State of Colorado

Department of Health Care Policy and Financing

Behavioral Health Quality Improvement Strategy

MARCH 2005

BEHAVIORAL HEALTH QUALITY IMPROVEMENT STRATEGY

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I. Background

In 1997, the Balanced Budget Act of 1997 (BBA) mandated that States ensure the delivery of quality health care by all Medicaid health plans. Section 1932(c)(l) of the Social Security Act, 42 Code of Federal Regulations (CFR) 438.200 requires the Department of Health Care Policy and Financing (the Department) to implement a quality assessment and improvement strategy for the Medicaid managed care population. It sets forth specifications for quality assessment and performance improvement strategies that the Department must develop. It also establishes standards that the Department and Behavioral Health Organizations (BHOs) must meet.

The BBA requires that the states conduct an annual evaluation of their Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs) to determine the MCOs' and PIHPs' compliance with federal and state regulations, standards for access to care, quality measurement and improvement and other contractual requirements. The Department has opted to complete this requirement by contracting with an External Quality Review Organization (EQRO). The current EQRO is Health Services Advisory Group, Inc. (HSAG). The federal Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS), regulates requirements for the external quality review (EQR).

The Behavioral Health Quality Strategy is a coordinated, comprehensive and ongoing effort to monitor, assess and improve the performance of all care and services provided through the contracted BHOs. The Department oversees the Behavioral Health Quality Strategy to verify that the performance of quality improvement functions is timely and effective.

The Behavioral Health Quality Strategy is designed to ensure that services provided to Medicaid members meet established standards for access to care, clinical quality of care and quality of service; to identify and document issues related to those standards; and to verify that appropriate corrective actions are taken to address those issues.

Managed Mental Health Care

The Colorado Medicaid Community Mental Health Services Program (Mental Health Program) is composed of five (5) geographic service areas. Each BHO is responsible for one of these service areas, which encompasses one or more whole counties. Each BHO must meet the federal PIHP requirements. The goals of the Mental Health Program are to:

1. Promote and assist in the recovery of individuals with mental illnesses through innovative services that empower consumers and families to determine and achieve their goals;
2. Assure access to necessary mental health services for consumers and families, including engaging individuals with serious mental illnesses who may not seek help on their own;
3. Provide the appropriate mix of mental health services that meet the needs of each individual consumer and family;
4. Assure that quality services are provided to consumers and families;
5. Provide all necessary services through a cost-effective system;
6. Achieve a coordinated system of delivering mental health services to Medicaid consumers; and
7. Maximize community resources in an effort to maintain the least restrictive level of care for consumers.

Department Responsibilities

The Department is responsible for the quality of care and availability of services provided to members of the Mental Health Program and is committed to ensuring an effective system of behavioral health quality assessment and improvement. The Behavioral Health Quality Strategy is designed to fulfill the following Departmental responsibilities as outlined in federal and state regulations. These responsibilities are to:

1. Have a strategy for assessing and improving the quality of managed care services offered by all BHOs.
2. Document the strategy in writing.
3. Provide for the input of members and other stakeholders in the development of the strategy, including making the strategy available for public comment before adopting it in final.
4. Ensure compliance with standards established by the Department.
5. Conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy as often as the Department considers appropriate, but at least every three years.
6. Submit to CMS the following:
    a. A copy of the initial strategy and a copy of the revised strategy, whenever significant changes are made.
    b. A report on the implementation and effectiveness of the strategy, at least every three years.

Behavioral Health Quality Strategy Elements

The Behavioral Health Quality Strategy must address or include, at a minimum, information relating to the following:

1. BHO contract provisions that incorporate the standards specified in 42 CFR.
2. Procedures for:
    a. Assessing the quality and appropriateness of care and services furnished to all Medicaid members covered by the BHO contracts.
    b. Identifying the race, ethnicity and primary language of each Medicaid member.
    c. Supplying race, ethnicity and primary language information to providers for each Medicaid member at the time of enrollment.
    d. Regularly monitoring and evaluating compliance with the standards.
3. For BHOs, any national performance measures and levels that may be identified and developed by CMS in consultation with the Department and other relevant stakeholders. (Note: At this time, no performance measures have been developed by CMS.)
4. Arrangements for annual external independent reviews of quality outcomes and timeliness of and access to the services covered under each contract.
5. For BHOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of 42 CFR 438.
6. An information system that supports initial and ongoing operation and review of the Behavioral Health Quality Strategy.

7. Standards at least as stringent as those in 42 CFR for access to care, structure, operations and quality measurement and improvement.

II. Behavioral Health Quality Strategy Scope

This section establishes the scope of work encompassed by the current Behavioral Health Quality Strategy and defines "significant changes" that will trigger stakeholder input.

The Department currently contracts with five (5) BHOs that serve as the Colorado Mental Health Program. During fiscal year (FY) 03-04, 369,472 Medicaid members were eligible to receive services from these BHOs.

The following are encompassed within the scope of the Behavioral Health Quality Strategy:

1. All Medicaid members who are eligible for behavioral health services.
2. All aspects of behavioral health care including accessibility, availability, level of care, continuity, appropriateness, timeliness and clinical effectiveness of care and services covered by the Mental Health Program.
3. All aspects of BHO performance relating to access to care, quality of care and quality of service, including subcontracts and delegation; provider issues; advance directives; practice guidelines; member rights and responsibilities; access and availability; utilization review; continuity of care; quality assessment and performance documentation; quality improvement; grievances, appeals and fair hearings, and credentialing and recredentialing.
4. All services covered including inpatient hospital services; under 21 psychiatric services; 65 and over psychiatric services; outpatient services; psychiatric services; rehabilitation services including partial long day, partial short day, group, individual, and individual brief; psychosocial rehabilitation services; clinic services, case management; medication management services; residential services; school-based services; and alternative services set forth in the BHO's proposal including vocational services, home-based services for children and adolescents, intensive case management and other services.
5. All providers, including physicians, hospitals or other health care professional or facility that serve clients enrolled in the Mental Health Program.
6. All providers and any other delegated or subcontracted provider type.
7. All aspects of BHO internal administrative processes which are related to service and quality of care including customer services, enrollment services, provider services, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information service and quality improvement.

