QUALITY MANAGEMENT PLAN
FY 2012 and FY 2013

BLUEBONNET TRAILS COMMUNITY SERVICES
QUALITY MANAGEMENT PLAN

FY 2012 and FY 2013

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________________________________ ________________

Executive Director Date

________________________________ ________________

Director of Quality Management Date

I. Purpose, Definitions and Authority

Purpose

The Local Authority Quality Management Plan provides Bluebonnet Trails Community Services (BTCS) with a systematic, objective and continuous process for monitoring, evaluating and improving the quality and appropriateness of the service delivery systems within our organization. It assists BTCS in assuring existing standards of care are met and provides the framework to obtain feedback from stakeholders on the manner in which the center conducts business. Since September 1, 2004, Resiliency and Disease Management has been integrated into all existing Quality Management processes for Mental Health (MH) services, with attention focusing on resource issues.

Definitions

In the Local Authority Quality Management Program at BTCS, quality for the organization and the network of providers is represented as a set of standards and expectations in the form of targets, objectives and outcomes.

By performing Quality Management activities we are assuring:

- consumers are receiving the services they need
- consumers are satisfied
- services are efficient and accessible
- services fulfill the requirements of the Performance Contracts with the Department of State Health Services (DSHS) and the Department of Aging and Disability Services (DADS)

Local Authority Quality Management is conducted at BTCS to assure compliance with laws and regulations, to provide objective data to manage the organization and to assure viability of the organization. Quality Management also defines the ongoing self-assessment processes for developing recommendations for improvement. The Quality Management Program facilitates implementation of the Program Compliance Plan.

The purpose of the Program Compliance Plan is to assure that services are needed, authorized, appropriately documented and benefit the consumer.

As indicated in our Local Plan, planning for quality begins with the adoption of a Mission and Vision that directs the organization to continually improve services, as defined by consumers, families and the community, within the organization. The Board of Trustees for BTCS has adopted a Mission for accountability to these stakeholders for utilization of resources in a cost efficient manner with processes for changing the system to meet their needs.

An integral part of planning for quality begins with local planning to set the direction for quality planning for the organization with expected identified outcomes. Long range planning takes place within the organization with input from all stakeholders at

the direction of the Board of Trustees. As the Local Authority for Mental Health and Intellectual Developmental Disabilities Services for the eight county area, the center is responsible for long range planning, resource allocation, obtaining the best value in service delivery, service appeals, grievance processes, protection of rights, businesses functions and accounting, network development and management and assuring quality of life for all individuals served. Overall, we provide services in 27 counties.

Planning occurs through the following:

- Self-assessment processes
- Planning and Network Advisory Committee (PNAC) Initiatives
- Advisory Groups
- Management initiatives
- Local Planning and Network Development (LPND) processes

To support the quality measurement component of the local planning process, this Quality Management Plan is entered as an Addendum to the BTCS Local Plan. The purpose of this coordination is to ensure that the Quality Management Plan measures our achievement of the stated goals; and to ensure communication of a common direction in our planning and measurement systems.

Authority

The Quality Management Program Plan of BTCS is authorized by:

- Requirements within the Performance Contract between BTCS and DSHS and DADS
- The Board of Trustees, the governing body of BTCS, who provide leadership, oversight, and regular review of the organization's performance
- The Executive Director of BTCS who has designated the responsibility for coordinating the Quality Management Program, all quality management activities and all self-assessment activities to the Quality Management Department

II. Structure, Organization and Functions

Organization

BTCS is organized into divisions as an authority of Mental Health and Intellectual Developmental Disabilities Services and as an internal provider of Mental Health and Intellectual Developmental Disabilities services. The authority assures required services are provided through a network of internal and external providers. A network of providers is available to provide both mental health and mental /developmental disabilities services. The network was developed through open enrollment and through requests for proposals. This enables us to give consumers a choice in selecting providers.

Services

The Local Authority provides the following services for **adults with Mental Illness**: Crisis Hotline, Mobile Crisis Outreach Team, crisis services, screenings, pre-admission assessments, Case Management, and treatment planning. BTCS assures the following services are provided by either internal or external providers: respite, medication administration, medication monitoring, pharmacological management, provision of medication, individual and group training such as medication training and supports and skills training and development, rehabilitative counseling, psychosocial rehabilitative services, supported employment, supported housing, inpatient services and intensive crisis residential services. Outreach, screening, assessment and referral for Substance Abuse (OSAR) services, and Jail Diversion are also provided.

The Local Authority provides the following services for **children with Mental Illness**: Crisis Hotline, Mobile Crisis Outreach Team, crisis services, screenings, pre-admission assessments, Case Management, and treatment planning. BTCS assures the following services are provided by either internal or external providers: respite, medication administration, medication monitoring, pharmacological management, provision of medication and training as medication training and supports and skills training and development, counseling, family support groups, and family partner support.

The Local Authority provides the following required services for **people with Intellectual Developmental Disabilities:** Screening and Eligibility determination, Service Coordination (Basic Service Coordination, Service Coordination for individuals enrolled in Texas Home Living program and HCS program, Continuity of Services for individuals who reside in state supported living centers, Continuity of Services for individuals who reside in Medicaid programs and Service authorization and Monitoring). BTCS assures the following community services are provided by either internal or external providers: respite, supported employment, employment assistance, day habilitation services, community support, behavioral support, nursing, specialized therapies and residential services.

As a provider of services under direction of the Local Authority we are also responsible for service delivery, operationalizing the mission of BTCS, establishing processes to assure quality of life, improving efficiency of the system and making adjustments in the delivery system to assure quality services.

Services are also provided to people with alcohol and substance abuse through our Outreach Screening Assessment Referral (OSAR) program. OSAR provides screening, referral and crisis intervention for clients and families as well as service coordination for eligible individuals.

The Local Authority also provides services through the Early Childhood Intervention program. Services include screening and assessment, Case Management services and therapy services.

Quality Management Program

The charge of the **Quality Management Department** is to assimilate data and information from Utilization Review, Quality Assurance functions, and internal/external audits and reviews. The department is responsible for reporting those findings to the Senior Management Team quarterly and making recommendations for system improvement.

Quality Management Program activities for BTCS are coordinated by the Quality Management Department. The Department includes the Director of Quality and Utilization Management, Utilization Management Manager, utilization review specialists, an auditor, and support staff. The Quality Management Department provides the common thread amongst all of the committees and assures that information is reviewed by the Senior Management Team.

Many of the functions related to quality and utilization management are reviewed on a daily basis by the Director of Mental Health and Intellectual Developmental Disabilities Provider Services, the Director of Behavior Health Essential Services, the Director of Intellectual Developmental Disabilities Authority Services, the Director of Early Childhood Intervention Services, and by department heads. This information is regularly reported to and reviewed by the Quality Management Department. Utilization and performance data is reviewed at the local level by program managers and at the Center level by the Utilization Management/ Quality Management Committee, which is made up of the Senior Management Team. Utilization data is also utilized by the directors of authority functions for resource allocation purposes.

The Quality Management Program of BTCS provides the structure for the Local Authority to:

- evaluate the efficiency of the organizations functioning
- evaluate services provided to our consumers through the network of providers
- evaluate services provided by the authority
- set goals and objectives for the organization to improve services
- ensure compliance with all laws, rules, policies and procedures for service implementation and billing
- conduct self -assessment activities
- conduct planning activities
- assure compliance with Resiliency and Disease Management by assuring services are ongoing, match the needs of the individual, are focused on recovery, and guided by evidenced-based protocols and a strength-based model of service

This is accomplished with input of information from the following committees.

Committees

The **Utilization Management/Quality Management Committee** (UM/QM Committee) is charged with reviewing, approving and assisting with the development of the Quality Management Program to ensure quality services for the people we serve are provided in the most efficient manner. This committee reviews utilization management data at the quarterly meetings, focusing on providing cost effective appropriate services. This includes review of the Resiliency and Disease Management Assessments to track trends and overrides. Changes to the organization are determined by the utilization data obtained. Membership is composed of the Senior Management Team which consists of the Executive Director, the Director of Mental Health and Intellectual Developmental Disabilities Provider Services, the Director of Behavioral Health Essential Services, the Director of Intellectual Developmental Disabilities Authority Services, the Director of Information Services, the Director of Quality Management and Utilization Management, the Director of ECI, Chief Financial Officer and the Medical Director.

The **Planning and Network Advisory Committee (PNAC)** is charged with ensuring that local stakeholders have direct input and involvement in assessing and determining the mental health and intellectual developmental disability service needs of the Center. This is accomplished through identifying the most important needs in the community, evaluation of cultural and ethnic issues and assessing progress towards implementation of the Local Plan. They are also charged with overseeing the objectivity in the procurement of services and the definition of best value in public mental health and intellectual developmental disability services. They review processes and make recommendations to the board as to whether management has been fair and objective in reviewing services. The PNAC is comprised of between five and nine members representative of people with mental illness and intellectual developmental disabilities local practitioners, and other interested members of our community.

The purpose of the committee is to advise the Board of Trustees on planning, contract issues, needs and priorities for the service area and for the center. Activities include surveys, needs assessments, assistance in development of goals and objectives in the Local Planning and Network Development process for BTCS and to monitor on a quarterly basis implementation of goals and objectives.

The **Safety/Risk Management Committee** is charged with insuring the health and safety of consumers and employees. Their purpose is to develop and establish procedures and requirements for the prevention of accidents or significant incidents. This is accomplished through meetings and the analysis of data related to consumer incidents/injuries (including abuse/neglect and client deaths), vehicle accidents, employee injuries, medical incidents (including illness), hospitalizations, infectious diseases and deaths. Data is also analyzed from environmental/Americans with Disabilities Act audits. Membership consists of the Safety Director and representatives from Mental Health, Mental Retardation/Developmental Disabilities, and Early Childhood Intervention services in all counties including direct care, management and support services staff. Meetings are held annually and information

is reviewed by the Senior Management Team. Information is also reported to DADS to assist in benchmarking with other states.

The **Consumer Rights Protection Office** is charged with reviewing all allegations of client rights violations and complaints and reviewing data to look for trends within the organization. They assure that persons served by BTCS are provided services and treatments in the least intrusive manner appropriate to the individual's needs, that they are afforded due process and that their rights are fully protected. They also must review all rights restrictions annually. Activities include promotion of policies and procedures to protect the rights of the people served and to assure the procedures are in compliance with all rules and regulations set forth by law and the performance contract. Additional activities include training for employees, families, consumers, advocates and the community in the rights of people with Mental Retardation/Developmental Disabilities and Mental Illness. There are currently two positions who share the duties of the Consumer Rights Protection Office at BTCS. Information on consumer complaints/feedback and appeals is reviewed at least quarterly by the Senior Management Team.

The **Advisory Boards** from Bastrop, Caldwell, Fayette, Gonzales, Guadalupe, and Williamson counties are charged with providing input and support into consumer and program needs and serving as a liaison with local community leaders for program assessment and support. The Home and Community Based Services and Texas Home Living programs have a Consumer Advisory Committee that includes a consumer and family members. The CAC reviews risk categories within the two waiver programs quarterly and annual satisfaction surveys to make recommendations towards quality improvement. Local Board activities include fundraising, provision of emergency services and funds, and community education. The boards consist of family members, non-affiliated community members, governmental officials, consumers, and advocates.

The **Professional Review Committee** provides a mechanism for clinical review, of sentinel events and oversight for issues related to the quality and appropriateness of service. Meetings are held as needed and topics may include, but are not limited to the following: Sentinel Event Reviews, Performance Profiling/Evaluation, Credentialing and Reappointment Reviews and Clinical Policy Development. The purpose of the Professional Review Committee is to provide a forum supporting the discussion of medical care provided by BTCS and to conduct professional review of medical and healthcare services to improve the quality of care pursuant to the Texas Revised Civil Statute Article 4495b and the Texas Health and Safety Code article 161.031-.033 which provide a privilege of confidentiality for professional review activities in the State of Texas. The Committee will oversee and ensure the delivery of quality care to the people served by BTCS.

III. Accountability and Resources

Accountability for assuring the Quality Management Program functions rests with the Director of Quality Management and Utilization Management. She is responsible for systematically reporting data to the senior management team, which is led by the Executive Director. The Executive Director provides leadership and support for management as they implement organizational goals and objectives. Performance expectations and results, utilization trends and recommendations for change are also communicated to the Board of Trustees, which guides the center through policy directives. In addition, the Board of Trustees holds each employee, contractor, or agent of BTCS accountable for complying with all laws, rules, policies and procedures for service implementation and billing.

The Executive Director charges the senior management team with responsibility for assuring quality in service delivery, including review of utilization management data, evaluating and improving processes, meeting performance expectations and implementation of corrective actions.

Major activities of the Quality Management Department include:

- development of the Quality Management Plan
- quarterly Utilization Management/Quality Management Committee meetings
- coordination of the data and plans of improvement for the Utilization Management/Quality Management Committee meetings
- development of Management Reports
- systematic review of the processes for Quality Management and review of Utilization Review information
- coordinating an internal review/auditing process of programs, contractors, billing and consumer care
- facilitating RDM Assessment Authorizations
- utilization management activities
- assuring through use of the fidelity instruments, compliance with the philosophy of Resiliency and Disease Management

Resources for Quality Management activities include center employees with responsibilities for reviewing internal accounting data, reimbursement functions, employee training information, program compliance, review and audit of the Medicaid Administrative Claiming data, and clinical records reviews.

IV. Monitoring, Evaluation and Trending

Measuring and Assessing Processes and Outcomes

Methods for measuring and assessing service processes and outcomes occur through the self-assessment activities conducted for both Mental Health and Intellectual Developmental Disabilities Services. Information on compliance with the Performance Contract, service delivery, assessment completion rates,

appropriateness of assessments, length of stay in the community, readmissions to state hospitals, discharge reasons, and encounter information are reviewed for adults and children receiving Mental Health Services. Information is also reviewed regarding improvement in school functioning for children receiving services. For consumers receiving Intellectual Developmental Disabilities services the interviews/surveys conducted serve as measures for evaluating the processes and reaching outcomes. Reimbursement data such as collections, aged accounts receivable and write-offs are also monitored and communicated to the programs.

