FY 2014–2015 Site Review Report Executive Summary

for

Rocky Mountain Health Plans

June 2015

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

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Introduction

Public Law 111-3, The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) applies several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the Balanced Budget Act of 1997, Public Law 105-33 (BBA). The BBA requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the 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 the three-year cycle, as well as trending of required actions. Section 3 describes the background and methodology used for the 2014–2015 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2013–2014 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the grievance and appeal record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2014–2015 and the required template for doing so. Appendix E describes the activities HSAG performed during the compliance monitoring process.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met,* or *Not Applicable.* HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score. Recommendations assigned for requirements scored as *Met* did not represent noncompliance with contract requirements or federal healthcare regulations.

Table 1-1 presents the scores for **Rocky Mountain Health Plans** (**RMHP**) for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard		# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
V	Member Information	23	23	12	11	0	0	53%
VI	Grievance System	26	26	20	6	0	0	77%
VII	Provider Participation and Program Integrity	17	16	15	1	0	1	94%
IX	Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals		**71**	**70**	**52**	**18**	**0**	**1**	**74%**

Table 1-2 presents the scores for **RMHP** for the grievances and appeals record review. Details of the findings for the record review are in Appendix B—Record Review Tools.

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	30	29	1	20	97%
Appeals	60	53	51	2	7	96%
Totals	**110**	**83**	**80**	**3**	**27**	**96%**

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

RMHP made clear to its members that its customer service department is available to assist **RMHP**'s members with understanding and using the benefits of the CHP+ plan. The first page of the benefits booklet invites members to call customer service for a brief orientation to benefits and procedures. This first page repeats the offer for assistance under the heading, "If You Have a Question or Concern." **RMHP** offers members information in large print, Braille, and Spanish and offers instructions for contacting **RMHP** using TTY equipment. **RMHP** reminds members throughout the handbook to call customer service for help with any questions or concerns and includes the local and toll free telephone number for customer service on every page.

RMHP informs members about the importance of having a primary care provider (PCP) who is responsible to monitor the member's overall health. Although referrals for specialty services are not required, **RMHP** encourages members to work with their PCP to identify when a specialist's services are needed, to choose a specialist who is in-network, and to help arrange for any necessary prior approvals.

RMHP's online searchable provider directory allowed members to search for providers based on provider name, location, network (Medicaid, CHP+, Medicare, etc.), provider type, gender, and specialty. The search results included provider name, address, telephone number, networks accepting new patients, and distance from entered location.

Summary of Findings Resulting in Opportunities for Improvement

The print version of **RMHP**'s provider directory specified that it was applicable to several of **RMHP**'s lines of business, which it listed; but the list did not include the CHP+ line of business. HSAG suggests that **RMHP** specify in its provider directory that the directory is also applicable to the CHP+ members.

The CHP+ benefits booklet included a list of member rights and responsibilities, which included the member's responsibility to provide **RMHP** notification about any claim or action against a third party responsible for illness or injury to the member as well as the member's responsibility to follow the protocols of the third party payor prior to receiving nonemergency services. While **RMHP** is compliant with this requirement, these responsibilities appear in the benefits booklet out of context; and the member may not understand the responsibilities. HSAG suggested that **RMHP** consider also including these responsibilities in the section of the booklet that specifically addresses third-party liability.

The **RMHP** CHP+ plan is not available to adults; therefore, HSAG recommends that **RMHP** remove the word "adult" from the appointment standards listed on page 9 of the benefits booklet.

Summary of Required Actions

Several sections of the CHP+ benefits booklet included language that exceeded the required 6th-grade reading level and could not be considered "easy-to-understand." Also, the resolution letter for two of the appeal records reviewed by HSAG included language not easy-to-understand. **RMHP** must measure the readability of its entire CHP+ benefits booklet to determine which sections do not meet the 6th grade reading level and then revise those sections, as necessary. **RMHP** must also review appeal resolution letters to be sure they meet the required reading level.

RMHP must add a statement to its CHP+ benefits booklet that tells members how to access interpreter services. HSAG also suggests that **RMHP** notify its members that interpreter services are free.