This Behavioral Health Quality Strategy will be amended to reflect changes in scope and identified needs. Significant changes to the Behavioral Health Quality Strategy that will require input from members and stakeholders are defined as:

1. Any change to the Behavioral Health Quality Strategy resulting from legislated, state, federal or other regulatory authority.
2. Any change in membership demographics of 50 percent or greater within one year.
3. Any change in the provider network of 50 percent or greater within one year.

III. Behavioral Health Quality Strategy Description

This section describes the formal process the Department uses to obtain beneficiary and stakeholder input and public comment on the Behavioral Health Quality Strategy before final adoption, as well as how and how often the Department will update the Behavioral Health Quality Strategy.

The Behavioral Health Quality Strategy is developed with input from the BHO leadership, BHO Quality Improvement personnel, Colorado Medicaid Community Mental Health Services Program Advisory Committee and other identified stakeholders.

The Department will post the Behavioral Health Quality Strategy on the Department's Web site and provide public notice to afford the public an opportunity to comment before final adoption.

Subsequent to stakeholders' input and public comment, a copy of the final document will be submitted to the CMS Regional Office.

The final Behavioral Health Quality Strategy will become effective April 1, 2005. The Department will provide CMS with periodic updates on the status of the Department's Behavioral Health Quality Strategy and will submit written revisions to the Behavioral Health Quality Strategy whenever significant revisions are made. The program is reviewed and evaluated annually, or more often, as additional information becomes available. A copy of the final document will be posted on the Department's Web site at http://www.chcpf.state.co.us/HCPF/mntlhlth/MHIndex.asp.

IV. Department Mission, Guiding Principles and Goals

Department Mission

The mission of the Department is to purchase cost-effective health care for qualified low-income Coloradans.

Department Guiding Principles

The guiding principles of the Department are to:

1. Treat clients with respect and consideration.
2. Be honest in relationships with each other, with partners and with the public.
3. Be focused, accountable and efficient.
4. Work to ensure access to appropriate, medically necessary health care for eligible individuals.
5. Purchase and finance health care in a cost-effective and responsible manner.
6. Evaluate success by using client input, outreach efforts and surveys. The Department will continually search for methods to improve quality, accessibility and cost effectiveness.

Department Goals

The Department has built a strategic plan based on the stated goals of CMS. In order to be compatible with the federal goals, the Department will:

1. Evaluate cost control mechanisms now operating in its programs to ascertain if it is getting the maximum value and cost benefit.
2. Avail itself of opportunities and resources to further the goal of improved health status of vulnerable Coloradans while achieving cost effectiveness.
3. Evaluate client health and satisfaction and model program design and purchase of service decisions in such a way to promote improved care delivery.
4. Value its human assets through effective recruitment, hiring and retention.

V. Behavioral Health Quality Strategy Purpose

The Department's purposes of the Behavioral Health Quality Strategy are:

1. To define and implement strategies for assessing and improving the quality of managed care services provided by BHOs.
2. To promote opportunities for partnerships with public and private entities involved in quality improvement efforts.

The specific purposes of the Behavioral Health Quality Strategy are to:

1. Provide direction and guidance for all staff in the pursuit of the Behavioral Health Quality Strategy goals.
2. Provide guidance for determination of activities for Medicaid members.
3. Provide guidance to identify race, ethnicity and primary languages spoken.
4. Assure an information system is in place that will support the efforts of the Behavioral Health Quality Strategy.
5. Establish and maintain standards for quality of care, access to care and quality of service.
6. Verify that services provided to Medicaid members conform to professionally recognized standards of practice and code of ethics.
7. Provide Medicaid members a means by which they may seek resolutions of perceived failure by providers or personnel to provide appropriate health care services, access to care or quality of care.
8. Establish, maintain and enforce a policy regarding public review, input and feedback on Behavioral Health Quality Strategy activities.
9. Establish, maintain and enforce a policy for protection of confidential member and provider information.

VI. Behavioral Health Quality Strategy Goals and Objectives

This section clarifies the goals and objectives of the Behavioral Health Quality Strategy in terms of outcomes, continuous quality improvement, collaboration (strategic partnerships) and systematic monitoring.

Goals

1. Consistent application of professionally recognized standards of care and code of ethics.
2. Continuous improvement in the behavioral health status of Medicaid members.
3. Improved quality of care.
4. Improved quality of services.
5. Improved access to care and services.
6. Improved member satisfaction.

Objectives

1. Identify and pursue opportunities for improving the health status of the enrolled population through behavioral health services.
2. Identify, review, monitor and pursue opportunities to resolve quality of care problems that directly or indirectly affect member care, and implement actions to prevent the recurrence of such problems.
3. Identify and pursue opportunities for improving quality of service.
4. Identify and pursue opportunities for improving accessibility of care and member satisfaction with care and service.
5. Evaluate the Behavioral Health Quality Strategy annually and modify it as necessary to achieve effectiveness.
6. Implement a systematic method for monitoring and evaluating providers' performance against established standards for quality, accessibility and appropriateness of care.
7. Monitor performance of providers in promoting and providing quality of care, access to care and service activities through the use of performance measures, member satisfaction reports, performance improvement projects and analysis of administrative data.
8. Monitor Medicaid members' satisfaction with their care, accessibility of care and service.
9. Monitor and evaluate administrative and clinical functions, including: subcontracts and delegation; provider issues/performance; advance directives; practice guidelines; member rights and responsibilities; access and availability (service delivery); utilization review; continuity of care; quality assessment and performance improvement documentation; quality improvement; grievances, appeals and fair hearings; and credentialing and recredentialing.
10. Monitor compliance with regulatory requirements of the Department and federal agencies with respect to quality improvement.
11. Monitor to assure that qualified practitioners are included in the networks, and monitor the established mechanisms for credentials review of network providers.

12. Monitor to assure contracts between the BHOs and their delivery networks meet the minimum qualifications to assure compliance with benefits delivery and operations.

VII. Behavioral Health Quality Strategy Functions and Activities

This section delineates the functions and activities planned to carry out the Behavioral Health Quality Strategy program and designates responsible parties. Table 1 demonstrates responsibility for the described functions and activities.

