COLORADO
Department of Health Care Policy & Financing

FY 2014–2015 Site Review Report Executive Summary

for

Rocky Mountain Health Plans Payment Reform Pilot Program

June 2015

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

HSAG HEALTH SERVICES ADVISORY GROUP
3133 East Camelback Road, Suite 100 • Phoenix, AZ 85016-4545
Phone 602.801.6600 • Fax 602.801.6051

Introduction

Colorado HB12-1281, enacted June 2012, created the Medicaid payment reform and innovation pilot program, which allowed the Department of Health Care Policy & Financing (the Department) to select **Rocky Mountain Health Plans** (**RMHP**) for implementation of a payment reform pilot program using alternative Medicaid payment methodologies. **RMHP**'s contract with the Department to implement the pilot program required **RMHP** to comply with federal Medicaid managed care regulations at 42CFR438 et seq. The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct a periodic evaluation of their Medicaid managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with federal healthcare regulations and contractual requirements. The Department has elected to complete this requirement 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. Effective July 2014, **RMHP**'s Medicaid managed care contract was discontinued, and members receiving services through **RMHP**'s Medicaid managed care program at that time were transitioned either to **RMHP**'s Regional Collaborative Care Organization (RCCO) or to the Payment Reform Pilot Program. The pilot program is required to comply with federal healthcare regulations. Therefore, this report reflects results from the 2014–2015 review of **RMHP**'s Payment Reform Pilot Program and includes historical data based on previous review of **RMHP**'s Medicaid managed care program. 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 standards reviewed over the past three years for the Medicaid managed care contract and the Payment Reform Pilot Program 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, 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 template required 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 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	25	25	20	5	0	0	80%
VI Grievance System	26	26	23	3	0	0	88%
VII Provider Participation and Program Integrity	15	15	14	1	0	0	93%
IX Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals	**71**	**71**	**62**	**9**	**0**	**0**	**87%**

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	41	40	1	9	98%
Appeals	60	51	50	1	9	98%
Totals	**110**	**92**	**90**	**2**	**18**	**98%**

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

RMHP refers to the Payment Reform Pilot Program line of business as "Prime." The Prime member handbook was written in easy-to-understand language and informed members that the handbook was available in alternative formats (including large print and Braille) and offered 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 on every page the local and toll free telephone numbers and email address for customer service as well as instructions for using TTY. **RMHP** had its member handbook translated into Spanish, and every page of the English version included a Spanish statement that offered members assistance in Spanish via customer service. The handbook reinforces that **RMHP**'s customer service department is available to assist in using Prime plan benefits and understanding them, including sample questions members might ask.

RMHP informs members about the importance of having a primary care provider (PCP) 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 in-network, and to help arrange for any necessary prior approvals.

RMHP dedicated several pages of the Prime member handbook to explaining Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits and the services available through Colorado's Healthy Communities program. **RMHP** produced age-specific fliers and brochures that delineate the importance of well-child visits, what parents and children can expect during well-child visits, and answers to common questions related to well-child visits and related immunizations. **RMHP** mails these brochures to members annually as a reminder to schedule well-child appointments.

Summary of Findings Resulting in Opportunities for Improvement

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, HSAG recommended that **RMHP** specify in a policy that it would provide members with written notice of any significant change at least 30 days before the intended effective date.

Summary of Required Actions

Although **RMHP** informed members in the member handbook that interpreter services are available, it did not tell members how to access those services. **RMHP** must add a statement to its

member handbook that tells members how to access interpreter services. HSAG also suggests that **RMHP** notify its members that interpreter services are free.

The **RMHP** Prime member handbook did not 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 additional questions.

Emergency/Urgent Care is discussed on pages 9 through 11 and on page 13 of the member handbook. Although **RMHP** provided examples of which conditions may constitute a life-or-limb-threatening or a non-life-or-limb-threatening emergency, the handbook did not include 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."

RMHP must revise its member handbook to include the statement that charges to members for poststabilization services provided by out-of-network providers 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 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.

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 Prime records reviewed, **RMHP** sent grievance and appeal acknowledgement letters and resolution letters within the required time frames and 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 of the requirements, 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 Prime 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 (currently 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 addresses appeals only, 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 Definitions 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 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 appeal actions only; and the grievance resolution letter is, by definition, not an action. **RMHP** must revise its grievance policy to accurately reflect the description of the second-level grievance review by the State. In one Prime grievance record reviewed on-site, the resolution letter stated that **RMHP** has no control over its providers' choice to impose late fees or require payment prior to service. **RMHP** must ensure that customer service and grievance staff members understand that providers must limit charges to members to Department-approved copays. **RMHP** must educate the provider and customer service staff involved with this grievance.

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 the State fair hearing. **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 services and the member is requesting continuation of the disputed services—in that case timely filing requirements in 42CFR438.420 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 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 Prime 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

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

[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).

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, and provided evidence of having monitored and imposed corrective actions on Express Scripts prior to terminating the contract. **RMHP** also provided evidence that it conducted a comprehensive predelegation assessment prior to contracting with MedImpact. In addition, **RMHP** expanded its contract with CCN during 2014 and performed a predelegation review of CCN's capacity to provide the additional scope of work. **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.