RMHP began notifying its members in July 2014 that it would be using a different pharmacy benefits manager, effective January 1, 2015 and continued to notify its members about the change using a variety of methods throughout the remainder of the year. While this process was compliant with the requirement to provide members with a 30-day advance notice, **RMHP**'s policies did not specify that it would notify members of significant changes at least 30 days before the intended effective date. Furthermore, page 55 of the benefits booklet stated that **RMHP** would notify members of any amendments to the benefits booklet within 60 days following the effective date of the amendment. **RMHP** must specify in its policy that it will notify members of any significant change at least 30 days before the intended effective date. **RMHP** must remove or correct the 60-day time frame included in the benefits booklet and add language that tells members how **RMHP** will notify them of any change in services or service delivery sites.

RMHP's fall newsletter served as the annual notice of members' right to request and obtain the information at 438.10(f)(6) and 438.10(g) and listed in Exhibit I-2. However, the newsletter only told members how to access the benefits booklet online. It did not tell members that they can also request and receive the information any time by calling customer service. **RMHP** must inform members in its annual notice both that **RMHP** will mail them a CHP+ benefits booklet any time it is requested and that members may request the booklet by calling customer service.

RMHP provided members information regarding various types of advance directives, forms used for implementing advance directives, and where to find additional information. The advance directives information provided to members did not inform members that complaints regarding noncompliance may be filed with the Colorado Department of Public Health and Environment. **RMHP** must add a statement to its benefits booklet that informs members that complaints regarding noncompliance with advance directives may be filed with the Colorado Department of Public Health and Environment.

The CHP+ benefits booklet included clear information about the amount, duration, and scope of benefits available; the procedures for obtaining those benefits; and the extent to which and how members may obtain services from out-of-network providers. While the benefits booklet tells members that they may receive services from any provider included in the provider directory, the print version of the provider directory states that some providers (clearly marked with a special symbol) are only available to members of **RMHP**'s preferred provider organization (PPO) health

plan. **RMHP** must state in the CHP+ benefits booklet that some providers included in the print version of the provider directory are not available to the CHP+ members.

Emergency/Urgent Care is discussed on pages 10, 11, and 16 in the benefits booklet. The "Glossary," page 79, contains a definition of "emergency care" that appears to be intended as the definition of "emergency medical condition." Although **RMHP** provided examples of which conditions may constitute a life- or-limb-threatening or a non-life-or-limb-threatening emergency and provided a portion of the federal definition of "emergency medical condition," neither the definition nor the discussion included reference to the prudent layperson role in determining whether a condition is an emergency medical condition. **RMHP** must revise its discussion regarding emergency medical care to include the federal definition of "emergency medical condition."

The CHP+ benefits booklet informs members that **RMHP** has a policy about the costs of poststabilization care and that members may call customer service to have the policy explained and/or to have a copy of it mailed to them. The handbook did not state that charges to members for poststabilization services must be limited to an amount no greater than what the organization would charge the member if he or she had obtained the services through the contractor. **RMHP** must revise its benefits booklet to include the statement that charges to members for out-of-network poststabilization services must be limited to an amount no greater than what the organization would charge the member if he or she had obtained the services through the contractor.

The benefits booklet does not inform members that enrollment in **RMHP** is voluntary, although the booklet does inform members that they must complete an application to enroll in the CHP+ program and a change form in order to disenroll. The booklet does not inform members of where to find the application or change form or where to submit it. **RMHP** must include in its CHP+ benefits booklet information about how to enroll and disenroll from the CHP+ program.

Page 62 of **RMHP**'s benefits booklet informs members that **RMHP** can terminate a member's coverage if the member refuses to follow his or her provider's recommended treatment. This statement is in direct conflict with the member's right to refuse treatment, as listed on page 64. **RMHP** must remove language from the booklet that informs members they can be disenrolled for refusing to follow recommended treatment.

