COLORADO
Department of Health Care Policy & Financing

FY 2014–2015 Site Review Report Executive Summary

for

Colorado Health Partnerships, LLC

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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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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).

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. 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 **Colorado Health Partnerships, LLC** (**CHP**) 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

Standard		# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
V	Member Information	20	20	20	0	0	0	100%
VI	Grievance System	26	26	20	6	0	0	77%
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**	**60**	**6**	**0**	**0**	**91%**

Table 1-2 presents the scores for **CHP** 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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Grievances	50	31	26	5	19	84%
Appeals	60	60	52	8	0	87%
Totals	**110**	**91**	**78**	**13**	**19**	**86%**

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

Member materials, including the member handbook, were written in easy-to-understand language. **CHP** developed a "simple word thesaurus" as a tool to assist with converting complex health plan jargon into 6th grade reading level language for member materials and communications. The handbook was well-organized and indexed to allow members to readily search for specific topics. **CHP** translated numerous written materials into Spanish, which were available for dissemination. **CHP** maintained member mailing lists of Spanish-speaking and English-speaking households and disseminated materials accordingly. **CHP** mailed all member materials within required time frames, including enrollment materials, the annual letter and privacy notice, and notice of significant change in benefits or other vital information (i.e., substance use disorder [SUD] benefits new in 2014). **CHP** clearly communicated to providers the responsibility to distribute specific information to members at provider facilities. **CHP** supported providers in this process through the provision of materials and member advocates located at the partner community mental health centers (CMHCs). Member advocates assisted members in understanding their rights and distributed vital member materials. Materials included grievance and appeal information, member handbooks, and other flyers and member communications. The annual on-site provider audit included monitoring the availability of member materials.

The **CHP** website was easy to navigate and included visible links to much of the essential member information. The website included a Spanish conversion tab and provided access to some member materials in Spanish, including the member handbook and many Achieve Solutions health information articles. Staff stated that members have accessed Spanish-translated Achieve Solutions articles in significantly increasing numbers over the past year. The member handbook and/or website included information on covered services, the Colorado Preferred Drug List (PDL), the Colorado Mental Health Treatment Act (CMHTA), community resources, grievance and appeal procedures, member rights, trainings, the Ombudsman, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, wrap-around services, advance directives, emergency services, and provider network directories. The provider directory included all required information, and staff stated that only providers accepting new patients are included in the directory. The member handbook stated that members do not have to pay for emergency or poststabilization services, and the Web-site included a link to **CHP**'s post-stabilization policy.

Summary of Findings Resulting in Opportunities for Improvement

HSAG recommends that **CHP** increase the number of predeveloped Spanish communications that are accessible through the website and that **CHP** consider putting a message on the Spanish translated pages of the website that informs members how to request other member materials in Spanish. In addition, when important member information, such as access to care standards or grievance and appeal information, is available on the **CHP** website only through the web-based

member handbook, HSAG recommends that the website provide a link or otherwise direct the member to the specific section/pages of the handbook to facilitate member access.

Although **CHP** demonstrated that there was a well-defined process for mailing the annual letter to members per requirement, HSAG noted that the language in the member handbook and member information requirements policy (i.e., "members will be informed of their right to receive information on an annual basis") may still imply that members may request information only once per year. HSAG recommends that **CHP** consider rewording these documents to ensure that they specify that the members will be notified annually of their right to request information at any time.

Although most member communications were written in easy-to-understand language, the appeal upheld resolution letters included too much medical terminology to be considered easy-to-understand. This deficiency was scored in the appeal record reviews in Standard VI.

The member information requirements policy and the member handbook stated that members would be notified 15 days ahead of a provider change. While this process might be more timely than the contract requirement stipulates, HSAG clarified that the requirement is member notification 15 days from notice of provider termination, not 15 days ahead of termination. HSAG recommends that **CHP** clarify its policy and member handbook to be consistent with the requirement.

During on-site interviews, staff stated that the provider directory lists only providers currently accepting new members, thereby eliminating the need to identify providers not accepting new patients, per requirement. However, it was not apparent in the provider directory that the list included only those providers. HSAG recommends that **CHP** clearly communicate that the directory only includes providers accepting new patients.

Summary of Required Actions

No actions were required for this standard.

