensure that CMHC providers are aware of, and in compliance with, the BHO's practice guidelines and grievance system and of any relevant policies and contract requirements (training completed, skills/certifications, completion of supervisory practices [performance reviews, etc.])?

How does the BHO ensure that the IPN is aware of, and in compliance with, the BHO's practice guidelines, grievance system, policies, and contract requirements?

How has the BHO evaluated the services provided by the CMHC for quality, appropriateness, and patient outcomes (including member satisfaction)?

Quality initiatives?

Chart reviews?

Other?

How has the BHO evaluated the services provided by independent contractors for quality, appropriateness, and patient outcomes (including member satisfaction)?

Has the BHO used complaint/grievance data in the category of professional conduct and competence to improve services provided? (If yes, how? If no, why?)

Appendix E. FY 06–07 Corrective Action Plan for Northeast Behavioral Health, LLC

The FY 06–07 corrective action plan with FY 07–08 findings and results follows this cover page.

Table E-1—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 A. The written agreement 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.	NBH asks for the assistance of HCPF personnel in regards to the definitions of subcontracting of provider services and delegated activities. NBH will revise its written delegation agreements with its three mental health centers regarding delegated activities to clearly specify the activities delegated and reporting responsibilities of the mental health centers. **September 2007 HCPF/HSAG comments:** Department staff will clarify this requirement with NBH.	June 15, 2007 July 20, 2007	The document entitled "Center Delegation Agreement (Revised July 2007)" in the Standard I folder.
Standard I: Delegation—FY 07–08 Document Review				
3.A. Content of Agreement specifies the activities Document(s) reviewed: ◆ Center Delegation Agreement template The revised Center Delegation Agreement template clearly specified the activities delegated to the CMHCs. Attachments to the agreement were consistent with the body of the agreement and accurately described activities reported as delegated by NBH management staff during the FY 07–08 site review. NBH management staff reported that the revised agreements are scheduled to be signed in March 2008. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
B. The written agreement 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.	NBH will revise its delegation agreement with North Range Behavioral Health (NRBH) regarding NRBH's reporting responsibilities for inpatient service authorization. **September 2007 HCPF/HSAG comments:** Plan accepted.	June 29, 2007	The document entitled "Center Delegation Agreement (Revised July 2007)" in the Standard I folder.
Standard I: Delegation—FY 07–08 Document Review				
3.B. Content of Agreement specifies the reporting responsibilities Document(s) reviewed: ◆ Center Delegation Agreement template Attachment E of the Center Delegation Agreement template for NRBH specified NRBH's responsibilities regarding authorization of services in response to after-hours requests for authorization of service. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
4. Policies and Procedures A. The Contractor has written procedures for monitoring the performance of subcontracts 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.	NBH will revise its policies and procedures to clarify the difference between monitoring of delegated activities and monitoring of providers. **September 2007 HCPF/HSAG comments:** The intervention is too vague and general; it should include details of planned monitoring activities for each of type of subcontractor and explain how new policies will differ from existing policies, how policies for delegation agreements will differ from policies for provider agreements, etc. (This is a continuing corrective action from FY 05–06.) Department staff will work with NBH to clarify this requirement.	June 20, 2007	The policies and procedures in the Standard I folder entitled "Delegation" and "Provider Agreement."
Standard I: Delegation—FY 07–08 Document Review				
4.A. Policies and Procedures for monitoring performance on an ongoing basis Document(s) reviewed: ◆ Policy 0018—Delegation ◆ Policy 064—Provider Agreements The Delegation policy described the procedures for monitoring the performance of delegates on an ongoing basis. The Provider Agreements policy described the procedures for monitoring the performance of providers on an ongoing basis. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
B. The Contractor has written procedures for monitoring the performance of subcontracts through formal review.	NBH must revise its policies/procedures related to monitoring delegates to align with its practices and to reflect accurate information.	NBH will include in its policies and procedures the formal process and mechanisms used to monitor the delegated activities. **September 2007 HCPF/HSAG comments:** The intervention should discuss the planned formal monitoring activities and the content changes that will be included in the policies. Please refer to the specific findings in the FY 06–07 site review report prepared by HSAG.	June 15, 2007	The policy and procedures entitled "Delegation" in the Standard I folder, page 3, with the relevant section highlighted in yellow.
Standard I: Delegation—FY 07–08 Document Review				
4.B. Policies and Procedures for monitoring performance through formal review Document(s) reviewed: ◆ Policy 0018—Delegation The Delegation policy stated that delegates are subject to formal review at least annually and refers to the delegation agreements for a detailed listing of monitoring and review activities performed by NBH. The Delegation Agreement template described a variety of monitoring activities, including annual audits. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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: 2. Designation of a compliance officer and compliance committee that is accountable to senior management.	NBH must revise the compliance plan to align with practices regarding the requirements for designation of a compliance officer.	NBH will review its compliance plan, which states that there is a designated compliance officer who is a member of the Compliance Committee. At its next meeting, NBH's Board of Members and Managers will reaffirm the individual who will be the compliance officer. **September 2007 HCPF/HSAG comments:** Please also provide documentation that the compliance officer has received the "effective training and education" as required by federal regulations. See 42 CFR 438.608(b)(3), program integrity requirements: (b) The arrangements or procedures must include the following: (3) Effective training and education for the compliance officer and the organization's employees.	May 30, 2007	The document in the Standard II folder entitled "Minutes of NBH Members & Managers May 30 2007," page 4, section highlighted in yellow. The policy and procedure in the Standard II folder entitled "Compliance," page 5, with the relevant section highlighted in yellow. The document in the Standard II folder entitled "John Rattle Compliance Officer Training"
Standard II: Provider Issues—FY 07–08 Document Review				
2.A.2. Program Integrity—Contractor has mandatory compliance plan that includes compliance officer and committee Document(s) reviewed: ◆ Title page from the conference, The Compliance Officer's Institute—Implementing and Maintaining Successful Compliance and Business Conduct Programs, March 25, 2007 ◆ Policy 0022—Compliance ◆ Minutes of the Board of Members and Managers meeting, May 30, 2007 The minutes of the Board of Members and Managers meeting indicated who the compliance officer for NBH was. NBH provided an announcement of the compliance training attended by the compliance officer in May 2007. The Compliance policy described the duties of the compliance officer and the duties and membership of the compliance committee for NBH. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	NBH will develop a system to ensure that possible instances of fraud will be reported to the Department as specified in the contract. The Compliance Committee will be responsible for developing this system. **September 2007 HCPF/HSAG comments:** NBH should describe the actions that will be taken (staff training, supervision, monitoring, etc.) to ensure that failure to report the previous incident involving possible fraud will not recur. NBH should describe the process/mechanism it will use to ensure that any possible instance of fraud is reported to the Department as required.	June 22, 2007	The policy and procedure in the Standard II folder entitled "Compliance," pages 9 and 14, with the relevant sections highlighted in blue.

