CHP+

Child Health Plan *Plus*

FY 2024–2025 Quality of Care Grievances Audit Report

June 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Department of Health Care Policy & Financing (the Department) defines "quality of care (QOC) concern" as a matter regarding QOC, patient access, or patient safety that represents a concern which requires action by the managed care entity (MCE) or the Department. "Grievance" is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination.[1] If a member complaint or grievance constitutes an expression of dissatisfaction about the QOC, it should be treated as a potential QOC grievance. The Department uses the Centers for Medicare & Medicaid Services' (CMS') definition of "quality of care grievance."[2] The MCEs must consider and process each QOC grievance as a potential QOC concern. This report will use the term quality of care grievance (QOCG), which will include the subset of quality of care concerns (QOCCs) and potentially significant patient safety issues. The Department requested that Health Services Advisory Group, Inc. (HSAG) conduct an audit each fiscal year (FY) of the four Child Health Plan *Plus* (CHP+) managed care organizations (MCOs) and the dental CHP+ prepaid ambulatory health plan (PAHP) (collectively referred to as "MCEs") to investigate how the MCEs responded to and investigated potential QOCGs, to assess a sample of potential QOCG cases for compliance with each MCE's own policies and procedures, and to evaluate the MCEs' compliance with any contract requirements in place during the calendar year (CY) 2024 review period. For additional information about the background of this project and the methodology used, please refer to Section 3—Methodology.

HSAG reviewed a total of 17 potential QOCGs that were identified and investigated by the five MCEs. This review was focused specifically on the QOCG process and was not a comprehensive review of the member grievance process. Each MCE had its own definition for QOC, QOCC, and/or QOCGs; its own severity rating scale; and procedures for investigating QOCGs. Most MCEs did not have policies or procedures to address follow-up with the member to determine if the member's immediate healthcare needs were being met. Most MCEs did not submit documentation related to ongoing training for MCE staff outside of the Quality Department on how to identify and/or submit a potential QOCG. Additionally, most MCEs did not submit any reference or training materials to assist with appropriately and consistently identifying which types of QOCGs should be labeled a critical incident or reviewed by a medical director. Lastly, MCE procedures to submit a QOC summary to the Department varied.

For additional information about the statewide findings of this project, please refer to Section 2—Findings and Assessment. For additional information about MCE-specific findings, please refer to Appendix A through Appendix E.

[1] Title 42 of the Code of Federal Regulations (42 CFR) §438.400(b). The Department follows the "grievance" definition as outlined by 42 CFR §438.400(b).

[2] "Quality of care grievances" are complaints about the quality of care received in hospitals or other provider settings. Additional information is available at: https://www.cms.gov/medicare/appeals-grievances/managed-care/grievances. Accessed on: May 5, 2024.

2. Findings and Assessment

Findings

Definition

While all five MCEs submitted policies and procedures to describe their processes for responding to member complaints about QOC and investigating potential QOCGs, each MCE used different operating definitions to guide the process.

Table 2-1 summarizes each MCE's QOC-related definitions.

Table 2-1—Definitions Used by the CHP+ MCEs

MCE	Definitions
Colorado Access (COA)	*Quality of Care Concern*—A concern that care provided did not meet a professionally recognized standard of healthcare. A QOC is a complaint made regarding a provider's competence, conduct, and/or care provided that could adversely affect the health or welfare of a member.
Denver Health Medical Plan, Inc. (DHMP)	*Quality of Care Concern*—A matter regarding quality of care, patient access, or patient safety that represents a concern which requires action by the Plan or the Department. *Quality of Care Grievance*—A member expression of dissatisfaction about any matter other than an adverse benefit determination.
Kaiser Permanente Colorado (Kaiser)	*Potential Quality of Care Issue (PQI)*—A member-expressed concern relating to the quality of care, which is not yet substantiated.
Rocky Mountain Health Plans (RMHP)	*Quality of Care*—The degree to which health services for enrollees/members increase the likelihood of the desired health outcomes and are consistent with current professional knowledge. *Quality of Care Issue*—When a Physician or Health Care Professional may have exhibited acts, demeanor, or conduct in his/her practice generally, or in his/her professional services to UnitedHealthcare Enrollees/Members, that are reasonably likely to be: a) detrimental to patient health or safety or to the delivery of patient care to Enrollees/Members; b) contrary to applicable participation agreements, administrative requirements or protocols related to QOC issues; c) below applicable professional standards; or d) unprofessional, harassing, intimidating, or disrespectful of patients, UnitedHealthcare personnel, or other practitioners, or in violation of patient-practitioner boundaries.
DentaQuest	*Quality of Care*—Care that is safe, effective, patient centered, timely, efficient, and equitable.

