COLORADO

Department of Health Care Policy & Financing

FY 2024–2025 Quality of Care Grievances Audit Report

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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 Colorado 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 (QOCG). The Department uses the Centers for Medicare & Medicaid Services' (CMS') definition of "quality of care grievance."[2] The MCEs must consider and process each QOCG as a potential QOC concern. This report will use the term 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 seven Regional Accountable Entities (RAEs) and two Medicaid managed care organizations (MCOs) (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 88 potential QOCGs that were identified and investigated by the nine 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 QOCGs and its own processes for investigating QOCGs. All nine MCEs used severity rating scales and included details in their written policies explaining the procedures for using the severity rating scale. All nine MCEs have a process for a two-level review, with the second review using a physician and/or physician committee. Of the 88 cases reviewed, 40 cases were substantiated and led to actions including tracking/trending, assigning staff member training/education, requesting documentation of policies, reporting to regulatory agencies, or developing a corrective action plan (CAP).

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 I.

[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 QOC 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 9, 2025.

2. Findings and Assessment

Findings

Definition

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

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

Table 2-1—Definitions Used by the MCEs

MCE	Definitions
RAE 1—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.
RAE 2—Northeast Health Partners (NHP)	*Potential Quality of Care Concern*—A clinical or system variance warranting further review and investigation to determine the provider's contribution to a quality issue or deviation from the standard of care or service. *Quality of Care Concern*—Concerns raised by HCPF [the Colorado Department of Health Care Policy & Financing], a provider, or the RAE regarding any concern made in regard to the professional competence and/or conduct of a physician or other health care provider, which could adversely affect the health, or welfare of a member.

MCE	Definitions
	Quality of Care Issue—An action or failure to take action on the part of a provider that has the potential to decrease the likelihood of a positive health outcome and/or is inconsistent with current professional knowledge and/or puts the safety of the member at risk.
RAE 3—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.
RAE 4—Health Colorado, Inc. (HCI)	*Potential Quality of Care Concern*—A clinical or system variance warranting further review and investigation to determine the provider's contribution to a quality issue or deviation from the standard of care or service. *Quality of Care Concern*—Concerns raised by HCPF, a provider, or the RAE regarding any concern made in regard to the professional competence and/or conduct of a physician or other health care provider, which could adversely affect the health, or welfare of a member. *Quality of Care Issue*—An action or failure to take action on the part of a provider that has the potential to decrease the likelihood of a positive health outcome and/or is inconsistent with current professional knowledge and/or puts the safety of the member at risk.
RAE 5—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.
RAE 6—Colorado Community Health Alliance (CCHA)	*Quality of Care Issue*—An identified issue that prompts a review focused on determining whether the quality of the services meets professionally recognized standards of care. QOC issues include potential, suspected, and realized events that may or may not have resulted in harm incurred by member(s).
RAE 7—CCHA	*Quality of Care Issue*—An identified issue that prompts a review focused on determining whether the quality of the services meets professionally recognized standards of care. QOC issues include potential, suspected, and realized events that may or may not have resulted in harm incurred by member(s).

MCE	Definitions
Denver Health Medical Plan (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.
Rocky Mountain Health Plans Medicaid Prime (RMHP Prime)	*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.

Number of QOCG Cases Investigated

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

Table 2-2—Number of Cases Investigated by MCE

MCE	# of Investigated Cases	Average Population
RAE 1—RMHP	309	**131,822**
RAE 2—NHP	27	**78,184**
RAE 3—COA	127	**267,168**
RAE 4—HCI	31	**114,494**
RAE 5—COA	61	**120,757**

MCE	# of Investigated Cases	Average Population
RAE 6—CCHA	59	**132,840**
RAE 7—CCHA	42	**153,839**
DHMP	18	**73,082**
RMHP Prime	44	**36,587**
Total	**718**	**1,108,773**

Severity Level

All nine MCEs reference using a severity rating scale for QOCG investigations. All nine MCEs had clearly written policies related to severity ratings, and the review of records demonstrated implementation of the policies as written.