Table 1—Responsibility for Functions and Activities

Functions and Activities	Responsibilities	
	BHO	Department
1. Conduct performance improvement projects and related activities.	✓	✓
2. Perform and/or monitor member satisfaction surveys and take action, where appropriate, to improve satisfaction.	✓	✓
3. Receive, investigate, and resolve member appeals and grievances as related to access to care, quality of care and service issues.	✓	✓
4. Monitor and evaluate covered behavioral health care services rendered to Medicaid members through the use of audits, data collection, performance improvement activities and outcomes assessments.	✓	✓
5. Conduct contract compliance reviews of BHOs for structure and operational compliance with the standards.		✓
6. Review a sample of network providers' member medical records to achieve compliance with regulations, standards and contractual requirements.		✓
7. Identify instances of potential quality issues. Review and resolve potential quality issues as appropriate.	✓	✓
8. Review utilization review activities to ensure that these activities do not have a negative impact on quality of care.	✓	✓
9. Review the credentialing activities of the BHOs and their subcontractors and providers.		✓
10. Review BHOs' internal practices regarding the handling of medical record information to achieve compliance with confidentiality policies and member rights.		✓
11. Review BHOs' quality improvement activities to achieve compliance with the requirements of the contract.		✓
12. Conduct an annual evaluation of the Behavioral Health Quality Strategy activities and effectiveness and report to CMS, stakeholders and other interested public groups.		✓
13. Publish and distribute to enrollees consumer information on grievances, appeals and fair hearing rights and procedures.	✓	
14. Make modifications to the Behavioral Health Quality Strategy as needed.		✓

VIII. Behavioral Health Quality Strategy Tactics

This section summarizes the tactics identified to achieve the Behavioral Health Quality Strategy monitoring and improvement objectives. Specific tactics to achieve the goals and objectives for FY 04-05 include the following:

1. Performance Improvement Projects

BHOs are required by contract to conduct two (2) performance improvement projects (PIPs) annually on topics approved by the Department. When the Department is directed by CMS to focus on a particular topic, the BHOs will conduct PIPs on that topic. Each BHO must complete PIPs in a reasonable timeframe to allow integration of findings into the BHO's overall quality assessment and improvement program and to produce new information on quality of care each year. Each BHO must report the results of each PIP on an annual basis with sufficient detail to allow the Department, through its EQRO, to validate the projects.

PIPs will be designed to achieve, through ongoing measurements and intervention, significant and sustained improvement in clinical care and nonclinical care areas that are expected to have a favorable effect on member health outcomes and satisfaction.

PIPs must include:

a. Measurement of performance using objective quality indicators,

b. Implementation of system interventions to achieve improvement in quality,

c. Evaluation of the effectiveness of the interventions, and

d. Planning and initiation of activities for increasing or sustaining improvement.

2. Validation of Performance Improvement Projects

The Department, through its EQRO, will validate the soundness and results of performance PIPs implemented by the BHOs each fiscal year. This process will follow the CMS protocol or an approach consistent with this protocol and will:

a. Assess BHOs' methodology, including study topics, questions, indicators, population, sampling methodology, data collection procedures, data analysis, data interpretation and performance improvement strategies and evaluate the extent to which reported improvement represents "real" improvement and whether the documented improvement has been sustained

b. Verify study findings

c. Evaluate overall validity and reliability of study results

The EQRO will produce individual performance improvement project reports for each BHO, detailing the monitoring process, documents reviewed, interviews conducted, individual findings, recommendations for improvement and corrective actions required. The EQRO also will produce one statewide report summarizing steps taken in the PIP validation process, materials submitted and reviewed, overall results of the validation process and detailed recommendations for improvement.

3. Performance Measures

BHOs are required by contract to measure performance. Annually, each BHO must measure its performance using standard measures required by the Department. The Department will review the measures and take corrective actions when necessary.

Additionally, the BHOs must calculate additional performance measures when they are developed by CMS.

The following measurements are used to evaluate BHO performance:

a. Penetration rates – children
b. Penetration rates – adults
c. Consumer perception of access
d. Consumer perception of outcomes
e. Consumer perception of quality
f. Consumer satisfaction with services
g. Consumer participation in service planning
h. Consumers linked to primary care
i. Children living in a family-like environment
j. Adults living independently
k. Employment
l. Positive change in problem severity – children
m. Positive change in problem severity – adults

4. Validation of Performance Measures

The Department, through its EQRO, will use CMS or comparable protocols to validate the accuracy of the performance measures reported by each BHO. The EQRO also will determine the extent to which the measures calculated by the Department and/or the Colorado Department of Human Services/Division of Mental Health have followed specifications for the calculation of the performance measures. The validation process shall be composed of three phases: pre-onsite, onsite and post-onsite. The EQRO will produce individual performance measure validation reports for each BHO detailing the monitoring process, documents reviewed, interviews conducted, individual findings, recommendations for improvement and corrective actions required. The EQRO also will produce one statewide BHO performance measure validation summary report.

5. Monitoring BHO Compliance

An annual monitoring process will be conducted with each BHO to determine compliance with state and federal regulations, contractual requirements and standards established by the National Committee for Quality Assurance (NCQA). This process shall follow the CMS protocol or similar approach and will rely on two main sources of information: document review and BHO personnel interviews. The EQRO will produce individual compliance reports for each BHO detailing the monitoring process, documents reviewed, interviews conducted, individual

findings, recommendations for improvement and corrective actions required. BHO corrective action plans require Departmental approval to ensure that the corrective actions meet the requirements and that corrective actions will be completed within a reasonable timeframe. The Department expects immediate corrective action for emergent or serious quality of care concerns. The Department will monitor all required actions until each BHO can demonstrate compliance.

6. Member Satisfaction

The Department will monitor BHO member satisfaction based on results of the annual Mental Health Statistics Improvement Program (MHSIP) report and annual Youth Services Survey (YSSF) for Families. The MHSIP and YSSF are both consumer surveys aimed at assessing consumer satisfaction and perception in areas such as access to care, quality of care, cultural sensitivity, participation in treatment and improvement in the clients well being and functioning. Where there appears to be significantly low scores, the BHO shall implement a corrective action.

