Colorado Medicaid
Community Mental Health Services Program

FY 2008–2009 Site Review Report

for

Northeast Behavioral Health, LLC

May 2009

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

HSAG Health Services Advisory Group

1600 East Northern Avenue, Suite 100 ◆ Phoenix, AZ 85020
Phone 602.264.6382 ◆ Fax 602.241.0757

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Overview of FY 2008–2009 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 fifth year that HSAG has performed compliance monitoring reviews of the BHOs. For the fiscal year (FY) 2008–2009 site review process, the Department requested a focused review of four areas of performance.[1-1] HSAG developed a review strategy consisting of four components for review, which corresponded with the four performance areas identified by the Department. These were: Member Information (Component 1), Notices of Action (Component 2), Appeals (Component 3), and Underutilization (Component 4). Compliance with federal regulations and contract requirements was evaluated through review of the four components. This report documents results of the FY 2008–2009 site review activities for the review period of July 1, 2007, through June 30 2008. 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. Completed data collection tools for each component are found in the appendices. In addition, HSAG has included an overview of **Northeast Behavioral Health, LLC** (**NBH**) follow-up activities and status regarding the corrective actions that were required as a result of the FY 2007–2008 compliance site review.

In developing the data collection tools and in reviewing the four 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 F).

[1-1] The Department developed these performance areas through surveys of participants from the Medicaid Mental Health Advisory Committee (MHAC) and the Medicaid Mental Health Planning and Advisory Council (MHPAC). The Department developed MHAC to exchange information and identify, evaluate, and communicate issues related to the Colorado Medicaid Community Mental Health Services Program. MHPAC was created as a result of federal laws passed in 1986 and 1992, which require states and territories to perform mental health planning in order to receive federal Mental Health Block Grant funds (Sections 1911–1920 of the Public Health Service [PHS] Act [42 USC 300x-1 through 300x-9] and Sections 1941–1956 of the PHS Act [42 USC 300x-51 through 300x-66]).

Objective of the Site Review

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

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

Summary of Results

HSAG assigned each element within the components in the Compliance Monitoring Tool a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Scored*. *Not Scored* was used when materials had been previously reviewed and approved by the Department as meeting requirements, but minor revisions would enhance the clarity or compliance of the materials. HSAG assigned each element within the record review tools a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* Based on the results from the Compliance Monitoring Tool, the record review scores, and conclusions drawn from the review activities, HSAG assigned each component of the review an overall score of *In Compliance*, *In Partial Compliance*, or *Not In Compliance.* HSAG assigned required actions to any individual element within the Compliance Monitoring Tool or the record reviews receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for enhancement for some components, regardless of the score. While HSAG provided recommendations for enhancement of BHO processes based on these identified opportunities for improvement, they do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **NBH** for each of the components. Details of the findings for each component follow in subsequent sections of this report.

Table 1-1—Summary of Scores for the Components

Component #	Description of Component	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable or Not Scored*	Score (% of *Met* Elements)
1	Member Information	25	20	20	0	0	5	100%
2	Notices of Action	9	9	6	3	0	0	67%
	Notices of Action Record Review	5	4	3	0	1	1	75%
3	Appeals	23	22	18	4	0	1	82%
	Appeals Record Review	7	7	6	0	1	0	86%
4	Underutilization	4	4	4	0	0	0	100%
	Totals	**73**	**66**	**57**	**7**	**2**	**7**	**86%**

Table 1-2 presents the overall score for **NBH** for each of the components.

Table 1-2—Results	
Component	**Overall Score**
Component 1—Member Information	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 2—Notices of Action	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*
Component 3—Appeals	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*
Component 4—Underutilization	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and all member informational materials and templates used by the BHO during the review period. While on-site, HSAG reviewed additional documentation and interviewed key BHO personnel. Details of the findings for Component 1 follow in Appendix A—Component 1.

Summary of Findings and Opportunities for Improvement

Overall Score: In Compliance

NBH had an effective mechanism for ensuring that it mailed the required information within one month of **NBH**'s notification of enrollment. Mailings occurred monthly. **NBH**'s materials were available in Spanish, large print, and audio format. In addition, staff members reportedly offered to read materials, when needed. **NBH** community mental health centers (CMHCs) used a teletype/telecommunications device for the deaf (TTY/TTDs) and the toll-free Relay Colorado telephone service for the deaf when needed. For oral interpretation services, **NBH** used contracted interpreters, the language line, or bilingual staff members available at some of the CMHC sites. While the consumer handbook included all of the requirements, some areas represented opportunities for improvement for **NBH**. The consumer handbook informed members that interpretation services were available and stated that mental health services were free; however, **NBH** may consider specifically informing members that interpretation services are free. Although the consumer handbook informed members that they may choose their provider, **NBH** may also consider specifically informing members of the process for changing providers, upon members' request. **NBH** mailed a letter annually informing members that they may request information about **NBH** and may receive another consumer handbook.

Summary of Strengths

NBH's advance directives materials included all of the required content. **NBH** had a variety of mechanisms designed to help members and potential members understand the requirements and benefits of the State plan. **NBH** also informed members of alternative formats for the written materials in several ways. In addition, **NBH** had implemented a secret shopper program during the review period. The secret shopper program evaluated the CMHCs' compliance with access standards. One scenario **NBH** used during secret shopper calls was a member calling in other languages (**NBH** used Spanish and German) to evaluate the centers' ability to use an interpreter or the language line.

Summary of Required Actions

There were no corrective actions required for this component.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation, interviewed key BHO personnel, and conducted a record review of documentation associated with completed notices of action.

For the record review, a sample of 10 actions with an oversample of 5 actions was requested. **NBH** provided one notice of action record. HSAG reviewed the record for timeliness and content related to notices of action. (The entire sample provided by **NBH** was reviewed since the BHO had fewer than 10 notices of action during the review period.) Details of the findings for Component 2 follow in Appendix A—Component 2.

Summary of Findings and Opportunities for Improvement

Overall score: In Partial Compliance

NBH had a mechanism for appropriate utilization control, ensuring that medically necessary services were provided in an amount, duration, and scope needed to achieve the purpose for which they were provided. **NBH**'s utilization management (UM) program included a process for sending notices of action when services were denied, terminated, reduced, or authorized in an amount, duration, or scope that was less than requested. The Utilization Management policies and procedures included most of the required provisions.

Notice of Action Record Review Summary

NBH submitted three records for review; however, HSAG determined that two of these records were not actions and were not applicable for the actions record review. Therefore, one notice of action for the review period of July 1, 2007, to June 30, 2008 was reviewed. The notice of action was sent to the member March 17, 2008, stating that **NBH** would discontinue Clozaril as of March 24, 2009, due to noncompliance with the federally mandated treatment protocol. This decision was made by a physician. The notice of action was easy to understand. The letter contained the action the BHO intended to take, the reason for the action, the member's right to appeal, information regarding the State fair hearing process, how to request an expedited resolution, the right to have benefits continue, and the circumstances under which the member may have to pay for continued services. The letter included incorrect information regarding the time frame to request continued services.

Summary of Strengths

The on-site record review demonstrated that **NBH**'s notice of action letter was easy to understand. **NBH** staff reported that notice of action letters were sent in Spanish when applicable. There was evidence that authorization decisions were based on both medical necessity and UM criteria. The record review also demonstrated that individuals making determinations adverse to members had the appropriate expertise and were not involved in a previous level of review.

Summary of Required Actions

NBH's definition of action was inconsistent between documents. The policy and the provider manual both indicated that provider-level decisions required a notice of action. Since the preamble to the BBA specifically states that actions are triggered by an MCO or PIHP decision, not by the provider's treatment decision based on professional judgment, **NBH** must revise all pertinent materials to include the correct definition of an action.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation, interviewed key BHO personnel, and conducted a record review of documentation associated with Medicaid member appeals.

For the record review, a sample of 10 appeals with an oversample of 5 appeals was requested. **NBH** provided one appeal record. HSAG reviewed the record for timeliness and content related to appeals. (The entire sample was reviewed since the BHO had fewer than 10 appeals during the review period.) Details of the findings for Component 3 follow in Appendix A—Component 3.

