COLORADO
Department of Health Care Policy & Financing

FY 2014–2015 Site Review Report Executive Summary

for

Access Behavioral Care—Denver and Access Behavioral Care—Northeast

March 2015

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

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The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct a periodic evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (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 behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

Access Behavioral Care began operations as the BHO for the northeast region of Colorado effective July 1, 2014. Therefore, 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 Access Behavioral Care—Denver and the review period of July 1, 2014, through December 31, 2014, for Access Behavioral Care—Northeast. Although the two lines of business were reviewed concurrently with results reported in this combined compliance monitoring report, any notable differences for each line 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. Section 2 contains graphical representation of results for all 10 standards across two three-year cycles, 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 appeals record reviews. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the BHO 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 within the compliance monitoring tool 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.

Table 1-1 presents the scores for **Access Behavioral Care—Denver** (**ABC-D**) for each of the standards. Findings for all *Met* 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 ABC-D

Standard		# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
V	Member Information	20	20	18	1	1	0	90%
VI	Grievance System	26	26	23	2	1	0	88%
VII	Provider Participation and Program Integrity	14	14	14	0	0	0	100%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals		**66**	**66**	**61**	**3**	**2**	**0**	**92%**

Table 1-2 presents the scores for **ABC-D** for the grievances and appeals reviews. 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 ABC-D

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Grievances	50	30	28	2	20	93%
Appeals	60	58	54	4	2	93%
Totals	**110**	**88**	**82**	**6**	**22**	**93%**

Table 1-3 presents the scores for **Access Behavioral Care—Northeast** (**ABC-NE**) for each of the standards. Findings for all *Met* 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 Scores for the Standards ABC-NE

Standard		# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
V	Member Information	20	20	18	1	1	0	90%
VI	Grievance System	26	26	23	2	1	0	88%
VII	Provider Participation and Program Integrity	14	12	12	0	0	2	100%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals		**66**	**64**	**59**	**3**	**2**	**2**	**92%**

Table 1-4 presents the scores for **ABC-NE** for the grievances and appeals reviews. Details of the findings for the record review are in Appendix B—Record Review Tool.

Table 1-4—Summary of Scores for the Record Reviews ABC-NE						
Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Grievances	50	34	32	2	16	94%
Appeals	12	12	12	0	0	100%
Totals	**62**	**46**	**44**	**2**	**16**	**96%**

Standard V—Member Information

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

The **ABC-D** and **ABC-NE** member materials, including member handbooks, were nearly identical. Staff confirmed that the provider network for the two service areas is one network available to any member in the **ABC-D** or **ABC-NE** areas. Therefore, there were no notable differences in the **ABC-D** and **ABC-NE** compliance findings related to member information.

The member handbook and other vital member materials were written in easy-to-understand language, were translated into Spanish and available in other languages on request, and were provided to members upon enrollment and at other times as required. The **ABC** website, which allowed members to select translation into one of more than 50 languages, also provided online access to the member handbook, member rights, provider directories, and many other member information resources. **ABC** has implemented numerous well-defined processes for the provision of language interpretation services at all essential points of member engagement. Policies and procedures and supporting documentation confirmed that **ABC** notified members within the required time frames of provider termination, privacy policies, any significant changes in information, and the member's right to request information. The member handbook and other member materials included information about grievance and appeal procedures, including information on access to the Ombudsman for Medicaid Managed Care. With limited exceptions, the member handbook adequately defined the scope of benefits available to members, authorization procedures, access to emergency and post-stabilization services, and applicable advance directives information.

Summary of Findings Resulting in Opportunities for Improvement

The **ABC** website included a comprehensive searchable community resource index. However, **ABC** did not communicate the availability of this community resource information to its members. HSAG suggests that **ABC** develop mechanisms to direct members to the **ABC** website to obtain community resource information.

Providers and subcontractors need to have mechanisms to provide members with information required in Exhibit A—2.6.11.1 of **ABC-D**'s and **ABC-NE**'s contracts with the Department. HSAG suggests that **ABC** assist its providers with meeting this requirement by including printable information on the provider section of its website, providing a supply of hard-copy member handbooks to its community mental health centers, and printing member rights posters for display at provider. In addition, HSAG suggests that **ABC** monitor providers' compliance through periodic site-visit spot checks or provider self-assessment monitoring tools.