Data Collection and Measurement

Data is gathered from databases such as the CARE (Client Assignment Registration) System and its many subsystems (Texas Home Living billing system, WebCARE, CMBHS, Client Abuse and Neglect System, Home and Community Based Services System, Intermediate Care Facilities for Mental Retardation billing system and the In-Home and Family Support System) and the Anasazi software database used by BTCS. Additionally, information is received from the Data Warehouse (MBOW) reports facilitated by DSHS and DADS, internal and external program audits (authority MH and IDD audits, Intermediate Care Facilities-Mental Retardation, TxHL, Home and Community Based Services, DARS Supported Employment Program and Early Childhood Intervention). In addition, on a monthly basis Business Objects reports are reviewed by the accounting department to assure encounter data is being reported correctly and to correct any inaccuracies. Data from chart audits, observations, committee meeting reports, budget reports and reports from the BTCS Incident/Injury reporting system are also utilized. The annual facility site safety inspections and environmental/Americans with Disabilities Act inspections provide valuable data on the safety and accessibility of our facilities. Satisfaction data is gathered from consumer surveys, interaction with community leaders and complaints to the Client Rights Officer.

Self Assessment Activities

An integral part of the Center's Quality Management Program is the development of the Local Plan. The Local Plan is developed with input from the community, families, clients, advocacy groups and other interested people. As part of the ongoing self-assessment process, development of the Local Plan determines the direction and key elements of the Quality Management Plan. Self-assessment activities include reviews of the following:

- Consumer input:
  Surveys from consumers receiving Intellectual Developmental Disabilities services, which include surveys of consumers receiving supported home living, supported employment, day habilitation, service coordination behavioral supports, nursing, residential and respite services. Surveys include information on satisfaction, outcomes, access to services and quality of services

  Surveys from consumers receiving Adult Mental Health and Children's Mental Health services, which include center implemented surveys of

satisfaction, outcomes, access to services and quality of services.

Focus group and community meeting information

- External input:
  Mental Health crisis services audit
  Mental Health Authority Services audit
  Mental Health Co-Occurring Psychiatric and Substance Use Disorders audit
  Intellectual Developmental Disabilities certification audits for HCS program (both authority and provider) and Texas Home Living program (both authority and provider) and ICF-MR
  Intellectual Developmental Disabilities HCS billing audits
  Intellectual Developmental Disabilities Authority Services audit
  DARS Supportive Employment Reviews
  HCS billing audits
  PNAC
  The Williamson County Subcommittee for Mental Health
  School Districts
  CRCG's
  Local Advisory Boards
- Internal organizational input:
  Internal compliance audits of the MH, IDD, ECI and OSAR programs
  Utilization Management/Quality Management Committee Quarterly Reports
  Review of critical data concerning client rights, client incidents and injuries, client health and client deaths
  Review of data concerning safety and employee incidents and injuries
  Ad Hoc Committees

Incorporated into both the Intellectual Developmental Disabilities and the Mental Health self-assessment processes is specific information obtained from consumer interviews/surveys, employee input, board initiatives/feedback and the PNAC .

Recommendations from self-assessment activities are shared with the Senior Management Team, boards, PNAC and providers.

Utilization Management.
Utilization Management activities provide the Center with a system of procedures designed to ensure that the services provided are cost effective, appropriate and the least restrictive. Utilization review is an analysis of the patterns of service usage to evaluate the appropriateness and efficiency of services. A variety of data and reports give us the tools to determine how to structure our organization to provide best value to our consumers: the right service, to the right person, at the right time, in the most cost-effective manner. This data has been used to guide us in decision-making regarding staffing, organization and cost effectiveness. The detailed Utilization Management Plan is made a part of the Quality Management Plan as Attachment B.

Data tracked and analyzed includes:

- Server productivity--average number of hours spent in direct service time by employees with consumers, and number of employees meeting targets set for direct service time
- Length of stay--by site, by diagnosis, and by service package. Data includes frequency and duration of services, number of contacts, length of time in service by number of contacts, by time from intake to discharge and total number of hours services were provided, and average hours of service for all individuals in the programs
- No show/cancellation rate-s-percentage of consumers who do not show for a scheduled appointment or cancel their appointment by service site and physician.
- Length of time for pharmacology services--average time it takes to deliver a pharmacological service by physician and site.
- Hospital utilization--number of hospital bed days utilized by consumers within the BTCS catchment area and related costs from the trust fund.
- Insurance revenue tracking--numbers of consumers without insurance, number who fall under the Maximum Ability to Pay scale, number with no income and no insurance and the number on the Medicaid pending list.
- Reimbursement tracking – collection rate, aged accounts and write-offs
- Medication service data--cost, frequency, physician prescribing patterns and whether the Center is the appropriate pay source for all medications purchased.
- Home and Community Based Services financial tracking--review of reports to maximize billing, provide cost effective services and control costs in the HCS programs.
- Number of days from the initial request for services to provision of the service.
- Unit service costs.
- Outlier information.
- Override rates based on the Level of Care Recommended by the Uniform Assessment compared to the Level of Care authorized.
- ECI program capacity
- IDD program capacity
- MH program capacity

The information is analyzed by comparing the data to established targets set by oversight agencies and the Center, other external requirements of contracts and by benchmarking with other centers. Statewide databases have greatly facilitated benchmarking with other centers, as information is timely, easy to access and available for downloading into common spreadsheets for further assessment. This review of provider performance data facilitates management decisions for the organization.

The results of the data, analysis and planned actions to be taken are communicated to the Center employees, Board of Trustees, Committees and Stakeholders.

Critical Data Review.
Risk Management/Critical Data is reviewed on a daily basis by the Program Directors, monthly by the Safety Director and Quarterly by the Utilization Management/Quality Management Committee, PNAC, Consumer Rights Protection Office and annually by the Safety/Risk Management Committee. Data reviewed, analyzed and trended includes:

- abuse and neglect
- consumer incidents and injuries
- medication errors
- employee Workers Compensation
- vehicle usage and accidents
- consumer restraints
- rights violations (including abuse/neglect)
- complaints
- deaths
- serious health related incidents
- infection control/infectious disease incidents
- results of on-site safety/environmental inspections which include a review of evacuation drills, fire marshal inspections, fire extinguishers, alarm and sprinkler inspection compliance, exit signs, health inspections and evacuation/disaster route postings
- environmental safety inspections, including review of the Fire Safety Codes

The Center currently has no programs serving meals to ten (10) or more consumers, if this occurs, a Health Department inspection will be obtained.

The data is analyzed and compared to established targets set by the organization, external requirements of contracts, and by benchmarking with other Centers. Benchmarking consists of comparing comparable data from one program to the data we have collected. Data is collected from other Centers through MBOW, DSHS and DADS profiles. Plans to address and reduce risk to the organization in each area are discussed at the Safety/Risk Management Committee meeting and at the quarterly Utilization Management/Quality Management Committee meetings, and documented in the minutes of the meeting. Upon identification of outliers, the Utilization Management/Quality Management Committee assigns responsibility for implementing a plan of correction for each outlier. Each center is charged with assuring the plans of corrections are implemented.

The results of all audits are shared with the program directors and appropriate oversight committees. In addition, data is contained in the Quarterly Utilization Management/Quality Management Plan report. Plans of correction are required and follow up is provided to assure that if the problems are systems failures, corrective

action is taken. When required, individual training occurs with employees to remedy problems.

Quality Assurance Activities.

Quality Assurance activities are performed at all levels of the organization. Activities include monitoring of:

- compliance with Intermediate Care Facilities for Mental Retardation, Home and Community Based Standards, TxHL, Early Childhood Intervention.
- performance contract tracking of compliance with meeting targets and data verification
- billing audits
- standards compliance reviews
- Medicaid Administrative Claiming quality reviews
- record audits, including quarterly random reviews by IDD Service Coordinator Supervisors to assure consumer change of preference forms indicate client choice, to assure the Person Directed Plan addresses the person's goals, that services are authorized and that authorized services are provided.
- financial tracking of costs and interventions by the internal auditor
- credentialing
- review of the Resiliency and Disease Processes, through the use of the Fidelity Instruments
- training
- conducting review of crisis services to assure crisis standards, MCOT rules and community standards are met
- conducting peer reviews on psychiatric services
- conducting Co-Occurring Psychiatric and Substance Use Disorders audits to assure services:
  - address both psychiatric and substance use disorders
  - facilitate accessing available services
  - are provided within established practice guidelines
  - are provided by competent staff in accordance with the individual's
  - treatment plan
  - documentation includes: the diagnosis of substance abuse, progress notes that address the co-occurring substance use disorder and linking activities with appropriate services, and a Treatment Plan that addresses the co-occurring
  - substance use disorder
  - completion of the fidelity instruments for RDM

Identified Needs for Improvement Process

When a problem is identified as a result of any quality assurance activities this will be communicated to the Executive Director and the Department Head. It is the

responsibility of the Department Head to submit a plan of correction to the Quality Management Director within 2 weeks. This plan should include the correction of any inconsistencies in implementation and improve noted processes.

Medicaid Fraud
The Quality Management Department is also responsible for assuring implementation of the centers Medicaid Fraud Program.

All employees and contractors of BTCS are obligated to provide Medicaid services in accordance with all State and Federal regulations governing the Medicaid program. BTCS is committed to ensuring that the manner in which these services provided by the Center is consistent with these regulations.

“Fraud” is defined by Medicaid as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.” “Abuse” is defined as “provider practices that are inconsistent with sound fiscal, business or medical practice, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Fraud and abuse are not billing or documentation errors; however those errors must be corrected as soon as they are recognized, and overpayments accruing to those errors must be reimbursed to the payor.

Employees or contractors engaging in activities, which the Center, Medicaid or Medicare regulatory agencies, the State Medicaid Fraud Unit, the State Attorney General’s Office of the Office of the Inspector General of the United States determine, are fraud are subject to disciplinary action including termination of employment or their contract for services with the Center. The Center and/or the aforementioned agencies may also file charges against the subject employee or contractor with local or Federal law enforcement agencies.

The six State and Federal laws governing Medicaid fraud (the Federal Anti-Kickback Statute, the Stark Law, the Texas Illegal Remuneration Statute, Civil Money Penalties Statute, the Federal False Claims Act, and the Medicaid Fraud Prevention Act) forbid:

- Billing for medically unnecessary services.
- Billing for a more expensive service than the service provided (up coding).
- Billing for services that were not provided.
- Falsifying information on cost reports.
- Billing for poor quality services
- Receiving a gift or benefit for referring a Medicaid recipient to a provider for medical services.
- Receiving a kick back from a contracted vendor.
- Using a false record to obtain Medicaid reimbursement.
- Acting knowingly or with “reckless disregard” or “deliberate ignorance” of the falsity of the claim.

- Presenting a claim for payment for services rendered by a person does not have the required license to provide the service.
- Billing for a service that has not been ordered by an appropriate practitioner.
- Billing for a for a product that has been mislabeled or adulterated
- Making a false statement or misrepresenting a material fact to obtain a benefit or payment.
- Concealing an event or fact that affects the initial or continued right to a payment or benefit.
- Applying for or receiving a benefit or payment on behalf of a recipient and converting some or all of the benefit or payment for use other than on behalf of the recipient.
- Making, causing to be made, inducing or seeking to induce the making of a false statement or misrepresentation regarding the conditions or operation of a facility to obtain certification or recertification.
- Making, causing to be made, inducing or seeking to induce the making of a false statement or misrepresentation regarding any other information required to be provided to the Medicaid program.
- Accepting or charging any gift, money or other consideration, other than the Medicaid payment, as a condition for the provision of services to a Medicaid recipient.
- Making a claim for payment and failing to indicate the type of license or identification number of the provider who actually rendered the services.
- Any person who knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; or knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person. In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false.

Employees and contractors reporting fraud are protected against retaliation by the Center. It is the responsibility of each employee, contract provider, vendor or agent of BTCS to report the suspicion or knowledge of any fraud or abuse (other than client abuse).

The Qui Tam Act is a part of the Federal False Claims Act which allows individuals to file suits under seal with U.S. Attorney alleging fraudulent Medicaid practice. The individual filing suit must be an “original source.” Financial rewards for Qui Tam plaintiffs can be significant. Plaintiffs may receive up to 30% of recovery plus

attorneys' fees and expenses. Staff received training in Medicaid Fraud through online training and through the employee handbook which contains a copy of the Medicaid Fraud Policy. The Medicaid Fraud Policy contains contact information for reporting fraud.

Stakeholder Input.

Stakeholders include consumers, their families, the community (including businesses), local officials, law enforcement agencies, school districts, other Health and Human Services Commission agencies, the state supported living centers and state hospitals, private providers, contractors and employees. Input is obtained through meetings, public forums, surveys, focus groups and through communication with advisory boards and the Board of Trustees. Stakeholder participation and input into the Quality Management Program is assured through the PNAC, local Advisory Boards, Consumer Advisory Committee, local consumer groups, Community Resource Coordination Groups (CRCGs), County Government and Interagency Councils. Information obtained from the stakeholders is addressed during the Self-Assessment and the Local Plan Development process.

Satisfaction.

Evaluation of the satisfaction of consumers, families and the community provides BTCS with important information used in developing recommendations from the Self-Assessment and the Local Plan. Stakeholder input and satisfaction is reviewed at all levels of the organization:

- consumer and family satisfaction surveys
- review of complaints/appeals
- interviews
- DSHS Adult Mental Health Consumer Satisfaction Surveys
- DSHS Child and Family Mental Health Consumer Satisfaction Surveys

Organizational Best Practices.

BTCS has adopted the definition of Best Practices from the Texas Health Quality Alliance as our definition. "Best Practices are specific risk adjusted approaches to identify the processes, procedures, and services that have known costs and outcomes". Best practices are defined through comparisons of data, cost and risk related to the provision of services. Through analysis of this information the organization is able to implement change and take action.

Best Practices identified by the organization have resulted in changes in the way medications are provided to BTCS consumers. The following is a partial list of established Best Practices benefiting the stakeholders of our service area during the last planning period:

- Continued use of the Patient Assistance Program for some consumers has allowed funds to be freed for improved services for others.