Summary of Findings and Opportunities for Improvement

Overall Score: In Partial Compliance

NBH had an established process that allowed members access to the **NBH** appeal process and the State fair hearing process. **NBH**'s policies, member materials, and provider materials indicated that members and authorized representatives may file an appeal orally or in writing. The materials, however, did not clarify that oral requests must be followed by a written request. **NBH** should await the Department's clarification regarding this requirement and ensure that materials reflect the appropriate information. **NBH**'s policies and templates included most of the requirements. The provider manual did not contain complete information about the State fair hearing process; however, the PowerPoint presentation given to the CMHCs and independent providers at the time of either hire or initial contracting contained complete and comprehensive information about the State fair hearing process. **NBH** may consider including State fair hearing information in the provider manual that is consistent with the information in the PowerPoint presentation.

NBH's consumer handbook informed members that they or authorized representatives may file appeals; however, the handbook did not specifically state that providers may act as authorized representatives with the member's permission. **NBH** may consider including information in the consumer handbook that informs members that providers may file appeals and file for State fair hearings on their behalf, or that providers may act as authorized representatives.

The expedited appeal denial template letter informed members that the request for the expedited process (quick appeal) had been denied and that the appeal would be resolved in the "regular way," indicating that the time frame would be 10 calendar days, and then continued to use the designation of "quick appeal." Since **NBH**'s member materials specifically defined an expedited review of an appeal as a "quick appeal" with a three-day resolution, **NBH** may want to review member materials for clarity and revise them as indicated.

Appeals Record Review Summary

NBH submitted two appeal records for review; however, one of the appeals occurred prior to the review period of July 1, 2007, to June 30, 2008 and was, therefore, not reviewed. The notice of action was a notice that Clozaril was to be discontinued due to the member's lack of follow-through and noncompliance with federally mandated requirements for appointments and lab tests. The notice of action was sent March 17, 2008. A request for a standard appeal was received on March 19, 2008, and acknowledged on March 21, 2008. **NBH** staff reported that at some point the ombudsman (who was representing the member) contacted **NBH** and withdrew the appeal, stating that the member was now represented by the Colorado Legal Center, which would be refiling the appeal. However, the record contained no documentation of communication from the ombudsman. The resolution was due March 29, 2008; therefore, it was not possible to determine whether the file was in compliance regarding the resolution time frame.

The appeal record contained a letter from an attorney with the Colorado Legal Center dated March 28, 2008. In the letter, the attorney thanked **NBH** for an "expedited review of the members' services," stating that the attorney considered the notice of action void and that **NBH** should contact the attorney if this was not correct. The record contained no documentation of communication to the attorney in response to this letter. **NBH** staff members reported that they had not interpreted the attorney's March 28, 2008, letter as a request for an expedited appeal and, therefore, did not process an appeal in response to the letter. **NBH** may consider clarifying the purpose of the attorney's communication.

On April 16, 2008, another letter was received from the attorney requesting an expedited appeal. This appeal was processed as an expedited appeal. The resolution was sent April 21, 2008 (within three working days). The record contained no evidence of reasonable efforts to make oral notification.

The original notice of action allowed the member 20 days to file the appeal. The Code of Federal Regulations (CFR), at 42 CFR 438.420, requires a member to file an appeal within 10 days or before services are terminated if benefits were to continue. When the attorney filed the appeal on April 16, 2008, the member no longer had appeal rights. **NBH** should have considered using an extension to counsel with the parties involved to avoid withdrawal of the appeal and potential loss of appeal rights.

Summary of Strengths

NBH's appeal process included an expedited appeal process. Members were informed of the appeal and State fair hearing processes via the consumer handbook, which was mailed according to a regular schedule, and distributed and discussed in a variety of community and member-specific forums. Providers were informed of the appeal process in the provider manual and in mandatory in-person training using a comprehensive PowerPoint presentation.

Summary of Required Actions

NBH's policies included the required time frames for resolving appeals; however, the policies were unclear regarding the notification time frame requirements. In addition, the consumer handbook contained an incorrect time frame for expedited resolution notification. **NBH** must revise materials containing resolution notification and time frames regarding appeals to reflect the BBA requirements.

The on-site record review indicated some confusion by **NBH** staff regarding application of the guidelines and **NBH** policies for processing appeals. As a result, the required time frame for resolving an appeal was not met (10 working days). **NBH** must ensure that it provides notice of resolution of an appeal within the required time frames.

NBH policies did not address the 14-calendar-day extension for expedited appeals. **NBH** must revise applicable policies and other materials to address the 14-calendar-day extension for expedited appeals.

Although **NBH**'s policies included reasonable efforts to provide oral notice of resolution for expedited appeals, the on-site record review of an appeal that was processed as an expedited request did not contain evidence of efforts to provide oral notice. **NBH** must develop a mechanism to document reasonable efforts to provide oral notice of resolution for expedited appeals.

The notice of action letter reviewed during the on-site record review did not provide the member accurate information regarding the circumstances under which benefits could continue during the appeal or State fair hearing process. **NBH** must ensure that the notice of action accurately informs members of the conditions under which benefits may continue during the appeal and State fair hearing processes.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation and interviewed key BHO personnel. Details of the findings for Component 4 follow in Appendix A—Component 4.

Summary of Findings and Opportunities for Improvement

Overall Score: In Compliance

NBH had a variety of methods to detect over- and underutilization. The Missed Appointments policy and the Missed Appointments section in the provider manual described risk categories and recommended responses for each risk category. The recommended responses to missed appointments appeared to be designed for CMHC providers. **NBH** may consider developing responses that take into consideration the limited resources available to the independent provider network. **NBH**'s utilization data was analyzed by CMHC and by level of care (outpatient, inpatient, residential program, etc.). **NBH**'s top utilizers reports included data from outpatient services that were both authorized and not authorized.

Summary of Strengths

NBH had several mechanisms to obtain information regarding missed appointments from the CMHCs and evaluate the information for trends. In addition, **NBH** provided specific direction to the CMHCs regarding missed appointments based on risks associated with certain members.

Summary of Required Actions

No corrective actions were required for this standard.

6. Follow-up on FY 2007–2008 Corrective Action Plan

for Northeast Behavioral Health, LLC

Methodology

As a follow-up to the FY 2007–2008 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all components for which it received a score of *In Partial Compliance* or *Not In Compliance*. The plan was to include interventions to achieve compliance and the timeline associated with those activities. 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 2007–2008 compliance monitoring site review, or until the time of the on-site portion of the BHO's FY 2008–2009 site review.

Summary of FY 2007—2008 Required Actions

As a result of the FY 2007–2008 site review, **NBH** was required to: (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.

NBH submitted a corrective action plan and supporting documentation to HSAG in August 2008.

Summary of Findings

NBH's Compliance policy was revised to indicate that **NBH** will report all possible instances of Medicaid fraud to the Department within 10 days of receipt of the information. The policy included a discussion of what may constitute a possible instance of fraud. The policy also included a time frame requirement for organizational providers reporting possible instances of Medicaid fraud to **NBH**. The log template demonstrated **NBH**'s planned tracking mechanism for incidents reported to **NBH** by providers. The e-mail dated June 19, 2008, was the first quarterly summary of compliance committee activity sent to the Department. E-mails dated April 29, 2008, and June 10, 2008, demonstrated **NBH**'s commitment to obtain technical assistance from the Department regarding reporting of possible instances of fraud and related definitions.

Summary of Required Actions

NBH successfully completed the FY 2007–2008 required actions. There were no required actions continued from FY 2007–2008.

The completed compliance monitoring tool follows this cover page.

