COLORADO

Department of Health Care Policy & Financing

FY 2014–2015 Site Review Report Executive Summary

for

Denver Health Medicaid Choice and Denver Health Medical Plan

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

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Introduction

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct a periodic evaluation of their Medicaid managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with federal healthcare regulations and contractual requirements. Public Law 111-3, The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) applies several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires CHP+ managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the BBA requiring that states also conduct a periodic evaluation of their CHP+ MCOs and PIHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's Medicaid and Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2014–2015 site review activities for the review period of January 1, 2014, through December 31, 2014, for Denver Health Medicaid Choice and for Denver Health Medical Plan (Denver Health's CHP+ HMO). Although the two lines of business were reviewed concurrently with results reported in this combined compliance monitoring report, the results for the CHP+ and Medicaid managed care lines of business are presented separately. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the four standard areas reviewed this year for both lines of business. Section 2 contains graphical representation of results for all standards reviewed over the past three years and trending of required actions. Section 3 describes the background and methodology used for the 2014–2015 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2013–2014 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the grievance and appeal record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2014–2015 and the required template for doing so. Appendix E describes the activities HSAG performed during the compliance monitoring process.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score. Recommendations for requirements scored as *Met* did not represent noncompliance with contract requirements or federal healthcare regulations.

Medicaid Results

Table 1-1 presents the Medicaid score for **Denver Health Medicaid Choice** (**DHMC**) for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Medicaid Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
V Member Information	29	29	27	2	0	0	93%
VI Grievance System	26	26	17	9	0	0	65%
VII Provider Participation and Program Integrity	17	16	16	0	0	1	100%
IX Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals	**77**	**76**	**65**	**11**	**0**	**1**	**86%**

Table 1-2 presents the Medicaid scores for **DHMC** for the record reviews. Details of the findings for the record review are in Appendix B—Record Review Tool.

Table 1-2—Summary of Medicaid Scores for the Record Reviews

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Grievances	45	27	21	6	18	78%
Appeals	30	30	22	8	0	73%
Totals	**75**	**57**	**43**	**14**	**18**	**75**

CHP+ Results

Table 1-3 presents the CHP+ scores for **Denver Health Medical Plan (DHMP)** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-3—Summary of CHP+ Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
V Member Information	29	23	21	2	0	6	91%
VI Grievance System	26	26	21	5	0	0	81%
VII Provider Participation and Program Integrity	17	17	17	0	0	0	100%
IX Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals	**77**	**71**	**64**	**7**	**0**	**6**	**90%**

Table 1-4 presents the CHP+ scores for **DHMP** for the grievance and appeal record reviews. Details of the findings for the record review are in Appendix B—Record Review Tool.

Table 1-4—Summary of CHP+ Scores for the Record Reviews

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Grievances	5	3	3	0	2	100%
Appeals	12	12	8	4	0	67%
Totals	**17**	**15**	**11**	**4**	**2**	**73%**

Standard V—Member Information

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

DHMC/P had policies and procedures that addressed member rights and described DHMC/P's processes for ensuring members are informed of, and understand, their rights. The Medicaid and CHP+ member handbooks and other member materials comprehensively defined member benefits and included the information required at 42CFR438.10. The handbook described member rights, including grievance and appeals procedures, in an easy-to-understand format. Member materials were available in other languages, Braille, large print, and audiotapes. Both the Medicaid and CHP+ member handbook informed members that member materials are available in alternative languages and formats, interpreter services are available for many languages at no cost to members, and how to obtain interpreter services. Member handbooks were produced bilingually within the same document. Both provider manuals informed providers that alternative formats and interpreter services are available to members, free of charge, and that providers may call Member Services for more information. DHMC/P informed members of the right to request and obtain an additional member handbook via the member handbook and an annual member newsletter article, which included a reminder of the content of the handbook.

DHMC/P had a process for sending the welcome packet, which included the member handbook and the provider directory. On-site DHMC/P staff members reported that Medicaid and CHP+ welcome packets were sent within approximately five days of DHMC/P receiving the eligibility file from the State. Staff reported that the provider directory was included in the Medicaid mailings but was not sent as part of the CHP+ welcome packets. Both member handbooks included a website address at which the handbooks could be accessed and the member services telephone number members could use to request a member handbook or provider directory. DHMC also used a variety of fliers distributed through the school-based health clinics and through direct mailings as well as birthday cards to educate and remind parents regarding the frequency and content of well-child exams and immunizations.