The **ABC-D** and **ABC-NE** member handbooks briefly described post-stabilization services and **ABC**'s financial responsibilities for post-stabilization care, including a statement that the hospital or acute treatment unit (ATU) will request authorization of post-stabilization services. However, the member handbooks may not have fully addressed the circumstances for Colorado Access' financial responsibility. Therefore, HSAG recommended that **ABC** evaluate member information materials related to post-stabilization services and revise them as needed to ensure that members understand that they are never responsible for either prior authorization or payment for post-stabilization services.

The 2014 BHO contract included a new requirement that the BHO include specified member information on the BHO website. The intent of this requirement is to make essential member information readily accessible to members through BHO websites. The **ABC** website does not provide access to grievance and appeals procedures or access to care standards except through the online member handbook. Additionally, the website does not inform users or contain links to direct users to the member handbook for this information. HSAG recommends that **ABC** develop a mechanism to make information concerning grievance and appeal procedures and access to care standards readily accessible on the organization's website.

Although policy ABC304 addressed member access to out-of-network providers, and the member handbooks instructed members to call Customer Services regarding out-of-network providers, the member handbooks did not describe "the extent to which members may get services from out-of-network providers," in accordance with the requirement. HSAG recommends that **ABC-D** and **ABC-NE** more explicitly explain the extent to which members may access out-of-network providers in its member information materials.

Summary of Required Actions

Neither the member handbooks nor the website included information to help members understand the Child Mental Health Treatment Act (CMHTA). Staff members stated that **ABC** was in the process of determining the best "language" for explaining CMHTA to members. **ABC-D** and **ABC-**

NE must determine the appropriate language to inform members of the CMHTA and update member materials to include this information.

ABC did not have policies or provider directives that communicated the expectation that providers and subcontractors provide members with information as delineated in Exhibit A—2.6.8.4 of its contract with the Department. **ABC-D** and **ABC-NE** must develop mechanisms to ensure that providers and subcontractors understand their responsibility to provide the required information to members. **ABC-D** and **ABC-NE** must also develop a mechanism to ensure that providers have the required information available and accessible to members.

Standard VI—Grievance System

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

Policies, procedures, and processes for managing grievances and appeals applied to both **ABC-D** and **ABC-NE**. **ABC** delegated grievance resolution to the community mental health centers in both regions. Delegates reported detailed grievance resolution information to Colorado Access staff, who entered the information into the central Altruista system. The **ABC-NE** contract was effective July 1, 2014, and **ABC** management staff reported it was still in the process of training delegates on the grievance policies and procedures. Both **ABC-D** and **ABC-NE** appeal processes were managed by corporate Colorado Access staff and tracked through the central Altruista information system.

Appeals and grievance processes were thoroughly defined in policies and procedures, described in the member handbooks and other member communications, and included in an appeals information attachment sent with notices of action and appeal resolution letters. Time frames for filing and resolving grievances and appeals were accurately defined and grievance and appeal record reviews demonstrated 100 percent compliance with all required time frames for both **ABC-D** and **ABC-NE**. State fair hearing processes were also thoroughly addressed in policies and member communications. Appeal and grievance decisions were made by persons uninvolved in any previous decision-making and by persons with appropriate clinical expertise, as applicable. Staff members stated that Colorado Access contracted with an external medical review vendor to make appeal decisions when an appropriate specialist was not available internally. Expedited review procedures and how members may request continuation of benefits were also adequately described in policies and member communications. Appeal resolution letters included a description of the appeal review results and the date of resolution, substantiated through record review scores of 100 percent on this element.

Summary of Findings Resulting in Opportunities for Improvement

HSAG recommends that **ABC-D** and **ABC-NE** consider the following changes to its appeals policy and procedure (ADM219):

- The policy addressed all required elements of the appeal process defined in 10 CCR2505-10, Section 8.209.4. G and H (requirement #15 on tool) with the exception of "oral inquiries seeking to appeal are treated as appeals to establish the earliest possible filing date." On-site interviews confirmed that **ABC-D** and **ABC-NE** are accurately applying this requirement in their appeal processes. HSAG recommends that it also be added to the policy.

HSAG recommends that **ABC-D** and **ABC-NE** consider the following modification to the Member Appeal Information attachment to the Notice of Action and Appeal Upheld letters:

- The attachment, in both the appeal section and the State fair hearing section, informed the member that the member may request continuation of benefits during the appeal, but did not inform the member how to request continuation of benefits or of the limited 10-day time frame for doing so. HSAG recommends that this information be added to the Member Appeal Information attachment.
- The attachment described the appeals process and State fair hearing processes. When the attachment is included with the Appeal Upheld letter, the only applicable information is the State fair hearing description. In order to avoid confusing the member with extensive appeals information, HSAG recommends that **ABC** include only the State fair hearing information with the Appeal Upheld letter.