- BTCS with local support has renovated and provides crisis respite services for clients. Clients from all counties are eligible to receive short term services in this program as space allows
- BTCS has continued to provide counseling services to adults and children through contracting with private providers. This gives consumers a choice in providers and access to services outside of BTCMHMR operating hours.
- The Williamson County MH Subcommittee continues to bring all agencies within the county together to plan and coordinate appropriate for services for people with mental illness.
- The determination of systemic Best Practices is an ongoing process. Best Practices identified for service delivery have resulted in improvements, standardization and streamlining of service processes and documentation.
- Joining the East Texas Behavioral Network has opened opportunities to buy services such as RDM authorizations and medications to maximize cost savings.
- Development of a monthly metrics report of utilization management information on clients served, number of services, utilization of services, recidivism and detailed program information

Contract Monitoring/Provider Profiling

Contract development and monitoring is accomplished as follows:

- personnel monitor the contract document to assure it contains all the required elements, signatures have been obtained and that it is renewed as required
- the Contract Monitor reviews to determine how well contractors are adhering to requirements of oversight agencies
  - billing accuracy as substantiated by service documentation
  - that services are delivered as required in the contract
  - timeliness of service delivery
  - access to services
- the Center Director reviews quality as indicated by consumer feedback and documentation
- the Safety Director conducts an environmental safety and health audit of the facility if the contract involves a specific site, such as a group home

There is a continuous feedback loop from direct care employees coming into contact with a contract service, regarding consumer satisfaction, safety, and quality of the service, to Contract Development and Monitoring staff.

Provider profiling is completed using data collected by the Center. Elements of the profile may include training compliance, consumer satisfaction, billing and documentation requirements, timeliness and access to services and quality of service. The Quality Management Department is responsible for tracking quality improvement efforts, bringing attention to areas needing improvement and monitoring to see that intervention has occurred. This information is communicated to the Senior Management Team.

Training Activities.
Quality Assurance for services is promoted in training activities. New employees receive training in all areas mandated by oversight agencies, program standards and BTCS policy. If required, annual refresher training occurs. Specialized training occurs for clinical employees and direct care employees both in orientation and on site. Ongoing training occurs in each site if identified as a need by audits or if requested by the employee or supervisor.

Credentialing.
The purpose of credentialing is to establish a procedure for eligible providers who wish to perform services on behalf of BTCS, either as part of the internal network or as a part of another health care plan to which we may contract. Credentialing serves to protect the safety and dignity of BTCS consumers by ensuring that services are provided by appropriately trained individuals and to ensure that the agency receives compensation for billable services rendered.

OSAR Measuring, Trending and Improvement.
Evidenced based practices – Using evidenced based practices such as utilization of LMSWs, LCSWs, LPCs, LCDC certified staff to perform all OSAR interviews. Using the DSHS guidelines and utilization of a state certified OSAR specialist, staff are trained and evaluated as to competency before starting work. When deficits are found systems will be fine tuned to improve services.

Client satisfaction – The OSAR will conduct telephone satisfaction interviews with 2% of clients interviewed. This will occur on a semi-annual basis. Data will be analyzed to determine areas of needed improvement relating to satisfaction.

Service capacity – service capacity will be determined by the wait time for initial face to face contact with the OSAR staff exceeds one week. If wait time exceeds one week the OSAR will re-evaluate staff allocation in each area and move staff to where the need is. In addition, the telephone interviews referenced above, the client will be asked questions related to access to services, including wait time, time to answer the phone, convenience of locations.

Client continuum of care – The OSAR provides screening, referral and crisis intervention for clients and families as well as service coordination for eligible individuals. Contact and progress will be documented by the identified service coordinator throughout the continuum of care. Monthly reviews will occur of documentation of the continuum of care process as evidenced by client record reviews. Using defined tool trends needing improvement will be identifies from the data and areas needing improvement will be noted.

Accuracy of data reported to the state – Audits of data entered into BHIPS will occur on a random basis to measure quality and accuracy. Data will be checked against the counselors’ schedules for quality and quantity of documentation.

The OSAR will participate in all data verification activities – Submit self audit results as required, and submit documentation as requested. In addition the OSAR will participate in onsite reviews.

The OSAR will Participate in and actively purse QMO activities – Supporting performance and outcomes improvement, the Center will continually evaluate the provision of services both formally and informally through a process of audits, interviews and documentation reviews.

The OSAR will respond to consultation recommendations by DSHS – Recommendations related to staff training, self-monitoring activities and use of quality management tools will be addressed to improve quality of services. BHIPS reports will be monitored weekly for accuracy of reporting.

V. Improvement and Tracking

The Quality Management Department is responsible for tracking quality improvement efforts, bringing attention to areas needing improvement and monitoring to see that intervention has occurred. This information is reviewed and analyzed with management, including the Senior Management Team, and any other relevant employees. This includes organizational processes and outcomes and service processes and outcomes. Information obtained through the measurement of organizational and service assessments are analyzed and procedures put in place for continuous quality improvement. Procedures can include action plans, goals, or continuous monitoring and feedback until acceptable thresholds are met. Directors are empowered to make changes to improve systems at the local level and the Senior Management Team at the organizational level.

At the provider level, server productivity, compliance with the performance contract, billing reconciliation, and risk management data are reviewed on a monthly basis. The local center directors review relevant reports with service providers to ensure needed services and assessments are provided in a timely manner, that there is adequate service documentation, and that work performance is maximized.

On a quarterly basis the following information and data is monitored and reviewed by the Utilization Management/Quality Management Committee:

- Utilization Management data (service utilization, waitlist, revenue resource availability, length of time in service, etc.)
- Critical incidents data (consumer incidents, injuries and illnesses, employee injuries, vehicle accidents, medication errors, deaths, rights violations, etc.)
- Quality Management Activities (billing accuracy, lost revenue report, data accuracy, target compliance requirements, etc.)

The following is collected and analyzed on a continuing basis by the Utilization Management/Quality Management Committee:

- stakeholder input
- consumer and community satisfaction
- organizational Best Practices
- contractor profiling

VI. <u>Communicating and Updating the Plan</u>

On an annual basis the Quality Management Plan will be reviewed by the Utilization Management/Quality Management Committee, the PNAC and the Board of Trustees. Needed revisions will occur with input from all stakeholders. Responsibility for this process lies with the Quality Management Department.

Information about the Quality Management Plan occurs through printed materials, distribution of the Plan, presentations and employee training sessions.

Attachment A: Program Compliance Plan

BLUEBONNET TRAILS COMMUNITY SERVICES

Original effective date: 12/00 | Operating Procedure
Revised: 5/3/2011 | Quality Management
Program Compliance Plan

PROGRAM COMPLIANCE PLAN

PURPOSE:

The purpose of the Program Compliance Plan (PCP) is to assure implementation of the Bluebonnet Trails Community Services (BTCS) policy to provide services, including Medicaid and Medicare, that are needed, authorized, appropriately documented and of benefit to the consumer. The PCP serves as the Corporate Compliance Plan for BTCS.

The BTCS PCP exists to assure compliance with all rules, policies, and procedures for service implementation and billing.

I. Standards of Conduct for employees, contractors or agents

The governing board of BTCS is the "Board of Trustees" and is appointed by the county judges in each of the eight counties. They are ultimately responsible for approving and assuring the implementation of all policies, including the standards of conduct. This is completed with the assistance of the Executive Director (ED) and his/her designees.

The standards of conduct are described as follows and have become the policies and procedures for BTCS. The standards of conduct are available for review by all employees, contractors and agents of the organization.

It is the responsibility of each employee, contractor or agent of BTCS to comply with all laws, rules, policies, and procedures for service implementation and billing. Each employee, contractor or agent of BTCS is held accountable to the organization for complying with all laws, rules, policies, and procedures for service implementation and billing. In addition, it is the responsibility of each employee, contractor, or agent of BTCS to report the knowledge of any fraud or abuse to the Corporate Compliance Officer (CCO). Employees, contractors or agents of BTCS will face disciplinary action for acts constituting fraud or abuse in any program. "Fraud" is defined by Medicaid as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person." "Abuse" is defined as "provider practices that

are inconsistent with sound fiscal, business or medical practice, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare."

Subcontractors and suppliers should be treated in a fair and reasonable manner, consistent with all applicable laws and regulations in accordance with good business practices. BTCS abides by the principle of competitive procurement to the extent possible. Purchasing decisions will be made based on objective criteria. BTCS will always employ the highest business standards. All requests for proposals will be judged objectively and in accordance with Center procedures before a selection is made. Employees will not accept gifts from businesses associated with BTCS without prior approval of the ED. Gifts of little value, (food or items to advertise), may be accepted by employees, contractors or agents of BTCS. We will not contract with any individual who is a current employee of BTCS.

A conflict of interest may occur if the employees, contractors, or agent's activities or personal interests influence or appear to influence their ability to make objective decisions in the course of their job responsibilities. A conflict of interest may also exist if the demands of any outside activities hinder or distract them from the performance of their job or cause them to use company resources for non-business reasons. It is the employees, contractors or agents responsibility to remain free of conflicts of interests in the performance of their job with BTCS.

It is the responsibility of each employee to safeguard the confidentiality of all client information, including clinical records, both paper and electronic. They are required to be safeguarded against loss, damage, or unauthorized use.

It is the responsibility of each BTCS employee, contractor, or agent to preserve our organization's assets, including time, materials, supplies, equipment and information. Assets are to be maintained for business related purposes. The personal use of any BTCS asset without the prior approval of the supervisor is prohibited. Use of BTCS assets for personal gain is also prohibited.

It is the policy of BTCS to keep complete and accurate records of all transactions. The Clinical Records Committee is charged with forms review and approval, review of the clinical records reviews, developing procedures for documentation practices in the consumer record, developing a standardized record system and determining the elements to be included in the official consumer record. The Committee meets quarterly.

In the day to day functions of BTCS issues arise that relate how people in the organization deal with one another. One example involves gift giving for

certain occasions. No one should feel compelled to give gifts to anyone and gifts should be appropriate to the occasion and never be lavish. Employees, contractors or agents should not be made to feel compelled in fundraising efforts.

Unethical or illegal behavior by center employees, contractor or agent of BTCS must be reported to the Director of Quality Management at 512-244-8232. This number will be considered the "Hotline" for the reporting of unethical or illegal behavior. BTCS has a zero tolerance policy for retaliation for reporting of unethical or illegal behavior.

The policies and procedures for BTCS are found on the Network for all employees to access. Employees are notified when any changes or revisions are made and may print them out for further dissemination as needed. Department heads and program directors are responsible for assuring all employees receive information and training on policies and procedures.

All employees, contractors and agents of BTCS will receive a copy of the PCP and ongoing training in its implementation

II. Oversight of the Program Compliance Plan

The Director of Quality Management has been designated as the Corporate Compliance Officer (CCO) for BTCS. The Director of Quality Management reports directly to the Executive Director and is charged with operating and monitoring the compliance program. The CCO has the authority to access all relevant documentation and records, including medical records, financial records, human resources files and records, all contracts, marketing materials, proposals, sales contracts and all agreements describing business relationships.

It is the responsibility of the CCO to oversee and monitor the PCP through Quality Assurance functions such as coordination of internal/external audits and reviews. The CCO, in partnership with Human Resources and Human Resource Development, will also be responsible for developing and implementing training for all employees in the compliance program through systematic competency based training.

The CCO is responsible for coordinating investigations and presenting the outcome to the ED of the organization for dispensation. To ensure long-term interest and a commitment to compliance, the organization will expect the highest standards of conduct from all employees, contractors and agents of the organization.

The Corporate Compliance Committee (CCC) will include the ED, CFO, Director of Provider Services, Directors of Authority Services, and the

Corporate Compliance Officer. The CCC is responsible for reviewing both the external environment for trends in failure to maintain compliance and our own internal compliance with program rules, both programmatic and fiscal compliance. The committee will assist in the development of the compliance program and policies and procedures for BTCS, by developing standards of conduct for employees, contractors and agents. In addition, the committee will recommend and review monitoring practices for compliance and assist the CCO in determining the organization's strategy for promoting compliance. Concerns, complaints and problems, as identified through information from the hotline and the Human Rights Officer (regarding complaints) will be reviewed by the CCC on a quarterly basis. Information reviewed will also include the outcome of any investigation that arises. Lastly, the committee will assist the CCO in creating the PCP and quarterly report format.

III. Delegation to trustworthy employees

Prior to becoming an employee, vendor, contractor or agent of BTCS, a review will be completed to insure the provider has not been excluded from participation from the Medicaid or Medicare program. This review is completed by the Quality Management Department for credentialed employees. Any potential employee, vendor, contractor or agent found to be excluded from the Medicaid or Medicare program is also excluded from doing business with BTCS.

If it is known that a potential employee, vendor, contractor or agent is currently under investigation they will be excluded from being hired or conducting business with BTCS until the investigation is complete. It is the responsibility of each department to insure compliance by reviewing the list of excluded providers on the Internet.

All employees undergo an interview, physical capacity review, criminal history check, drug screening, and reference check prior to employment. Providers must meet applicable health plan credentialing requirements and maintain applicable licenses, certifications, registrations and other legally necessary and recognized credentials in accordance with the laws of the State of Texas and policies of the Texas Department of Mental Health and Department of Aging and Disability (DSHS AND DADS). Credentialing is performed for eligible providers who wish to perform services on behalf of BTCS, either as part of the internal network or as a part of another health care plan with whom BTCS may decide to contract and to protect the safety and dignity of BTCS consumers by ensuring that services are provided by appropriately trained individuals and to ensure that the agency receives compensation for billable services rendered in behavioral health and chemical dependency.

IV. Training and education of employees, contractors and agents

Training for new providers begins with the New Employee Orientation program under the direction of the Human Resource Development Department. New employees receive training in all areas mandated by DSHS and DADS, program standards and BTCS policy. This is the first education employees receive regarding program compliance, ethics, accountability and their duty to report fraud or abuse. Specialized training occurs for clinical employees and direct care employees both in orientation and on site. All staff are retrained annually.

The Sr. Management Team is notified of any changes, clarifications or revisions to rules, policies and procedures through consortium meetings, workshops, printed materials, journals and over the Internet. Information is forwarded to all employees, including clinicians, auditors, medical employees, the Quality Management Department and the Reimbursement Department. Additionally, training occurs at the provider level through Service Coordinator meetings and training meetings for providers of rehabilitation services. As requested, training is provided by the Quality Management Department.