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(3) Contract: II.G.d.g & II.G.d.h	1. The Contractor provides all members the required information (see below) within a reasonable time after the BHO receives notice of enrollment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: NBH staff described the process used to identify new enrollees monthly and send the required information. NBH staff reported that its data management delegate (InNet) pulls the new enrollee information from the State's database monthly and provides the data to NBH. NBH provided invoices from Westview Printing, demonstrating that the consumer handbook was mailed to new enrollees monthly. NBH's consumer handbook included the required member information.	
	Required Actions: None	
Contract: II.G.d.b	2. The Contractor has a mechanism to help members and potential members understand the requirements and benefits of the plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The Member Information policy (0032) stated that NBH's director of consumer and family affairs, parent family advocates, and consumer service representatives have primary responsibility to ensure that consumers understand the requirements and benefits of the State plan. NBH also used its consumer handbook to help members understand the requirements and benefits of the plan. NBH staff described numerous community forums and member meetings and programs where the director of consumer and family affairs distributed and discussed the information contained in the consumer handbook. In addition to NBH mailing the consumer handbook, providers were expected to distribute the consumer handbook at intake for services. The provider manual informed providers of their responsibility to distribute the consumer handbook at the intake appointment.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(b)(1)&(3) 42CFR438.10(d) Contract: II.G.d.a; II.G.d.c; & II.G.d.d	3. The Contractor provides all enrollment notices, informational materials (handbooks, newsletters, directories), and instructional materials (health education, grievance system notices) in a manner and format that may be easily understood: ◆ In the prevalent non-English language. ◆ In alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The writing and format of NBH's informational materials made them easy to understand, and the materials were available in Spanish, large print, and an audio format. Members were notified in English and in Spanish that alternative formats were available and how to request them. The right to get special services (such as audio or large-print materials) was on the list of rights in the consumer handbook. Spanish materials were provided for HSAG's review. In addition to providing large-print materials, NBH reported that support staff and NBH staff offer to read materials to members, if needed. NBH staff reported that for hearing impaired-members, NBH and the CMHCs have a TTD/TTY telephone line and also use Relay Colorado as needed.	
	Required Actions: None	
42CFR438.10(c)(4)&(5) Contract: II.G.d.c; II.G.d.e; & II.G.d.f	4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The Member Information policy stated that NBH makes oral interpretation services available free of charge and that members are informed of this service. NBH's consumer handbook (Welcome Letter page) notified members that translation services into any language are available and instructed members on how to inquire about those services. NBH also reminded its members that these services were available in the annual letter. NBH's provider manual notified providers that oral interpretation services (including sign language) were available to all members free of charge. NBH staff reported that the CMHCs have staff members and therapists who are bilingual. In addition, NBH reported that during the review period, NBH quality management staff performed a secret shopper project to ensure compliance with access standards, and that the project included scenarios of Spanish-speaking and German-speaking member calls. While the consumer handbook met the standard regarding this requirement and informed members that all mental health services are free, NBH may consider specifying that interpretation services are at no cost to the member.	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.10(c)(5) Contract: II.G.d.f	5. The Contractor notifies members that written information is available for prevalent non-English languages and how to access the materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: NBH's Welcome Letter informed members that the consumer handbook is available in Spanish and gave instructions on how to obtain the Spanish version of the handbook. The Welcome Letter was included as part of the consumer handbook, and the information about obtaining a consumer handbook in Spanish was also in the annual letter (mailed annually in December).	
	Required Actions: None	
42CFR438.10(d)(2) Contract: II.G.d.f	6. The Contractor notifies members that written information is available in alternative formats and how to access the materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: NBH's Welcome Letter (the first page of the consumer handbook) informed members that member materials are available in alternative formats and gave instructions on how to obtain them. This information was also included in the annual letter (mailed annually in December).	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(2) Contract: II.G.d.k	7. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information (42CFR438.10), upon request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The Member Information policy stated that Medicaid members would be notified annually of their right to request and obtain a copy of the consumer handbook. NBH provided a copy of the annual member letter in which this notification was included and an invoice showing that the letter was mailed in December 2007 (the annual mailing that was during the review period). The annual letter was written in English on the front and in Spanish on the back, with the English side informing members in Spanish that the Spanish letter was on the reverse side.	
	Required Actions: None	
42CFR438.10(f)(4) Contract: II.G.d.i	8. The Contractor gives written notice of any significant change in information to members at least 30 days before the intended effective date of the change.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The consumer handbook stated that members will be given a 30-day notice of any significant change. As an example of compliance, NBH provided a copy of the annual letter, mailed in December 2007, which informed members of NBH's impending move to a new location. NBH reported that there had been no other significant changes since that time.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(5) Contract: II.G.d.j	9. The Contractor makes a good-faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who is receiving or has received in the last six months his or her primary mental health care from, or was seen on a regular basis by, the terminated provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: NBH's consumer handbook informed members that they would be told if their current provider is no longer going to be in the NBH network "within 15 days after NBH knows what is going to happen." This information was also included in the provider manual, where NBH specified the responsibilities of NBH and the responsibilities of the CMHC and stated that information sent to members would include how members might continue service with the terminated provider. During the on-site interview, NBH staff reported that NBH provided notice if a provider in the independent provider network (IPN) gave notice of termination or was terminated by NBH. NBH provided an example of a letter that was sent during the review period.	
	Required Actions: None	
42CFR438.10(f) Contract: II.G.d.g.	10. Member information materials include: ◆ Names, locations, and telephone numbers of, and non-English languages spoken by, current contracted providers, including identification of providers who are not accepting new patients. ◆ Any restrictions on freedom of choice among network providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: NBH's consumer handbook included, as an insert, a list of current contracted providers. This list included names, locations, telephone numbers, a list of other languages spoken, and whether or not the provider was accepting new patients. The list of current providers was easily located on NBH's Web site. The NBH consumer handbook also explained how members can choose a provider. Staff members stated that NBH places no restrictions on choosing a provider. While the consumer handbook met the standard for this requirement by clearly stating that members may choose their provider, NBH may consider informing members of the process to change providers after treatment has begun.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f) Contract: II.G.d.g	11. Member information materials include: ◆ Member rights as specified in 42CFR438.100. ◆ Additional member rights that include the right to: ▪ Have an independent advocate. ▪ Request that a specific provider be considered for inclusion in the network. ▪ Receive a second opinion. ▪ Receive culturally appropriate and competent services from participating providers. ▪ Receive interpreter services for members with communication difficulties or for non-English-speaking members. ▪ Prompt notification of termination or changes in services or providers. ▪ Express an opinion about the Contractor's services to regulatory agencies, legislative bodies, or the media without the Contractor causing any adverse effects upon the provision of covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The NBH consumer handbook included a comprehensive list of member rights. These rights were also included in the annual letter, mailed to members in December. Member rights were easily accessible on the NBH Web site, as well.	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	12. Member information regarding the grievance, appeal, and fair hearing procedures have been approved by the Department and include: ◆ The right to file grievances. ◆ The right to file appeals. ◆ The right to a State fair hearing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: NBH's consumer handbook included the member's right to file grievances and appeals and the right to a State fair hearing. NBH provided a copy of a letter from the Department approving the content of the consumer handbook. NBH staff reported that any updates to the handbook since that time resulted from the corrective action process in previous years, and as part of that process, the updates were approved by the Department as completed corrective actions.	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	13. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The requirements and time frames for filing grievances and appeals. ◆ The method for obtaining a State fair hearing. ◆ The rules that govern representation at a State fair hearing.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The consumer handbook included the requirements for filing grievances and appeals and the method for obtaining a State fair hearing with the rules that govern the State fair hearing process. The handbook included the time frames for filing a grievance and an appeal of an action (20 calendar days); however, the handbook did not address the time frame for filing an appeal if a service had been terminated (10 calendar days). The discussion of action and appeal did not clarify that services could only be continued if they had been authorized, and the discussion did not separate the filing requirements and time frames for the two types of actions. NBH may consider clarifying the discussion regarding actions and appeals to specify the requirements and time frames for denial or limited authorization, and for termination, suspension or reduction of services previously authorized.	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	14. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The NBH consumer handbook informed members that the Office of Consumer and Family Affairs (OCFA) is available to help members file a grievance or an appeal, or request a State fair hearing. The consumer handbook included toll-free numbers members may use to file a grievance or an appeal. The consumer handbook also informed members that if they were uncomfortable working with NBH, they could contact the ombudsman for Medicaid managed care and included contact information for the ombudsman. Furthermore, NBH stated that this information, presented in poster format, is located at NBH and each service site. The Consumer Information page of the NBH Web site also listed the availability of assistance and toll-free telephone numbers.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(g) Contract: II.G.d.g	15. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State fair hearing is filed within the timeframes specified for filing ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The consumer handbook included information about continued benefits and that the member may have to pay for the benefits (services) if the appeal decision is not in favor of the member. The discussion of actions, appeals, and State fair hearings did not clearly identify that notices of action denying a new request (or limiting authorization of a new request) would not include the option to continue benefits (as continued services may only occur with reduction or termination of services that had been previously authorized). It was also unclear in the discussion that the member must request, and the appeal and continued services must occur, within 10 days of the notice of action to reduce or terminate services. NBH may consider revising the NBH consumer handbook to delineate the difference between actions to deny or limit authorization and actions to reduce, suspend, or terminate services previously authorized and the requirements for filing an appeal and requesting continued benefits (see 42 CFR 438.420(b)(1) through (5).	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	16. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The NBH consumer handbook informed members that a family member or an advocate may file an appeal on their behalf if the member authorizes the advocate as its designated consumer representative (DCR). The consumer handbook did not specify that a provider may file on behalf of the member or that a provider may be a DCR. The provider manual, however, informed providers that they may file appeals on behalf of a member if the member identifies the provider as his or her DCR.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(6) Contract: II.G.d.g	17. Information provided to members includes: ◆ The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. ◆ Procedures for obtaining benefits, including authorization requirements. ◆ The extent to which and how members may obtain benefits from out-of-network providers. ◆ How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract, including any cost-sharing and how transportation is provided.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: Section 1 of the NBH consumer handbook, Getting and Choosing Services, included comprehensive information regarding the amount, duration, and scope of benefits available; procedures for obtaining benefits and necessary authorization; and how to obtain benefits from out-of-network providers. The NBH consumer handbook did not completely address how and where to access benefits available under the State plan, but not covered by NBH. This discussion only addressed transportation, did not include other benefits (i.e., wraparound benefits), and stated that NBH did not pay for transportation but did not clarify that it would be covered through other Medicaid monies. NBH may want to expand its consumer handbook discussion about benefits covered under the State plan.	
	Required Actions: None	
42CFR438.10(f)(6) Contract: II.G.d.g	18. Information provided to members includes: ◆ The extent to which and how after-hours and emergency coverage are provided, including: ▪ What constitutes an emergency medical condition, emergency services, and poststabilization services with reference to the definitions in 42 CFR 438.114(a). ▪ The fact that prior authorization is not required for emergency services. ▪ The process and procedures for obtaining emergency and poststabilization services, including the use of the 911 telephone system or its local equivalent. ▪ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services. ▪ The fact that the member has the right to use any hospital or other setting for emergency care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The NBH consumer handbook included information about care available after hours and how to access it, and what members should do in case of an emergency. This information included the definition of an emergency, that members do not need authorization for	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	treatment of an emergency, how to get treatment (including use of the 911 telephone system), locations of area emergency rooms, and a reminder to members that they can seek treatment at any setting that provides emergency care.	
	Required Actions: None	
42CFR438.10 Contract: II.G.d.g	19. Information provided to members includes policies on referral for specialty care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The consumer handbook instructed members to contact their care coordinator for referral to specialty care.	
	Required Actions: None	
42CFR438.10 42CFR438.6(I)(2) 42CFR422.128 Contract: II.G.d.g	20. Member information regarding advance directives for adult members includes: ◆ The member's right to formulate advance directives. ◆ The member's rights under the State law to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment. ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State agency. ◆ The Contractor's policies regarding implementation of advance directives, which must include: ▪ A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. ▪ The difference between institution-wide conscientious objections and those raised by individual physicians. ▪ Identification of the State legal authority permitting such objection. ▪ Description of the range of medical conditions or procedures affected by the conscientious objection. ▪ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	condition or mental disorder and is unable to receive information. ▪ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. ▪ Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. ▪ The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive. ▪ Provisions for ensuring compliance with State laws regarding advance directives. ▪ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. ▪ Provisions for the education of staff concerning its policies and procedures on advance directives. ▪ Provisions for community education regarding advance directives that includes: • What constitutes an advance directive. • Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. • A description of applicable state law concerning advance directives.	
	Findings: NBH's consumer handbook informed members of their right to formulate an advance directive, the right to accept or refuse medical or surgical treatment, and how to file a complaint regarding non-compliance with the advance directive. The provider manual clearly stated that there are no treatments to which NBH has a conscience objection. The Member Rights policy and the provider manual included the process for documenting an advance directive in a prominent part of the member's record, stated that care may not be conditioned on whether the member has an advance directive, and addressed education of staff members. The policy included a provision that members will be notified of a change in State law within 90 days following the change. NBH staff reported that member materials, which included information about advance directives, was distributed at a variety of community forums and member advocate meetings.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
Contract: II.G.d.h	21. Information provided to members includes: ◆ The fact that no fees may be assessed for covered mental health services provided to enrolled members. ◆ Notice that the member has been enrolled in the Community Mental Health Services Program operated by the Contractor, and that enrollment is mandatory. ◆ The Contractor's hours of operation. ◆ That assistance is available through the Medicaid Managed Care Ombudsman Program and how to access ombudsman services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: NBH's Welcome Letter informed members that services provided to Medicaid members by NBH are free. The Welcome Letter also stated that Medicaid members are enrolled in NBH automatically if they live in one of the 12 listed counties. The notice of automatic enrollment was also provided to members via the annual letter mailed in December. The consumer handbook included hours of operation for NBH. NBH provided members information about the availability of assistance through the Medicaid Managed Care Ombudsman Program and how to access ombudsman services in its consumer handbook. NBH staff reported that this information is also displayed on posters printed in English and Spanish, which are displayed at NBH and all of its service centers.	
	Required Actions: None	
Contract: II.G.d.h	22. Information provided to members includes: ◆ Appointment standards for routine, urgent, and emergency situations. ◆ Procedures for requesting a second opinion. ◆ Procedures for requesting accommodations for special needs, including written materials in alternative formats. ◆ Procedures for arranging transportation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The consumer handbook provided members with comprehensive information regarding appointment standards, procedures for requesting a second opinion, and special accommodations, including materials in alternative formats and transportation.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10 Contract: II.G.d.h	23. Information provided to members includes: ◆ Information on how members will be notified of any changes in services or service delivery sites. ◆ Procedures for requesting information about the Contractor's Quality Improvement Program. ◆ Information on any member and/or family advisory boards the Contractor may have in place.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The NBH consumer handbook informed members that NBH will notify them of any significant changes. NBH may consider specifying how this notification will occur (i.e., in writing or another format). The consumer handbook provided information about NBH's quality improvement program, including its consumer advisory groups and how to request more information.	
	Required Actions: None	
42CFR438.10 Contract: II.G.d.g	24. Additional information that is available upon request: ◆ Physician incentive plans	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: NBH's consumer handbook stated that NBH does not have a physician incentive plan.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10 Contract: II.G.d.g	25. Information that must be made available annually and upon request: ◆ Information on the structure and operation of the Contractor ◆ The Contractor's service area ◆ The benefits covered under the contract ◆ The fact that no fees may be assessed for covered mental health services provided to enrolled members ◆ To the extent available, quality and performance indicators, including enrollee satisfaction	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The NBH consumer handbook included information on the structure and operation of NBH and its service area, its covered benefits, that services are free to enrolled Medicaid members, and that information regarding the quality program (including copies of reports) is available upon request. Members were reminded about the availability of this information in the annual letter mailed in December.	
	Required Actions: None	