Standard VI—Grievance System

Summary of Strengths and Findings as Evidence of Compliance

CHP's policy and procedures, as well as various member and provider communications, clearly substantiated that **CHP** had a well-defined, robust process for processing member grievances and appeals. Policies and procedures included definitions of a grievance and an appeal, procedures and time frames for processing grievances and appeals, and thorough member communications regarding the resolution of grievances and appeals. With every notice of action and appeal resolution letter, **CHP** included a grievance and appeal brochure that detailed grievance and appeal procedures. **CHP** developed a grievance and appeal training module that was used to formally train ValueOptions (VO) and CMHC staff as needed. Grievances were investigated, resolved, and documented in the grievance database by **CHP**'s Office of Member and Family Affairs (OMFA) staff and member advocates at the partner CMHCs (delegates for processing grievances). The VO clinical department processed all appeals, with coordination by the OMFA. Appeals were tracked

and files maintained in the VO *Service Connect* appeals database. Grievance records reviewed on-site demonstrated 84 percent overall compliance with required elements, and appeal records reviewed scored 87 percent overall compliance with the required elements. With the exception of some confusion regarding timely filing requirements related to continuation of previously authorized services, all grievance and appeal procedures were accurately defined in multiple documents. OMFA staff members were actively involved in assisting members with grievances, appeals, and State fair hearings—and efficiently achieving resolution. The appeal policy stated that expedited appeals would be resolved in three calendar days (per URAC requirements) rather than three working days. Staff members confirmed compliance with this time frame during the on-site interview. **CHP** informed members and providers of grievance and appeal procedures in the member handbook and provider manual. Appeal resolution letters included applicable dates, reviewer credentials, thorough descriptions of disposition, and alternatives for next steps. The **CHP** OMFA staff demonstrated in-depth knowledge of the grievance and appeal processes and conscientious commitment to successful program outcomes.

Summary of Findings Resulting in Opportunities for Improvement

Several acknowledgement letters reviewed during the on-site record review (all processed by one of the CMHCs) stated that the grievance would be resolved by a date that was less than the required 15 working days, and the specified dates varied (e.g., seven days, eight days, and 21 days). Once the member is notified that the grievance will be resolved by a specific date, that date becomes the standard with which the plan must comply. While most of these grievances were resolved within the time frame specified in the letter, one case exceeded the time frame specified in the letter (but was within the required 15-day time frame). HSAG recommends that **CHP** evaluate the reasons that the CMHCs implemented a process that establishes a time frame for grievance resolution that is less than the required 15 working days for Medicaid members and reinforce with the CMHCs that regulatory requirements and **CHP** policies and procedures allow for resolution within 15 working days from receipt of the grievance.

The appeals and grievance policies, the member handbook, and grievance and appeal brochure accurately stated that a 14-calendar-day extension for resolving grievances or appeals may be granted if **CHP** needs more information and it is in the member's best interest, and also stated that **CHP** would inform the member of the reason for the extension and why it is in the member's best interest. However, samples of grievance extension and appeal extension letters included a check box for either "**CHP** needs more information" or "Member requested extension," without an explanation of why it was in the member's best interest. HSAG recommends that **CHP** expand information in the extension letters to specify why it is in the member's best interest to extend the time frame.

During on-site interviews, staff members confirmed that the grievance and appeal brochure—which included detailed descriptions of grievance, appeal, and State fair hearings procedures—is included in all appeal resolution letters. The appeal resolution letter is sent to the member at the completion of an appeal when the only further option is for the member to request a State fair hearing. Therefore, to promote clarity of understanding by the member, HSAG recommends that **CHP** consider both eliminating information regarding the appeal process in any appeal resolution letter and limiting information in this letter to applicable State fair hearings processes.

Information included in the Denial to Process Expedited Appeal letter and on-site discussions demonstrated that **CHP** had an understanding of, and implemented, appropriate procedures related to denials of expedited appeal requests. However, no written policy or procedure detailed the processes related to handling a denial of an expedited appeal request. HSAG recommends that **CHP** include this information in written policies or procedures.

Staff members stated in the desk review document submission that the grievance and appeal training module outlined the provision of assistance to members in preparing appeals, including "obtaining records to be used as evidence and securing translators and interpreters"; however, the training materials submitted did not include this information. HSAG observed that this is an important component of assisting members and recommends that **CHP** consider including this information in the training module.

Staff members stated in the desk review document submission: "For members who are deceased, the member's legal representative can act as a party to the appeal." However, no documents submitted, including the appeal policy, included a statement that a party to the appeal may include the representative of a deceased member's estate. HSAG recommends that **CHP** consider revising its written policies to add such a statement.