Specific, one on one competency based training for service coordinators is provided by clinical employees. Training for providers of skills trainers is provided by the program director and the skills training specialist. Training for providers of Medical services occurs at monthly physicians meetings and individually by the Medical Director. Ongoing training occurs in each site if identified as a need by audits or if requested by the employee or supervisor. Records of attendance are kept of all training conducted.

V. Monitoring of systems

Systems have been put in place to assure compliance, correct any errors and repay billing errors through auditing and reviews as follows:

- Duplicate billing audits

  Through the automated billing system, any overlapping or duplicate billings are noted. Quality Management employees review all noted overlapping or duplicate billings and obtain corrections or resolve discrepancies before they are billed. This may include corrections to the billing system, corrections to the documentation or clarification of the services provided. A clinician resolves all associated tasks related to duplicate billing.
- Medicaid Audits

  The Quality Management Department employees and clinicians conduct Post Billing Medicaid audits of HCS and Texas Home Living services, ECI service coordination and therapy, MH and IDD service coordination and rehabilitation services. At least 10% of the individuals

receiving Medicaid services each quarter are reviewed to assure the following: the data supports the billing, the individual is eligible for the service, and the service was provided on the date and at the time shown on the claim.

- Special audits of Card Services

  As requested, audits of Medicaid and Medicare Card Services occur. Approximately 5% of the people receiving Card services are reviewed to assure the following: the data supports the billing, the service was provided by a credentialed clinician, and the service was provided on the date and at the time shown on the claim.
- Review of external audits

  All external audits are reviewed by the Quality Management Department. Plans of correction are coordinated if needed and information is disseminated to the field.
- Records reviews

  Record reviews to assure documentation follows all standard rules and BTCS procedures are conducted by the Clinical Records Administrator.

Through our client database, Anasazi, notification is sent to providers when services or activities are required to meet standards. These reports are compiled by the Program Directors, who are responsible for ensuring compliance with timelines. Also, the Anasazi Suspense system suspends all billings that do not meet the eligibility requirements or authorization requirement of the specific Medicaid program. Program Directors are responsible for correcting the Anasazi system or notifying the Reimbursement Department that the service should not be billed and the reason why.

Results of audits are reviewed by the Utilization Management/Quality Management Committee (also the CCC), Planning and Network Advisory Committee, and the Professional Review Committee. The charge of the Professional Review Committee is to oversee and ensure the delivery of quality care to the people served. Topics discussed may include, but are not limited to the following:

Sentinel Event Reviews
Performance Profiling/Evaluation
Utilization Review
Credentialing and Reappointment Review
Clinical Policy Development

Plans of correction are required and follow up is provided to assure that if the problems are systems failures, corrective action is taken. When required, individual training occurs with employees to remedy problems. At the conclusion of each audit a face-to-face exit and education session with program directors and employees occurs. Copies of all audits are distributed to the Program or Center Directors to develop a plan of correction. The plan

of correction is sent to Quality Management employees to recoup funds or resolve any further discrepancies.

Ongoing monitoring of employee feedback, appeals outcomes and disciplinary action will occur at the quarterly Utilization Management/Quality Management Committee meeting. This meeting will also serve as a meeting of the Corporate Compliance Committee. An annual external audit of Medicaid and Medicare processes may be conducted if a consultant is available.

VI. Disciplinary systems enforcement

It is the policy of the BTCS that all employees are expected to comply with BTCS' Standards of Conduct and performance. Any noncompliance with these standards must be remedied in a timely manner.

BTCS endorses a policy of progressive corrective action, which provides employees with ongoing written feedback from their supervisor, with a notice of deficiencies and the opportunity to improve. However, the ED retains the right to override all of these procedures at her/his discretion.

The BTCS Board of Trustees' authority for all operations, and policies and procedures is vested with the ED. BTCS employees are employed at the pleasure of the ED. BTCS operates under the legal doctrine of "EMPLOYMENT-AT-WILL" and, within requirements of state and local law regarding employment, can dismiss an employee at any time, with or without notice, for any reason or no reason. Every effort is made to ensure that employee dismissals are not made in an arbitrary and capricious manner; however, these personnel policies do not constitute an employment agreement between the Center and any of its employees and in no way restricts the at-will nature of employment. BTCS has the right to change these policies at any time, without prior notice to employees.

Each employee receives an annual evaluation, which, in addition to work tasks, addresses compliance with BTCS policies and procedures.

VII. Response to detected offenses and prevention of reoccurrence

Based on internal audits, compliance error rates are kept by center, program and by employee to assure mistakes are corrected and patterns of mistakes are addressed. All errors require that a plan of correction be submitted to the Quality Management Department. Patterns of complaints and errors are reviewed by the CCC to determine the plan of action to take to resolve the problem. The plan may include but is not limited to, additional training, changes in policies or procedures or changes in our systems of service

delivery. When questionable conduct is identified, it is investigated and if needed, disciplinary action is taken.

It is the policy of BTCS to provide services, including Medicaid and Medicare, that are needed, authorized, appropriately documented and of benefit to the consumer. All programs will follow the appropriate rules, policies, and procedures for service implementation and billing. It is the policy of BTCS to repay any funds, including Medicaid and Medicare, received in error.

BLUEBONNET TRAILS COMMUNITY SERVICES

Original effective date: 9/1/08 | Operating Procedure
Revised: 09/03/2010 | Human Resources
Business Code of Conduct

BUSINESS CODE OF CONDUCT

I. Statement of Policy

Bluebonnet Trails Community services (BTCS) employees, contract providers, vendors and agents of the organization will exhibit behavior based on honesty, integrity and a sense of fairness. It is the responsibility of each employee, contract provider, and agent of the organization to maintain the highest standard of business ethics. This includes taking timely and responsive, positive action to prevent or correct any improper or inappropriate acts. The BTCS Board of Trustees and Management are committed to providing avenues through which ethical issues may be raised, reviewed and resolved openly and honestly.

The Business Code of Conduct is accessible to all employees, contract providers, vendors and agents of the organization and can be found on the Center's Intranet (BT Library Drive). The appropriate personnel are notified of any changes or revisions to BTCS policies and procedures. Revised policies and procedures are made available for printing in order to facilitate further dissemination, as needed. Department Heads and Program Directors are responsible for ensuring that all employees, contract providers, vendors and agents of the organization receive information and training on policies and procedures in a timely manner. Questions concerning the Business Code of Conduct or the Program Compliance Plan can be directed to the attention of his/her BTCS supervisor or appropriate Department Head or his/her designee.

II. Ethical Standards.

The business conducted by BTCS will be delivered in an environment with the highest ethical, legal and professional standards. Honesty, integrity and impartiality will be demonstrated when dealing with BTCS consumers, providers, vendors, regulators, competitors, community, employees and agents of the organization. Interactions with consumers should at all times promote the consumer's sense of self-worth, self-reliance, trust, dignity and choice. BTCS is committed to the highest ethical, legal and professional standards and abides by the principle of competitive procurement to the extent that it is possible. All requests for proposals applications will be judged in an objective manner and in accordance with BTCS procedures. Purchasing

decisions are based on objective criteria. The organization will not contract with any individual who is currently an employee of BTCS. The Board of Trustees, employees, contract providers, vendors and agents of the organization will make every effort to avoid even the appearance of illegal, unethical or unprofessional conduct.

III. Conflict of Interest

Employees, contract providers, vendors and agents of the organization are expected to exhibit professional loyalty to the Center. Employees, contract providers, vendors and agents of the organization are expected to avoid conflicts of interest and opportunities for personal gain for themselves individually, members of their immediate families and others which may impede their best judgment. A conflict of interest could be described as an activity or personal interest that influences or appears to influence an individual's ability to make objective decisions in the course of his/her job duties. Employees are expected to use good judgment, adhere to high ethical standards, and avoid situations that create an actual or perceived conflict between their personal interests and those of the organization Conflicts of interest or unethical behavior may take many forms including but not limited to the acceptance of gifts from consumers of the organization. Employees are prohibited from employing or conducting business with consumers.

Employees are encouraged to seek assistance from their managers with any legal or ethical concerns. However, Bluebonnet Trails realizes this may not always be possible. As a result, employees may call Human Resources Manager at 244-8352 to report anything that they cannot discuss with their manager.

IV. Gifts and Favors

The following are expectations of BTCS employees, contract providers, and agents of the organization:

- Gifts of entertainment from vendors should be limited to common business courtesies, which may include an occasional lunch or dinner or a gift of limited value. Monetary gifts or any favors in attempt to gain unfair influence or advantage are never acceptable.).
- Employees, contract providers, and agents of the organization should not seek to gain influence or advantage of a customer, potential customer or business by providing inappropriate gifts or entertainment. Any gift should be limited in value and consistent with common business courtesies. Gifts may only be accepted if they have a nominal retail value and only on appropriate occasions (for example, a holiday gift). Giving monetary gifts is never acceptable. Employees may not use proprietary and/or confidential information for personal gain or to the organization's detriment nor may they use assets or labor for personal use.

Employees, contract providers and agents of the organization should seek guidance from the appropriate Department Head or his/her designee regarding these incidents as they occur, and prior to taking any action or accepting any gift.

- In the day-to-day operations of the Center, circumstances arise surrounding how people relate to one another, which may include gift giving for special occasions. No one should be made to feel compelled to give gifts to anyone. If individuals choose to give gifts, they should be appropriate to the occasion and should never be lavish.
- Employees, contract providers, vendors and agents of the organization should never be made to feel compelled to participate in fundraising activities.

V. Outside Business and Financial Interests

The following are guidelines for employees, contract providers and agents of the organization regarding interests outside of the business conducted by BTCS:

- Employees, or members of their respective families, and employees, contract providers, and agents of the organization should not have substantial financial or business interest with a competitor, consumer or supplier of BTCS without first reviewing the nature of activity with the appropriate Department Head or his/her designee.
- Each employee's employment should be his/her first business priority. Any other employment or business activity will be considered secondary and should not interfere with individual employee job performance and responsibilities.

VI. Compliance

The following are guidelines for compliance with this Business Code of Conduct:

- Employees, contract providers, vendors and agents of the organization are committed to complying with all federal and state laws and regulations, with an emphasis on preventing fraud and abuse.
- BTCS will conduct audits and other risk evaluation to monitor compliance and assist in the reduction of identified problem areas.
- BTCS will maintain processes to:
    1. Detect Medicaid/Medicare or other third party payer compliance offenses;
    2. Initiate corrective and preventive action;
    3. Report to appropriate oversight authorities, both professional and regulatory, when appropriate; and
    4. Address consequences for employees, contract providers, vendors and agents of the organization for failure to comply with standards, policies and procedures.

It is the responsibility of each employee, contract provider, vendor or agent of BTCS to report the suspicion or knowledge of any fraud or abuse (other than client abuse) to the Corporate Compliance Officer (CCO) by way of email, at corporate.compliance@bbtrails.org or by calling the "Hotline" at (512) 244-8232. Employees, contract providers, vendors or agents of BTCMHMRC will face disciplinary action for acts constituting fraud or abuse in any program. "Fraud" is defined by Medicaid as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person." "Abuse" is defined as "provider practices that are inconsistent with sound fiscal, business or medical practice, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare."

VII. Accounting and Reporting

It is the policy of BTCS to keep complete and accurate records of all transactions and all services provided. Each employee, contract provider, vendor and agent of the organization will ensure the integrity of the Center by accurately and truthfully recording all corporate information, accounting and operational data through strict adherence to established accounting and business procedures and clinical records policy. The procedure for keeping clinical records can be found on the Center's Intranet (BT_Library Drive).

VIII. Corporate Resources

Each employee, contract provider, vendor and agent of the organization is expected to use corporate assets economically and safeguard corporate assets at all times. Corporate assets include, but are not excluded to, time, materials, supplies, equipment and information. Corporate assets must be used for business-related purposes only. The personal use of any BTCS asset without the prior approval from the supervisor is strictly prohibited. The use of BTCS assets for personal gain is also strictly prohibited. The BTCS policy regarding Internet use can be found on the Center's Intranet (BT_Library Drive).

IX. Political Activities

As good citizens, each employee, contract provider, vendor and agent of the organization is encouraged to participate in the political process. However, BTCS must ensure that the political activities and contributions of employees, contract providers, vendors and agents of the organization do not appear to represent the opinions of BTCS.

X. Confidentiality

All employees, contract providers, vendors and agents of the organization are expected to diligently safeguard against loss, damage or unauthorized use, all BTCS records, whether paper or electronic, that are deemed confidential, as

described in BTCS policy and federal and state law. This includes information about BTCS consumers and their families, internal operations, and fellow employees, contract providers, vendors and agents of the organization. BTCS policies and procedures related to confidentiality are located on the Center's Intranet (BT_Library Drive).

XI. Consumer Focus

Because BTCS consumers are the primary focus of every activity, each employee, contract provider, vendor and agent of the organization will be committed to continually improving our products, services and cost competitiveness to meet the individual needs of each BTCS consumer.

XII. Employee Relations

Each employee, contract provider, vendor and agent of the organization is expected to perform his/her assigned tasks in a responsible, reliable and cooperative manner and to treat one another with fairness, mutual respect, dignity and trust.

XIII. Controlled Substances and Alcohol. .

Bluebonnet Trails Community Services (BTCS) is a drug and alcohol free workplace.

It is BTCS's policy that there is zero-tolerance for the consumption of or being under the influence of drugs and/or alcohol on any Community Center property, during a Community Center activity or during duty hours. These acts are illegal and/or jeopardize the safety of employees, contract providers, vendors, agents of the organization and consumers, as well as reduce productivity, reliability and trustworthiness. "Zero-tolerance" means that consuming or being under the influence of drugs and/or alcohol, if determined by reasonable suspicion, can result in immediate termination from employment without review or administrative recourse. "Reasonable suspicion" shall be determined by direct observation or the positive results of a drug/alcohol test.
Bluebonnet Trails is committed to providing a safe, healthy, and efficient working environment for all employees and those who do business with Bluebonnet Trails as well as protecting its reputation in the community. To help achieve this goal, employees are prohibited from:

- **Possessing, distributing, selling, manufacturing, or being under the influence of any illegal drug;**
- **Consuming alcoholic beverages while on Center premises, customer premises, in Center vehicles, or while on Center business or time**
- **Abusing inhalants or prescription drugs or possessing prescription drugs that have not been prescribed for the employee by a physician**
- **An employee who violates this policy is subject to corrective action up to and including termination of employment. Use of**

some drugs is detectable for several days. Detection of such drugs or the presence of alcohol will be considered being "under the influence."