The "Preauthorization" section on page 10 of the benefits booklet informs members that **RMHP** must approve some types of care before the member receives it. The "Care Management and Quality Improvement Programs" section on page 12 informs members they can call customer service and ask for care management if they have any questions about approved or denied services. Additionally, **RMHP** provides information about how to initiate appeals related to utilization management on pages 45 and 46. The information presented is scattered throughout the booklet; therefore, it does not effectively provide a clear explanation of **RMHP**'s utilization management program or how it is used to determine medical necessity. **RMHP** must revise information in its member handbook related to its utilization management program to clearly identify the department within **RMHP** that implements the utilization management program, describe how **RMHP** determines medical necessity, remind members of their right to appeal decisions, and provide appropriate points of contact and telephone numbers for use by members desiring more information or having more questions.

Standard VI—Grievance System

Summary of Strengths and Findings as Evidence of Compliance

RMHP had effective systems for processing grievances and appeals and for assisting members with access to the State's fair hearing process. **RMHP** communicated the grievance system processes to members via the member handbook and to providers via the provider manual. **RMHP** also communicated that assistance with filing grievances and appeals was available. **RMHP** informed members that they must follow an oral request to appeal with a written request. **RMHP** maintained a grievance and appeal database as well as individual grievance and appeal records, reporting grievances and appeals to the Department quarterly, as required.

The on-site record review demonstrated that, for all CHP+ records reviewed, **RMHP** sent appeal acknowledgement letters and grievance and appeal resolution letters within the required time frames and that those letters included the required content. HSAG also found that the individuals who reviewed grievances and appeals had the appropriate clinical expertise and had not been involved in any previous level of review.

Summary of Findings Resulting in Opportunities for Improvement

Although **RMHP**'s policies addressed each requirement, evidence existed of reference to appeals as complaints, or that members could "complain" when referring to filing an appeal. This same dynamic appeared in the CHP+ member handbook. HSAG recommends that **RMHP** review policies to clearly separate filing an appeal from the process of expressing grievances or complaints. To that end, HSAG also recommended that **RMHP** either add definitions or clarifying language to its complaint form in the member handbook (intended for use in filing both grievances and appeals) or develop a separate appeal form.

Summary of Required Actions

The definition of "action" in the Appeals policy and procedure (which applied to both the CHP+ and the Medicaid Prime lines of business) was incomplete and could lead to confusion on the part of staff members or others needing to use the policy. Instead of reading "failure to act within the time frames for resolution of grievances and appeals," the related bullet was worded, "failure to act within the time frames in this policy." The policy deals with a variety of time frames (in addition to the resolution time frame) and only addresses appeals rather than grievances and appeals; therefore, this definition may be confusing for staff members unfamiliar with the regulations in 42 CFR 438. In the *Grievance Policy and Procedure*, the list of items that members may not file a grievance about (as they would constitute an action) did not include the failure to act within the time frames for resolution of grievances and appeals. The Definition section of the *Grievance Policy and Procedure* defined this requirement as, "failure to act within the time frames in Process." This is incomplete and confusing. **RMHP** must review and revise all applicable policies and procedures to ensure accurate, complete, and consistent definitions of "action."

RMHP's policies and procedures ensured that members have the right to file grievances 30 days following the incident. In addition, during the on-site interview, **RMHP** staff members articulated the accurate time frame; however, the Complaint Form (used for filing both grievances and appeals) found in the CHP+ member handbook stated that members have six months to file a grievance. **RMHP** must revise the Complaint Form used by CHP+ members, to ensure that members are accurately informed of the 30-day-filing time frame for grievances. In addition, HSAG recommends that **RMHP** consider either developing a separate form for filing appeals or revise the complaint form to include the appropriate definitions and circumstances for filing grievances and for filing appeals.

In one CHP+ grievance record reviewed on-site, the resolution letter and the acknowledgement letter were one and the same, which is acceptable; however, the letter was sent within three working days (rather than the required two working days) of receipt of the grievance. **RMHP** must ensure that acknowledgement letters are sent within two working days of receipt of the grievance.

