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March 28, 2013

TO: The Honorable Mele Carroll, Chair
House Committee on Human Services

FROM: Patricia McManaman, Director

SUBJECT: **H.C.R. 192/H.R. 153 – REQUESTING THE DEPARTMENT OF HUMAN SERVICES TO STUDY THE RIGHTS AND DUE PROCESS REQUIREMENTS REGARDING COMPLAINTS, GRIEVANCES, AND APPEALS ACROSS CARE SETTINGS FOR MEDICAID NURSING FACILITY LEVEL OF CARE CLIENTS WHO RECEIVE HOME AND COMMUNITY-BASED SERVICES**

Hearing: Thursday, March 28, 2013; 10:00 a.m.
Conference Room 329, State Capitol

PURPOSE: The purpose of this resolution is have the Department of Human Services conduct a study on the level of compliance with certain regulatory requirements in health care settings that provide care for Medicaid nursing home level of care individuals enrolled in the QUEST Expanded Access (QExA).

DEPARTMENT'S POSITION: The Department of Human Services (DHS) provides the following comments on H.C.R.192.

The DHS appreciates this resolution's recognition of DHS' efforts to rebalance long-term care services and success in doing so with the majority of individuals receiving long-term care services now receiving them in their own homes or in the community.

The DHS fully understands its regulatory requirements and responsibility for overseeing the entire Medicaid program, including home and community-based services (HCBS).

The extensive scope of this resolution, which effectively covers the entire Medicaid long-term care enterprise, will require a significant appropriation to fund the mandated study that will need to be procured. Because the MQD is required by federal regulation to have an independent External Quality Review Organization (EQRO) that reviews compliance with federal regulations, there is no apparent added value for the use of taxpayer's funds for the study required by this measure. The most recent EQRO report is included for your reference.

In addition, requiring this study to be completed by January 2014 will necessitate that MQD resources be redirected from implementing by January 1, 2014, the new Medicaid eligibility criteria and methodology requirements under the Affordable Care Act, from completing the section 1115 demonstration waiver renewal, from procuring QUEST Integration and its focus on improving transition of care for vulnerable individuals, from transforming behavioral health services delivery, and from the ability to support other healthcare transformation activities.

HMS 902, which is used to fund these activities, continues to be substantially under funded, and the $1.5 million removed from the MQD base in response to a contract under the previous administration from which MQD did not benefit, that primarily served other aspects of the DHS, has not been restored despite annual requests by the DHS.

This resolution includes a cornucopia of requirements seemingly reflecting an understandable misunderstanding of the complex Medicaid program. Although HCBS is used to describe long-term care services provided outside of nursing facilities, HCBS includes a broad array of services and activities with a complex system of administration at the State level. Compliance with applicable federal regulations is overseen by the

federal Centers for Medicare & Medicaid Services. Regulatory requirements are based on federal law or the Code of Federal Regulations. The DHS contracts with health plans are an operational tool, and the Med-QUEST Division (MQD) quality strategy and standards have no regulatory or contractual authority.

The MQD provides oversight of compliance with federal regulations regarding service delivery and related complaints, grievances, and appeals in its section 1115 demonstration waiver. The Department of Health's (DOH) Developmental Disability Division has this responsibility for the 1915c Developmental Disability/ Intellectual Disability waiver. Licensing or certification of case management agencies and of facilities such as Community Care Foster Family Homes and Expanded Adult Residential Care Homes is done by either the DHS' Social Services Division or Department of Health's Office of Health Care Assurance. The health plans manage their own contracts with network providers, and the long-term care ombudsman also has an independent overall role. Although the title of the measure is specific to HCBS, the requirements of the measure also pertain to long-term care facilities.

The 2012 External Quality Review (EQR) compliance review, which is posted on the Med-QUEST Division (MQD) website, includes follow-up reviews of each QUEST and QExA plans corrective actions implemented to address deficiencies noted during the 2011 review. It describes the actions taken by the contractor, upon MQD's approval, and the staff activities related to the oversight and monitoring of heath plan appeals and grievances.