Policy ADM203 (Grievance Process) adequately defined the disposition time frames for grievances and stated that "in most cases" a written resolution notice is sent to the member. Staff members stated that "in most cases" refers to the time frames and not the written resolution. Since all grievances require a written notice of disposition, HSAG recommends that **ABC-D** and **ABC-NE** clarify the language in the policy accordingly.

Four of 10 (40 percent) of **ABC-D** and one of 10 **ABC-NE** grievance record reviews included a 14-day extension of the time frame for resolving the grievance. The template language in the extension letter implied that the extension was necessary to gather more information to make a decision in the member's best interest. However, reviewers observed in several cases that the circumstances documented in the file may not have justified the need for an extension. HSAG recommends that **ABC-D** and **ABC-NE** carefully evaluate whether grievances are being resolved expeditiously and ensure that any extensions of the time frames for resolution are in the members' best interests.

Summary of Required Actions

The grievance resolution letter template included a section for results of the resolution process and the date resolved. However, the record reviews for **ABC-D** and **ABC-NE** each included two resolution letters in which the description of the results either did not provide evidence that the grievance was adequately resolved or did not provide enough information for the member to understand how the grievance was resolved. Therefore, both **ABC-D** and **ABC-NE** grievance

record reviews scored 80 percent compliance with the requirement for the resolution notice to include the *results* of the resolution process. **ABC-D** and **ABC-NE** must ensure that resolution letters include an adequate explanation of results of the grievance process so that the member will understand that the grievance was actually resolved.

The State fair hearing section (III.S.1) of **ABC**'s appeals policy stated, "Except for Actions that involve the suspension, termination, or reduction of services, members may request a State fair hearing…within 30 calendar days of the Notice of Action." The **ABC-D** and **ABC-NE** member handbooks similarly stated that the member may request a State fair hearing within 30 calendar days "if your request is about a treatment that has not been approved" and specified that the member must request a State fair hearing within 10 calendar days "if your request is about treatment that has been approved before." This information is inaccurate. The reduced time frame for filing an appeal or requesting a State fair hearing applies only when the member requests continuation of benefits during an appeal or State fair hearing. If the member is not requesting continuation of benefits, the member may request a State fair hearing of any action (including suspension, termination, or reduction of previously approved services) within the 30 calendar day time frame. **ABC-D** and **ABC-NE** must revise policies and procedures and related member communications, including the member handbooks, to accurately describe:

- That a member may file an appeal or request a State fair hearing for any action (including suspension, termination, or reduction of services) within 30 calendar days from the date of the Notice of Action, unless the member is requesting continuation of previously authorized services during the appeal or State fair hearing process.
- When requesting continuation of previously authorized services pending the outcome of an appeal or State fair hearing, the member has 10 calendar days or until the intended effective date of the action to file the appeal or request a State fair hearing

ABC's Professional Agreement template required providers to comply with all grievance and appeal processes; however, its provider manual did not include detailed information about grievance and appeal policies and procedures as specified in the requirement. The website also did not include detailed information about grievance and appeals procedures for providers. Staff members stated that the grievance and appeal section had been inadvertently omitted from the **ABC** provider manual during a recent revision process. **ABC-D** and **ABC-NE** must provide grievance and appeal information, as specified in the requirement, to providers and subcontractors at the time they enter into a contract.

Appeal record reviews included four of 10 **ABC-D** records in which the Appeal Upheld letter was written in difficult-to-understand language. The appeal review result in the member letter appeared to incorporate verbatim the medical reviewer's findings, often containing medical jargon. **ABC** must develop a mechanism to ensure that appeal resolution letters are written in language easy for members to understand.

Standard VII—Provider Participation and Program Integrity

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

All policies, procedures, and processes related to the requirements for Provider Participation and Program Integrity apply to both **ABC-D** and **ABC-NE**. Although staff reported that it was premature to implement some of the specific provider monitoring activities in the **ABC-NE** region, there were no notable differences in compliance findings.