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
RAE 1—RMHP	Four severity level assignments: *No Issue, Minor, Moderate,* and *Serious*.
RAE 2—NHP	The Quality Connect system gives the potential QOC case an automatic preliminary rating of *Not an Incident*, *Minimal*, *Moderate*, *Major*, or *Sentinel*; however, the case will get a final determination of *Unable to Determine*, *Unfounded*, or *Founded*.
RAE 3—COA	Two-factor severity rating; possible 0–3 *Level of Harm* score and possible 0–5 *Action Required* score.
RAE 4—HCI	The Quality Connect system gives the potential QOC case an automatic preliminary rating of *Not an Incident*, *Minimal*, *Moderate*, *Major*, or *Sentinel*; however, the case will get a final determination of *Unable to Determine*, *Unfounded*, or *Founded*.
RAE 5—COA	Two-factor severity rating; possible 0–3 *Level of Harm* score and possible 0–5 *Action Required* score.
RAE 6—CCHA	Two-factor severity rating; possible 0–5 severity level assignment and possible 0–5 remedial action step.
RAE 7—CCHA	Two-factor severity rating; possible 0–5 severity level assignment and possible 0–5 remedial action step.
DHMP	Three severity level assignments: *Substantiated*, *Unsubstantiated*, and *Inconclusive*.
RMHP Prime	Four severity level assignments: *No Issue, Minor, Moderate,* and *Serious*.

Qualifications of Staff Members Investigating Cases

All nine MCEs used a two-level review in most cases: the first review was performed by a professional with various qualifications and/or degrees that the MCE determined appropriate for investigating cases; and the second review was performed by a physician and/or physician committee for cases that met criteria for a physician review, as determined by the first-level reviewer. Some of the MCEs do not require a physician review if a QOC registered nurse (RN) assigns the case a lower severity rating.

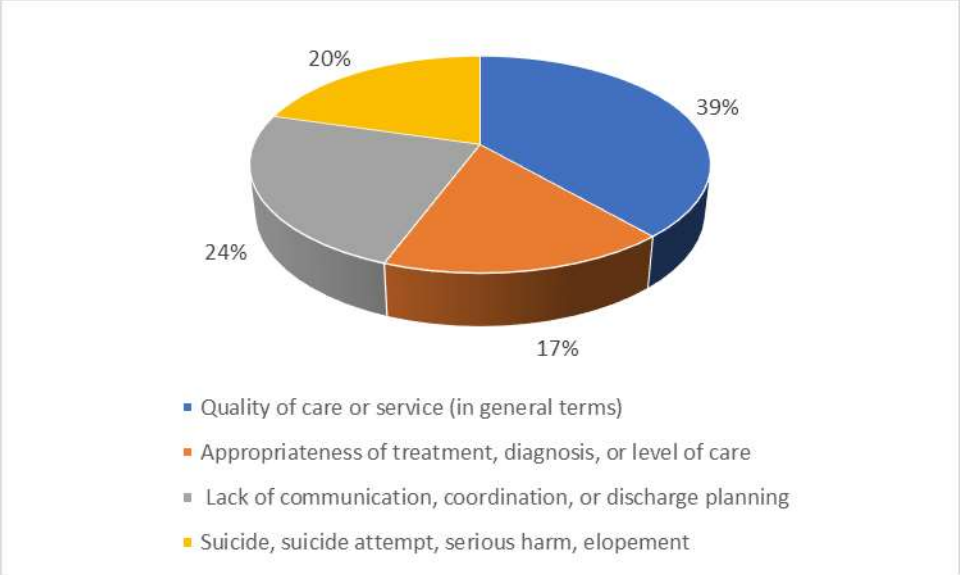
Overview of Sampled Cases

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



Adherence to Internal Policies and Procedures

Through a review of records, HSAG determined that all nine MCEs followed, or mostly followed, their policies and procedures for investigating, analyzing, tracking, trending, and closing QOCG investigations according to their stated policies and procedures. Two MCEs (NHP and HCI) did not consistently follow their own timelines for completing QOCG investigations. Additionally, two MCEs (NHP and HCI) did not follow their policy related to the contract requirement of following up with the member to ensure immediate healthcare needs are being met.