Number of QOCG Cases Investigated

Table 2-2 presents the number of QOCG cases each MCE reported investigating during CY 2024, and the average CHP+ member population as reported by the MCE.

Table 2-2—Number of Cases Investigated by MCE

MCE	# of Investigated Cases	Average Population
COA	5	60,049
DHMP	0	8,426
Kaiser	6*	7,600
RMHP	5**	11,242
DentaQuest	1	85,750
Total	**17**	**173,067**

*Kaiser originally reported four cases during the CY 2024 review period. However, during the interview, Kaiser staff submitted two additional cases that were not included in the initial submission.

**RMHP originally reported seven cases during the CY 2024 review period. However, during the record review, HSAG verified that two cases were not applicable due to either being outside the review period or not being a CHP+ member.

Severity Level

All five MCEs referenced using a severity rating scale for QOCG investigations. All five MCEs had clearly written policies related to severity ratings, and the review of records demonstrated implementation of the policies as written for four of the five MCEs. HSAG was unable to evaluate DHMP's implementation of policies since DHMP did not report any QOCGs during the CY 2024 review period.

Table 2-3 describes the severity rating scale for each MCE.

Table 2-3—Severity Rating Scale Used by Each MCE

MCE	Severity Rating Scale
COA	Two-factor severity rating; possible 0–3 *Level of Harm* score and possible 0–5 *Action Required* score.
DHMP	Three severity level assignments: *Substantiated*, *Unsubstantiated*, and *Inconclusive*. No records were submitted to determine if DHMP used severity ratings.
Kaiser	Two-factor severity rating; possible 0–2 for level of practitioner responsibility and possible 0–3 for level of system issue/responsibility.

MCE	Severity Rating Scale
RMHP	Four severity level assignments: *No Issue*, *Minor*, *Moderate*, and *Serious*.
DentaQuest	Three severity level assignments: *Minor*, *Significant*, and *Major*.

Qualifications of Staff Members Investigating Cases

The four CHP+ MCOs used a two-level review: the first review was performed by either a registered nurse (RN) or a master's level clinician, and the second review was performed by a physician and/or physician committee for cases the first reviewer deemed met criteria for physician review. DentaQuest, the dental CHP+ PAHP, used only board-certified dentists as consultants.

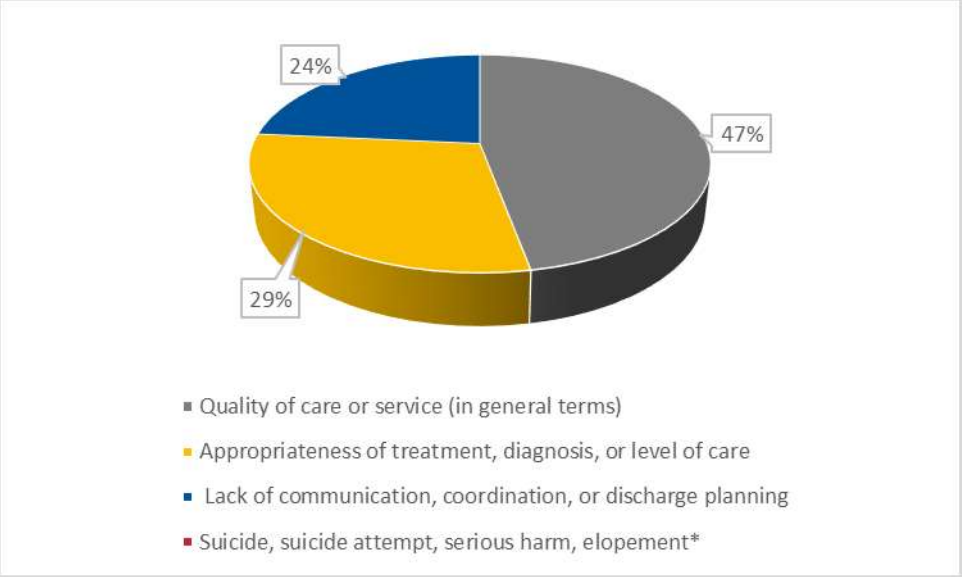
Overview of Sampled Cases

HSAG categorized the cases reviewed into four broad categories of case type:

- Quality of care or service (in general terms)
- Appropriateness of treatment, diagnosis, or level of care
- Lack of communication, coordination, or discharge planning
- Suicide, suicide attempt, serious harm, elopement

Figure 2-1 presents the percentage of cases reviewed in each case type category.