Regarding the effectuation of appeal resolution, the appeal policy and member communications noted that **CHP** may recover the cost of services continued during an appeal "if the State fair hearings officer upholds the denial," but did not address the ability of the health plan to recover the cost of continued services during an appeal when the member does not request a State fair hearing. Staff stated that **CHP** rarely, if ever, attempts to recover the cost of continued services during an appeal from the member. HSAG recommends that **CHP** clarify the policy and member communications to address the recovery of costs of services continued during an appeal when **CHP** upholds the original denial.

Summary of Required Actions

Six of the 10 appeal resolution letters reviewed on-site were written in difficult-to-understand language, resulting in a 40 percent compliance score with this element. The appeal review results included in the Appeal Upheld letter contained too much clinical information and medical jargon to be considered easy-to-understand. **CHP** must develop a mechanism to ensure that appeal resolution letters are written in language that is easy for members to understand.

The grievance policy and member and provider communications stated that a grievance will be resolved with the letter sent to member within 15 working days. However, 2 of the 10 (20 percent) grievance resolution letters reviewed were not mailed within the required time frame. **CHP** must ensure that all grievances are resolved and that a grievance resolution letter is sent to the member within 15 working days of receipt of the grievance.

The grievance policy, member communications, and grievance resolution letter template stated that the grievance resolution letter would include a restatement of the complaint, information considered, and the disposition with the date resolved. However, 3 of 10 (30 percent) grievance

records reviewed did not adequately address the member's full complaint. **CHP** must ensure that the grievance is fully addressed in the description of the results of the resolution process.

The grievance policy, appeal policy, grievance and appeals brochure, member and provider communications, and notice of action letter accurately stated that an appeal must be filed 30 calendar days from notice of action. However, the provider manual also inaccurately stated that an appeal of reduction, suspension, or termination of previously approved services must be filed in 10 days. The reduced 10-day time frame for filing an appeal applies only when the member is requesting continuation of previously approved services during the appeal. **CHP** must correct the provider manual to ensure that members may appeal an action to reduce, suspend, or terminate previously approved services within 30 calendar days of the notice of action—*unless* the member is requesting continuation of benefits during the appeal.

Similarly, all submitted documents stated that a State fair hearing must be requested within 30 days of the notice of action and that the member may request a State fair hearing the same time as filing an appeal, and encouraged members to do so. However, the State fair hearing section of the member handbook, the grievance and appeal brochure, and the provider manual inaccurately stated that State fair hearings related to the reduction, suspension, or termination of previously authorized services must be requested within 10 calendar days. **CHP** must correct member and provider materials to clarify that members may request a State fair hearing for reduction, suspension, or termination of previously authorized services within 30 calendar days of the notice of action, *unless* the member is requesting continuation of benefits pending the State fair hearing decision.

Although staff members confirmed that **CHP** applies a three-calendar-day standard to the resolution of expedited appeals, the grievance and appeal brochure stated that expedited appeals would be resolved in three working days. **CHP** must revise the grievance and appeal brochure to be consistent with **CHP** policies and procedures concerning the three-calendar-day time frame for resolving expedited appeals.

Two of 10 (20 percent) appeal records reviewed did not have an appeal resolution letter sent within the required 10-working-day time frame. **CHP** must ensure that members/designated client representatives (DCRs) are notified in writing of the outcome of a standard appeal within 10 working days of receipt of the appeal.

Reviewers noted several cases in the appeal records reviewed in which the resolution letter was sent to the DCR but not copied to the member. The member, as a party to the appeal (10 CCR 2505—10, Section 8.209.4.I), must be copied on all correspondence related to an appeal, including the acknowledgement letter, extension letter—if applicable, and resolution letter. **CHP** must ensure that the member (as well as the DCR), is included on all correspondence related to the appeal.