Case Outcomes

Of the 88 cases reviewed, 40 cases were substantiated and led to actions including tracking/trending, assigning staff member training/education, requesting documentation of policies, reporting to regulatory agencies, or developing a CAP.

Regulatory Agency Reporting

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

Table 2-4—MCE Regulatory Agency Reporting

MCE	Regulatory Agency Reporting
RAE 1—RMHP	Reported to the State medical board, other applicable licensing boards, and the Colorado Department of Public Health and Environment (CDPHE), if appropriate.
RAE 2—NHP	Reported to the appropriate State licensing board and/or regulatory agencies.
RAE 3—COA	Notification to the appropriate regulatory agencies, licensing boards, and/or law enforcement agencies.
RAE 4—HCI	Reported to the appropriate State licensing board and/or regulatory agencies.
RAE 5—COA	Notification to the appropriate regulatory agencies, licensing boards, and/or law enforcement agencies.
RAE 6—CCHA	Reported to the Colorado Department of Regulatory Agencies (DORA), Professions and Occupations Board.
RAE 7—CCHA	Reported to the DORA, Professions and Occupations Board.
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.
RMHP Prime	Reported to the State medical board, other applicable licensing boards, and the CDPHE, if appropriate.

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 [prepaid ambulatory health plan], 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 QOCG and QOCC audit activities in FY 2024–2025, HSAG found the following strengths:

- Four MCEs (RMHP RAE 1, RMHP Prime, COA RAE 3, and COA RAE 5) 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 different definitions of QOC, QOCGs, QOCCs; different severity rating scales; and different investigation processes.
- While each of the MCEs submitted policies and procedures for investigating potential QOCGs, several of the nine MCEs were not able to describe consistent processes related to training staff members outside of the Quality Department on identifying and submitting QOCGs.
- Most of the MCEs had policies that assigned the responsibilities to Quality Department staff members for determining when a potential QOCG is a critical incident or requires review by a medical director. However, the QOCG policies and procedures did not include 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 detailed documentation, 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.
- Clarify the expectations related to each MCE's contract requirement to notify the Department when the MCE receives a QOCG.
- Provide the MCEs with direction related to each MCE's contract requirement related to following up with a member to address any immediate healthcare needs.

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 brought 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 designed 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 Medicaid 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 count of the total number of QOCG referrals received, total number of QOCGs investigated, and a total number of QOCGs that were substantiated during the CY 2024 period. 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 QOCG and its resolution/outcome. Each MCE completed information and file transfers using HSAG's Secure Access File Exchange (SAFE) site.

[3] 42 CFR §438.66(b).

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.

4. Web-Based Interviews

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

1. Ensure mutual understanding of documents submitted.
2. Clarify and confirm organizational 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 I include MCE-specific findings. Table 3-1 presents Colorado's MCEs.

Table 3-1—Colorado's MCEs

Medicaid RAEs	Services Provided
RAE 1—RMHP RAE 2—NHP RAE 3—COA RAE 4—HCI RAE 5—COA RAE 6—CCHA RAE 7—CCHA	MH inpatient and outpatient services, substance use disorder (SUD) inpatient and outpatient services, and coordination of both physical health (PH) and behavioral health (BH) services for adults and children enrolled in Medicaid.
Medicaid MCOs	**Services Provided**
DHMP	PH primary, inpatient, outpatient, specialty, and acute care for a subset of adults and children who are RAE Region 5 members. MH and SUD inpatient and outpatient services for a subset of RAE Region 5 members.
RMHP Prime	PH primary, inpatient, outpatient, specialty, and acute care for a subset of RAE Region 1 members.