Summary of Findings Resulting in Opportunities for Improvement

In addition to providing a complete description of benefits in the member handbook, DHMC/P held a monthly luncheon for new Medicaid and CHP+ members. Although content was well designed to provide members with a comprehensive overview of benefits and information about DHMC/P, and feedback from members who had attended was positive, average attendance had consistently been 10–15 members per session while average new membership was approximately 2,000 members per month. DHMC/P may want to consider methods to publicize the luncheon to reach a larger percentage of its new membership.

Summary of Required Actions

Both the CHP+ and the Medicaid handbooks stated that members may "go to the State of Colorado" if unhappy about the outcome of their grievance. The handbook provided a toll-free number for doing so and stated, "you can also write to the Department of Health Care Policy & Financing Managed Care Benefits Section," but neither handbook included the address. DHMC/P must revise member handbook information regarding the State-level grievance review to include the address where members may send the request for the second-level grievance review by the Department.

Much of the information in the Medicaid member handbook regarding Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and related services was inaccurate or incomplete. For example, the handbook stated that EPSDT services are available to children "from birth up to 20 years of age" in one section and accurately stated that EPSDT is for members "aged 20 and under" in another section. DHMC must revise the member handbook to accurately and completely describe EPSDT and related services. DHMC should also submit the revised Medicaid member handbook to the EPSDT administrator at the Department for approval to ensure the accuracy of information provided to members regarding EPSDT and related services.

The CHP+ member handbook listed the appointment standard for "non-urgent/non-emergent (physical/mental health)" as within 30 days and "non-urgent, with symptoms or a substance abuse condition" as within two weeks. The CHP+ contract does not allow for a 30-day time frame for timeliness in scheduling non-urgent care. DHMP must revise the CHP+ member handbook to accurately reflect appointment standards.

Standard VI—Grievance System

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

DHMC/P had a well-defined grievance system that included policies and procedures to address grievances, appeals, and member access to State fair hearings. With the exception of the Drug Authorization policy, policies and procedures were clear and included the required content and accurate time frames for standard reviews, expedited reviews, and extension processes. HSAG found ample evidence that providers and members were notified of member rights related to the grievance system.

The on-site record review demonstrated that in most cases DHMC/P implemented its policies, as written. There was evidence that providers filed appeals on behalf of members and that grievances and appeals were accepted both verbally and in writing. DHMC/P sent acknowledgement and resolution letters according to the time frames, with some exceptions.

Summary of Findings Resulting in Opportunities for Improvement

During the on-site discussion, staff indicated that notices of actions were not typically sent for medication changes. Most cases are typically treatment decisions, based on the provider's professional judgment, and would not require a notice of action; however, DHMC/P may want to review its practices to ensure that for any managed care decision (such as deletions from the formulary that result in discontinuing an authorization of a medication for a particular member), a notice of action is sent.

Summary of Required Actions

As the Drug Utilization policy did not include that the termination, suspension, or reduction of a previously authorized service (in this case a medication) is an action, DHMC/P must revise its Drug Utilization policy/procedure to depict that the termination, suspension, or reduction of a previously authorized service (in this case, a medication) is an action.

During the on-site record review, HSAG found that only seven of nine grievance acknowledgement letters were sent within the two-working-day time frame; therefore, DHMC must develop a mechanism to ensure that grievance acknowledgement letters are consistently sent to members within the required two-working-day time frame.

During the on-site record review, HSAG found that only eight of nine Medicaid grievance disposition letters were sent within the 15-working-day time frame; therefore, DHMC must develop a mechanism to ensure that Medicaid grievance disposition letters are consistently sent to members within the required 15-working-day time frame.

During the on-site record review, HSAG found that only six of nine Medicaid grievance disposition letters included all required content; therefore, DHMC must develop a mechanism to ensure that Medicaid grievance disposition letters consistently include all required elements.

During the on-site record review, HSAG found that only four of five Medicaid appeal acknowledgement letters were sent within the two-working-day time frame; therefore, DHMC must develop a mechanism to ensure that Medicaid appeal acknowledgement letters are consistently sent to members within the required two-working-day time frame.