The 2012 review also focused on the federal managed care regulations and MQD contract requirements related to communicating key rights and information requirements to members and providers through handbooks, manuals, correspondence

and provider contracts on the member grievance system that also included the health plan's processing of member grievances.

In addition, the MQD will have the EQR contractor review grievance system standards in the 2013 review to ensure sustained improved performance in this area.

To provide oversight of its managed care programs, the MQD has numerous reporting requirements of its health plans and a calendar and report templates can be provided to the Legislature upon request.

Thank you for the opportunity to provide comments on this measure.

Compliance Monitoring Follow-Up Review

The 2012 compliance monitoring review activity included follow-up reviews of each health plan's required corrective actions implemented to address deficiencies noted during the 2011 review. The previous compliance review (2011) and this year's follow-up reviews (2012) focused on the federal managed care regulations and the MQD contract requirements related to the structure and operations standards (42 CFR 438.214–230 and associated cross-references). The five standard areas assessed the health plans' processes and performance in selecting and overseeing service providers and delegates; communicating key rights and information requirements to members and providers through handbooks, manuals, correspondence, and provider contracts; and administering the member grievance system, which included the health plans' processing of member grievances and appeals.

All five of the health plans achieved full compliance in the review of the provider selection standard last year; therefore, no corrective action plans (CAPs) were required in that area. Because the grievance system standard had the greatest number of findings and required corrective actions across all five health plans, the MQD targeted this area for technical assistance and increased monitoring activities. HSAG provided a focused training session on grievances and appeals in April 2012, prior to the final re-evaluation reviews of the health plans. Individualized technical assistance was also provided at each health plan as indicated by its areas of deficiency. The MQD staff continued to perform oversight and monitoring of select health plan appeals and/or grievance files, and also performed additional reviews of grievance system letter templates, policies and procedures, and provider and member handbook information as part of its readiness review process following award of the new QUEST contract.

HSAG performed the majority of follow-up reviews on-site at each health plan, and also performed reviews of appeals or grievances where indicated. Two of the final follow-up reviews were performed through telephonic interview sessions and electronic exchange of health plan information. Each health plan prepared for the re-evaluation by submitting documentation of its CAP implementation activities (policies, manuals, meeting minutes, etc.) which HSAG reviewed prior to the interview sessions. Representatives of the MQD accompanied HSAG during all follow-up review activities. The results of the re-evaluations were documented as part of the health plans' CAP reports to create a permanent record of how each deficiency was addressed by the health plan and the degree of sufficiency of the actions in achieving compliance. Following are summaries of each health plan's follow-up compliance review results.

AlohaCare

Results

The scores from HSAG's 2011 compliance review, the number of CAPs required, and results of the 2012 follow-up reviews of AlohaCare are displayed in Table 3-1:

Table 3-1—Compliance Standards and AlohaCare's Results

Standard #	Standard Name	2011 Compliance Review Score	# of CAPs Required	# of CAPs Closed	2012 Final Follow-Up Review Score
I	Delegation	77%	5	5	100%
II	Member Information	94%	4	4	100%
III	Grievance System	72%	15	15	100%
IV	Provider Selection	100%	0	NA	100%
V	Credentialing	96%	3	3	100%
	Totals	89%	27	27	100%

NA = Not Applicable. Re-evaluation was not necessary as the health plan achieved 100% for the standard or the standard was not applicable to the plan.

Conclusions and Recommendations

AlohaCare addressed its member information standard deficiencies by:

- Improving the understandability of written letters to members (at or below a 6.9 grade reading level).
- Expanding and clarifying certain member handbook information.

As a result of deficiencies identified in the area of delegation, AlohaCare implemented CAPs to:

- Include in its delegation agreements the specific duties being delegated, the delegate's reporting requirements, and all required contract provisions.
- Implement a delegation documentation tracking and archiving mechanism, and ensure assignment of responsibility for delegates.
- Ensure that all delegates are subject to an annual formal review by the health plan.