The appeal policy, provider manual, and member handbook all accurately defined how the member may request continuation of previously authorized services during an appeal or State fair hearing and how long the benefits will continue. However, all three documents incorrectly stated that when members are requesting continuation of previously authorized services, members must file an appeal within 10 days of the notice of action or *within 10 days before* the intended date of the action. As outlined in 10 CCR 2505-10, Section 8. 209.4.S, the member must file an appeal or State fair hearing request within 10 days of the notice of action or before the intended effective date of

the proposed action, whichever is later (not 10 days before the intended effective date). **CHP** must clarify within the policy and member and provider materials that the member may request continuation of previously authorized services pending the outcome of an appeal or SFH by filing on or before the later of 10 days after mailing the NOA, or by the intended effective date of the action.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

CHP described a thorough NCQA-compliant provider selection and credentialing process that combined the resources of the national VO credentialing organization and a local credentialing committee which maintained local control over defining provider network needs, monitoring provider quality of care concerns, and final approval of network providers. All policies, verification, screening, and review functions related to provider credentialing and recredentialing are the responsibility of the national VO network services staff and credentialing committee. The provider credentialing database is maintained by the national VO organization. **CHP** delegated provider monitoring and audit activities to VO Colorado, a partner owner of **CHP**. **CHP**/VO had extensive policies and procedures and implemented numerous ongoing monitoring and audit activities to evaluate provider performance and hold providers accountable for compliance with contract requirements including access and availability, clinical treatment standards, medical record documentation, grievances, quality of care, utilization patterns, and federal and State sanctions and licensing requirements. **CHP** also initiated efforts to combine all audit results into a comprehensive provider-specific performance report. **CHP** demonstrated, through sample documentation and on-site interviews, that it takes corrective action when needed based on monitoring results. Provider contracts specifically outlined provider responsibilities to comply with policies and procedures, the provider manual, and State and federal requirements—and included provisions for revocation or sanctions based on performance. Although advance directives are minimally applicable in the BHO environment, **CHP** addressed advance directives in policies, trainings, and member and provider communications.

Both **CHP** and VO maintained a written compliance plan; code of conduct; fraud, waste, and abuse policies; and compliance oversight committees. **CHP** delegated many of the compliance oversight activities to VO; however, **CHP** had a local compliance officer and a compliance oversight group (COG) who coordinated activities between **CHP** and VO. Each CMHC also maintained a compliance program and reported Medicaid-related activities and results to the **CHP** COG. The COG reported to the **CHP** Class B Board. **CHP** and VO policies and activities related to internal monitoring and reporting of violations of the compliance program or detection and prevention of fraud, waste, and abuse were comprehensive and included screening of provider claims and records, annual employee training, a reporting hotline, and corrective actions and disciplinary processes. Documents submitted and on-site interviews demonstrated that **CHP** had an active and in-depth commitment to maintaining integrity in both the provider network and the administrative organization.

Summary of Findings Resulting in Opportunities for Improvement

CHP met all requirements of this standard. No opportunities for improvement were identified for this standard.

Summary of Required Actions

No actions were required for this standard.

Standard IX—Subcontracts and Delegation

Summary of Strengths and Findings as Evidence of Compliance

CHP delegated numerous operational functions to its partner owner, VO. The operational agreement with VO is the ownership agreement between VO and **CHP** and describes VO responsibilities as a partner in the LLC, including sanctions. The **CHP** Delegation Agreement with VO outlines the specific administrative functions to be performed by VO and refers to the VO Management Services Agreement, which specified the sanctions for nonperformance, including withholding of compensation and termination. The Member Participation Agreement outlined **CHP**'s agreement with the eight participating CMHCs for provision of covered services and performance of specific functions such as staff credentialing and grievance functions. The Member Participation Agreement served as the delegation agreement with the CMHCs. The agreement addressed provisions for sanctions and for implementation of corrective action plans. While the ownership/partnership and delegate agreements reflect complex legal and regulatory interrelationships, staff stated that the functional relationships are long-standing, effective, and well-understood.

The functional relationships among **CHP**, VO, and the CMHCs pre-dated the existing delegation agreements and related requirements; therefore, **CHP** did not perform pre-delegation assessments of delegate capabilities. VO submitted ongoing reports to the Board related to delegated activities and to a comprehensive annual delegation audit conducted by an independent auditor engaged by **CHP**. **CHP** submitted the audit tool, which demonstrated a detailed assessment of documents and/or on-site review pertaining to the delegation contract requirements. Results of the audit were reported to the Board and corrective action plans for performance deficiencies were implemented. **CHP** staff also performed annual audits of CMHC requirements through medical record and process reviews, which were reported to the Board with any identified corrective action plans.

Summary of Findings Resulting in Opportunities for Improvement

CHP is required to notify the Department of any decision to terminate a subcontractor 60 days prior to termination. Although staff stated that this situation has not occurred, neither the delegation agreement nor the Management Services Agreement stated that **CHP** will notify the Department as specified in the requirement. HSAG recommends that such a statement be added to policies and/or agreements.

Summary of Required Actions

No actions were required for this standard.