- **Refusal to submit to a drug and/or alcohol screen is grounds for immediate termination**
- **Employees using prescription drugs according to a physician's instructions or using over-the-counter drugs for medicinal purposes are required to notify their supervisor in the event such drugs would impair their physical, mental, emotional, or other faculties..**

The organization's substance-abuse program includes several components to support its efforts to remain drug-free, including:

- **Drug testing of all applicants considered for employment;**
- **Drug testing when a supervisor suspects that an employee is "under the influence" during working hours;**
- **An Employee Assistance Program (EAP). The Employee Assistance Program (EAP) is a confidential resource designed to assist employees and their eligible dependents in dealing with challenges and problems such as substance abuse. Employees and/or eligible dependents can reach an EAP representative by dialing (800) 343-3822.**

All information relating to drug and/or alcohol screens is to be kept strictly confidential. The information will be maintained separately from the employee's personnel file. These medical files will be kept locked and secured and access will be limited to certain individuals in the organization. Under no circumstances should the results of a drug and/or alcohol screen be discussed with individuals who do not have a work-related need to know.

If a supervisor suspects that an individual is at work and under the influence of alcohol and/or drugs, the supervisor should notify the Human Resources Manager and/or an officer in the organization to seek authorization to test the employee. The supervisor will be granted permission to test the employee if sufficient objective symptoms exist to indicate the employee may be under the influence of drugs and/or alcohol.

While the organization does not condone the abuse of alcohol, prescription drugs, and/or use of illegal drugs, Bluebonnet Trails does recognize that addiction to drugs and/or alcohol can be treated. If an employee recognizes a personal addiction or abuse problem and seeks assistance from management in advance of detection, the organization will assist the employee in seeking treatment. The confidential nature of the employee's counseling and rehabilitation for drug and/or alcohol abuse will be preserved.

XIV. Reporting Misconduct

The following are obligations for reporting misconduct: It is the responsibility of each employee, contract provider, vendor or agent of BTCS to report the suspicion or knowledge of any fraud or abuse (other than client abuse) to the Corporate Compliance Officer (CCO) by way of email, at corporate.compliance@bbtrails.org or by calling the "Hotline" at (512) 244-8232.

- If necessary, the issue may be brought to the attention of the BTCS Executive Director or her designee.
- Reporting violations will remain confidential unless otherwise obliged by professional code of conduct, state or federal law. Employees, contract providers, vendors and agents of the organization may, however, be required to substantiate any allegations of wrongdoing.
- Employees, contract providers, vendors and agents of the organization cannot be punished or subjected to reprisal because he/she, in good faith, reports a violation of this Business Code of Conduct. BTCS has a "zero tolerance policy" with regard to retaliation and it will be adhered to in all such instances.

XV. Appropriate Workplace Dress

It is the expectation of Bluebonnet Trails Community Services that all employees will be dressed in a manner suitable to the job they are doing, and consistent with the standards of the community where they provide services. It is each Center Director and their subordinate
supervisors' responsibility to determine if their staff is appropriately attired. Bluebonnet Trails employees will present a professional image in their community while doing the work of the Center. This may vary from work location to work location. Professional staff and staff working in offices are to adhere to standard American office dress. A supervisor may send any employee home to change, if she/he deems the employee's dress not suitable.

Staff is prohibited from wearing the following clothing or articles of clothing:

Soiled, worn, ragged or holey clothing; tank tops; bare midriff tops; halter tops, strapless tops, clothing that shows undergarments (sheer); men's sleeveless shirts; gym or workout attire spandex tops or pants; bicycle shorts; over-sized clothing or revealing clothing; cut offs; "short shorts" (shorter than finger-tip length); unsafe shoes; T-shirts with alcohol or illegal drug-related logos/slogans; and T-shirts with logos/slogans that demean race, color, national origin, religion, gender, age, disability or sexual orientation.

All employees should practice commonsense rules of neatness, good taste, and comfort. Provocative clothing is prohibited. Bluebonnet Trails reserves the right to determine appropriate dress at all times and in all circumstances and may send employees home to change clothes

should it be determined their dress is not appropriate. Employees will not be compensated for this time away from work.

XVI. Equal Employment Opportunity

Our goal at Bluebonnet Trails is to recruit, hire, and maintain a diverse workforce. Equal employment opportunity is good business as well as being the law and applies to all areas of employment, including recruitment, selection, hiring, training, transfer, promotion, termination, compensation, and benefits.

As an equal opportunity employer, Bluebonnet Trails does not discriminate in its employment decisions on the basis of race, religion, color, national origin, gender, sexual orientation, age, military status, disability, or on any other basis that would be in violation of any applicable federal, state, or local law. Furthermore, Bluebonnet Trails will make reasonable accommodations for qualified individuals with known disabilities unless doing so would result in an undue hardship, safety, and/or health risk.

XVII. Conclusion

It is the responsibility of each employee, contract provider, vendor and agent of the organization to maintain the highest standards of business ethics. This includes taking positive action to prevent or correct any improper or inappropriate acts. BTCS Board of Trustees and Management are committed to providing avenues through which ethical issues may be raised, reviewed and resolved openly and honestly.

Bluebonnet Trails Community Services

Utilization Management Plan

FY 2012-2013

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SECTION 1 - INTRODUCTION

Bluebonnet Trails Community Services' (BTCS) Utilization Management (UM) Department is responsible for the planning, organizing, directing, and controlling of healthcare services provided to consumers; balancing cost-effectiveness, efficiency, and quality while ensuring uniform distribution of services based on consumer need. Systematic data-driven processes direct consumer care and decision making to ensure an optimal level of service is provided consistent with consumer diagnosis and level of functioning within the financial restraints of funding. This including but not limited to service authorization, concurrent review, retrospective review, discharge planning, and utilization care management.

Section 1.1 – Purpose

The primary purpose of BTCS's UM Department is to employ a systematic assessment process for measuring mental health service needs among consumers based on their most recent diagnosis, dimensions and symptoms. Second is to ensure timely authorization and provision of these services. Third is to efficiently manage the cost of providing these services with a methodology for quantifying the assessment of the appropriateness of services provided.
The primary focus of the UM Department is to prevent over utilization of care, under utilization of care, and inefficient use of resources.

Section 1.2 – Utilization Management Goals

In order to fulfill our purpose the UM Department's goals are to:

- Ensure fair and equal provision of mental health services when medically necessary and appropriate;
- Ensure delivery of services at the appropriate level of care in a cost effective manner;
- Ensure services provided meet all professionally recognized standards;
- Continually monitor and evaluate the adequacy and appropriateness of mental health care and services provided;
- Work to improve the health status of persons served by identifying opportunities for education, mental health promotion, and mental illness prevention;
- Implement continuing utilization review of participating internal and external providers to prevent inappropriate or sub-standard care and limit inappropriate utilization of resources;
- Continually identify and address opportunities to improve efficiency in the delivery of care and services by developing and maintaining appropriate programs, training and services;
- Continually measure performance in existing programs and services in order to identify and prioritize areas for improvement;
- Recognize and address the evolutionary nature of utilization management and the efficiencies that will be gained as managers/directors improve their ability to use data and clinicians gain trust in UM as facilitating access to appropriate care rather than as a barrier;

- Use data to identify patterns of utilization, work with clinicians to determine if the patterns and variation are desirable or not; and to make needed improvements;
- Ensure that clinically qualified persons make decisions to authorize or deny services;
- Conduct retrospective reviews in conjunction with other functions such as quality management, claims management and data verification to maximize the use of staff resources;
- Expect the integration of utilization data into various local authority functions to include strategic and local planning;
- Use the least possible resources, require limited infrastructure and meet professional expectations for provision of services;
- Ensure the appropriate management and utilization of resources for community mental health services and that as many consumers as possible receive the services they need in a timely manner consistent with the policies and guidelines established by oversight agencies; and
- Monitor data entered into oversight agency databases on a routine basis to assess performance, to include the outcomes of service delivery. This will include data that reflects patterns of current service utilization and the clinical/assessment decisions used to make those decisions. When outliers or trends are detected which reflect unusual or unexpected results, the causes will explored identified and remedied.

Section 1.3 – Utilization Management Plan

The Utilization Management Plan (UM Plan) is consistent with BTCS's identified goals and applicable regulatory and contractual requirements.
The UM manager/director under the direction of a UM psychiatrist and in consultation with the UM Committee, assumes the responsibility for execution of the UM Plan. The procedures, authority, and accountability outlined in the UM Plan are designed to ensure effective implementation of the UM program and to meet DSHS rule and contractual requirements. The UM Plan will be reviewed and updated annually or more frequently if needed. The UM Plan will be distributed, along with training, to network providers on relevant aspects of the UM Plan.

- The UM Plan addresses the standard of care received by people served by measuring the outcome of that care as changes in their mental health assessment status, utilization level of services and their satisfaction with services provided.
- The UM Plan also addresses the provider of mental health care service by monitoring and evaluating patterns of practice and professional performance in relation to criteria measuring quality and utilization of services.
- The UM Plan addresses the cost effective delivery of quality health care services by measuring the compliance of providers and their staff to established utilization protocols, to the use of cost-effective alternatives to delivery of services, and outcome measures. The Utilization Management Program is evaluated quarterly by the UM Committee. Needed information

is added to the quarterly review process to continually update and improve the program.

- The UM Plan provides for training/resources to remedy deficits in provider/staff practices/performances.

Section 1.4 - Provider Mandate
All internal and external providers are subject to the provisions of the UM Plan. All components and activities of the UM Plan and the related policies, procedures, and protocols by which the UM Plan is implemented will be communicated to participating providers as part of their credentialing process. All components of the UM Plan which detail the criteria or describe the processes by which the Plan is implemented will be readily available to the person served, service providers, purchasers or payers of service.

Section 1.5 - Contracting Providers
BTCS at its sole discretion will determine criteria, policies, and procedures, if any, which differ from those required of employee providers for participation in and compliance with the UM Plan and our provider network.

Section 1.6 - Limitations
Nothing in the UM Plan limits BTCS's discretion in reviewing and evaluating internal or external providers according to the provisions of the UM Plan or in any other fashion. Nothing in the UM Plan will be construed to interfere with or in any way affect a provider's obligation to exercise independent medical judgment in rendering mental health care services.

Section 1.7 - Amendments
The UM Plan may be modified or otherwise amended at any time by the UM Committee at its sole discretion. Any modifications or amendments to the UM Plan will be effective for all new or existing providers from the effective date of change specified in written notice to the effected provider.

Section 1.8 - Notice
Written notice of modifications or amendments to the UM Plan will be delivered by:

- Interoffice Memorandum,
- Staff meetings and training sessions,
- Sent by mail addressed to the other party at the last known address given by the party,
- Personal delivery of written notice to the party, or
- Contract Addendum or Contract Addendum.

SECTION 2 - UTILIZATION MANAGEMENT COMMITTEE

Section 2.1 - **Purpose**
The primary function of the UM Committee is to monitor utilization of BTCS clinical resources in order to assist the promotion, maintenance and availability of high quality care in conjunction with effective and efficient utilization of resources.

Section 2.2 - Objectives
UM Plan Objectives are to:

- Assure the overall integrity of the BTCS utilization management process to include timely and appropriate assignment of Mental Health levels of care based on the DSHS UM Guidelines, and ECI and IDD Services based contracted obligations;
- Assure that all BTCS staff involved in the UM process are qualified to fulfill their functions and that inter-rater reliability is being maintained;
- Approve the process used to review and authorize the provision of mental health services, including an appeal system for adverse determination decisions for both MH and IDD Services;
- Analyze utilization patterns and trends to include gaps in services, rates of no shows for appointments/services, billing issues, underdeveloped frequently requested services, existing services that are under- and over-utilized, and barriers to access;
- Establish mechanisms to report quantitative and qualitative information on service utilization and service delivery to BTCS management and staff, the Board, providers and other interested persons in a timely manner;
- Provide a mechanism to identify potential quality issues and to forward them to the Quality Management Department;
- Assist in the ongoing modification of screening criteria, standards, and review methods under the control of BTCS and provide relevant feedback to the DSHS and DADS;
- Prepare and arrange educational programs to address deficiencies noted by review findings.

Section 2.3 – Delegation of Responsibility
The Board of Trustees of BTCS has delegated the responsibility for developing and implementing the UM Program to the UM Committee. The UM Program includes the UM Plan and all UM activities. All activities of the UM Program are subject to UM Committee review and approval. Improvements are made to the UM Program and the UM Plan as deficiencies are recognized in the program. The UM Program results are used to make management decisions to improve services and cost effectiveness of the services.

Section 2.4 – Membership
The UM Committee is a standing committee of BTCS Center and consists of **the Senior Management** Team including the UM Physician, Utilization Manager, and representatives from QM and Fiscal services, management staff, mental health professionals, financial and information management staff, and other BTCS staff and

professionals. In addition, BTCS is also a member of ETBHN which has it's UM committee that functions as a part of BTCS. The primary function of the UM Committee is to monitor utilization of BTCS clinical resources to ensure they are being expended effectively and efficiently. The UM Committee assists the promotion, maintenance and availability of high quality care through the evaluation of clinical practices, services and supports delivered by BTCS and its contracted providers using clinical, encounter and administrative data and performance measures.

Section 2.5 – Confidentiality

All activities and deliberations which in any way involve review or evaluation of the care or services received by a member or delivered by a provider are confidential and are subject to applicable sections of state and federal law affecting confidentiality. Documents and other information prepared as a function of these UM activities will be released only as required by provisions of purchaser contracts or other Center agreements, subject to applicable state and federal law. No voluntary disclosure of peer review information will be made except to persons authorized to receive such information in the conduct of Utilization or Quality Management activities. All such information is strictly confidential and is not discoverable. The data generated and utilized according to provisions of the UM and Quality Management Plans are maintained in a confidential manner and where possible through the mechanism of codes and summary information. Only those persons who require information to recommend corrective action are given access to those identifiers.