7. Quality Strategy Team

The Department requires BHOs to submit several compliance reports that assist the Department in monitoring and ensuring that areas such as access to care, quality of care and grievances and appeals are in compliance with federal and state laws and regulations as well as contract requirements. After receipt of the BHOs' required compliance reports, the Department's Quality Strategy Team will meet to review the reports for compliance. The Quality Strategy Team will implement corrective actions when the review indicates the BHO is not complying with its contractual requirements, as monitored in the reports.

On a quarterly basis, the Quality Strategy Team will review the following reports from the BHOs: access to services reports, network capacity and services reports, grievance and appeal reports and alternative services reports.

On an annual basis the Quality Strategy Team will review the following reports from the BHOs: annual quality reports including the results and status of each PIP, results of the BHOs' internal member satisfaction surveys, program impact analysis and annual reports and quality improvement plans.

8. Monitoring of Encounter Data

The Department will monitor encounter data for timely and complete submission. Encounter data will be based on service dates from a 12-month interval and will include submission of all required and alternative services directly to the Department and/or its designee in the methods, frequency and formats determined by the Department. The Department will annually validate a sample of encounter claims.

9. Comparative Information on All BHOs

The Department's EQRO will annually provide a summary compliance report on the BHOs performance for all mandatory and optional activities. This includes but is not limited to VPIPs, VPM, compliance monitoring and member satisfaction. The Department will use this information to assess the overall quality of the Mental Health Program and to identify trends and BHO performance that significantly falls below the median. If the Department identifies a trend indicating that a BHO's performance significantly falls below the median, corrective actions will be required if appropriate.

10. Compliance with Standards for Information System Support and Maintenance

The Department will continue to utilize the information system and established eligibility processes to collect and identify race, ethnicity and primary language spoken and report this information to contracted BHOs. Reporting race, ethnicity and primary language information to the BHOs is essential for the provision of culturally and linguistically appropriate care as required by contract (see Section IX of this document).

a. The Department will work with the Colorado Benefits Management System (CBMS) project manager and the Medicaid Management Information System (MMIS) manager to determine how the eligibility information system changes may enhance the process used to collect race, ethnicity and primary language spoken information.

After the new system is reviewed, assessed and strengths and weaknesses are identified, the Department will develop action steps to enhance the process for collecting race, ethnicity and primary language information.

IX. Contract Provisions and Department Standards for Access to Care

This section outlines and discusses the contract provisions that must be met by contracted BHOs regarding Department standards for access to care and services, including availability of services; assurances of adequate capacity and services; coordination and continuity of care; and coverage and authorization of services.

Availability of Services

The Department has implemented programs and processes to monitor and assure that members' access to care is not restricted. Contracts with BHOs contain provisions that incorporate access and availability standards and protocols. In addition, BHOs are required to comply with access requirements outlined in Title 10, Colorado Revised Statutes (C.R.S.) and Managed Care Regulation 42 CFR.

BHOs are required by contract to establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the residence of members so as not to result in unreasonable barriers to access and to promote continuity of care, taking into account the usual means of transportation ordinarily used by members. Each BHO shall have providers located throughout the BHO's service area within 30 miles or 30 minutes travel time to the extent such services are available. When a second opinion is necessary, BHOs must provide for one with a contracted qualified health care professional or arrange for one outside the network.

When covered services are not available from contracted providers, the contract requires the BHOs to provide adequate and timely services out of network and coordinate payment with the out-of-network provider.

BHOs are required by contract to verify that all participating providers meet licensing and certification requirements through a formal credentialing program that complies with the standards of the NCQA for initial credentialing and recredentialing of providers. All BHOs contracted laboratory testing sites are required to have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.

BHOs are required by contract to have policies and procedures for ensuring access to appropriate services 24 hours per day, seven (7) days per week for all members. In addition, routine services must be scheduled within seven (7) days; urgent care must be scheduled within 24 hours of the BHO's notification; and emergency care must be provided by phone within 15 minutes of initial contact and in-person within one hour in urban/suburban areas and within two (2) hours in rural/frontier areas.

The Department has detailed contract requirements for BHOs to facilitate the provision of culturally and linguistically appropriate care to members. The BHOs' policies and procedures must be culturally appropriate and competent. Translation of BHOs' member materials into prevalent languages of non-English speaking member populations is also contractually required. Policies and procedures for the provision of interpreter services is required for members with communication disabilities or for non-English speaking members. For members with visual impairments, materials are required to be in Braille, large print or audiotapes.

BHOs are required by contract upon request of the member to provide a second opinion from a qualified health care professional within the network or arrange for the member to obtain one outside the network at no cost to the member.

Assurance of Adequate Capacity and Services

To ensure an appropriate network of providers that is sufficient to provide adequate access to all covered services, the Department requires BHOs to maintain a network of providers that is sufficient in number, mix and geographic location to meet the mental health needs of the anticipated number of members in its service area. The Department requires BHOs to work cooperatively with the Department to develop network adequacy standards. In establishing and maintaining the provider network, the BHO shall consider the following:

1. Offering contracts to both Essential Community Providers and other providers;
2. The anticipated enrollment;
3. The expected utilization of services;
4. The numbers and types of providers in terms of training, experience and specialization required to furnish contracted Medicaid services;
5. The numbers of network providers who are not accepting new Medicaid patients; and
6. The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical access for members with disabilities.

Coordination and Continuity of Care

The BHOs must provide or arrange for the provision of all medically necessary mental health services to members seeking mental health services. The BHOs must assess the need for services, develop a service plan, provide or arrange for necessary services, coordinate mental health services rendered by multiple providers, coordinate mental health services with other health care and human services agencies and providers and refer members to other health care and human services agencies and providers as appropriate.

Recognizing the importance to members of needed medical care, the BHOs must make reasonable efforts to assist individuals to obtain necessary medical treatment. If a member is unable to arrange for supportive services necessary to obtain medical care due to her/his mental illness, these supportive services shall be arranged for by the BHO or another person who has an existing relationship with the member whenever possible.

BHOs must assign a care coordinator to each member receiving mental health services. Members and/or their legal representatives shall have the opportunity to participate in the assessment of member needs and the development of service plans.