For the grievance system standard, AlohaCare addressed deficiencies by:

- Implementing a process to consider the earliest date possible as the filing date for grievances and appeals and to accept oral appeals, with follow-up to obtain a member's written appeal request.
- Issuing member grievance resolution letters that address all grievance issues raised.
- Revising policies and other applicable documents, including member communications, to include more complete information about the option to continue benefits during an appeal or administrative hearing and the circumstances to which this may apply.
- Clarifying and differentiating the processes for member appeals and provider grievances.

For the credentialing standard, AlohaCare implemented CAPs to:

- Perform timelier monitoring of federal and State sanctions and exclusions when credentialing providers.
- Ensure that any State or CMS survey it accepts in lieu of its own site visit meets the health plan's own organizational provider standards.
- Revise its credentialing policies/procedures to include a process for ensuring that nonaccredited organizational providers credential their practitioners.

As a result of its CAP interventions, AlohaCare was found to be fully compliant with the delegation, member information, grievance system, and credentialing standards and had no continuing recommendations.

HMSA

Results

The scores from HSAG's 2011 compliance review, the number of CAPs required, and results of the 2012 follow-up reviews of HMSA are displayed in Table 3-2:

Table 3-2—Compliance Standards and HMSA's Results

Standard #	Standard Name	2011 Compliance Review Score	# of CAPs Required	# of CAPs Closed	2012 Final Follow-Up Review Score
I	Delegation	100%	0	NA	100%
II	Member Information	92%	5	5	100%
III	Grievance System	76%	14	14	100%
IV	Provider Selection	100%	0	NA	100%
V	Credentialing	98%	2	2	100%
	Totals	92%	21	21	100%

NA = Not Applicable. Re-evaluation was not necessary as the health plan achieved 100% for the standard or the standard was not applicable to the plan.

Conclusions and Recommendations

HMSA addressed deficiencies noted for the member information standard by:

- Ensuring member correspondence is understandable and written at a 6.9 or lower grade level.
- Revising and correcting information in the member handbook related to grievances and appeals.

As a result of deficiencies identified in grievance system area, HMSA implemented CAPs to:

- Ensure that grievance and appeal acknowledgment letters are sent to members within the required time frames.
- Revise its policy and process to ensure that grievances are resolved and a resolution letter is sent within 30 days.

- Ensure that members are aware that grievance resolution letters can be made available in the member's primary language.
- Revise its policy and process to clarify that appeals may be accepted when filed orally and followed with a written request, and to consider the oral contact date as the date of filing.
- Clarify and differentiate the processes for member appeals and provider appeals, and ensure that members are included as parties to the appeal for those related to coverage, provision, or payment of medically necessary services.
- Ensure that appeals are resolved and that a resolution letter is sent within the required time frames.
- Establish processes to notify members of the reason for any time frame extension of an appeal resolution not requested by the member, and to notify the MQD related to expedited appeals as required in the contract.

HMSA addressed deficiencies related to the credentialing standard by:

- Ensuring that any State or CMS survey it accepts in lieu of its own site visit meets the health plan's own organizational provider standards.
- Revising its credentialing policies/procedures to include a process for ensuring that nonaccredited organizational providers credential their practitioners.

As a result of its CAP interventions, HMSA was found to be fully compliant with the member information, grievance system, and credentialing standards, and had no continuing recommendations.

Kaiser

Results

The scores from HSAG's 2011 compliance review, the number of CAPs required, and results of the 2012 follow-up reviews of Kaiser are displayed in Table 3-3:

Table 3-3—Compliance Standards and Kaiser's Results

Standard #	Standard Name	2011 Compliance Review Score	# of CAPs Required	# of CAPs Closed	2012 Final Follow-Up Review Score
I	Delegation	NA	0	NA	100%
II	Member Information	95%	3	3	100%
III	Grievance System	62%	16	16	100%
IV	Provider Selection	100%	0	NA	100%
V	Credentialing	100%	0	NA	100%
	Totals	**89%**	**19**	**19**	**100%**

NA = Not Applicable. Re-evaluation was not necessary as the health plan achieved 100% for the standard or the standard was not applicable to the plan.