Results for Member Information							
Total	Met	=	20	X	1.00	=	20
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	5	X	N/A	=	N/A
Total Applicable		=	20	**Total Score**		=	20

Total Score ÷ Total Applicable	=	100%

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.400(b) Contract: Exhibit G—8.209.2	1. The Contractor defines action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The consumer handbook included a definition of an action that was easy to understand, comprehensive, and correct. The Utilization Management policy (009) and the provider manual included a definition of action, but linked the action to a decision that the provider would make, rather than to the BHO's decision. In addition, the provider manual included three definitions of an action (pages 37, 43, and 160). While none of the definitions in the provider manual was incorrect, there were three different lists of items that were considered an action. NBH may consider reviewing all pertinent documents to ensure that all definitions of an action are consistent.	
	Required Actions: The preamble to the BBA specifically states that actions are triggered by an MCO or PIHP decision, not by the provider's treatment decision. Therefore, NBH must revise all pertinent materials to include the correct definition of an action.	
42CFR438.404(a) Contract: Exhibit G—8.209.4.A.1	2. Notices of action must meet the language and format requirements of 42CFR438.10 and ensure ease of understanding.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: NBH's notice of action letter sent to members (as evidenced by the record review) was easy to understand. NBH staff reported that notice of action letters are sent in Spanish when applicable.	
	Required Actions: None	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.404(b) Contract: Exhibit G—8.209.4.A.2	3. Notices of action must contain: ◆ The action the Contractor has taken or intends to take. ◆ The reasons for the action. ◆ The member's (and provider's on behalf of the member) right to file an appeal and how to do so. ◆ The member's right to request a State fair hearing and how to do so. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that. ◆ The circumstances under which the member may have to pay for the costs of services if continued benefits are requested.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: NBH's Utilization Management policy included the list of required content for notice of action letters, which met the requirements. NBH had one template for notices of action. The template included language regarding continuation of benefits and stated that members could request continuation of benefits (services) if the member filed within 20 days of the notice of action. NBH staff stated that this template letter was used for all actions. NBH may consider either tailoring notice of action letters to the appropriate situation or developing two templates that contain correct information for members (i.e., if the notice of action is a denial or limited authorization of a request for services, there should not be continuation-of-benefit language in the letter as it would not pertain; if the action is a termination, reduction, or suspension of a previously authorized service, members may request continuation of benefits if the appeal is filed in a timely manner, defined as within 10 calendar days of the notice of action or prior to the effective date of the action).	
	Required Actions: NBH must ensure that notices of action sent to members are accurate, offer benefits only if applicable, and contain the correct timelines for filing to qualify for continued benefits.	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.404(c) Contract: Exhibit G—8.209.4.A.3	4. The notice of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized, Medicaid-covered services, at least 10 days before the date of action (unless extenuating circumstances exist—found in Exhibit G) ◆ For denial of payment, at the time of any action affecting the claim ◆ For standard service authorization decisions that deny or limit service, within 10 calendar days ◆ For service authorization decisions not reached within 10 calendar days, on the date the time frames expire ◆ For expedited service authorization decisions, within three days	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Management policy included all the applicable time frames. The notice of action record reviewed involved a change in current treatment and indicated that a notice of action was sent eight days before the effective date of the change.	
	Required Actions: NBH must ensure that notices of action are sent within the required time frames.	
42CFR438.404(c) Contract: Exhibit G—8.209.4.A.4	5. If the Contractor extends the time frame for authorization decisions (see Standard I) it provides the member: ◆ Written notice of the reason for the decision to extend the time frame. ◆ The right to file a grievance if the member disagrees with the decision. ◆ Issuance of its decision (and carries out the decision) as expeditiously as the member's health condition requires and no later than the date the extension expires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Management policy included the above provisions. NBH reported that there had been no authorization decisions extended during the review period. The actions record review did not contain any actions that resulted from new requests for services; therefore, there was not an opportunity to evaluate examples.	
	Required Actions: None	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.210(a)(3)(ii) Contract: II.J.a..d.2	6. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Management policy discussed criteria for UM decisions and stated that decisions are not made based on diagnosis, type of illness, or the condition of member. The UM policy contained criteria for levels of care and indicated that authorization decisions are based on medical necessity and the UM criteria. The actions record review contained no actions for denial of services based on diagnosis or condition (i.e., developmental disability). NBH staff reported that the executive director had received no direct calls related to denials of service to developmentally disabled individuals and that any complaints regarding that issue would be processed using the grievance system processes.	
	Required Actions: None	
42CFR438.210(a)(3)(iii) Contract: II.J.a.d.3	7. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Management policy discussed criteria for UM decisions, which were based first on medical necessity and second on criteria in Appendix B of the policy and procedure and Appendix B of the provider manual. The UM policy defined medical necessity. NBH staff confirmed that all authorization decisions were made using the UM criteria and medical necessity.	
	Required Actions: None	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.210(b)(3) Contract: II.J.a.f	8. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM policy described the required qualifications of UM professionals in each job classification. The policy also stated that all service denials based on medical necessity are reviewed by either the director of UM or the medical director, and that only a psychiatrist or psychologist may deny inpatient or residential care. The notice of action record reviewed demonstrated that the decision was made by an individual with appropriate expertise (the denial was made by a physician).	
	Required Actions: None	
42CFR438.210(c) Contract: II.J.a.h	9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. (Notice to the provider does not need to be in writing.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM policy stated that a written notice of action is mailed to both the provider and the member. The actions record review did not contain actions resulting from a new request for services; therefore, there was no opportunity to evaluate an example.	
	Required Actions: None	

Results for Notices of Action							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	0	X	N/A	=	0
Total Applicable		=	9	**Total Score**		=	6