The BHOs must follow state and federal laws and regulations regarding the treatment of mental health consumers including discharge planning.. .

BHOs must maintain written policies and procedures to ensure timely coordination of the provision of covered services to members to promote and ensure service accessibility, attention to individual needs, continuity of care, maintenance of health and independent living.

BHO contracts clearly specify that the confidentiality of all member records and other materials, in any form, including electronic shall be protected. The contracts also require that, except for purposes directly connected with the administration of the Medicaid program, the BHOs may not disclose information about or obtained from any member in a form identifiable with the member without the prior written consent of the member or a minor's parent or guardian. An exception to this would be

the disclosure of information in summary, statistical or other form that does not identify particular individuals.

Coverage and Authorization of Services

The BHOs are required by contract to demonstrate commitment to the recovery model as expressed in the Surgeon General's Report on Mental Health[1]. It is recognized that recovery must be highly individualized while sharing many attributes across members. Member empowerment is an essential ingredient of recovery along with community reintegration and normalization of the life environment. Empowered recovery enables members to be not only in charge of their illness but also fully in charge of their lives. Major contributors to the opportunity for individual recovery involve the inclusion of member, family and advocates in a broad range of decisions from treatment planning to resource planning. Other aids to individual recovery involve the availability of member-driven and member-run programs, services and activities developed in conjunction with Members and their families.

The BHOs' contract includes a separate attachment, which lists all of the services that a BHO is required to provide its Medicaid members. All services included on the list must be provided or the BHO must arrange for them to be provided. The following services are included:

1. Inpatient hospital services
2. Under 21 psychiatric services
3. Sixty-five (65) and over psychiatric services
4. Outpatient services
5. Psychiatric services
6. Rehabilitation services including partial long day, partial short day, group, individual and individual brief
7. Psychosocial rehabilitation services
8. Clinic services, case management
9. Medication management services
10. Residential services
11. School-based services
12. Alternative services set forth in the BHO's proposal including vocational services, home-based services for children and adolescents, intensive case management services and other services

BHOs are further required to ensure that the services provided are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. In addition, the BHOs must provide the same standard of care for all members regardless of eligibility category and shall make all covered services to members as accessible in terms of timeliness, amount, duration and scope as those services are accessible to beneficiaries under Medicaid fee-for-service.

[1] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

The BHOs are required by contract to provide all medically and/or clinically necessary mental health services to all Medicaid eligible persons enrolled in the Mental Health Program. The following definition shall be used to determine if a service is medically or clinically necessary:

A covered service shall be deemed medically or clinically necessary if, in a manner in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care:

1. The service is reasonably necessary for the diagnosis or treatment of a covered mental health disorder or to improve, stabilize or prevent deterioration of functioning resulting from such a disorder;
2. The service is furnished in the most appropriate and least restrictive setting where services can be safely provided; and
3. The service cannot be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.

The BHO, in consultation with the service provider, member, family members and/or person with legal custody, shall determine the medical and/or clinical necessity of the covered service.

The authorization process shall take into consideration other factors, such as the need for services and supports to assist a member to gain new skills or regain lost skills that support or maintain functioning and promote recovery.

The BHO shall not deny services based on medical or clinical necessity solely because the member has a poor prognosis or has not shown improvement, if the covered services are necessary to prevent regression or maintain present condition.

X. Contract Provisions and Department Standards for Structure and Operations

This section outlines and discusses the contract provisions that must be met by contracted BHOs regarding Department standards for structure and operations at the health plan including provider selection, member information, confidentiality, enrollment and disenrollment, grievance systems and subcontractual relationships.

Provider Selection and Retention

BHOs are required to have written policies and procedures governing the selection and retention of providers. All BHOs' participating providers must meet licensing and certification requirements through a formal credentialing program that complies with the standards of the NCQA for initial credentialing and recredentialing of providers. Information from the accreditation of primary care clinics by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) may also be used to assist in meeting NCQA credentialing standards. All BHOs' contracted laboratory-testing sites are required to have either a CLIA Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.

BHOs' credentialing programs must include policies and procedures for detecting and reporting incidents of questionable practice, in compliance with Colorado Statutes and regulations, the Health Care Quality Improvement Act of 1986 and NCQA standards. BHOs are prohibited from employing or contracting with providers who are excluded from participation in federal health care programs as set forth in 42 CFR 438.214(d). In addition, BHOs are prohibited from discriminating against providers who serve high-risk populations or specialize in conditions that require costly treatment.

Member Information

BHOs are contractually required to provide to all members, including new members, materials that include general information about services offered by the BHOs and complete statements concerning member rights and responsibilities within a reasonable time after the BHO is notified of the member's enrollment.

BHOs are also required to provide periodic updates to member materials when needed to explain changes to policies. Prior to printing, the BHO must submit the updated materials to the Department for review and approval at least 30 calendar days prior to the targeted printing date and notify the member regarding changes in information at least 30 days prior to the change effective date. On urgent issues, the BHO can work with the Department to expedite the review process. Minimum requirements for information to be included in the member materials are listed in Appendix A.

BHOs are required to ensure that written information provided to members is, to the extent possible, written at the sixth grade level, unless otherwise directed by the Department, translated into other non-English languages prevalent in the BHO's service area and provided in alternative formats. Alternative formats include, but are not limited to, Braille, large print, audio tape and electronic formats.

BHOs must ensure that members understand that enrollment in the BHO is mandatory. Members must be provided sufficient information for them to understand their benefits; how to access covered services including authorization requirements; what benefits may be obtained from out-of-network providers; what constitutes an emergency medical condition; how to access emergency care after hours; and the fact that emergency services do not require prior authorization.

Confidentiality

Contracted BHOs are required to protect the confidentiality of all member records and other materials, in any form, including electronic that are maintained in accordance with their contract with the Department. Except for purposes directly connected with the administration of the Medicaid program, no information about or obtained from any member in possession of the BHOs can be disclosed in a form identifiable with the member without the prior written consent of the member or a minor member's parent or guardian. The exception to this is the disclosure of information in summary, statistical or other form that does not identify particular individuals. The BHOs are required to have written policies governing access to and duplication/dissemination of all such information. The BHOs must also advise their employees, agents and subcontractors that they are subject to these confidentiality requirements. In addition, BHOs must provide their employees, agents and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted.