Figure 2-1—Percentage of Case Types



*None of the cases submitted for the CY 2024 review period were related to suicide, suicide attempt, serious harm, or elopement.

Adherence to Internal Policies and Procedures

Through a review of records, HSAG determined that the four MCEs that submitted a sample QOCG case for review followed their own policies and procedures. HSAG was unable to evaluate DHMP since DHMP did not report any QOCGs for the CY 2024 review period.

Case Outcomes

Five of the 17 cases reviewed were substantiated and led to the MCE taking actions such as tracking/trending or sending an education letter to the provider. In the other 12 cases, the MCEs determined that the cases were unsubstantiated and that no further action was required.

Regulatory Agency Reporting

Table 2-4 presents each MCE and its practices, stated in policy and during interviews, for reporting QOC investigations to regulatory agencies.

Table 2-4—MCE Regulatory Agency Reporting

MCE	Regulatory Agency Reporting
COA	Notification to the appropriate regulatory agencies, licensing boards, and/or law enforcement agencies.
DHMP	If the allegations are found to be substantiated and harm occurred to the member, the case must be reported to the State and any other applicable regulatory body.
Kaiser	Reported to the Department of Regulatory Agencies (DORA).
RMHP	Reported to the State medical board, other applicable licensing boards, and the Colorado Department of Public Health and Environment (CDPHE), if appropriate.
DentaQuest	Reports provider terminations to the appropriate licensing agency and/or the National Practitioner Data Bank.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the strengths and opportunities for improvement for the MCEs in each of the domains of quality, timeliness, and access to care and services. In this report, the icons indicate that the strength or opportunity for improvement is related to the associated domain.

		
Quality	**Timeliness**	**Access**
CMS defines "quality" in the final rule at 42 Code of Federal Regulations (CFR) §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP [prepaid inpatient health plan], PAHP, or PCCM [primary care case management] entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through: its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement."[1]	The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] NCQA further states that the intent of this standard is to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCE—e.g., processing appeals and providing timely care.	CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[3]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

[2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

Strengths

Based on the FY 2024–2025 audit activities, HSAG identified the following strengths:

- Kaiser provided a guide for the grievance and appeal staff members to identify which complaints warrant referral to a quality review coordinator (QRC) for review to determine if further investigation is needed. Additionally, Kaiser provided a checklist for QRCs to use to determine if a

referral to a quality physician review is warranted. HSAG determined these to be best practices within Kaiser's processes.

- Two MCEs (Kaiser and DHMP) reported processes in which call center management audits calls regularly to ensure call center employees are appropriately identifying and referring any potential QOCCs.
- Two MCEs (RMHP and COA) described and documented intentional efforts to build relationships with providers to improve the process of addressing potential QOCGs in a timely and efficient way.

Assessment and Opportunities for Improvement

Based on the FY 2024–2025 audit activities, HSAG found the following opportunities for improvement:

- The MCEs used a different definition of QOC, QOCGs, QOCCs, and different investigation processes.
- While each of the MCEs submitted policies and procedures for investigating potential QOCGs, three of the five MCEs (DHMP, RMHP, and DentaQuest) did not submit any policies, procedures, or reference documents related to training staff members outside of the Quality Department on identifying and submitting QOCGs.
- Three of the MCEs (COA, DHMP, and DentaQuest) had policies that assigned the responsibilities to Quality Department staff members for determining when a potential QOCG meets the threshold for assignment as a critical incident or review by a medical director without any reference or training materials to assist with appropriately and consistently identifying which types of QOCGs should be labeled a critical incident or reviewed by a medical director.