Total Score ÷ Total Applicable	=	67%

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.402(a) Contract: Exhibit G—8.209.1	1. The Contractor has a system in place that includes an appeal process and access to the State fair hearing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy (0083) described appeal and State fair hearing processes that met all of the requirements. The consumer handbook and the provider manual informed members and providers of their rights to appeal and access the State fair hearing process.	
	Required Actions: None	
42CFR438.400(b) Contract: Exhibit G—8.209.2	2. The Contractor defines an appeal as a request for review of an action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy, the provider manual, and the consumer handbook included the BBA definition of an appeal.	
	Required Actions: None	
42CFR438.402(b)(1) Contract: Exhibit G—8.209.1	3. The Contractor has provisions for who may file: ◆ A member may file a PIHP-level appeal and may request a State fair hearing. ◆ A provider, acting on behalf of a member and with the member's written consent, may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member. (The State permits the provider to act as the member's authorized representative.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy stated that members or designated representatives may file appeals and that consumers are informed of the State fair hearing process, which may be used instead of or simultaneously to the NBH appeal process. The policy defined a designated consumer representative to include providers. The provider manual informed providers that they may file an appeal on behalf of a member. The consumer handbook informed members that a family member or DCR may file; however, it did not specify that a provider may act as the DCR. NBH may consider including information in the consumer handbook that informs members that providers may file appeals and for State fair hearings on their behalf, or that providers may act as a DCR.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.402(b)(3) Contract: Exhibit G—8.209.4.F	4. The member may file an appeal either orally or in writing and must follow an oral request with a written request (unless the request is for expedited resolution).	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The Appeal of an Action policy, the provider manual, and the consumer handbook stated that appeals may be filed orally or in writing; however, none of the documents informed staff, members, or providers that oral requests for an appeal must be followed with a written request. The BBA requires that oral requests for an appeal be followed by a written request. The Department will send a clarification to the BHOs regarding this requirement.	
	Required Actions: None	
42CFR438.402(b)(2) Contract: Exhibit G—8.209.4.B	5. An appeal may be filed 20 calendar days from the date of the notice of action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The notice of action template letter included the timeline. The OCFA training manual included the filing timeline of 20 days. The Appeal of an Action policy stated that the member may file an appeal within 20 days of the notice of action. Members were informed of the filing timeline in the consumer handbook. Since there was some confusion on the part of NBH that the 20-day filing timeline was for notices of action that resulted in a denial or limited authorization of services (not resulting from the termination, reduction, or suspension of services), NBH may consider clarifying this in its materials. In addition, although the provider manual informed providers that they may file on behalf of members, the provider manual did not include filing time frames. NBH may consider including these time frames in the provider manual.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.402(b)(3) Contract: Exhibit G—8.209.4.N	6. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing 20 days from the date of the notice of action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy stated that upon contacting the OCFA director regarding an appeal, members are informed that they may request an administrative hearing and that they have 20 days to do so. The consumer handbook informed members that they may ask for a State fair hearing at the same time they are going through to the NBH appeal process. The OCFA training manual included notifying the consumer that the State fair hearing process may occur simultaneous to the appeal process, and the 20-day timeline for filing.	
	Required Actions: None	
42CFR438.406(a) Contract: Exhibit G—8.209.4.C	7. In handling appeals, the Contractor must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy stated that the director of OCFA can assist the member with writing the appeal letter. Members were informed via the action letter that they may ask for help writing an appeal letter. The consumer handbook offered assistance with special needs (hearing, seeing, translation, signing, or physical needs). The Member Information policy included the procedure for obtaining interpretation services. Providers were informed via the provider manual that interpretation services were available. The consumer handbook included the TTY/TTD phone number.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.406(a) Contract: Exhibit G—8.209.4.D	8. The Contractor acknowledges each appeal in writing within two working days of receipt, unless expedited resolution is requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy stated that a written acknowledgment by the director of OCFA would be mailed within two working days from receipt of the appeal. Members were informed in the consumer handbook that they would receive an acknowledgment after NBH receives the appeal. The actions record review demonstrated that the acknowledgment was sent to the member within two days of NBH receiving the appeal.	
	Required Actions: None	
42CFR438.406(a) Contract: Exhibit G—8.209.4.E	9. The Contractor ensures that the individuals who make decisions on appeals are individuals who: ◆ Were not involved in any previous level of review or decision making. ◆ Have the appropriate clinical expertise in treating the member's condition or disease if they are deciding an appeal of a denial based on lack of medical necessity or an appeal of a denial that involves any clinical issues.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy described the process for ensuring that professionals who make decisions about appeals were not involved in a previous level of review and had the clinical expertise to make the determination. Members were informed about this process via the consumer handbook. The appeal tracking form included a section that NBH staff used to track decision-makers to ensure that noninvolved staff were used at each level of review. The on-site record review demonstrated that a physician who had not been previously involved made the appeal decision. (NBH had one appeal during the review period.)	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.406(b) Contract: Exhibit G—8.209.4.G—I	10. The Contractor's appeal process must provide: ◆ That oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution. ◆ The member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents considered during the appeals process. ◆ That either of the following individuals are included as parties to the appeal: ▪ The member and his or her representative ▪ The legal representative of a deceased member's estate	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy and the consumer handbook indicated that appeals are accepted in person, in writing, or by telephone. Since the policy did not stipulate that oral appeals be followed by written requests, the policy did not delineate the difference between filing dates if there were both oral and written requests. The record review on-site, however, indicated that oral requests are processed per the requirements. The Appeal of an Action policy, the provider manual, and the consumer handbook included information about processing appeals and informed members and providers of the right to present evidence and review medical records, and who may be parties to the appeal.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.408(b)&(d) Contract: Exhibit G—8.209.4.J	11. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires: ◆ For standard resolution of appeals, 10 working days from the day the Contractor receives the appeal ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy stated that the appeal reviewer makes the decision and provides the OCFA director with the information within 10 days of receiving a standard appeal and within 3 days for an expedited review. The policy did not address the notification timeline for standard or expedited appeals. The discussion in the consumer handbook regarding standard appeals was in compliance; however, the consumer handbook informed members that an expedited decision would occur within three days, with notification to follow in another 2 days. The appeal record reviewed on-site did not appear to be in compliance with the time frame; however, there were events reported by NBH staff that had not been documented and may have indicated compliance (see the summary of findings in Section 4—Component 3—Appeals).	
	Required Actions: NBH must revise its policies and other documents pertaining to the appeal process to specify the notification time frames for standard and expedited appeals and ensure that the time frames comply with the requirements. NBH must also develop a mechanism to document verbal communication pertinent to the appeal, particularly when documentation of verbal communication could affect compliance with the required time frames.	
42CFR438.408(c) Contract: Exhibit G—8.209.4.K & 8.209.5.E	12. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if either: ◆ The member requests the extension. ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The consumer handbook informed members that the appeal resolution could be extended. The Appeal of an Action policy addressed the 14-day extension for standard appeals; however, the policy did not address an extension process for expedited appeals.	
	Required Actions: NBH must revise its policies and other pertinent documents to clarify that time frames to resolve both standard and expedited appeals may be extended for up to 14 days if the member requests the extension or if NBH shows the need for additional information and how a delay is in the member's interest.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.408(b)(3) Contract: Exhibit G—8.209.4.K & 8.209.5.E	13. If the Contractor extends the time frames, it must—for any extension not requested by the member—give the member written notice of the reason for the delay.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: This requirement was included in the Appeal of an Action policy, the consumer handbook, and the OCFA training manual. NBH's resolution extension template letter included examples of reasons.	
	Required Actions: None	
42CFR438.408(d) Contract: Exhibit G—8.209.4.L	14. For notice of an expedited resolution of an appeal, the Contractor must also make reasonable efforts to provide oral notice of resolution.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy stated that for expedited appeals NBH would make reasonable efforts to provide oral notice of the resolution. Members were informed of this policy via the consumer handbook. While NBH's policy was in compliance, an appeal record reviewed on-site indicated that the appeal was eventually processed as an expedited appeal, with no documentation of reasonable efforts to provide oral notice of the resolution.	
	Required Actions: NBH's appeal records must include documentation of reasonable efforts to provide oral notice of appeal resolution.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.408(e) Contract: Exhibit G—8.209.4.M	15. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: ▪ The right to request a State fair hearing and how to do so. ▪ The right to request that benefits continue while the hearing is pending and how to make the request. ▪ That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Notice of Action policy had provisions to include the decision, reason for the decision, and information about how to use the State fair hearing process in the notice of appeal determination letter. Each of these items was included in the notice of appeal determinations letter reviewed in the appeal record on-site. Members were informed about the content of the notice of appeal determination via the consumer handbook.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.410 Contract: Exhibit G—8.209.4.P—R	16. The Contractor has an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes the following: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: ▪ Transfer the appeal to the time frame for standard resolution. ▪ Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two calendar days.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy described an expedited review process for appeals that met the requirements. The policy did, however, also include a statement that NBH will ensure that no punitive action would be taken against a provider who requests an expedited notice of action. While not out of compliance, this language is awkward and not descriptive of what the provider would request. NBH may consider clarifying the policy. Members were informed about the expedited process in the consumer handbook. The expedited appeal denial template letter informed the member that his or her request for an expedited process (referred to as a "quick appeal") had been denied and that the appeal would be resolved in the "regular way," indicating that the time frame would be 10 calendar days. The template letter, however, continued to refer to a "quick appeal." Since NBH's member materials specifically defined an expedited review of an appeal as a "quick appeal" with a three-day resolution time frame, NBH may consider reviewing member materials for clarity and revising them as indicated.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.414 Contract: Exhibit G—8.209.3.B	17. The Contractor must provide the information about the grievance system specified in 42CFR438.10 to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The right to file grievances. ◆ The right to file appeals. ◆ The right to a State fair hearing. ◆ The requirements and time frames for filing grievances and appeals. ◆ The method for obtaining a State fair hearing. ◆ The rules that govern representation at the State fair hearing. ◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone. ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for a State fair hearing is filed within the time frames specified for filing. ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending if the final decision is adverse to the member. ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: NBH staff reported that CMHC providers and independent providers are required to attend training. The PowerPoint presentation included all of the required information regarding the grievance system. The provider manual included most of the information about the grievance system; however, the provider manual was missing the time frame for filing appeals and detailed information regarding the State fair hearing process. While this requirement was met via the PowerPoint presentation, NBH may consider including the time frame for filing appeals and revising the State fair hearing information in the provider manual to be consistent with the information in the PowerPoint presentation.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.416 Contract: Exhibit G—8.209.3.C	18. The Contractor maintains records of all appeals and submits quarterly reports to the Department.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: On-site review of the appeals log and case-specific appeal records demonstrated compliance. In addition, quarterly reports were submitted to the Department as required.	
	Required Actions: None	
42CFR438.420(b) Contract: Exhibit G—8.209.2 & 8.209.4.S	19. The Contractor continues the member benefits if: ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice of action ▪ The intended effective date of the proposed action ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy included all of the above provisions; however, the policy did not define the timely filing of an appeal as filing within 10 days of the notice of action or the date of the intended action. The notice of action that was sent to a member (as evidenced by record review on-site) stated that benefits would continue if the member filed an appeal within 20 calendar days of the notice of action. In addition, the notice of action sent to the member did not accurately inform the member about the circumstances surrounding continued benefits.	
	Required Actions: NBH must develop a mechanism to ensure that notices of action inform members of each of the qualifications and include accurate information regarding the request for continued benefits during the appeals process.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.420(c) Contract: Exhibit G—8.209.4.T	20. If the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal ◆ Ten days pass after the Contractor mails the notice providing the resolution of the appeal against the member, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached ◆ A State fair hearing officer issues a hearing decision adverse to the member ◆ The time period or service limits of a previously authorized service has been met	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy included all of the listed provisions. The appeal reviewed on-site contained extenuating circumstances (see the summary of findings for Component 3).	
	Required Actions: None	
42CFR438.420(d) Contract: Exhibit G—8.209.4.U	21. If the final resolution of the appeal is adverse to the member—that is, it upholds the Contractor's action—the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this rule.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy and the consumer handbook included this requirement. The appeal decision reviewed on-site upheld NBH's decision; however, NBH provided an alternative service and, therefore, no costs were applicable to recover.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.424 Contract: Exhibit G—8.209.4.V	22. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy, the consumer handbook, the action letter template, and the appeal determination template included this requirement. This provision was not applicable to the appeal record reviewed on-site.	
	Required Actions: None	
42CFR438.424 Contract: Exhibit G—8.209.4.W	23. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appeal of an Action policy and the consumer handbook included this statement. This provision was not applicable to the appeal record reviewed on-site.	
	Required Actions: None	