BHOs must comply with all federal and state laws and regulations including but not limited to the requirements of 45 CFR 205.50, as amended, and to Article 16, Title 10 paragraph 423, C.R.S., as amended, and 45 CFR Parts 160 and 164, as amended, and 42 CFR 431.304–431.307, as amended, regarding confidentiality of health information about any member.

Enrollment and Disenrollment

The Mental Health Program is a mandatory program approved by CMS under a 1915 (b) waiver. Most Medicaid members are automatically enrolled into the BHO in their service area. The following individuals are not eligible for enrollment in the Mental Health Program:

1. Qualified Medicare Beneficiary only (QMB-only)
2. Qualified Working Disabled Individuals (QWDI)
3. Qualified Individuals 1 (QI 1)
4. Special Low Income Medicare Beneficiaries (SLMB)
5. Undocumented aliens
6. Program of All-inclusive Care for the Elderly (PACE)
7. Refugee Program (non-categorical refugee assistance)
8. Individuals who are inpatient at the Colorado Mental Health Institute at Pueblo (Institute) who are:
    a. Found by a criminal court to be Not Guilty By Reason Of Insanity (NGRI)
    b. Found by a criminal court to be Incompetent to Proceed (ITP)
    c. Ordered by a criminal court to the Institute for evaluation (e.g. competency to proceed, sanity, conditional release revocation, pre-sentencing)
9. Individuals between ages 21 and 64 who receive inpatient treatment at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan
10. Individuals who are NGRI and who are in the community on Temporary Physical Removal (TPR) from the Colorado Mental Health Institute at Pueblo and who are eligible for Medicaid are

exempted from the Mental Health Program while they are on TPR. TPR individuals remain under the control and care of the Colorado Mental Health Institute at Pueblo

11. Classes of individuals determined by the Department to require exclusion from the Mental Health Program
12. Individuals who receive an individual exemption as set forth at 10 CCR 2505-10, Section 8.212.02

Complaints, Grievance and Appeals

BHOs are required to establish an internal complaints process under which a member may challenge the denial of coverage of, or payment for, services in accordance with 42 CFR 434.32, and comply with all requirements of the Department's complaint process specified at 10 CCR 2505-10, Section 8.209. BHOs are further required to use the Department's BHO complaint data reporting tool to record, track, resolve and assess members' complaints and appeals. BHOs must also use Department defined data elements, sequence order and response codes to record complaint and appeal information. The completed data reporting form must be submitted to the Department within 30 calendar days following the end of each quarter, along with a completed Department complaint-reporting questionnaire that provides a written analysis of complaint data.

Department procedures for the review of BHO grievances and appeals files and for identifying systematic problems is as follows:

1. The Department shall review a random sample of the BHO's grievance and appeal files during the annual site review process.
2. Each file is reviewed to determine whether grievance and appeal regulations have been followed, the appropriateness of the resolution/disposition of the grievance or appeal and any overall patterns related to the nature/topic of the complaints.
3. The results of each file review are documented on a checklist and the BHO is given an overall score for compliance in this area.
4. Any systematic problems with the entities grievance and appeal process or patterns of complaints are documented in the Department's final site visit report and a corrective action is required.

Subcontracts and Delegation

BHOs are responsible for all work performed under their contract with the Department, including work performed through subcontracts. The Department has established requirements for BHO oversight of subcontractors.

BHOs are required to evaluate the subcontractor's ability to perform delegated activities before entering into a subcontract and oversee performance once the agreement is in place.

A written agreement with each subcontractor must specify the activities the BHO has delegated to the subcontractor and the subcontractor's reporting responsibilities. The written agreement must also include provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. Subcontracts must meet the requirements of 42 C.F.R Section 434.6, as amended. All subcontracts must provide for access to all records by the Secretary of the U.S. Department of Health and Human Services, as specified in 45 C.F.R Part 74, as amended.

Written oversight policies and procedures must include monitoring of services provided through subcontracts for quality, data reporting and other applicable provisions of the BHO's contract with the Department. If the BHO identifies deficiencies or areas for improvement, the BHO and subcontractor must take corrective action. If the BHO is terminating any existing subcontract, the BHO must notify the Department in writing at least 60 calendar days prior to the termination of services or less than 60 calendar days based on quality or performance issues. BHOs must explain how the replacement of these services will be performed.

Upon the Department's request, the BHOs must provide the Department with copies of any existing subcontracts as well as full descriptions of procedures and policies regarding subcontracts and performance monitoring. BHOs must notify the Department in writing

XI. Contract Provisions and Department Standards for Quality Measurement and Improvement

This section of the Behavioral Health Quality Strategy outlines and discusses the contract provisions that BHOs must meet regarding Department standards for performance measurement and improvement systems.

Practice Guidelines

The Department has established policies for the development and use of practice guidelines. BHOs must ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field, consider the needs of the member, are adopted in consultation with participating providers and are reviewed and updated annually.

BHOs must have mechanisms in place to ensure the consistent application of review criteria for authorization decisions and to consult with the requesting provider when appropriate. BHOs must notify the requesting provider 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. The notice to the provider does not need to be in writing.

Quality Assessment and Performance Improvement Program

BHOs are required to implement and maintain a system for detecting the over-utilization and under-utilization of health care services. The system should include the BHO's policies and procedures for detecting and addressing the over-utilization and under-utilization of services that shall be submitted during the annual site visit process. The Department shall review policies and procedures and request copies of internal reporting on utilization monitoring as well as evidence of how the BHO manages/corrects problem cases. If the Department identifies that utilization is not being adequately monitored and/or corrected, then the detection of over-utilization and under-utilization will be identified as a required corrective action item. The Department shall approve all corrective action plans to address deficits in detecting and addressing over-utilization and under-utilization of services and monitor the corrective action through completion.