Section 2.6 – Procedures

The UM Committee operates according to established guidelines in Section 3.

Section 2.7 – Authority

The UM Committee receives its authority from the Board of Trustees of BTCS and reports to the UM Physician designated to oversee the UM Program.

Section 2.8 – Composition of the UM Committee

Required membership includes:

- BTCS UM Physician
- UM Representative
- Quality Management Representative
- Fiscal/Financial Services Representative

Participation by others may be indicated depending on the nature of issues under consideration. Examples include:

- BTCS Clinical/Professional staff and ETBHN Clinical/Professional staff
- Contracts Management
- Network Development
- Information Systems
- Medical Records
- Consumer Rights Officer
- Mental Health Professionals

- Intake and eligibility staff
- Intellectual Developmental Disabilities Professionals

Section 2.9 – Appointing Members to the UM Committee
All UM Committee members are appointed by BTCS's CEO. These individuals demonstrate leadership in their designated areas, provide data analysis and information as needed, conduct reviews as requested and effectively communicate information and committee findings to stakeholders.

Section 2.10 – Conflict of Interest
No UM committee member may participate in the review of a case in which he/she has a conflict of interest (e.g., has been professionally involved, has a personal or financial relationship with the provider or consumer, etc.). BTCS will identify other potential conflict of interest situations and include such situations in training for UM staff and UM Committee members.

Section 2.11 – Training Members of the UM Committee
BTCS will ensure that all UM Committee members receive appropriate training to fulfill the responsibilities of the committee. BTCS must provide each member of the UM committee a copy of the UM Plan, the current DSHS UM Guidelines and other oversight guidelines and information necessary to perform their function. The UM Physician, or his/her designee, will discuss with each new member of the committee: the role of the UM Committee, type of cases, data and information reviewed by the committee, and clarify the UM program and processes. All participants in the UM process are subject to strict confidentiality practices, as defined by DSHS and other applicable rules.

Section 2.12 – Meetings
UM Committee meetings are held quarterly or more frequently as needed at a designated time and at the call of the UM Committee Chairman.

Section 2.13 – Minutes
The UM Department is responsible for taking, distributing, and storing minutes of every UM Committee meeting.

SECTION 3 – IMPLEMENTING THE UTILIZATION MANAGEMENT PLAN

Section 3.1 – General Provisions
The UM Committee establishes and approves all provisions of the UM Plan including utilization review standards, monitoring criteria, review processes or other protocols, and policies and procedures by which the plan is implemented. All components of the UM Plan which detail the criteria or describe the processes by which the plan is implemented are readily available to persons served, providers, purchasers, payers, or other regulatory bodies.

Section 3.2 – Objectives

The responsibilities of the UM Committee in implementing the UM Plan are:

- To achieve the highest possible efficiency in the delivery of care and services;
- To ensure prompt identification and analysis of opportunities for education and improvement in the delivery of care and services with implementation of action, for resolution and follow up;
- To improve the mental health status of persons served in the community through improvement in the processes of delivering care and services;
- To satisfactorily monitor, evaluate, and resolve problems and concerns identified by utilization review activities; and
- To ensure the confidentiality of all utilization management activities, decisions, and recommendations.

Section 3.3 – Functions

The purpose of the UM Plan includes the following functions:

- To allow for professional oversight of utilization management, all UM functions (with the exception of physician oversight) will be fulfilled by the physician who provides oversight of UM Program and/or the Utilization Manager or Director or UM staff or designee. Physician oversight of UM processes will be accomplished by a board eligible psychiatrist who possesses a license to practice medicine in Texas. The oversight function includes approval of all policies and procedures related to UM, to include changes based on new technology and availability of resources.
- To allow for consistent monitoring of clinical resources. The primary function of the UM Committee is to monitor utilization of clinical resources to ensure they are being expended effectively and efficiently. The UM Committee assists the promotion, maintenance and availability of high quality care through the evaluation of clinical practices, services and delivered supports, by staff and contracted providers using clinical, encounter and administrative data and performance measures.
- To allow for consistent application of the UM Guidelines and processes. This will be accomplished through ongoing supervision of staff and management of UM operations.
- To ensure ongoing evaluation of clinical performance and practices. To implement, monitor, review, and evaluate utilization management guidelines and monitoring criteria as they apply to professional and institutional practice and performance. The guidelines and criteria must be objective, measurable, clinically valid, and compatible with established principles of patient care.
- To ensure consistent Reporting of Clinical Data. To develop and maintain a process for provider submission of clinical information which will include at minimum telephonic and/or electronic submission and will ensure that consumer-specific information gathered for utilization review remains confidential in accordance with all applicable laws and is shared only with those that have the need for and authority to receive it.

- To perform utilization reviews and authorizations/reauthorizations of all level of care service packages for outpatient care as indicated by the SHS UM Guidelines.
- To perform utilization reviews and authorizations/reauthorizations of inpatient admissions to state hospitals and to community psychiatric hospitals when general revenue allocation or local match funding is being used for all or part of that hospitalization.
- To verify, and ensure documentation of, medical necessity for all services provided.
- To ensure timely authorizations designed to ensure delivery of medically necessary services without delay.
- To employ utilization care management in order to accommodate unusual circumstances where telephonic and documentation review might not be sufficient to make an appropriate authorization decision. This function includes coordinating services for persons with special circumstances and needs, and facilitating authorization where it cannot be effectively conducted through the usual processes, necessitating direct contact with the provider, consumer and/or family members.
- To ensure that providers have documented competence in assessment using the RDM Assessment, Symptom Scales and/or Ohio Scales.
- To ensure client's and providers receive timely notification of authorization determinations.
- To provide a timely and objective appeal process in accordance with 25 TAC § 401.464 and for Medicaid recipients in accordance with 25 TAC § 412.313 (b)(20)(C), regarding a Medicaid recipient right to request a Medical Fair Hearing, ensuring all consumers access to an objective appeals process when services are denied, limited or terminated. BTCS will ensure that all providers and consumers are provided information about their right to appeal and the process to do so.
- To maintain documentation on appeals.
- To support collection and analysis of data by continuously evaluating the performance of an effective management information system.
- To collect utilization management data; to identify, track, trend, and analyze that data; and on the basis of this review and analysis to recommend appropriate educational programs and corrective actions and monitor the implementation and the outcomes of the recommended programs and actions. This information is to be used in ongoing analysis of systemic issues that may support clinical management decisions.
- To supervise and support the utilization review activities of clinical and non-clinical personnel.
- To develop a process for provider submission of clinical information which will include at minimum telephonic and/or electronic submission and will ensure that consumer-specific information gathered for utilization review remains confidential in accordance with all applicable laws and is shared only with those that have the need for and authority to receive it.

- To educate providers concerning inappropriate utilization of care or delivery of services identified by findings and analyses generated by utilization review activities.
- To provide a process to receive/respond to provider complaints.
- To communicate significant or continued provider non-compliance with utilization review guidelines and monitoring criteria to the Credentialing Committee for its evaluation and action.
- To ensure continuity and coordination of services among multiple mental health community service providers.
- To continuously, review the appropriateness and effectiveness of the UM Plan and to present a yearly evaluation of current activities and an outline of proposed activities to the Executive Management Team.
- To submit utilization data to DSHS according to their Data Reporting Guidelines.

Any UM activities which are delegated to an external entity (to include another LMHA or ASO) will be under a written contract with the UM Contractor that is consistent with all applicable rules and DSHS Performance Contract requirements will be employed. BTCS's internal UM Committee will be maintained or another appropriate BTCS committee will be designated to:

- review the reports produced by the UM Contractor,
- make improvements in BTCMHMR processes that impact utilization of resources; and
- evaluate the effectiveness of interventions to improve provider practices.

Section 3.4 – Utilization Review Activities

UM activities include evaluating the adequacy, appropriateness and quality of services provided to persons receiving services. All BTCS mental health services will be reviewed when needed, without regard to payment source. Decisions made by the UM staff or designee and UM Committee will be based on objective and valid criteria and standards approved by DSHS and DADS.

Utilization reviews are conducted for the following purposes:

- **Service Package Authorization:** Retrospective oversight of initial and subsequent level of care assignments to ensure consistent application of DSHS UM guidelines.
- **Authorization for Continued Stay:** Concurrent review to establish need for continued services or review of automatic authorizations.
- **Outlier Review:** Retrospective and concurrent review of data to identify outliers followed by review of individual cases to determine need for change in level of care assignment or service intensity. May result in referral for peer review or other oversight activities.
- **Inpatient Admission and Discharge Planning:** Prospective or concurrent review of inpatient admissions to ensure most clinically effective and efficient Length of Stay. Review of discharge plans to ensure timely and appropriate treatment following an inpatient stay.

- **Administrative Review:** Review of clinical and administrative documentation for timeliness and adequacy of UM processes to include reimbursement, corporate and contract compliance, data verification and rehabilitation plan oversight.
- **Interagency Interface:** UM must be committed to not only reviewing practices related to resource utilization, but also to taking action to modify inappropriate, inefficient or ineffective utilization. UM will interface among the various BTCS authority functions, including; Quality Management, Provider Relations, Claims/Reimbursement, Management of Information Services for effective and efficient management of resources, identification of gaps in service delivery and resolution of over- and underutilization of services/resources. Interface between UM and other BTCS functions will occur through exchange of data, information and reports, joint participation in a variety of committees and collaboration in planning, projects and operational initiatives.

Section 3.5 – Evaluation and Assessment of Providers
Provider profiles will be developed in part by analyses of compliance with utilization review guidelines. Profiles are utilized to identify areas for improvement in the quality and efficiency of services rendered by providers. Educational programs are recommended based on information identified and analyzed in developing the profiles.

Section 3.6 – Certification of Medical Necessity of Care or Services
All decisions substantiating the medical necessity for delivery of care or services are made on the basis of the guidelines and criteria adopted by the UM Committee based on the Resiliency and Disease Management Program. All information required to make a decision for medical necessity will be acquired through the appropriate review and certification processes implemented as part of the UM Plan.

Section 3.7 – Appeals Process
The purpose of the appeals process is to provide a process for a person served who has had service or care denials, reductions or terminations authorized by the Utilization Manager because they do not meet the guidelines or criteria for medical necessity as defined by provisions of the UM Plan or they are non-covered services. This process is separate and distinct from the process that allows a person with Medicaid coverage the right to request a Medicaid fair hearing.

BTCS is dedicated to providing mental health services that are viewed as satisfactory by persons receiving those services and their LAR. Any decision to deny, reduce or terminate a service will be done in writing. This written notice will include the reason for the denial, reduction or termination. Instructions on how to request an appeal of that decision will also be included.

Upon request, a person, provider, or payer can request a review of issues regarding medical necessity by the UM Physician. Any affected person, provider, or payer may appeal a decision to deny care or services for medical necessity at any time during

the pre-treatment, treatment, or post-treatment process. All appeals must be submitted in writing to the UM department who will coordinate review and evaluation of an appeal with the Medical Director to make a final determination on an appeal.

SECTION 4 – UM PLAN ACTIVITIES AND PROCESSES

Section 4.1 – Guidelines for Developing Standards and Monitoring Criteria

The UM Committee uses various guidelines and publications as resource information to develop guidelines and monitoring criteria for utilization review activities, those include but are not limited to:

- DSHS Community Standards for Mental Health Services
- DSHS Performance Contract
    - Resiliency and Disease Management
    - Adult Texas Recommended Authorization Guidelines
    - Child & Adolescent Texas Recommended Authorization Guidelines
    - DSHS Clinical Guidelines
    - DSM-IV
- Intellectual Developmental Disability Service Data in CARE
- OSAR and ATR Program Data in BHIPS
- ECI Data in Anasazi

Utilization management guidelines and criteria are used for screening utilization review activities and do not meant to constitute standards of care. All guidelines, monitoring criteria, review processes and protocols, and policies and procedures are continuously reviewed, evaluated, and updated by the UM Committee.

Section 4.2 – Assessing Utilization

Proper utilization of mental health resources will be assessed by provider profiles and UM activities oversight. Provider profiles, documenting compliance with utilization review guidelines and monitoring criteria will be developed. Profiles are used to identify areas of improvement in the effectiveness and efficiency of the delivery of care and services rendered by providers. Educational programs for providers will be implemented based on information identified and analyzed in developing the profiles.

UM activities will be reviewed on an ongoing basis and in depth quarterly.

Section 4.3 – Provider Profiling

Provider profiles, to include data and relevant methodology used for the purpose of describing and evaluating a provider's mental health practice performance in relation to the use of resources and compliance with utilization review guidelines, as well as monitoring criteria will be developed. Profiles will be used to identify areas in need of improvement in the effectiveness and efficiency of the delivery of care and services rendered by providers. Educational programs for providers will be implemented based on information identified and analyzed in the process of developing the profiles. Findings and analyses that identify opportunities to improve effectiveness

and efficiency in the delivery of care and services and opportunities for appropriate education of clients, providers, purchasers, and payers will be reported to the UM Committee.

The primary objective of profiling is to encourage high-quality service delivery, which includes appropriate utilization of resources and results in improved consumer satisfaction and positive outcomes. Profiles will be employed for informational purposes for BTCS and providers including information concerning factors that influence utilization rates and outcomes. Provider utilization profiles may also be used for calculating payment, making contract and/or termination decisions. Providers who advocate for necessary and appropriate mental health care and services for consumers will not experience retaliation by BTCS. BTCS will not terminate, demote or refuse to compensate a provider because the provider advocates in good faith for a consumer, seeks reconsideration of a decision denying a service, or reports a violation of law to an appropriate authority.