During the on-site record review, HSAG found that only three of five Medicaid and one of two CHP+ appeal resolution letters were sent within the 10-working-day time frame; therefore DHMC/P must develop a mechanism to ensure that Medicaid and CHP+ appeal resolution letters are consistently sent to members within the required 10-working-day time frame.

During the on-site record review, HSAG found that four of five Medicaid and one of two appeal resolution letters included all required content; therefore, DHMC/P must develop a mechanism to ensure that Medicaid and CHP+ appeal resolution letters consistently include all required elements.

During the on-site record review, HSAG found that in one Medicaid record, the previous reviewer made the subsequent decision and was not qualified to have made the decision on either occasion. In one additional Medicaid record, a grievance/appeal staff member made the decision on an appeal

related to the denial of a request for a particular medication. In one CHP+ record, HSAG found that a grievance/appeal staff member upheld a claims denial for an out-of-network provider to which a DHMP physician referred the member because no pediatric oncologist was available within the Denver Health and Hospital Authority (DHHA) system. Grievance and appeal staff members do not have the clinical expertise to determine if an appeal (which may have been determined administratively upon the initial decision) involves clinical issues that will require a provider to determine if certain administrative requirements (i.e., using an out-of-network provider because the specialty is not available within the network) should be waived. DHMC/P must therefore ensure that appeal decisions are reviewed by providers with the appropriate clinical expertise that had not been involved in a previous level of decision.

DHMC/P had three separate policies that included a definition for timely filing. The definitions varied in accuracy, completeness, and content. Furthermore, during the on-site interview, grievance/appeal staff members were unable to clearly articulate a complete definition of timely filing. DHMC/P should consider reviewing policies for consistency across programs, and periodic training of grievance/appeal staff members specifically regarding federal regulations. Also related to the definition of timely filing, DHMC/P's policy/procedures and member and provider materials indicated that members who are appealing an action that terminates, suspends, or reduces previously authorized services that the member is receiving have 10 days from the notice of action to file the appeal regardless of whether the member is requesting continuation of services. DHMC/P must review applicable policies and member and provider materials to ensure that it is clear that members need only to comply with timely filing requirements delineated in 42CFR438.420 if requesting the continuation of previously authorized services that the MCO is proposing to terminate, suspend, or reduce.

Standard VII—Provider Participation and Program Integrity

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

DHMC/P operates a primarily closed campus system of providers. The provider manuals are comprehensive. Policies and procedures delineated contractual obligations as well as requirements for ongoing monitoring. Monitoring activities included, but were not limited to the Healthcare Effectiveness Data and Information Set (HEDIS®[1-1]), performance improvement projects (PIPs), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[1-2]). In addition, the DHHA Integrity Office is contracted through a memorandum of understanding (MOU) to conduct medical record reviews. Credentialing policies and processes were thorough, and the monitoring of provider quality and appropriateness was comprehensive and adequately reported. Physicians, employees, directors, vendors, and officers were queried monthly for suspension, exclusion, and

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

debarment. Systems were in place to ensure compliance with provider non-discrimination, sanctions and exclusions, and freedom to act on behalf of members. Policies were in place for reporting adverse licensure or professional review actions; no such actions took place in calendar year (CY) 2014. Compliance training was thorough and occurred at all levels. Various, creative methods were used to provide ongoing compliance training activities and delineate policies and processes.

Summary of Findings Resulting in Opportunities for Improvement

No opportunities for improvement were identified for this standard.

Summary of Required Actions

There were no required actions related to this standard.

Standard IX—Subcontracts and Delegation

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

Current subcontracted delegates included MedImpact, Denver Health and Hospital Authority, and University Physicians. Policies and procedures related to subcontracts and delegation included the required information. HSAG found evidence of a signed, executed agreement with each delegate that also included all required provisions. The agreements also outlined a process for providing oversight and monitoring of subcontractors and delegates while maintaining ultimate responsibility of all delegated tasks. In CY 2014 no corrective actions were required of subcontracted delegates.

Summary of Findings Resulting in Opportunities for Improvement

No opportunities for improvement were identified for this standard.

Summary of Required Actions

There were no required actions related to this standard.