FY 2014–2015 Site Review Report Executive Summary

for

Colorado Choice Health Plans

April 2015

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

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Introduction

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 managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the Balanced Budget Act of 1997, Public Law 105-33 (BBA). The BBA requires that states conduct a periodic evaluation of their 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 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 FY 2014–2015 site review activities for the review period of January 1, 2014 through December 31, 2014. 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. Section 2 contains graphical representation of results for all 10 standards across the three-year cycle, as well as 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 some way 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.

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 assigned for requirements scored as *Met* did not represent noncompliance with contract requirements or federal healthcare regulations.

Table 1-1 presents the scores for **Colorado Choice Health Plans** (**Colorado Choice**) 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 Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
V Member Information	23	23	17	6	0	0	74%
VI Grievance System	26	26	7	19	0	0	27%
VII Provider Participation and Program Integrity	17	16	11	3	2	1	69%
IX Subcontracts and Delegation	5	5	3	2	0	0	60%
Totals	**71**	**70**	**38**	**30**	**2**	**1**	**54%**

Table 1-2 presents the scores for **Colorado Choice** for the denials record review. Details of the findings for the record review are in Appendix B—Record Review Tool.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Grievances	NA	NA	NA	NA	NA	NA*
Appeals	18	18	13	5	NA	72%
Totals	**18**	**18**	**13**	**5**	**NA**	**72%**

*__Colorado Choice__ reported no grievances for calendar year 2014.

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

Colorado Choice had a process in place to ensure that the member welcome packet was sent to members within a week of receiving eligibility files from the Department. The member handbook informed members that they have the right to request a member handbook or provider directory at any time and that the handbook and all member information are available in other languages and formats at no charge. The handbook also stated that customer service has free interpreter services. **Colorado Choice** had a vendor for language line services; however, used bilingual staff for Spanish interpretation.

The member handbook also adequately addressed emergency and poststabilization services as well as access standards, advance directives, co-pays, how to obtain covered benefits and services, how to choose and change PCPs, voluntary enrollment, and disenrollment, and informed members that additional information is available upon request. **Colorado Choice** used the annual member letter to inform members about the CHP+ plan, member rights and responsibilities, grievance and appeal rights, and how to request additional copies of the handbook.

Summary of Findings Resulting in Opportunities for Improvement

The provider manual included the translation services procedure only under the Medicare section. HSAG recommended that **Colorado Choice** clarify that oral interpretation is available for CHP+ members as well.

The provider directory was available on the **Colorado Choice** website, and the member handbook informed members that a directory could be accessed on the website or requested from customer service. **Colorado Choice** may want to consider mailing the provider directory with the welcome packet in the initial member mailing.

Summary of Required Actions

The member handbook and other vital member materials were written at a readability level significantly higher than sixth grade. **Colorado Choice** must consistently use some mechanism to determine readability and understandability of documents. Recognizing that some words must remain in the documents due to federal regulations or contract requirement, **Colorado Choice** must develop a mechanism to work around these words and phrases and ensure that the rest of the document in question is easy to understand and at the sixth grade reading level, to the extent possible.

While **Colorado Choice** had selected documents available in Spanish and informed members via the member handbook that the handbook and other materials were available in Spanish, the handbook was not readily available in Spanish. In addition, neither the member welcome letter nor

annual letter informed members of availability in Spanish. **Colorado Choice** must have a Spanish version of the member handbook available to respond to member requests for such. **Colorado Choice** must also have other vital materials such as the welcome and annual letters available in Spanish and inform members that all vital materials are available in Spanish, which is the prevalent non-English language in the **Colorado Choice** service area (per the 2010 census: http://www.mla.org/map_data).

While **Colorado Choice** provided a policy on-site that addressed member rights, the policy did not contain key required elements related to notifying members of significant changes. **Colorado Choice** must revise or develop a policy that includes the procedural components, time frames, departmental responsibility, and manner in which notice will be provided to members regarding a significant change in member handbook information.

Member handbook information regarding time frames and information related to the member's right to request that the disputed services continue during an appeal or State fair hearing must be clarified. **Colorado Choice** must also provide specific notice to members that assistance in filing appeals may consist of help completing forms or putting oral requests for appeals or a State fair hearing in writing and providing interpreter services.