Conclusions and Recommendations

Kaiser addressed deficiencies noted for the member information standard by:

- Ensuring member grievance and appeal resolution notices are understandable and written at a 6.9 grade reading level or lower.
- Ensuring all member materials include a language block informing the member how to access translation services or how to request the information in an alternate language.
- Revising and correcting information in the member handbook related to grievances and appeals.

For the grievance system standard, Kaiser implemented CAPs to:

- Develop policies and procedures to describe its inquiry process.
- Ensure that processes followed for Medicaid member grievances are consistent with policy requirements and the health plan's contract with the MQD.
- Treat all expressions of dissatisfaction as grievances and issue a written resolution even when the issue is resolved at the initial point of contact.

As a result of its CAP interventions, Kaiser was found to be fully compliant with the member information and grievance system standards, and had no continuing recommendations.

Ohana

Results

The scores from HSAG's 2011 compliance review, the number of CAPs required, and results of the 2012 follow-up reviews of Ohana are displayed in Table 3-4:

Table 3-4—Compliance Standards and Ohana's Results

Standard #	Standard Name	2011 Compliance Review Score	# of CAPs Required	# of CAPs Closed	2012 Final Follow-up Review Score
I	Delegation	100%	0	NA	100%
II	Member Information	98%	1	1	100%
III	Grievance System	95%	4*	4*	100%
IV	Provider Selection	100%	0	NA	100%
V	Credentialing	93%	6	6	100%
	Totals	96%	11	11	100%

NA = Not Applicable. Re-evaluation was not necessary as the health plan achieved 100% for the standard or the standard was not applicable to the plan.
*** = Includes an "additional finding" related to pharmacy authorizations that was identified during the appeal file review.**

Conclusions and Recommendations

Ohana addressed deficiencies noted for the member information standard by:

- Clarifying and expanding its member handbook information related to continuation of benefits during an appeal or administrative hearing, and regarding the rules that apply to a State administrative hearing.

Ohana implemented CAPs related to the grievance system standard to:

- Revise applicable documents to provide a consistent and accurate definition of appeal and a consistent and accurate time frame for processing appeals.
- Clarify, correct, and expand grievance system information given to providers.

Ohana's CAPs related to the credentialing standard were implemented to:

- Ensure accurate tracking and reporting of credentialing and recredentialing due dates.
- Revise the credentialing policies and procedures to address or clarify certain policy provisions required by the NCQA standards.
- Revise its forms and tools as needed to accurately list criteria to be evaluated for certain provider types.
- Develop and implement a mechanism for assessment of organizational providers and ensure that if a State or CMS survey is accepted in lieu of its own site visit, that the survey meets the health plan's own organizational provider standards.
- Revise the agreement with its credentialing delegate to accurately reflect the scope of the delegated activities.

An additional finding during the on-site review, which was outside the scope of the standards but required correction, prompted the following CAP action by Ohana:

- Development and implementation of a process to better manage pharmacy requests for additional information during the service authorization process by using more of the allowable authorization time frame and/or extending the time frame as necessary to make a service authorization determination.

As a result of its CAP interventions, Ohana was found to be fully compliant with the member information, grievance system, credentialing standards, and the additional finding, and had no continuing recommendations.

UnitedHealthcare Community Plan

Results

The scores from HSAG's 2011 compliance review, the number of CAPs required, and results of the 2012 follow-up reviews of UHC CP are displayed in Table 3-5:

Table 3-5—Compliance Standards and UHC CP's Results

Standard #	Standard Name	2011 Compliance Review Score	# of CAPs Required	# of CAPs Closed	2012 Final Follow-Up Review Score
I	Delegation	91%	2	2	100%
II	Member Information	91%	6	6	100%
III	Grievance System	79%	12	12	100%
IV	Provider Selection	100%	0	NA	100%
V	Credentialing	25%	38	38	100%
	Totals	64%	58	58	100%

NA = Not Applicable. Re-evaluation was not necessary as the health plan achieved 100% for the standard or the standard was not applicable to the plan.