Results for Appeals							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	1	X	N/A	=	0
Total Applicable		=	22	**Total Score**		=	18

Total Score ÷ Total Applicable	=	82%

Component 4 —Underutilization: Partial Review of Standard X—Quality Assessment and Performance Improvement		
References	**Requirement**	**Score**
42CFR438.240(b)(3) Contract: II.I.e	1. The Contractor's QAPI program includes mechanisms to detect both underutilization and overutilization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Reports that evaluated overutilization were: the benefit limit reports, the 50 highest users report, the 100 highest users report, the emergency room (ER) highest users report, and the nonclient ER users report. To track underutilization, NBH compared several indicators: hospital admissions, average length of stay, 7-day and 30-day follow-up after hospital discharge, and ER utilization.	
	Required Actions: None	
UM Criteria – Section IV	2. The Contractor has policies and procedures outlining the activities undertaken to specifically identify and address underutilization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Mechanism to Detect Over and Underutilization policy (0043) described requiring reports from the CMHCs detailing lack of follow-through with routine outpatient treatment. NBH staff stated that the reports from the CMHCs are cross-referenced with the ER utilization reports. NBH also reported that the resulting information is used to target members for outreach activities. The NBH QI and UM Program Impact Analysis report indicated that the CMHCs demonstrated a compliance rate of 95.9 percent regarding requirements for addressing missed appointments. This rate was based on medical record review of CMHC records by NBH staff. The Missed Appointments policy and the Missed Appointments section in the provider manual described risk categories and recommended responses for each risk category. The recommended responses to missed appointments appeared to be designed for CMHC providers. NBH may consider developing responses that consider the limited resources available to the independent provider network.	
	Required Actions: None	

Component 4 —Underutilization: Partial Review of Standard X—Quality Assessment and Performance Improvement		
References	**Requirement**	**Score**
UM Criteria – Section IV	3. The Contractor's policies and procedures include the mechanism for routine trending and analysis of data by levels of care and by provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Mechanism to Detect Over and Underutilization policy stated that utilization data sources included utilization reports on inpatient and outpatient services (hospital admission rates, inpatient lengths of stay, top diagnoses, follow-up after discharge, hospital recidivism, tracking of benefit limits, ER visits, and program use of preauthorized services). Data was analyzed by CMHC and by level of care (outpatient, inpatient, residential program, etc.) as evidenced by the summary report of Underutilization of Services, and the Benchmark Report.	
	Required Actions: None	
UM Criteria – Section IV	4. Trending includes services prior authorized and not prior authorized.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: NBH's Benchmark Report included trending of intensive levels of service and routine outpatient services provided by the independent provider network, which required prior authorization, as well as emergency room services, which did not require prior authorization. In addition, NBH's top 100 utilizers report (NBH-wide) and the three top 50 utilizers report (by CMHC) included utilization data for all services, which included non prior authorized services such as outpatient individual and group therapy, family therapy, clubhouse services, and recovery-based services.	
	Required Actions: None	

Results for Underutilization							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	0	X	N/A	=	0
Total Applicable		=	4	**Total Score**		=	4

Total Score ÷ Total Applicable	=	100%

Appendix B. Notice of Action Record Review Tool for Northeast Behavioral Health, LLC

The completed notice of action record review tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Behavioral Health Organization (BHO) Actions Record Review Tool *for* Northeast Behavioral Health, LLC

Review Period:	July 1, 2007–June 30, 2008
Date of Review:	February 4, 2009
Reviewer:	Barbara McConnell
Participating BHO Staff Member:	Carol Staples and Scott Wylie

1	2	3	4	5	6	7	8	9	10	11
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for all Notices		
File #	Member ID	Date of Initial Request	Date Notice Sent	Number of Days for Decision	Notice Sent Within Time Frame	Date Notice Sent	Notice Sent Within Time Frame	Reasons are Easy to Understand	Decision Made by Qualified Clinician	Notice Includes all Required Content
1	XXXXX	N/A	N/A	N/A	M ☐ N ☐ N/A ☒	3/17	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: A notice of action was sent March 17, 2008, to the member stating that NBH would discontinue the member's Clozaril as of March 24, 2009, due to noncompliance with the federally mandated treatment protocol. This decision was made by a physician. The notice of action was written in a manner that was easily understood. The letter contained the action the BHO intended to take, the reason for the action, the member's right to appeal and to a State fair hearing, how to request an expedited resolution, the right to have benefits continue, and the circumstances under which the member may have to pay for the continued services. The letter included incorrect information regarding the time frame to request continued services (see Component 3—Requirement 11 for scoring related to this item).										
2					M ☐ N ☐ N/A ☐		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: **NOTE—There were two additional records submitted for review as actions; however, these situations were not actions, as defined in the BBA, and were not included in this report.**										
# Applicable Elements					0		1	1	1	1
# Compliant Elements					0		0	1	1	1
Percent Compliant										

Legend:
M = Met
N = Not met
N/A = Not applicable

Total Applicable Elements:	**4**
Total # Compliant Elements:	**3**
Total Percent Compliant:	**75%**

Appendix C. Appeals Record Review Tool for Northeast Behavioral Health, LLC

The completed appeals record review worksheet follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix C. Colorado Behavioral Health Organization (BHO) Appeals Record Review Tool *for* Northeast Behavioral Health, LLC

Review Period:	July 1, 2007–June 30, 2008
Date of Review:	February 4, 2009
Reviewer:	Barbara McConnell
Participating BHO Staff Member:	Carol Staples

1	2	3	4	5	6	7	8	9	10	11	12	13	14
File #	**Member ID**	**Date Appeal Received**	**Evidence of Reasonable Assistance**	**Date of Acknow-ledgment Letter**	**Acknow-ledgment Within 2 Working Days**	**Decision-maker—Previous Level**	**Decision-maker—Clinical Expertise**	**Expedited**	**Time Frame Extended**	**Date Resolution Letter Sent**	**Resolved in Required Time Frame**	**Resolution Notice Includes Required Content**	**Resolution Notice Easy to Understand**
1	XXXXX	3/19/08 3/28/08 4/16/08	M☒ N☐ U☐	3/21 N/A N/A	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☒ N☐	Y☐ N☒	4/21/08	M☐ N☒	M☒ N☐	M☒ N☐
Comments: The notice of action in this case was a notice that Clozaril was to be discontinued due to the member's lack of follow-through and noncompliance with federally mandated requirements for appointments and lab tests. The notice of action was sent March 17, 2008. A request for a standard appeal was received on March 19, 2008, and acknowledged on March 21, 2008. NBH staff reported that at some point the ombudsman (who was representing the member at that point) contacted NBH and withdrew the appeal, stating that the member was now represented by the Colorado Legal Center which would be refiling the appeal. The record contained no documentation of communication from the ombudsman, although there was an internal NBH e-mail on April 2, 2008, referring to the ombudsman having withdrawn the appeal. The resolution was due on April 2, 2008; therefore, documentation of communication with the ombudsman was important to determine whether the standard appeal was resolved on time. The appeal record contained a letter from an attorney with the Colorado Legal Center dated March 28, 2008. In the letter, the attorney thanked NBH for an "expedited review of the members' services," stating that the attorney considered the notice of action void and that NBH should contact the attorney if this was not correct. The record contained no communication to the attorney in response to this letter. The record contained evidence that staff members at the CMHC were attempting to contact and work with the member to offer an alternative medication, but they had difficulty reaching the member. When the member presented to the CMHC, the member continued to insist on receiving Clozaril instead of the alternative medication offered. NBH staff members reported that they had not interpreted the attorney's letter of March 28, 2008, as a request for an expedited appeal and, therefore, did not process an appeal in response to the letter. Another letter was received from the attorney April 16, 2008, requesting an expedited appeal. This appeal was not acknowledged (which was not required) and it was processed as an expedited appeal. The resolution was sent April 21, 2008 (within three working days). The record contained no evidence of reasonable efforts at oral notification. The original notice of action allowed the member 20 days to file an appeal. Federal regulations, at 42 CFR 438.420, require the member to file an appeal within 10 days or before the services are terminated if benefits were to continue. When the attorney filed the appeal on April 16, 2008, the member no longer had appeal rights. NBH should have considered using an extension to counsel with the parties involved to avoid withdrawal of the appeal and potential loss of appeal rights.												
# Applicable Elements		1		1	1	1				1	1	1	
# Compliant Elements		1		1	1	1				0	1	1	
Percent Compliant													