Standard II: Provider Issues—FY 07–08 Document Review

2.B. Program Integrity—Contractor reports possible instances of fraud to the Department within ten business days

Document(s) reviewed:

- Policy 0022—Compliance

The policy clearly described the Compliance Committee's process for reviewing reports and incidents and for reporting possible instances of Medicaid fraud to the Department within 10 days of receipt of the information. During the follow-up on-site review, a review of the Compliance Committee meeting minutes indicated that there were at least two instances of possible fraud that were not reported to the Department. The committee had investigated the incidents and determined that there was fraudulent behavior on the part of the therapist; however, the therapist's caseload did not include Medicaid recipients.

This required action remains outstanding. NBH must report all instances of possible Medicaid fraud to the Department within 10 days of receipt of the information. NBH must also work with the Department to obtain technical assistance regarding expectations and the definition of possible fraud.

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
6. Monitoring of Providers C. The Contractor monitors covered services provided under provider agreements for Member Outcomes	NBH must monitor covered services provided under provider agreements for member outcomes. Monitoring must be representative of the entire network.	NBH has initiated a process for measuring external provider network (EPN) member outcomes that is more closely aligned to the process by which Provider Center member outcomes are measured. **September 2007 HCPF/HSAG comments:** The planned intervention should provide a specific description of the process that NBH plans to use to monitor independent providers for member outcomes.	Started April 2007	The document in the Standard II folder entitled "2007 Adult NBH External Provider Consumer Satisfaction Survey." The document in the Standard II folder entitled "2007 Youth NBH External Provider Consumer Satisfaction Survey." The document in the Standard II folder entitled "Northeast Behavioral Health-QAPI Plan for HSAG (2007–2008)," pages 9, 11, 14–16. The relevant sections are highlighted in yellow.