Policies and procedures documented thorough processes for credentialing and recredentialing providers in compliance with National Committee for Quality Assurance (NCQA) and URAC standards. Policies also specified methods for pre-credentialing and monthly monitoring for provider sanctions against applicable federal and state databases, monitoring of grievances and other quality of care actions against providers, annual on-site audit of medical record standards for a rotating sample of high volume providers, and quarterly secret shopper surveys to monitor access to care standards. All findings were reported to senior management committees and were considered in the recredentialing process as appropriate. Provider corrective action plans were developed to address identified deficiencies. **ABC** also described and provided examples of a provider profile report used for monitoring provider utilization trends and a provider self-assessment tool for medical record documentation requirements. Staff members stated that **ABC-NE** mechanisms for provider monitoring will be the same as those demonstrated for **ABC-D**, but that it was premature (at the time of the on-site review) for implementation of some of the monitoring activities and development of corrective action plans. Policies and procedures stated that **ABC** does not discriminate against providers and does not restrict providers from acting on behalf of their patients. **ABC** notified providers of reasons for declining participation in the network, which staff stated is generally due to analysis of network sufficiency for the number or types of providers needed to serve the members.

The Colorado Access Professional Provider Agreement (applicable to all lines of business) included all required elements. The provider agreement and provider manual also stated that providers were prohibited from billing or charging members for any reason, and members were encouraged to call Colorado Access to report any billing complaints.

Numerous corporate policies and procedures, the Corporate Compliance Plan, and the Medicaid Compliance Plan documented robust and well-established procedures to guard against fraud, waste, and abuse (FWA) and to maintain all corporate compliance standards. All adverse outcomes related to sanction screenings, suspected FWA, quality of care concerns, and Health Insurance Portability and Accountability Act (HIPAA) violations were reported to the Department.

Advance Directives policies and communications to providers and members documented that **ABC-D** and **ABC-NE** had addressed all applicable advance directives requirements outlined in federal

regulations. Colorado Access added a direct link to the Colorado State law concerning advance directives to their website during the on-site audit.

Summary of Findings Resulting in Opportunities for Improvement

ABC used several mechanisms for ongoing monitoring of providers for select contract requirements, including a provider self-assessment tool to evaluate medical record documentation and a provider profile report primarily focused on utilization trends. HSAG recommends that **ABC** consider enhancing its on-site audits and provider self-assessment tool to include a broader set of provider contract requirements such as compliance with grievance procedures, compliance with credentialing standards, compliance with advance directives, or other quality management activities. HSAG also observed that the use of a broadly applied self-assessment tool would enable **ABC-D** and **ABC-NE** to apply monitoring activities to an increased sample of providers. Additionally, HSAG recommends that **ABC** consider sharing the provider profile report, used primarily for internal monitoring, with the individual providers for review and feedback.

The Professional Provider Agreement described broad contract requirements and did not specify many provider rules and responsibilities detailed in the provider manual. HSAG recommends that, if the provider is expected to comply with the procedures outlined in the provider manual, **ABC-D** and **ABC-NE** should explicitly reference the provider manual in the Professional Provider Agreement.

Summary of Required Actions

There were no required actions for this standard.

Standard IX—Subcontracts and Delegation

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

All policies, procedures, and processes related to the requirements for Subcontracts and Delegation were corporately driven and applied to all Colorado Access lines of business, including **ABC-D** and **ABC-NE**. There were no notable differences in compliance findings between **ABC-D** and **ABC-NE**. **ABC** primarily delegated grievance reviews and credentialing responsibilities to providers and claims processing responsibilities to an outside vendor. Policies and written agreements with delegates documented that **ABC** retains ultimate responsibility for delegated functions. Pre-delegation assessment of a prospective delegate's capabilities included extensive desk review and on-site audit of policies, procedures, and adequacy of staff to perform the delegated activities. Colorado Access performed a comprehensive annual audit of the delegates and performed ongoing monitoring through periodic reports submitted by the delegate. Any deficiencies identified in pre-delegation or ongoing audits required a corrective action plan, with re-audit every three months until action plans were completed. Delegation agreements described the delegated responsibilities in detail, periodic reporting responsibilities of the delegate, annual audit by Colorado Access with action plans to remedy any deficiencies, and the ability of Colorado Access to revoke delegated functions or the entire delegation agreement based on inadequate performance of the delegate. Documentation of both audit findings and any required follow-up was maintained in a comprehensive database, the Compliance 360 system. All delegation assessment results and ongoing monitoring activities were reported to the Delegation Oversight Committee (DOC), as evidenced in the DOC minutes.

During on-site discussions, staff members demonstrated that audit results were documented and tracked in the Compliance 360 system and discussed examples of action plans, including one that required weekly on-site meetings between Colorado Access compliance staff and the delegate. Staff members stated that action plans are initiated regularly to correct gaps in performance and audits have, on occasion, resulted in revocation of delegated functions or delegate status.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Access' processes related to delegation of **ABC** responsibilities were comprehensive and actively implemented. HSAG identified no additional opportunities for improvement.

Summary of Required Actions

There were no required actions for this standard.