Recommendations

Statewide Recommendations for the MCEs

Based on the findings, HSAG concluded that the most common recommendations for the MCEs were:

- Provide more specific training and resources related to identifying critical incidents and which potential QOCGs are appropriate for medical director review to improve efficiency, consistency, and timeliness.
- Update policies and procedures to include training objectives and timelines to ensure all MCE staff are aware of how to identify and submit a potential QOCG. Consider additional monitoring or interrater reliability (IRR) approaches to ensure consistency when identifying cases.

Statewide Recommendations for the Department

Based on the findings, HSAG recommends that the Department:

- Provide specific definitions for QOC, QOCGs, and QOCCs.
- Work with DentaQuest to provide clear requirements and expectations for addressing QOCGs.
- Clarify the expectations related to the contract requirement of Department notification of QOCGs and receipt of QOC summaries for each QOCG.
- Provide the MCEs with direction related to the member follow-up contract requirement.
- Work with MCEs that reported few QOCGs to ensure member information, provider information, and internal staff training meet the Department's expectations. Consider contractually requiring an annual training for all member-facing staff members.

3. Methodology

Background

The Department is required to contract with an external quality review organization (EQRO) to monitor, at least annually, the MCEs on a variety of topics, including grievances and appeals, medical management, and quality programming.[3] The MCEs are responsible for receiving, investigating, and resolving potential QOCGs reported to the MCE by members or their representatives and/or identified by the MCE. In an effort to understand QOCG activity in the State, and to design a robust monitoring mechanism, the Department requested that HSAG develop an audit to gather information regarding the processes for addressing QOCGs. This project was designed as a focus study with the goal of providing information to the Department for use in improving monitoring efforts, ultimately resulting in improved health outcomes for Colorado's CHP+ members. The review period was January 1, 2024, through December 31, 2024, and the audit activity took place in FY 2024–2025.

Methodology

To evaluate each MCE's process for managing, investigating, and resolving QOCGs during the CY 2024 review period, HSAG used the following methodology:

1. Document Request
2. Initial Document Review (of policies and procedures, workflows, etc.)
3. QOCG Case Review
4. Web-Based Interviews
5. Reporting

1. Document Request

HSAG requested that each MCE submit documents including policies and procedures, any related desktop protocols, process documents, and member and provider informational materials regarding QOCGs. In addition, HSAG requested that each MCE submit a complete list of QOCGs that warranted investigation during the CY 2024 review period, whether the final outcome was substantiated or not. HSAG selected a sample of up to 10 cases for review for each MCE. If the MCE had 10 or fewer cases within the review period, HSAG requested review materials for each case. The MCEs then submitted to HSAG all review materials for each case, which included documentation of the investigation of the

[3] 42 CFR §438.66(b).

QOCG and its resolution/outcome. Each MCE completed information and file transfers using HSAG's Secure Access File Exchange (SAFE) site.

2. Initial Document Review

During the initial document review, HSAG reviewed all submitted documentation, which included policies, procedures, and related documents, to understand how the MCEs defined QOCG and each MCE's standard procedures for addressing QOCGs.

3. QOCG Case Review

HSAG assessed the following:

- Definitions.
- Number of QOCG cases reported.
- Severity level definitions.
- Qualifications of staff members investigating cases.
- Case sample overview.
- Adherence to internal policies and procedures.
- Case outcomes.
- Regulatory agency reporting process.

4. Web-Based Interviews

HSAG collaborated with each MCE and the Department to schedule and conduct web-based interviews in the spring of FY 2024–2025 with key MCE staff members to:

1. Ensure a mutual understanding of documents submitted.
2. Clarify and confirm MCE implementation of policies, procedures, and related documents.
3. Discuss the case review findings, opportunities for improvement (if any), and recommendations for process improvement, if applicable.

As a result of the initial document review, case review, and web-based interviews, HSAG requested and reviewed additional documents, as necessary.

5. Reporting

This report documents HSAG's findings of each MCE's process for addressing QOCGs. Section 2—Findings and Assessment provides statewide aggregated results and recommendations. Additionally, Appendix A through Appendix E include MCE-specific findings. Table 3-1 presents Colorado's MCEs.

Table 3-1—Colorado's CHP+ MCEs

MCE	Services Provided
COA	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care
DHMP	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care
Kaiser	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care
RMHP	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care
DentaQuest	Dental services