Legend:
M = Met
N = Not met or No
U = Unable to determine
Y = Yes
N/A = Not applicable

Total # Applicable Elements	**7**
Total # Compliant Elements	**6**
Total Percent Compliant	**86%**

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

Table D-1 lists the participants in the FY 2008–2009 site review of **NBH**.

Table D-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Rachel Henrichs	Project Coordinator
NBH Participants	**Title**
Heidi Bemowski	Quality Improvement Associate Director
Terri Houkom	Quality Improvement Assistant
Julie Kellaway	Quality Improvement Director
LaRue Leffingwell	Compliance and Contract Coordinator
John Rattle	Chief Financial Officer
Carol Staples	Office of Consumer and Family Affairs Director
Karen Thompson	Executive Director
Scott Wylie	Utilization Manager
Department Observers	**Title**
Jerry Ware	Quality Compliance Specialist
Marceil Case	Behavioral Health Specialist

Appendix E. Corrective Action Plan Process for FY 2008–2009 for Northeast Behavioral Health, LLC

NBH is required to submit to the Department a CAP for all elements within each component scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each element that requires correction, the health plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. Supporting documents should not be submitted and will not be considered until the plan has been approved by the Department. Following Department approval, the BHO must submit documents per the timeline that was approved.

Table E-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each BHO will submit a CAP to the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or the file transfer protocol (FTP) site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must address the planned intervention(s) to complete the required actions, and the timeline(s) for the intervention(s).
Step 2	**Prior approval for timelines exceeding 30 days**
	If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, the BHO must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	The Department will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan, or ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the plan, the BHO should implement all the planned interventions and submit evidence of such intervention to HSAG via e-mail or the FTP site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

Table E-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all 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 CAP follows.

Table E-2—FY 2008–2009 Corrective Action Plan *for* NBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
2. Notices of Action 1. The Contractor defines action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole or in part, of payment for a service. ◆ The failure to provide services in a timely manner. The failure to act within the time frames for resolution of grievances and appeals. **Findings:** The Utilization Management policy (009) and the provider manual included a definition of action, but linked the action to a decision that the provider would make, rather than to the	The preamble to the BBA specifically states that actions are triggered by an MCO or PIHP decision, not by the provider's treatment decision. Therefore, NBH must revise all pertinent materials to include the correct definition of an action.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* NBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
BHO's decision. In addition, the provider manual included three definitions of an action (pages 37, 43, and 160). While none of the definitions in the provider manual was incorrect, there were three different lists of items that were considered an action. NBH may consider reviewing all pertinent documents to ensure that all definitions of an action are consistent.				
3. Notices of action must contain: ◆ The action the Contractor has taken or intends to take. ◆ The reasons for the action. ◆ The member's (and provider's on behalf of the member) right to file an appeal and how to do so. ◆ The member's right to request a State fair hearing and how to do so.	NBH must ensure that notices of action sent to members are accurate, offer benefits only if applicable, and contain the correct timelines for filing to qualify for continued benefits.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* NBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that. ◆ The circumstances under which the member may have to pay for the costs of services if continued benefits are requested. **Findings:** The template included language regarding continuation of benefits and stated that members could request continuation of benefits (services) if the member filed within 20 days of the notice of action. NBH staff stated that this template letter was used for all actions. NBH may consider either tailoring notice of action letters to the appropriate situation or developing two templates that contain correct information for members.				

Table E-2—FY 2008–2009 Corrective Action Plan *for* NBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
4. The notice of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized, Medicaid-covered services, at least 10 days before the date of action (unless extenuating circumstances exist—found in Exhibit G) ◆ For denial of payment, at the time of any action affecting the claim ◆ For standard service authorization decisions that deny or limit service, within 10 calendar days ◆ For service authorization decisions not reached within 10 calendar days, on the date the time frames expire ◆ For expedited service authorization decisions, within three days	NBH must ensure that notices of action are sent within the required time frames.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* NBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
Findings: The notice of action record reviewed involved a change in current treatment and indicated that a notice of action was sent eight days before the effective date of the change.				
3. Appeals 11. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires: ◆ For standard resolution of appeals, 10 working days from the day the Contractor receives the appeal ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal **Findings:** The policy did not address the notification timeline for	NBH must revise its policies and other documents pertaining to the appeal process to specify the notification time frames for standard and expedited appeals and ensure that the time frames comply with the requirements. NBH must also develop a mechanism to document verbal communication pertinent to the appeal, particularly when documentation of verbal communication could affect compliance with the required time frames.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* NBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
standard or expedited appeals. The consumer handbook informed members that an expedited decision would occur within three days, with notification to follow in another 2 days. The appeal record reviewed on-site did not appear to be in compliance with the time frame; however, there were events reported by NBH staff that had not been documented and may have indicated compliance.				
12. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if either: ◆ The member requests the extension. ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest. **Findings:** The Appeal of an Action policy addressed the 14-day extension for standard appeals;	NBH must revise its policies and other pertinent documents to clarify that time frames to resolve both standard and expedited appeals may be extended for up to 14 days if the member requests the extension or if NBH shows the need for additional information and how a delay is in the member's interest.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* NBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
however, the policy did not address an extension process for expedited appeals.				
14. For notice of an expedited resolution of an appeal, the Contractor must also make reasonable efforts to provide oral notice of resolution. **Findings:** While NBH's policy was in compliance, an appeal record reviewed on-site indicated that the appeal was eventually processed as an expedited appeal, with no documentation of reasonable efforts to provide oral notice of the resolution.	NBH's appeal records must include documentation of reasonable efforts to provide oral notice of appeal resolution.			
19. The Contractor continues the member benefits if: ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice of action	NBH must develop a mechanism to ensure that notices of action inform members of each of the qualifications and include accurate information regarding the request for continued benefits during the appeals process.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* NBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
▪ The intended effective date of the proposed action ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits. **Findings:** The Appeal of an Action policy did not define the timely filing of an appeal as filing within 10 days of the notice of action or the date of the intended action. The notice of action that was sent to a member (as evidenced by record review on-site) stated that benefits would continue if the member filed an appeal				

Table E-2—FY 2008–2009 Corrective Action Plan *for* NBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
within 20 calendar days of the notice of action. In addition, the notice of action sent to the member did not accurately inform the member about the circumstances surrounding continued benefits.				

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

The following table describes the activities 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 F-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 on October 3, 2008, for the BHO and the Department to preview the FY 2008–2009 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 provided a presentation to the Department and the BHOs on January 27, 2009, titled "Developing and Implementing Corrective Action Plans." In this presentation, HSAG reviewed the timeline and requirements for the corrective action plan process. ◆ 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 the BHO's 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 BHO's contract, dated March 1, 2007, to develop the 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 four components. ◆ Documents requested included applicable policies and procedures, minutes of key BHO committee or other group meetings, reports, logs, and other documentation.

Table F-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ 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., certain original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents needed that HSAG identified during its desk audit. ◆ HSAG requested and reviewed additional documents needed that HSAG identified 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 2008–2009 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 required of the BHO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2008–2009 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.