The following will be considered in using provider profiles for various purposes:

- **Provider education:** Data on a provider will be classified in order to evaluate and educate the provider, in terms of services provided, referral practices, etc. Profiles will inform the provider about cost effective management of consumer sub-populations. Data will illustrate a provider's cost effectiveness in managing specific types of consumers. The provider will be informed precisely where improvement may be needed.
- **Basis for compensation:** BTCS may elect to provide higher reimbursement to those providers who care for more acute or more complex consumers.
- **Retention of providers:** A contract termination decision will never be based exclusively on a provider's profile unless: the problem is ongoing; the provider has been informed of the problem and given sufficient time to correct the behavior; with respect to termination for over-utilization, the provider's consumer population has been carefully considered and appropriately risk adjusted (evaluation of case mix).
- **Credentialing and re-credentialing:** Provider profiles will be considered but will not be determining factors in credentialing decisions.
- **Improving practice patterns & the profiling process**: Quality management processes may be used to identify best practices, ineffective practices, productivity, or to develop a better profile instrument.

Provider attributes for which validated objective measures are nonexistent, will not be profiled or used. The following provider data may be used for profiling as it exhibits attributes that can be objectively quantified and reliably measured:

- length of stay (LOS)
- readmission or recidivism rates to identified services
- number of requests for special or support services
- prescription charges
- number of inpatient bed days

- number of outpatient service days
- use of crisis services & emergency room visits
- lab tests
- individual achievement of clinical outcomes
- number of adverse determinations
- number of appeals

BTCS will ensure data sources are accurate, and is aware of the limitations of certain data sources as follows:

- Claim Forms may be insufficient to determine performance results because they do not capture clinical characteristics about consumers; outcome of the care provided or detailed information on the severity of the consumer's condition.
- Coding may hamper data accuracy and reliability related to unclear definitions of diagnosis, condition or treatment or inaccurate coding.
- Medical Records may be incomplete or imprecise. Providers may err in their documentation not directly related to reimbursement.

Methods of Profiling will be constructed to answer specific questions and use appropriate statistical methods to differentiate providers with a degree of reliability. Before providers are profiled, they will be involved in the selection of measures and in identifying complicating factors such as case mix. The provider utilization profile will be designed to answer a concise question and be clearly interpretable. Data sources for utilization profiles will range from claims databases maintained by BTCS to individual consumer records kept in providers' offices and at service sites.
A profile will be based on a scientifically drawn sample of eligible subjects or on a complete census. BTCS will not formulate a profile until enough data are acquired to render the profile statistically useful. To attain statistical validity, adequate amounts of data will be collected over a sufficient time period or data may need to be pooled with other sources.

Cautions Will Be Taken in Use of Utilization Data. Utilization review patterns will be compared to detect deviations above and below the norm are frequently conducted. A provider will not be penalized for exceeding utilization rates unless rates are risk adjusted for the consumer population. Comparison of utilization patterns will only be between providers of the same services with control for as many variables as possible.

Section 4.4 – Contact With and Receipt of Information from Providers

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- Initial Contact: UM will work with all designated providers seeking routine information about eligibility and services. In no event will this preclude a BTCS representative from contacting a provider or others in his/her employ where a review might otherwise be unreasonably delayed or where the

person designated is unable to provide the necessary information or data requested by BTCS.

- Collection of Information**:** Providers will submit clinical documentation to BTCS as specified in the provider manual and/or their contract, consistent with applicable laws on confidentiality. When conducting routine utilization review activities, BTCS will collect only the information necessary to authorize the admission, procedure, or treatment, and/or length of stay, such as, identifying information about the person receiving services, clinical information regarding the diagnoses of the person receiving services, medical history relevant to the diagnoses, the person's prognosis, and the treatment plan prescribed by the treating provider along with the provider's justification for the treatment plan. Personnel employed by, or under contract with, BTCS who obtain information regarding a consumer's specific medical condition, diagnosis, and treatment options or protocols directly from the physicians, will be qualified according to guidelines of oversight agencies.

Section 4.5 – Utilization Review

Purpose:

Ensure timeliness of service authorization reviews, determinations, and notification of determinations.

Procedure:

Upon receipt of all required information, requests for authorization of services will be reviewed by the BTCS UM staff or designee in accordance with the following standards.

Initial Determinations

- Determination will be made within two business days.
- Notification to the provider of determination by telephone, email or facsimile will be made within two business days of making the determination.
- If facsimile or email is not used, then written confirmation of the decision will be sent to the provider within three business days of the telephone notification.

Concurrent Review

- Determination will be made within one business day.
- Notification to provider of determination by telephone, email or facsimile will be made within two business days of making the determination.
- If facsimile or email is not used, then telephone confirmation to the provider which will be followed by written confirmation of the decision to the provider within two business days of the telephone notification.

Retrospective Review

- Determination will be made within 30 business days.
- Written notification will be made to the provider of denial determinations within five business days of making the determination.

Section 4.6 – UM and Review System Process

Purpose:

To ensure that the authorization and utilization management system facilitates timely access to services and that the safety of persons requesting or receiving services is not compromised.

Procedure:

- To facilitate management of timely and appropriate service utilization, BTCS coordinates the flow of information between the crisis response system, single point of entry and the utilization management program.
- Access to utilization management staff will be consistent throughout each business day. After hours, there will be a back-up system to accept and record messages for non-emergent or urgent care and to refer callers back to the crisis system, if needed. Message recorders will have time/date-received capability, and non-urgent recorded messages are returned within two business days when sufficient information for a return call is provided. A toll-free telephone number will be available for long distance calls made within BTCS service area.
- UM staff or designee will be available throughout the business day to review clinical information needed to make authorization decisions.
- For potential adverse determination decisions, psychiatric consultation will be available twenty-four hours a day through the crisis response system.

BTCS will provide a twenty-four hours a day seven days a week telephone answering system and FAX machine through which authorization request messages may be received. If the provider has any concerns about the case (i.e., that any of the admission criteria are not met, the assigned LOC is incorrect, or the consumer refuses some or all the services) the provider must contact UM to document and discuss the case.

Section 4.7 - Persons with Special Circumstances/Needs

Purpose:

To ensure that utilization management criteria are applied in such a way that persons with special circumstances receive the services they need and ensure linkage with needed services external to BTCS's provider network.

Procedure:

BTCS will ensure identification of a person with special circumstances and be flexible in the application of UM guidelines in making authorization decisions to ensure needed access to care.

"Special circumstances" may include, but are not limited to, a person who in addition to their psychiatric needs has at least one of the following:

- a physical disability
- an acute health condition, life-threatening or terminal illness
- developmental disability
- a woman who is pregnant

Upon identification of a person with special circumstances, the Utilization Manager will review the details of the case and fulfill the Utilization Care Management functions or refer to other UM staff assigned to that function.

Section 4.8 - Clinical Overrides and Exceptions

Purpose:

To ensure that:

- BTCS has an expedient mechanism to override the UM Guidelines and Texas Recommended Authorization Guidelines (TRAG) when there is the need.
- BTCS has a process to make exceptions to and manage the number of units of service authorized for a consumer.
- DSHS has the clinical information it needs to evolve and improve the DSHS UM Guidelines and the TRAG.

Procedure:

Clinical Overrides:

1. BTCS may authorize a clinical override to the DSHS UM Guidelines which result in placement in a higher service package for the following reasons:

- **Consumer need:** A person has a medical need for services that are included in a service package other than the one recommended by the TRAG.
- **Continuity of Care:** The TRAG recommends a lower service package but the person is maintained in the current service package for clinical reasons such as ensuring that improvements are maintained.
- **Other:** A person presents for care and a clinician determines that an extenuating circumstance exists that requires the person to be served for reasons not captured in one of the other deviation reasons.

2. BTCS may authorize an override to the DSHS UM Guidelines which result in placement in a lower level service package for the following reasons:

- **Consumer Choice:** A person chooses not to receive services in the service package recommended by the TRAG and wants to move to a less comprehensive package.
- **Resource Limitations**: Capacity for the TRAG recommended service package is not available. Applicable to non-Medicaid eligible consumers only.

Exceptions:

BTCS may authorize an exception to the amounts of service within a service package for persons who have reached the maximum service unit limits of a level of care or for greater than it routinely authorizes, for the following reasons:

- **Consumer need:** A person in services and their clinician determine that an extenuating circumstance exists that require the person to be served with an increased frequency or duration of services than is routinely authorized by the LMHA

Requests for Clinical Overrides:

Admission: If, when applying the DSHS UM Guidelines and the TRAG, the LPHA conducting the initial eligibility determination, determines that one of the approved conditions exists for granting a clinical override, BTCS will do the following:

- **Overrides for a higher service package** – contact the Utilization Manager and provide the necessary information and documentation to grant or deny the request.
- **Override for a lower service package** – ensure that an opening is available in the lower service package by either contacting UM staff per procedure or

through use of BTCS automated system which ensures that the service capacity for this consumer is available.

During the Course of Treatment: If, after completion of the TRAG, the provider determines that one of the approved conditions exists for granting a clinical override or exception, the provider will do the following:

- Contact the Utilization Manager and provide them with the required clinical information and documentation. This must be accomplished through means consistent with written agreements with BTCS, applicable laws on confidentiality and any DSHS requirements.
- The exception and clinical override processes are not intended as mechanisms for appeal.

These mechanisms ensure consumer's access to clinically appropriate services while the MH R&DM process is under development and so that an excessive burden of proof is not placed on the provider as long as they comply with the BTCS's requirements.

Note: Only BTCS Utilization Manager, ETBHN designee, and/or UM Physician will grant a clinical override which places a person into a higher level of care. All clinical overrides will be clinically and administratively documented as required by DSHS and BTCS.
BTCS will develop time frames for the process for granting exceptions and clinical overrides, considering availability, demand, BTCS service capacity and other relevant factors.

Granting Clinical Overrides and Exceptions:

- Upon request or identification of a person meeting the criteria for an override or exception, the Utilization Manager or UM Physician will evaluate the mental health treatment needs of the consumer, additional information about his/her history, current special needs and/or circumstances and the provider's documentation of special accommodations needed to provide the indicated mental health service.
- Utilization Manager or UM Physician will ensure that they have the necessary clinical information to make the exception or clinical override decision. This may include contact with the provider, the person requesting or receiving services and family members.
- The Utilization Manager and/or UM Physician will document the reasons for all exceptions and overrides.

Tracking, Reporting and Evaluation of Clinical Overrides:
The UM Committee will review aggregate data about the reasons for all exceptions and overrides at every meeting. The UM Committee will ensure that periodically, an in depth analysis is conducted and reviewed by the Committee. This will include review of a sample of cases as well as aggregate and individual data available

through WebCARE Business Objects applications. BTCS will document the reasons for all clinical overrides and report them to DSHS on a quarterly basis. The information to be reported will include the following:

- Provider and consumer's reason/clinical justification for the requested override
- LMHA decision and reason for granting or denying the request for clinical override

Section 4.9 - Adverse Determinations

Purpose:

To ensure that all adverse determinations (i.e. a decision to deny, reduce or terminate a service) are objective and based on the DSHS UM Guidelines, rules and regulations.

Procedure:

Adverse determinations are service authorization denials that may be appealed, and include those in which persons seeking services are found ineligible for services during the eligibility determination process:

- who, based on clinical determination, have been terminated from services;
- who, based on clinical determination, have had an involuntary reduction in their services;
- who, based on clinical determination, have been denied access to a service/support they request to receive;
- who, based on clinical determination that non-payment is not related to the person's mental illness and that the proposed action would not cause the person's mental or physical health to be at imminent risk or serious deterioration, may experience an involuntary reduction or termination of services **(does not apply to persons for whom BTCS is identified as responsible for providing court-ordered outpatient services)**; or,
- are referred to their third-party coverage.

BTCS will respond to adverse determinations in accordance with the following framework:

- The Utilization Manager, and as appropriate the UM Physician, will conduct a review of all necessary information.
- Denial of services based on an administrative determination, such as failure to comply with contractual authorization procedures, will be made by the Utilization Manager or the UM physician. At the time of the decision to deny further authorizations, the UM staff assigned to the case will verbally notify the appellant and person requesting or receiving services, if different, and his/her provider. Within three business days of the decision, a Denial of Authorization letter will be mailed to the appellant and person requesting or receiving services, if different, and his/her provider. The appeal process will not go further for an administrative denial.
- A proposal to refer a person to his/her third party coverage in accordance with Title 25, TAC Chapter 412, Subchapter C (relating to Charges for Community Services) and/or denial of services based on a clinical determination will only be made by the Utilization Manager, if available, or the UM physician. At the

time of the decision, the UM staff assigned to the case will verbally notify the person receiving services and his/her provider of the proposed action. Within three business days of the decision, a Notice of Proposed Action letter will be mailed to the person receiving services and his/her provider.

- A proposal to reduce or terminate services based on a clinical determination that nonpayment is not related to the person's mental illness and that the proposed action would not cause the person's mental or physical health to be at imminent risk or serious deterioration will only be made by the UM Manager or physician. This proposal is not applicable for persons for whom BTCS is identified as responsible for providing court-ordered outpatient services. At the time of the decision to reduce or terminate services in accordance with Title 25, TAC Chapter 412, Subchapter C (relating to Charges for Community Services) the Utilization Management staff assigned to the case will verbally notify the person receiving services and his/her provider of the proposed action. Within three business days of the decision, a Notice of Proposed Action letter will be mailed to the person receiving services and his/her provider. BTCS will not take the proposed action while an appeal of the proposed action is pending.

Notification letters will be sent in a timely manner in accordance with a determined notification schedule, and will contain content that clearly explains the utilization management decision and all recourses available.

Section 4.10 - Right to Make a Complaint and Right to Appeal

Information about the rights of persons requesting or receiving services to express concerns or dissatisfaction or appeal an adverse determination decision will be posted at all service sites and included in the Consumer Rights Handbook. The information will include:

- An easily understood explanation of the appeal process;
- How the consumer may receive assistance in requesting an appeal;
- The consumer's right to meet with the person(s) who will be deciding the appeal;
- Time frames for the appeal review; and,
- Method used to inform the consumer of the outcome of the appeal review.

At intake, BTCS staff will review the Consumer Rights Handbook with the person receiving services and/or Legally Authorized Representative (LAR), who signs a statement indicating receipt of this information. Each year, the service provider will review the information with the persons receiving services and/or their LAR. Additionally, persons requesting or receiving services and/or the LAR will be informed that they may contact the DSHS Consumer Services and Rights Protection Office at any time regarding any concern or complaint and will be given the toll free number (1-800-252-8154).