Standard II: Provider Issues—FY 07–08 Document Review

6.C. Monitoring of Providers—The Contractor monitors covered services provided under provider agreements for Member Outcomes

Document(s) reviewed:

- External Provider Consumer Satisfaction Survey—Adult, 2007 – Results
- External Provider Consumer Satisfaction Survey—Youth, 2007 – Results
- NBH Quality Improvement and Utilization Management Performance Indicators Benchmark Report—FY 2006–2007

During the FY 06–07 site review, NBH provided evidence of monitoring member outcomes for members served by NBH's three in-network CMHCs; however, evidence of monitoring member outcomes for members served by the independent provider network was not provided. The performance indicators report and the external provider consumer satisfaction results reports indicated that NBH monitored outcomes for members served by the independent provider network. This required action has been completed.

Table E-1—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.	NBH will correct its procedures to state that notice must be given at least 90 days prior to termination as stated in the Contract. **September 2007 HCPF/HSAG comments:** Plan accepted.	June 15, 2007	The document in the Standard II folder entitled "Termination of Provider Agreements—Correction of NBH's Policy and Procedures," with the relevant section highlighted in yellow.

Standard II: Provider Issues—FY 07–08 Document Review

8. Termination of Provider Agreements

Document(s) reviewed:

- The Provider Agreements policy

The revised policy stated that NBH 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. The policy included the provision that such notice be given at least 90 days prior to termination of the services unless the termination is based on quality or performance issues. The contract cover sheet used when contracts are terminated was consistent with the policy. This required action has been completed.

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	NBH provides a Power Point presentation on Consumer Rights for use in annual center staff training. NBH will invite EPN providers to attend the annual consumer rights training and incorporate that training into the ongoing Colorado Client Assessment Record (CCAR) training for EPN providers. During EPN administrative review, attendance at training will be noted. NBH will implement a mechanism during chart reviews to ensure rights are taken into account by the external providers. **September 2007 HCPF/HSAG comments:** NBH should explain how NBH will ensure on an ongoing basis that all independent providers are aware of the consumer rights requirements. For example, identify the training frequency, steps that will be taken to educate independent providers who do not attend the consumer rights training, etc. Also, provide details regarding the specific criteria that will be used when conducting record reviews to determine whether independent practitioners have taken member rights into account.	June 15, 2007	The document in the Standard IV folder entitled "Member Issues—Changes to Policy and Procedure regarding EPN taking consumer rights into account," with the relevant section highlighted in yellow. The document in the Standard IV folder entitled "Member Rights and Responsibilities—Independent Provider Training Handout."

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard IV: Member Rights and Responsibilities—FY 07–08 Document Review				
2.A. Takes Rights into Account Document(s) reviewed: ◆ Member Issues policy ◆ Member Rights and Responsibilities Independent Provider Training ◆ Letter to independent provider network The Member Issues policy indicated that NBH's methods for training providers to take member rights into account consisted of informing CMHC providers of their responsibilities through initial orientation and annual training, and informing independent providers through online training. The policy described the method for tracking provider training and auditing charts for evidence that rights are taken into account. In addition, a letter describing the online member rights training was sent to independent providers in November 2007. The Outpatient Provider Audit form included sections for the reviewers to indicate whether the member had signed the service plan, whether the therapist had reviewed the member's rights with the member, and whether the member's family was involved in the treatment. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	NBH will ensure that consumer responsibilities and expectations for participation in receiving covered services are communicated to consumers, staff, and providers in a consistent manner. The list of member responsibilities as documented in NBH policies and procedures and the provider manual will be used in the member handbook. The member handbook will be revised to reflect the complete list of expectations. Providers and staff will be informed of the complete member responsibilities list through the next newsletter. NBH will implement a mechanism during chart reviews to ensure that responsibilities of consumers are taken into account by providers. **September 2007 HCPF/HSAG comments:** NBH should also indicate how member rights and responsibilities will be communicated/distributed to existing consumers, staff, and providers on an ongoing basis. Also, provide details regarding the criteria that will be used when conducting record reviews to determine whether the independent practitioners have taken member rights into account.	August 31, 2007 June 30, 2007 June 15, 2007	The document in the Standard IV folder entitled "Steps to ensure member R-R are distributed." The document in the Standard IV folder entitled "Annual Letter 2007," page 2. The document in the Standard IV folder entitled "Member Issues—Changes to Policy and Procedure regarding member R-R are communicated," with the relevant section highlighted in yellow. The document in the Standard IV folder entitled "Member Rights and Responsibilities—Independent Provider Training Handout."