RMHP's *Grievance Policy and Procedure*, which applied to both the CHP+ and the Medicaid Prime lines of business, stated that the grievance resolution letters will include "further appeal rights and how to further appeal the grievance." The policy listed the required components of a resolution letter, which inaccurately included the right to appeal the grievance decision. Members may only appeal actions; and the grievance resolution letter, by definition, is not an action. **RMHP** may include in the grievance resolution letters information about the second-level grievance review by the Department, and this was accurately depicted in the grievance resolution letters reviewed on-site. **RMHP** must revise its grievance policy to accurately reflect the description of the second-level grievance review by the Department.

The "Member Appeals Time Grid" attachment to the appeals policy incorrectly stated that the member has 30 days from the date of the appeal resolution letter to request a State fair hearing. The resolution letter template accurately reflected the filing time frame and addressed the timely filing requirements for the continuation of services situation. **RMHP** must clarify its policy to state that members have 30 days from the notice of action to request a State fair hearing (unless the health plan has provided 10-day advance notice of termination, suspension, or reduction of the previously authorized and disputed service and the member is requesting continuation of the disputed services—in that case timely filing requirements in 42 CFR 438.420 apply).

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

RMHP had a robust credentialing and recredentialing program that included comprehensive policies and procedures effectively articulating how **RMHP** complies with National Committee for Quality Assurance (NCQA) standards and guidelines for credentialing and recredentialing. **RMHP** provided evidence that provider quality, appropriateness, and medical records standards were routinely monitored at both the aggregate level through Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] performance measures as well as topic-specific quality improvement initiatives and at the provider level via provider specific medical record audits. **RMHP**'s nondiscrimination policies met the requirements. **RMHP** routinely screened its providers and employees against regulatory databases, and policies and procedures regarding incentives met the requirements. Provider services contracts were thorough, included all regulatory requirements, and applied to all applicable lines of business. The corporatewide compliance plan and related fraud and abuse policies and procedures were thorough, employee training was conducted annually, and policies related to compliance were described in the provider manual and the Medicaid Member Handbook. **RMHP** included, in the member and provider materials, methods for reporting suspected fraud and abuse. Monitoring for fraud and abuse included system edits and internal auditing processes. Numerous committees and reporting structures existed related to decision making and oversight of the credentialing, quality improvement, and compliance programs.

Summary of Findings Resulting in Opportunities for Improvement

While **RMHP** described processes for monthly claims accuracy audits, it may want to consider periodic audits to verify the accuracy of claims denials.

Summary of Required Actions

RMHP's Advance Directives policy was missing the following:

- Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law.
- Provisions for the education of staff concerning its policies and procedures on advance directives.
- Provisions for community education regarding advance directives that include:
  - What constitutes an advance directive.
  - Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment.
  - Description of applicable State law concerning advance directives.

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

RMHP must revise its applicable policies and procedures to include the required advance directive provisions.

Standard IX—Subcontracts and Delegation

Summary of Strengths and Findings as Evidence of Compliance

RMHP delegated credentialing and recredentialing to 15 of its physician groups; specific utilization review activities to CareCore National, LLC (CCN); and pharmacy claims processing to MedImpact (**RMHP**'s pharmacy benefit manager [PBM]). During the review period, **RMHP** terminated its contract with Express Scripts, the previous PBM. **RMHP** provided evidence of having monitored and imposed corrective actions on Express Scripts prior to terminating the contract. **RMHP** provided evidence of completing a comprehensive predelegation assessment of MedImpact prior to contracting. In addition, **RMHP** also expanded its contract with CCN during 2014 and performed a predelegation review of CCN's capacity to provide the additional scope of work. **RMHP** also delegated select activities related to the provision of behavioral health services and, during the review period, changed from Life Strategies to ValueOptions (VO). **RMHP** provided evidence of having monitored and imposed corrective action for Life Strategies prior to terminating its contract as well as having conducted a predelegation assessment of VO prior to signing a contract. **RMHP** provided evidence of ongoing monitoring (joint committee processes and regular review of delegates' reporting) and formal annual audits of each delegate. **RMHP** had a written delegation agreement with each delegate that included the required provisions.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.