Conclusions and Recommendations

UHC CP addressed deficiencies noted for the delegation standard by:

- Amending certain delegation agreements to contain all of the required contract provisions.

UHC CP addressed deficiencies noted for the member information standard by:

- Ensuring member information materials and appeal resolution notices are understandable and at a 6.9 grade reading level or lower.
- Expanding and clarifying certain member handbook information (related to referrals, specialty services, authorization procedures, member liability for payment, and provider's ability to file grievances and appeals on behalf of the member).

As a result of deficiencies identified in the area of grievance system, UHC CP implemented CAPs to:

- Ensure the timely processing of all appeal cases, including resolution and written acknowledgement.
- Ensure members are offered or made aware of available assistance with filing grievances and appeals and ensure staff members are trained on the member's right to file appeals orally or in writing.
- Clarify the definition of appeal in the policy.
- Document and ensure that grievance and appeal decisions are made by qualified personnel who have not been previously involved in a decision on the case.
- Provide prompt oral notice to members when a request for an expedited appeal is denied.

- Ensure that staff members are trained and follow correct processes regarding the member's right to have benefits continued during an appeal, when applicable.
- Clarify grievance system information given to providers.

To address deficiencies identified in the area of credentialing, UHC CP implemented CAPs to:

- Develop and implement a well-defined process with written policies and procedures that articulate its decisions for applying the NCQA standards to its credentialing and recredentialing program.
- Ensure that one of its credentialing delegates produces accurate data for tracking recredentialing due dates.
- Develop and implement a mechanism for assessment of organizational providers and ensure that if a State or CMS survey is accepted in lieu of its own site visit, that the survey meets the health plan's own organizational provider standards.
- Revise one of its credentialing delegation agreements to include all of the provisions required by the NCQA standards.
- Ensure that future file reviews performed to oversee the delegated credentialing activities are performed on both credentialing delegates and include Hawaii credentialed providers.

As a result of its CAP interventions, UHC CP was found to be fully compliant with the delegation, member information, and credentialing standards, and had no continuing recommendations in those areas.

In the grievance system standard area, the health plan successfully resolved five of twelve open CAP items, and continued on a CAP for the remaining seven items. The MQD and HSAG provided oversight and monitoring of the health plan's corrective actions to address and resolve the continuing deficiencies. During an additional site visit in late September, which included appeal record reviews of the entire population of appeals that UHC CP received during the review timeframe, the health plan was found to have taken significant steps toward resolving its remaining deficiencies related to:

- Ensuring consistency of grievance and appeal processing terminology used across its documents (policies/procedures, tracking logs, training materials, job aides).
- Ensuring members receive adequate and timely outreach and assistance to secure the signature required for processing grievances or appeals submitted by a representative, and that appeals are not dismissed prematurely while attempting to secure the member's signature.
- Ensuring members are included as a party to the appeal and timely receive all correspondence sent to the authorized representative or provider that initiated the appeal case.
- Ensuring that a member's expression of dissatisfaction with a provider that was received in the course of handling an appeal was processed and tracked as a grievance.
- Ensuring that appeal resolution letters contained clear, accurate, and easily understandable information about the appeal decision.
- Ensuring that pharmacy authorization decisions include a process for requesting and considering additional information from the prescriber in order to prevent premature denial

decisions which are then frequently overturned upon appeal and receipt of the needed information.

- Ensuring that decisions to approve or deny certain psychotropic medications are consistent with State law (HAR 346-59.9).

UHC CP received technical assistance and feedback from both the MQD and HSAG throughout the CAP monitoring process. Upon completion of the final follow-up review in September, UHC CP's compliance CAPs were determined to be "closed" for purposes of the EQRO's compliance review activity; however, the MQD will continue its close monitoring of the appeal processes to ensure that the recently observed improvements are sustained by the health plan over time.