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard IV: Member Rights and Responsibilities—FY 07–08 Document Review				
3. Member Responsibilities Document(s) reviewed: ◆ Annual member letter ◆ External provider rights and responsibilities training ◆ Description of how NBH will communicate rights and responsibilities to members The member rights and responsibilities in the member materials and provider training materials were consistent. The November letter distributed to providers informed providers of the required online training, which included discussion of member rights and responsibilities. This required action has been completed.				

Table E-1—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	NBH will ensure that its standardized forms for communicating with consumers and for processing grievances and appeals are accurate, consistent, and clear by creating a file of master forms, one for grievances and one for appeals, and using only those forms in the Policy and Procedures Manual and the Procedure Manual for the Office of Consumer and Family Affairs. The master forms will be edited to reflect only the purpose of its specific use, either for grievances or for appeals, and appear in the specific section of the above-mentioned documents that are either grievances or appeals. The Policy and Procedures Manual will be edited with a clear section on grievances with forms and appeals with forms. That format will also be used in the Delegation Agreement and the Procedure Manual for the Office of Consumer and Family Affairs. Descriptions of these processes will also be consistent and clearly delineated in all documents. The procedure for appeals will be clarified in all documents, the Policy and Procedures Manual, the Provider Manual, the Delegation Agreement, and the Procedure Manual for the Office of Consumer and Family Affairs. The procedure is that all appeals will be referred to	July 15, 2007 July 15, 2007 Will be completed as soon as clarification letter is received	The document in the Standard IX folder entitled "Steps to ensure grievances and appeals policies are communicated." The document in the Standard IX folder entitled "Annual Letter 2007," page 1. The document in the Standard IX folder entitled "Member Issues—Changes to Policy and Procedure regarding grievances," with relevant changes in red text or with a strike-through.

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
	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.	the director of the Office of Consumer and Family Affairs for processing and reporting. The BHO will ensure that all complaints and consumer quality-of-care concerns are processed and reported according to grievance requirements. In order to encourage consumers to discuss all their concerns, NBH will edit its forms so that they communicate with consumers in softer language, and write descriptions of the grievance processes in softer language in the consumer handbook. NBH will continue to use personal letters with friendly and soft language to report the outcome and corrective actions relevant to the concern expressed. **September 2007 HCPF/HSAG comments:** NBH should explain how it will communicate clarifications about grievance and appeals policies to consumers, mental health center staff, and independent practitioners on an ongoing basis. Also, NBH states that "the BHO will ensure that all complaints and consumer quality-of-care concerns are processed and reported according to grievance requirements." Please clarify how NBH will ensure that all grievances are processed as required, whether through a formal communication process with the QAPI committee, audits of grievance records, etc.	From HCPF July 15, 2007	

Table E-1—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—FY 07–08 Document Review				
1. Grievance and Appeal Records Document(s) reviewed: ◆ Description of processes to communicate the grievance and appeal processes to providers and provider agencies ◆ Annual member letter ◆ Grievance policy ◆ Appeal policy ◆ OCFA procedure manual for processing grievances and appeals ◆ Quality assessment and performance improvement plan ◆ Online provider training—PowerPoint presentation All pertinent documents have been revised to clearly delineate between the processing of grievances and appeals, and to clearly describe the responsibilities of the NBH OCFA director and the representatives at each of the CMHCs. In addition, the documents clearly indicated that all expressions of dissatisfaction are processed as grievances. This required action has been completed.				

Table E-1—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.	NBH will edit its Policy and Procedures Manual in the Appeals section, other documents, and the member handbook to include the statement that a consumer can present evidence and allegations of fact or law in person as well as in writing when filing an appeal. **September 2007 HCPF/HSAG comments:** NBH should explain how it will inform mental health center staff, independent practitioners, and consumers about the requirement to allow consumers to present evidence in person when filing an appeal. Also specify the "other documents" to be edited (as referenced above).	July 15, 2007	The document in the Standard IX folder entitled "Steps to ensure the appeals process is communicated." The document in the Standard IX folder entitled "Member Issues—Changes to Policy and Procedure regarding appeals," with relevant sections highlighted in yellow or written in red text.