The member handbook stated that a member's failure to notify **Colorado Choice** within 48 hours of an emergency hospital admission may result in a reduction or denial of coverage. **Colorado Choice** must remove from all member materials language indicating that **Colorado Choice** would refuse to pay for emergency services based on notification requirements.

Colorado Choice must include in its member information regarding third party liability that members must follow the third party's protocols in receiving nonemergent services.

Standard VI—Grievance System

Summary of Strengths and Findings as Evidence of Compliance

Colorado Choice had processes in place both for processing grievances and appeals and for informing members of their right to a State fair hearing. **Colorado Choice** recently designated one staff member to process grievances and appeals. This will increase consistency and potentially improve compliance with requirements for processing grievances and appeals. The health plan had a desktop procedure (DTP), which included some definitions, time frames, and procedural directions for staff processing grievances and appeals.

Summary of Findings Resulting in Opportunities for Improvement

The definition of "grievance" was technically accurate in **Colorado Choice**'s documents (the DTP, provider manual, and member handbook); however, **Colorado Choice** separately defined "complaint" and stated that a complaint is less formal than a grievance. Complaints must be treated in the same manner as grievances, and separating the definitions in this way may cause providers or staff members to fail to capture or report, or to underreport, grievances. HSAG recommends that

Colorado Choice combine within vital documents, for tracking and quality purposes, the definitions of "complaint" and "grievance"—to encourage capture of all expressions of dissatisfaction.

Summary of Required Actions

Colorado Choice did not have policies and procedures that fully addressed the grievance system. While the DTP addressed some aspects of the system, it did not address all required elements. Furthermore, although DTPs are helpful in providing guidance to staff, they are not formal enough to meet the Department's requirement that health plans have policies and procedures. Pertinent elements of the grievance system that **Colorado Choice** must address in policy/procedure follow:

- Complete description of an action—under what circumstances members may file an appeal. Missing from the list was failure to meet the time frames for resolution of grievances and appeals and denial of the member's rights to seek out-of network services under specific circumstances described at 42CFR438.52.
- The definition of an appeal
- Who has authority to file grievances, appeals, and requests for State fair hearings
- Who may make decisions on grievances and appeals
- Time frames for filing and resolving appeals and requesting State fair hearings
- Processes for ensuring that members follow an oral request for an appeal with a written, signed appeal
- How the health plan will offer and provide assistance to members filing grievances and appeals or requesting a State fair hearing
- All provisions and member rights associated with the grievance system, as described in 10 CCR 2505-10 §8.209
- Required content of appeal and grievance resolution letters
- Extensions for processing grievances and appeals
- Expedited appeal processes
- The continuation of previously authorized services that the health plan has proposed to terminate, suspend, or reduce via a 10-day advance notice, including the time frame for continuation of those services and effectuation and payment of such services

Colorado Choice must ensure that grievance resolution letters address members' specific expressions of dissatisfaction. **Colorado Choice** must also ensure that all appeals are addressed and notice provided within the required time frames.

Colorado Choice must revise the member handbook as follows:

- Clarify that members have 30 days to file an appeal, except when they are requesting continuation of previously authorized services. If a member is requesting continuation of previously authorized services, the appeal must be filed within 10 days from the notice of action (or *before* the intended effective date of the action).
- Describe the types of assistance available in filing grievances and appeals.

- Include a complete description of an action and inform members under what circumstances members may file an appeal. Missing from the list was failure to meet the time frames for resolution of grievances and appeals and denial of the member's rights to seek out-of network services under specific circumstances described at 42CFR438.52.
- Include a complete definition of "appeal."

During the on-site record review, HSAG found that appeals were not being acknowledged in writing and appeal resolutions were not consistently sent within the required 10-working-day time frame. **Colorado Choice** must ensure that all appeals are acknowledged in writing within two working days after the receipt of the appeal and that appeals are resolved with written notice sent within the required time frames.

Colorado Choice must revise information for the provider regarding the grievance system to include:

- Time frames and processes for filing grievances and appeals and requesting a State fair hearing.
- Procedures related to continuation of previously authorized services that the health plan has proposed to terminate, suspend, or reduce.
- The complete definition of "appeal."