Section 4.11 - Confidentiality and Proper Use of Identifying Information

All activities that involve use of or access to confidential consumer information will be conducted in a manner that safeguards confidentiality and prevents BTCS liability in

connection with disclosures of confidential information. All BTCS staff will be responsible for safeguarding the confidentiality rights of consumers. Disclosure will be made only within the limits of informed consent of the parties involved or as required by applicable federal and state law. All UM activities are part of the internal Peer Review Process and are subject to confidentiality regulations. All physician and non-physician participants in the UM process will protect confidentiality as required by HIPPA and BTCS policies. All UM committee members will sign a confidentiality statement prior to participation on the committee. BTCS will ensure that identifying information gathered for the purpose of utilization review will be used solely for the following purposes:

- Utilization Review
- Utilization Care Management
- Discharge Planning
- Claim Management
- Quality Assurance/Improvement
- Auditing for Contractual Purposes

Concerning review by DSHS or an Independent Review Organizations, when applicable identifying information obtained during the process of utilization review will be shared only with those agencies and persons that have the authority to receive such information.

Provider Responsibility to Assist With Appeals:
BTCS will inform and educate providers regarding their obligation to, upon request, assist a person requesting or receiving services in appealing an adverse determination decision, as well as inform the provider of their obligation to, upon request, file an appeal on the person's behalf. BTCS will inform and educate providers about these obligations as follows:

- in the RFP (if applicable);
- at the time of contracting;
- annually with BTCS service providers;
- in writing as part of the provider manual; and,
- at the time of contract renewal.

If BTCS receives a complaint that a provider did not facilitate access to the appeals procedure, a person designated by BTCS will investigate the provider's procedures. Additionally, BTCS will inform providers of the right of persons requesting or receiving services and/or their LAR to contact the DSHS Consumer Services and Rights Protection Office at any time regarding a concern or complaint and will be given the toll free number (1-800-252-8154). The provider will be required to post this toll free number at all service sites.

Section 4.12 - Appeals of Adverse Determinations

BTCS will establish an appeals process in accordance with T.A.C. 401.464. (Rule Governing Notification and Appeals Process). The BTCS appeals process will provide a mechanism for persons requesting or receiving services, their legally authorized representative (LAR), persons advocating on the person's behalf and

providers to challenge utilization management/resource allocation decisions with which they disagree. In addition, the appeals process will serve to:

- facilitate the request for review and reconsideration of adverse determination decisions;
- allow the identification and resolution of ongoing service problems through the analysis of appeal trends and feedback to appellants; and,
- allow BTCS to prospectively evaluate and take appropriate action on potential risk issues.

In accordance with Title 25, TAC Chapter 419, Subchapter G relating to Medicaid Fair Hearings, BTCS will afford persons an opportunity to a fair hearing in any Medicaid case for an individual whose claim for services is denied or not acted upon promptly or BTCS takes action to suspend, terminate or reduce services, including a denial of prior authorization request for Medicaid-covered services. Although the Medicaid fair hearing process is distinct from the appeal processes, similar activities may be synchronized. The UM appeals processes described here are also separate from those appeal processes applicable to the Consumer Benefits Assistance Plan, as defined in Attachment XVI of the FY2004
Performance Contract.

Procedure:

The person requesting or receiving services, his/her LAR, his/her provider or someone else acting on the person's behalf has 30 calendar days after receipt of written notification of an adverse determination to initiate a request for appeal.

Appeals are submitted as follows:

- Persons requesting or receiving services may appeal an adverse determination decision either in writing or verbally.
- BTCS may request that the person's LAR, an appeal representative or the person's provider submit the request to appeal an adverse determination decision in writing.
- The adverse decision written notification must also allow the appealing party an opportunity to submit, in writing, good cause for having a particular type of specialty provider review the case. In such circumstances, the appeal will include a review by a provider in the same or similar specialty as typically manages the specialty condition, procedure, or treatment under review.
- All requests to appeal an adverse determination decision will be routed to a central point of contact designated by BTCS.

BTCS's procedure for appeals includes the following provisions:

Routine Appeal Process

- If a person requesting or receiving services requests assistance in completing a written appeal, BTCS will provide such assistance.
- As soon as all necessary information is received by BTCS, the UM representative will submit the person's chart and other data necessary to review the adverse determination decision to a designated individual who was not involved in the original authorization decision. The individual reviewing the appeal may obtain additional information including but not limited to, interviews

with the person requesting or receiving services, the person's LAR, anyone the person designates to advocate for him/her and the person's provider.

- For appeals of decisions regarding care provided by physicians, the appeal will be reviewed by the UM physician or other designated physician who is not involved in provision of care.
- Review of the appeal will be complete within twenty business days of receipt of notification to appeal unless BTCS CEO grants an extension of the timeframe.
- Following the appeal decision, the UM staff assigned to the case will verbally, in person or telephone, notify the appellant and person requesting or receiving services, if different, and his/her provider of the decision.
- Within three business days of the decision, the UM staff assigned to the case will mail written notification of the decision (an Appeal Resolution letter) to the appellant and person requesting or receiving services, if different, and his/her provider. The letter will include information about making a complaint to the DSHS Consumer Services and Rights Protection Ombudsman if they are not satisfied with the appeal decision.

Routine Second-Level Process

- Once the appellant and person requesting or receiving services, if different, and his/her provider is notified of the appeal resolution, s/he will have ten business days to contact DSHS Office of Consumer Services and Rights Protection-Ombudsman (1-800- 252-8154) for further review of their concerns about the appeal decision and any proposed action.

Expedited Initial Appeal Process

- BTCS will have an expedited appeal process based on the immediacy of the condition. Any denial of admission or continued stay for inpatient services will be allowed an expedited appeal process. Within one hour of making the adverse decision, BTCS will notify the person requesting or receiving services, the person's LAR, anyone the person designates to advocate for him/her or the person's provider of the adverse decision.
- Once notified of a denial of inpatient services or continued stays for hospitalization, the person requesting or receiving services, the person's LAR, anyone the person designates to advocate for him/her or the person's provider will have one business day to request an appeal through the UM Department. However, if notification of the denial is made at 5:00 PM or later, they will have until 8:30 AM the next business day to make the request.
- A BTCS physician who was not involved in the original authorization decision will review the appeal. The expedited appeal is to be completed based on the immediacy of the condition and no later than one calendar day from the date that all information necessary to complete the review is received by BTCS.
- Within one calendar day of the decision, the UM staff assigned to the case will verbally, in person or by telephone, as well as certified mail (Appeal Resolution letter), notify the appellant and person requesting or receiving services, if different, and his/her provider of the decision.

Expedited Second Level Appeal Process

- Once notified of an appeal resolution the appellant and person requesting or receiving services, if different, and his/her provider have one business day to request a second review of the appeal through the UM Department. However, if notification of the appeal decision is made at 5:00 PM or later, they will have until 8:30 AM the next business day to make the request.
  - A UM representative will gather all necessary data and forward it to an external physician reviewer or a BTCS physician not involved in the initial appeal decision. The physician reviewer will then conduct a review and make a determination regarding the appeal. The expedited second level appeal will be completed based on the immediacy of the condition and no later than one calendar day from the date that all information necessary to complete the review is received by BTCS.
- Within one business day of the decision, the UM staff assigned to the case will verbally, in person or by telephone, as well as by certified mail (Appeal Resolution letter), notify the appellant and person requesting or receiving services, if different, and the person's provider explaining the resolution of the appeal.

BTCS staff designated to manage appeals will be responsible for:

- Coordinating and facilitating the appeal process;
- Assisting the appellant/LAR/provider, as needed, to meet required timeframes;
- Collecting additional information from UM staff, the person requesting or receiving services, LAR, and/or provider, as appropriate;
- Maintaining an appeals log categorized by cause and disposition including length of time for resolution of each appeal;
- Maintaining a record of the appeal for a minimum of six years;
- Collecting, trending, and analyzing appeal data to identify service problems or potential risk issues; and
- Sharing relevant appeals data with Quality Management and other appropriate management staff.

Appeal Acknowledgement

In response to a request to appeal of an adverse determination decision, to include a proposed action, BTCS will mail an Appeal Acknowledgement letter to the appellant or person requesting or receiving services if different or his/her LAR.

The letter will include:

The date of BTCS's receipt of the appeal;

- A unique file or identification number to be assigned to the complaint;
- A description of the appeal procedures and time frames;
- An opportunity for the appealing party to submit the reason for the appeal;
- Information on how the appellant may provide additional information (in writing, in person, by telephone, or through an authorized representative) to the file for the reviewer who will be making the appeal decision and the date by which all information must be submitted to BTCS
- Notification that the appellant has the right to meet in person with the reviewer who will be deciding the appeal; and

- Notification that the denied services, supports, or treatment will not be initiated or re-instituted until the appeal process is complete and only if the decision is in the appellant's favor. This requirement will not apply when the person receiving services or his/her LAR requests a second review of the appeal of BTCS's proposed action by the DSHS Office of Consumer Services and Rights Protection

Appeal Resolution
Following review of an appeal of an adverse determination, an Appeal Resolution letter will be sent to the appellant and person requesting or receiving services, if different, and his/her provider as notification of the decision. In all cases, the Appeal Resolution letter will contain:

- the decision;
- the principle reason for the decision;
- the specialization of providers consulted; and
- the description of the appeal and/or complaint process
- the DSHS Consumer Services and Rights Protection Office address and toll free number.

In all cases when an adverse determination decision is modified or reversed by BTCS, the Appeal Resolution letter will also include:

- the plan to re-engage the person into services.

Section 4.13 - Discharge Planning
The purpose of the discharge planning process is to identify those admissions that will benefit from early discharge intervention, that require alternative treatment settings or mechanisms post-discharge, and to facilitate the availability of and transfer to least restrictive settings of care or services. The discharge planning process will include referral to appropriate community resources.
Discharge Planning will include analysis of data to identify opportunities to improve effectiveness and efficiency in delivering care and services and opportunities for appropriate education of clients, providers, purchasers, and payers.

Section 4.14 - Case Management
The purpose of the case management process is to facilitate the delivery of mental health care services to patients with serious, complicated, protracted, or chronic illnesses or conditions and to provide appropriate early identification and intervention for those patients. Case management may involve aspects of concurrent review and discharge planning, but will focus on the most effective use of resources for the seriously or chronically mentally ill.
Case management will also include analysis of data to identify opportunities to improve effectiveness and efficiency in delivering care and services and opportunities for appropriate education of clients, providers, purchasers, and payers.

Section 4.15 - Outpatient Services Review

The purpose of the outpatient services review process is to assess the effectiveness and efficiency of care and services delivered in provider offices and other outpatient facilities.
The Outpatient Services Review process includes:

- Provider utilization guidelines and criteria for evaluation of care and services rendered in outpatient settings;
- Tracking, trending, and analysis of the results of those reviews;
- Development of a performance profile based on these findings and

The Outpatient Services Review process will include analysis of data to identify opportunities to improve effectiveness and efficiency in delivering care and services and opportunities for appropriate education of clients, providers, purchasers, and payers. Findings and analyses will be reported to the UM Committee.

Section 4.16 – Wait List Management
Initial Intake and Placement on the Waiting List

1. BTCMHMR will define its capacity to provide services within each level of care for adults and children. When service capacity is exceeded, BTCS will use established guidelines and criteria for placing people on the waiting list. These criteria will include procedures for triage and prioritization based on urgency of clinical need. NOTE: Persons with Medicaid will not be placed on a waiting list.
2. The waiting list will identify:
   - persons waiting for admission into the most appropriate level of care as indicated by the TRAG,
   - persons who have been admitted to the next appropriate level of care due to lack of capacity in the most appropriate level of care, usually a lower level of care than indicated by the TRAG, and
   - persons who have not been admitted into services due to lack of capacity in all appropriate levels of care.

Monitoring and Management of the Waiting List
Current service capacity information will be maintained by BTCS and made accessible to BTCS staff responsible for eligibility determination, level of care assignment and authorization. The waiting list will be monitored by designated staff every 30 days and by the UM Department at least every 90 days for consideration in BTCS resource management and allocation decisions. Persons on the waiting list for admission into services or the most appropriate level of care as indicated by the TRAG will be contacted at a frequency sufficient to determine and prioritize their needs. Contacts will determine whether the level of care for which the person is waiting is still desired by the person. Persons on the waiting list for admission into services or the most appropriate level of care as indicated by the TRAG will be authorized and referred to appropriate providers as soon as service capacity allows. People will be removed from the waiting list once they are admitted into the most appropriate level of care or when it is determined that they either no longer need or desire services. Service capacity and procedures used to manage the waiting list will be routinely reviewed by the UM Committee and adjusted as needed.
BTCS will report data about the waiting list according to the criteria in their performance contract with DSHS on a quarterly basis.

Section 4.17 - Referral Management
The purpose of the referral management process is to ensure that referral to other services as identified by the UM Committee are medically necessary and appropriate. The referral management process includes:

- Providing criteria for referral to other services;
- Implementing retrospective review or authorization of such referrals;
- Tracking referrals and their outcomes;

Referral Management will include analysis of data to improve effectiveness and efficiency in delivering care and services and opportunities for appropriate education of clients, providers, purchasers, and payers.

Section 4.18 - Medical Information System
The purpose of this process is to assist the Executive Management Team in implementing an electronic medical information system that has the ability to capture utilization data, identify and track quality measures and outcomes, trend and analyze satisfaction survey data, and compare compliance with recommended clinical and administrative guidelines to assure the effectiveness of UM findings and assessments.

Section 4.19 - Education
As an aspect of the implementation of the UM Plan, the UM Committee will identify areas where education of clients, staff, providers, or payers will promote improved effectiveness of care and efficiency in the delivery of services.

Section 4.20 - Evaluation and Oversight
The UM Committee will continuously review and assess the appropriateness and effectiveness of the UM process. Oversight of the UM process will rests with the UM Committee. Reports will be disseminated at quarterly meetings of the committee for in-depth review of UM activities. Fidelity Tools will be utilized to assure compliance with Resiliency and Disease Management.

The UM Plan will be reviewed and updated biannually.