BHOs are required to investigate any alleged quality of care concerns upon request of the Department. A brief but clear description of the issue, the efforts that the BHO took to investigate the issue and the outcome of the review must be submitted to the Department. The professional involved in the investigation should contact the member for his or her perspective as needed. The outcome review must include whether or not the issue was found to be a quality of care issue and what action the BHO intends to take. The BHOs are not required to disclose any information that is confidential by law.

BHOs must also monitor member perceptions of accessibility and adequacy of services through the use of member satisfaction surveys, anecdotal information, grievance and appeals data and enrollment and disenrollment information. BHOs must develop a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected or when a serious compliant is reported.

BHOs are required to conduct PIPs and to measure and report their performance to the Department as outlined in Sections VIII.1. and VIII.3. of this document.

BHOs must maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program on at least an annual basis. An annual report must be submitted to the Department detailing the findings of the program impact analysis. The report shall describe the BHO's techniques to improve performance, the outcome of each PIP and the overall impact and effectiveness of the quality assessment and improvement program. The Program Impact Analysis and Annual Report must provide sufficient detail for the Department to validate the BHO's PIPs according to 42 CFR parts 433 and 438, External Quality Review of Medicaid Managed Care Organizations.

Quality Monitoring Elements

BHOs are required to participate in the annual external independent review of quality outcomes, timeliness of, and access to the services covered under this contract. The external review will cover state and federal regulations, contract requirements and NCQA standards. These requirements have been organized into 13 standards, which are identified in Section II of this document.

Health Information System

The BHOs are required to ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic and consistency; and collecting service information in standardized formats to the extent feasible and appropriate.

The BHOs must maintain health information systems that collects, analyzes, integrates and reports data. The system must provide information on areas including, but not limited to, utilization and grievances and appeals.

The BHOs must make all collected data available to the Department and/or designee and, upon request, to CMS.

The BHOs must submit Medicaid claim forms for each service provided to each member.

1. Each BHO must ensure that data received from providers is accurate and complete by:
    a. Verifying the accuracy and timeliness of reported data;
    b. Screening the data for completeness, logic and consistency; and
    c. Collecting service information in standardized formats to the extent feasible and appropriate.
2. Each BHO shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including utilization and grievances and appeals.
3. Each BHO shall make all collected data available to the Department and/or designee and, upon request, to CMS.
4. Each BHO shall submit Medicaid claim forms for each service provided to each member.

XII. Intermediate Sanctions

This section describes an intermediate sanction system that will be applied based upon the results of the BHOs' quality/monitoring activities. It describes how the Department uses intermediate sanctions in support of its Behavioral Health Quality Strategy and addresses the requirements specified in 42 CFR 438 Subpart I, and reviews the methodology for using sanctions to address identified quality of care problems.

BHOs are required by contract to comply with all provisions of the contract and its amendments, if any, and act in good faith in the performance of the provisions. The BHOs agree that failure to comply with the contract provisions may result in the application of remedial actions and/or termination of the contract. The following constitute grounds for remedial action:

1. Substantial failure to provide medically necessary services that the contractor is required to provide, under law or this contract, to a member.
2. Imposition on members' premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
3. Actions that discriminate among members on the basis of their health status or need for health care services.
4. Misrepresentation or falsification of information furnished to the Department, CMS, members, potential members or providers.
5. Failure to provide medical records and other requested documents for non-emergency review within 30 calendar days of the date of the written request.
6. Direct distribution or indirect distribution, through any agent or independent contractor, of any marketing materials that have not been approved by the Department or that contain false or materially misleading information.
7. Failure to satisfy the scope of work found in the contract, as determined by the results of monitoring activities or audits described in Section II.H. of the contract.
8. Failure to comply with the requirements for physician incentive plans.
9. Violation of any other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and its implementing regulations.

If deficits in compliance are identified, the Department requires that the BHOs develop a corrective action plan to address the identified deficits. All corrective action plans are submitted to the Department for approval and are monitored by Department staff for a pre-determined amount of time. If, at the end of the time period, Department staff identifies a deficit in the BHO's performance that is not successfully addressed through the corrective action process, staff will document the issues, efforts made by the Department to address the issue(s) with the BHO and make a recommendation to management to utilize contract remedies. Department staff that identifies a severe deficit in the BHO, such as those which will seriously impact the health and welfare of its members, may make emergency recommendations to management to utilize contract remedies.

Contract remedies include:

1. Withhold payment to the BHO until the necessary services or corrections in performance are satisfactorily completed,

2. Impose monetary fines,
3. Impose temporary management of the contractor,
4. Allow members the right to terminate enrollment without cause,
5. Suspend new member enrollment,
6. Suspend payment for enrollments after the effective date of the sanction for each failure to adhere to contract requirements, or
7. Terminate the contract.

The application of remedies is a matter of public record.

The use of intermediate sanctions for non-compliance is described in Section 1932(e) of the Social Security Act as enacted in the BBA Section 4707(e). This provision states that a hearing must be afforded to contractors before termination of a contract under this section can occur.

XIII. Behavioral Health Quality Strategy Monitoring and Evaluation

This section explains how the Department will regularly monitor and evaluate the BHOs' compliance with Department standards for access, structure and operations, and quality measurement and improvement activities.

Program Organizational Structure

1. The Department approves the Behavioral Health Quality Strategy and maintains ultimate authority for overseeing its management and direction. The Behavioral Health Quality Strategy supports the authority and responsibility of the Department for the development and implementation of effective management of the Behavioral Health Quality Strategy. The Department is responsible for reporting Behavioral Health Quality Strategy activities, findings, and actions to the stakeholders, public, legislators, governor and CMS.
2. The Department oversees the Behavioral Health Quality Strategy's overall effectiveness and staff performance in carrying out the requirements and reviews and approves the Behavioral Health Quality Strategy itself.
3. The Quality Improvement/Behavioral Health Benefits Section of the Department has management responsibilities for the Behavioral Health Quality Strategy. This section also reviews and reports issues, formulates policies and procedures and makes recommendations to the Department. The Quality Improvement/Behavioral Health Benefits Section is responsible for developing processes that track and measure the efficiency and effectiveness of care and service. This section is also responsible for overseeing the work of the EQR vendor and for reviewing and approving the EQR contract deliverables.
4. Based on the results of annual compliance monitoring, PIP validation and performance measure validation among all BHOs, the Department will work with the Behavioral Health Quality Improvement Committee and other stakeholder groups to identify clinical and non-clinical issues to be addressed through future Behavioral Health Quality Strategy goals, objectives and tactics.