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

Colorado Choice had policies and procedures for the selection and retention of providers that clearly described the intent to comply with standards and guidelines for credentialing and recredentialing delineated by the National Committee for Quality Assurance (NCQA). **Colorado Choice** provided evidence of monitoring providers and services rendered as required by the managed care contract. The **Colorado Choice** provider agreement addressed all required elements. **Colorado Choice** had processes for ensuring that contracted providers, directors, and officers of **Colorado Choice** had not been excluded from federal healthcare participation.

Colorado Choice had a compliance plan that both described its commitment to comply with applicable federal and State standards for detecting and guarding against fraud, waste, and abuse and included most of the required elements of a compliance plan.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Choice had no examples or a template letter to use should the health plan deny a provider participation in the network; staff members reported that the health plan had never had the occasion to deny participation. HSAG recommended that **Colorado Choice** develop a template letter with field for the required content so that, if **Colorado Choice** should deny a provider participation in the network, it may easily meet the requirement to state the reason for the denial in the letter.

Summary of Required Actions

The **Colorado Choice** provider manual depicted the time frame for making standard preservice authorization decisions as 14 days rather than 10 calendar days, as required by Colorado (10 CCR 2505-10 §8.209.4.A.3.c). **Colorado Choice** must revise provider materials to clearly depict the accurate time frame for processing service authorization requests.

The **Colorado Choice** Credentialing Plan stated that providers would be notified of the credentialing decision, but did not specify that if the health plan declined to include a provider in the network it would inform the provider of the reason for the decision. **Colorado Choice** must revise the credentialing plan to include the process for notifying provider applicants of the reason for denying participation in the network.

Colorado Choice had no policy that addressed notifying the Department of provider terminations that could cause the delivery of covered services to be inadequate in a given area. On-site, **Colorado Choice** staff members stated that they would use the quarterly reporting of network adequacy to accomplish this. This would be insufficient as this reporting occurs after the fact. The contractually required deliverable is 60 days prior to the effective date of the termination. **Colorado Choice** must develop a sufficient mechanism for reporting provider terminations that may cause insufficiency in the network.

Colorado Choice's advance directives policy adequately described all requirements, with the exception of community education. While the policy indicated that information regarding advance directives was posted on the **Colorado Choice** website, no information was found on the website. **Colorado Choice** must either follow through with provisions for community education regarding advance directives, as stated in its policy, or revise the policy to depict **Colorado Choice**'s practices related to community education regarding advance directives.

Colorado Choice did not have a policy that described **Colorado Choice**'s response when allegations of fraud are reported and pending. **Colorado Choice** must develop policies and procedures that describe the health plan's intent and processes for suspending payments to providers against whom there is a credible allegation of and/or investigation of a credible allegation of fraud.

Standard IX—Subcontracts and Delegation

Summary of Strengths and Findings as Evidence of Compliance

Colorado Choice had an agreement with each delegate that included the required content. **Colorado Choice** also provided evidence of monitoring its delegates and working with the delegates to correct deficiencies found via monitoring activities.

Summary of Findings Resulting in Opportunities for Improvement

On-site, HSAG recommended that **Colorado Choice** consider types of monitoring that encompass ongoing monitoring and formal review and then develop a delegation oversight plan for each delegate, with specific oversight reviewed by the Quality Improvement Committee.

Summary of Required Actions

Although **Colorado Choice** policies regarding delegation described predelegation assessment as well as ongoing monitoring and formal review of delegates, **Colorado Choice** policies also stated that predelegation assessment and monitoring activities are not required for delegates that are URAC accredited. Since the Department does not deem health plans for compliance with requirements based on URAC accreditation, the health plan may not deem its delegates for URAC accreditation. **Colorado Choice** must perform predelegation assessment and monitoring activities (both ongoing and formal review) for all delegates regardless of URAC accreditation status. **Colorado Choice** must also revise policies and procedures accordingly.

Colorado Choice policies and procedures indicated that ongoing monitoring procedures may occur as infrequently as annually and did not describe formal review (which may occur annually). While **Colorado Choice** provided evidence on-site of ongoing monitoring of its delegates, no evidence of formal review was provided. **Colorado Choice** must ensure that delegates are subjected both to formal review at least annually and to ongoing monitoring between formal review cycles.