Standard IX: Grievances, Appeals, and Fair Hearings—FY 07–08 Document Review

6. Appeals Process

Document(s) reviewed:

- Description of required actions taken
- Appeal of an Action policy
- Member handbook submitted January 22, 2008

The Appeals section of the revised member handbook and the Appeal of an Action policy found in Section 5 of the Policy and Procedures Manual included the requirement that members may present evidence in writing or in person when filing an appeal. These required actions have been completed.

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	The procedure will be revised as follows: Notification of Providers of their Rights: Providers will be notified of their rights in the credentialing and recredentialing application addendum packet, which is sent to practitioners with their Colorado Health Care Professionals Credentials Application. Should a provider not be accepted into the network, they will be notified of their appeal rights via the denial letter. A letter template will also be written and NBH will review the appeal process. **September 2007 HCPF/HSAG comments:** NBH should provide a copy of the revised application addendum packet and the letter template.	The policy will be updated in July 2007.	The document in the Standard X folder entitled "Credentialing—Changes to Policy and Procedure Regarding Notification of Providers of their Rights," pages 1 and 2, with relevant sections highlighted in yellow.
Standard X: Credentialing—FY 07–08 Document Review				
3.P. Content of Policies and Procedures—How the applicant is notified of rights and appeal process Document(s) reviewed: ◆ Credentialing policy in provider issues section of Policy and Procedures Manual The revised Credentialing policy included a description of how applicants are informed of their rights under the credentialing program, including how applicants are informed of their appeal rights. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	The procedure will be revised as follows: Ongoing Monitoring: NBH monitors disciplinary actions from the State on a monthly basis. NBH monitors disciplinary actions from the Office of Inspector General (OIG) semiannually. The provider coordinator will get the information from the appropriate Web site and pull the reports. The names on the reports will be checked against the providers in the NBH provider network. For State disciplinary actions, a notice of action letter is sent to the provider asking the provider to respond to the sanction. Per the NBH provider contracts, providers have 30 days to notify NBH of any sanctions against them. The credentialing committee will follow up on the sanction and the medical director will sign off on any recommendation the committee makes. For OIG sanctions, the employee or subcontract will be terminated, as NBH contractually cannot hire or affiliate with anyone on the list. **September 2007 HCPF/HSAG comments:** The OIG database is updated monthly, and the National Committee for Quality Assurance (NCQA) requires that sanctions be checked within 30 days of posting. NBH must check this data source for sanctions every month and must revise its policies to include this requirement.	The provider coordinator has been monitoring the licensure disciplinary actions since July 2006 and the OIG since February 2007. The policy will be updated in July 2007.	The document in the Standard X folder entitled "Credentialing—Changes to Policy and Procedure Regarding Ongoing Monitoring," with the relevant section highlighted in yellow.

Table E-1—FY 06–07 Corrective Action Plan *for* NBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard X: Credentialing—FY 07–08 Document Review				
3.Q. Content of Policies and Procedures—Ongoing Monitoring of sanctions, complaints, and adverse events (for high-volume providers). Document(s) reviewed: ◆ Credentialing policy in provider issues section of Policy and Procedures Manual The revised Credentialing policy included a description of NBH's processes for ongoing monitoring of sanctions, complaints, and adverse events. This required action has been completed.				

Table E-1—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.	NBH will work with the Department to establish an effective method for preparing for future site reviews. **September 2007 HCPF/HSAG comments:** Plan accepted.		
NBH's Preparation for the Site Review: FY 07–08 Document Review				
NBH met with the Department following the FY 06–07 site review to discuss document submission and preparedness for compliance monitoring site review activities. The document submissions for the corrective action plan and for the FY 07–08 site reviews were well organized and contained the required information. This required action has been completed.				

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

Table F–1 lists the participants in the FY 07–08 site review of **NBH**.