Conflict of Interest

No member of a Behavioral Health Quality Strategy development team or the review entity will have a conflict of interest. Team members will not review or participate in the review of their own services, BHOs or direct competitors or be associated through financial arrangements.

Upon request, information regarding the Behavioral Health Quality Strategy is available to Medicaid members and practitioners. The Department will provide the public with written information.

Department Annual Behavioral Health Quality Strategy Evaluation

At least annually, an EQR by a qualified vendor reviews data and reports of the Behavioral Health Quality Strategy activities and findings to assess the effectiveness of the Behavioral Health Quality Strategy. This evaluation includes a review of completed Behavioral Health Quality Strategy activities, trending of clinical and service monitors, effectiveness of the Behavioral Health Quality Strategy monitoring and review activities, effectiveness of the Behavioral Health Quality Strategy in identifying quality of care performance issues and the success of the Behavioral Health Quality Strategy in improving member care and provider performance. The specific EQR activities include

document reviews, on-site reviews, site review reports and corrective action plans for all CMS protocols: compliance monitoring, performance improvement projects and performance measures. The annual evaluation will be published on the Department's Web site.

In addition to the EQR activities, the Department will monitor BHO member satisfaction based on results of the annual MHSIP report, annual YSSF, other member surveys, focus groups, anecdotal information and grievance and appeals data.

XIV. Approval

The Strategy was reviewed and approved by the following Department members:

Submitted to CMS		March 31, 2005
Approvals by the Department	Laurel Karabatsos, Director Health Benefits Division	Date
	Donna Kellow, Manager Quality Improvement/Behavioral Health Benefits Section	Date

Appendix A Enrollee Materials

The Contractor shall provide all Enrollment notices, informational materials and instructional materials relating to Members in a manner and format that may be easily understood.

The Contractor shall have in place a mechanism to help Members and potential Members understand the requirements and benefits of the plan.

The Contractor shall notify Members that oral interpretation is available for any language and written information is available in the prevalent languages spoken in the community and how to access those services.

Written material for Members shall use easily understood language and format and be available 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.

The Contractor shall make oral interpretation services available free of charge to each Member. This applies to all non-English languages, not just those that the state identifies as prevalent.

The Contractor shall inform all Members that information is available in alternative formats and how to access those formats.

The Contractor shall furnish to each of its Members the information specified in 42 C.F.R. Section 438.10 paragraph (f)(6) and paragraph (g) within a reasonable time after the Contractor receives, from the Department or its contracted representative, notice of the Member's Enrollment. This information shall include:

Names, locations, telephone numbers of and non-English languages spoken by current contracted Providers in the Member's Service Area, including identification of Providers that are not accepting new patients.

Any restrictions on the Member's freedom among network Providers.

Member rights and protections, as specified in 42 C.F.R. Section 438.100.

Information on grievance and fair hearing procedures and the information specified in 42 C.F.R. Section 438.10(g)(1).

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.

The extent to which and how, after-hours and emergency coverage are provided, including:

What constitutes an Emergency Medical Condition, Emergency Services and Post-Stabilization Care Services, with reference to the definitions in 42 C.F.R. Section 438.114(a).

The fact that prior authorization is not required for Emergency Services.

The process and procedures for obtaining Emergency Services, including 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 Post-Stabilization Care Services covered under the Contract.

The fact that the Member has a right to use any Hospital or other setting for emergency care.

The Post-Stabilization Care Services rules set forth at 42 C.F.R. Section 422.113(c).

Policy on Referrals for specialty care.

That no fees may be assessed for covered mental health services provided to Enrolled Members.

How and where to access any benefits that are available under the State Plan but are not covered under the Contract, including any cost sharing and how transportation is provided.

Grievance, appeal and fair hearing procedures and timeframes, as provided in 42 C.F.R. Sections 438.400 through 438.424, in a Department-developed or Department-approved description, that shall include the following:

For state fair hearing:

The right to hearing;

The method for obtaining a hearing; and

The rules that govern representation at the hearing.

The right to file grievances and appeals.

The requirements and timeframes for filing a grievance or appeal.

The availability of assistance in the filing process.

The toll-free numbers that the Member can use to file a grievance or an appeal by phone.

The fact that, when requested by the Member:

Benefits shall continue if the Member files an appeal or a request for state fair hearing within the timeframes specified for filing; and

The Member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member.

Any appeal rights that the Department chooses to make available to Providers to challenge the failure of the organization to cover a service.

Advance Directives, as set forth in 42 C.F.R. Sections 438.6(i)(2).

Additional information that is available upon request, including the following:

Information on the structure and operation of the Contractor; and

Physician incentive plans as set forth in 42 C.F.R. Section 438.6(h).

The Contractor also shall furnish to each of its Members the following information required by the Department within a reasonable time after the Contractor receives, from the Department or its contracted representative, notice of their Enrollment:

Notice that the Member has been Enrolled in the Mental Health Program operated by the Contractor and that Enrollment is mandatory;

The Contractor's hours of operation;

Additional Member rights, including the right to:

Have an independent advocate.

Request that a specific Provider be considered for inclusion in the Provider network.

Receive a second opinion.

Receive culturally appropriate and competent services from Participating Providers.

Receive interpreter services for Members with communication Disabilities 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.

Assistance available through the Medicaid Managed Care Ombudsman Program and how to access Ombudsman Program services.

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.

Information on how Members shall 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 board(s) the Contractor may have in place.

The Contractor shall give each Member written notice of any change (that the Department defines as "significant") in the information specified in 42 C.F.R. Section 438.10 paragraph (f)(6) and paragraph (g) at least thirty (30) calendar days before the intended effective date of the change.

The Contractor shall make a good faith effort to give written notice of Termination of a contracted Provider, within fifteen (15) calendar days after 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.

The Contractor shall notify all Members of their right to request and obtain the information listed in 42 C.F.R. Section 438.10 paragraph (f)(6) and paragraph (g), at least once a year.