Table F–1—HSAG Reviewers and BHO Participants		
HSAG Review Team		**Title**
	Barbara McConnell, MBA, OTR	Project Director
	Hector Cariello, MPH-HCAHPS	Project Coordinator (conducted member interviews in Spanish)
	Rachel Henrichs	Project Coordinator (conducted member interviews and telephone assessment calls)
NBH Participants		**Title**
Heidi Bemowski		Assistant Director of Quality Improvement, NBH
Julie Kellaway		Director of Quality Improvement, NBH
LaRue Leffingwell		Compliance and Contract Coordinator, NBH
Anne Mitchell		Director of Utilization Management, NBH
John Rattle		Chief Financial Officer, NBH
Phyllis Benedetti-Sitzman		Quality Assurance Coordinator, Larimer County Mental Health Center
Carol Staples		Director, Office of Consumer and Family Affairs, NBH
Karen Thompson		Executive Director, NBH
Department Observers		**Title**
Sue Carrizales		Behavioral Health Policy Specialist, Department of Health Care Policy & Financing

Appendix G. Corrective Action Plan Process for FY 07–08 for Northeast Behavioral Health, LLC

NBH is required to submit to the Department a corrective action plan for all components scored as *In Partial Compliance* or *Not In Compliance*. The corrective action plan with supporting documents must be submitted within 30 days of receipt of the final report. For each element that requires correction, the plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion.

Table G-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each BHO will submit a corrective action plan to the Department within 30 calendar days of receipt of the final EQR site review report via the file transfer protocol (FTP) site with an accompanying e-mail notification regarding the posting. For each of the components receiving a score of *In Partial Compliance* or *Not In Compliance*, the corrective action plan must address the planned intervention(s) to complete the required actions and the timeline(s) for the intervention(s).
Step 2	**Documents submitted with the corrective action plan**
	The BHOs should complete the required actions and submit documentation substantiating the completion of all required corrective actions.
Step 3	**Prior approval for timelines exceeding 30 days**
	If the BHO plans to complete the required action later than 30 days following the receipt of the final report, it must obtain prior approval from the Department in writing.
Step 4	**Progress reports may be required**
	For any planned interventions receiving an extended due date beyond 30 days following receipt of the final report, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements in the corrective action plan.
Step 5	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the corrective action plan and supporting documentation, the Department will inform the BHO as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements, or (2) the BHO must submit additional documentation. The Department 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.

The template for the corrective action plan follows.

Table G-2—FY 07–08 Corrective Action Plan *for* NBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
1. Access to Care				
2. Coordination of Care				
3. Oversight and Monitoring of Providers				
4. Member Information				
5. Review of Corrective Action Plans and Supporting Documentation				

Appendix H. Compliance Monitoring Review Activities for Northeast Behavioral Health, LLC

The following table describes the activities that were performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, February 11, 2003.

Table H–1—Compliance Monitoring Review Activities Performed

For this step,	HSAG…
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff provided an orientation at the B-QuIC meeting on November 27, 2007, for the BHO and the Department to preview the FY 07–08 compliance monitoring review process and to allow the BHOs to ask questions about the process. HSAG reviewed the processes related to the request for information, CMS' protocol for monitoring compliance, the components of the review, and the schedule of review activities. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives responded to questions from the BHO related to the process and federal managed care regulations to ensure that the BHO was prepared for the compliance monitoring review. HSAG maintained contact with the BHO as needed throughout the process and provided information to key management staff members about review activities. Through this telephone and/or e-mail contact, HSAG responded to the BHO's questions about the request for documentation for the desk audit and about the on-site review process.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the FY 07–08 BHO contract to develop HSAG's monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the desk audit request and sent a documentation request form and an on-site agenda. The BHO had 30 days to provide all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the five components. ◆ Documents requested included applicable policies and procedures, minutes of key BHO committee or other group meetings, reports, logs, and other documentation. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

Table H–1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
Activity 4:	**Conducted Interviews**
	Prior to the on-site portion of the review: ◆ HSAG conducted interviews of Medicaid members who had received or requested to receive services from the BHO. ◆ HSAG conducted telephone assessments of the BHO's access processes. During the on-site portion of the review: ◆ HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	During the on-site portion of the review: ◆ HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document, i.e., the original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents that HSAG needed during its desk audit. ◆ HSAG requested and reviewed additional documents that HSAG needed to review during the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	Following the on-site portion of the review: ◆ HSAG met with BHO staff to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 07–08 Site Review Report to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions to be required of the BHO to achieve full compliance with managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 07–08 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG coordinated with the Department to incorporate the Department's comments. ◆ HSAG distributed a second draft report to the BHO for review and comment. ◆ HSAG coordinated with the Department to incorporate the BHO's comments and finalize the report. ◆ HSAG distributed the final report to the BHO and the Department.