

DEPARTMENT OF
**Managed
Health Care**
Help Center

DIVISION OF PLAN SURVEYS

**1115 WAIVER SENIORS AND PERSONS WITH
DISABILITIES (SPD) ENROLLMENT SURVEY**

**SURVEY REPORT
FOR THE
DEPARTMENT OF HEALTH CARE SERVICES**

**1115 WAIVER SURVEY
OF
L.A. CARE**

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: May 8, 2013

**1115 Waiver Survey Report of the SPD Enrollment
L.A. Care
A Full Service Health Plan
May 8, 2013**

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EXECUTIVE SUMMARY

The California Department of Health Care Services (“DHCS”) received authorization (“1115 Waiver”) from the federal government to conduct mandatory enrollment of seniors and persons with disabilities (“SPD”) into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The Department of Managed Health Care (the “Department”) entered into an Inter-Agency Agreement with the DHCS¹ to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California’s strong patient-rights laws. Mandatory enrollment began in June 2011.

On January 24, 2012, Local Initiative Health Authority for L.A. County dba L.A. Care (the “Plan”) was notified that its Medical Survey had commenced and was requested to provide the Department with the necessary pre-onsite data and documentation. The survey team conducted the onsite portion of the survey from July 10, 2012 through July 13, 2012. The Department closed the survey on September 19, 2012. However, on November 28, 2012, the Department determined that additional information was required for the completion of this routine survey and the survey review process was re-opened. The Department completed its investigatory phase and closed the survey on February 12, 2013.

SCOPE OF SURVEY

The Department is providing DHCS this written summary report of medical survey findings pursuant to the Inter-Agency Agreement and has identified potential deficiencies in Plan operations supporting SPD membership. This medical survey evaluated the following elements specifically related to the Plan’s delivery of care to the SPD population pursuant to the DHCS contract requirements and compliance with the Act:

I. Utilization Management

The Department evaluated Plan operations related to utilization management, including implementation of the utilization management program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting over- and under-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

II. Continuity of Care

The Department evaluated Plan operations to determine whether medically necessary services are effectively coordinated both inside and outside the network, to ensure the coordination of special arrangement services, and to verify that the Plan provides for completion of covered services by a non-participating provider when required.

¹ The Inter-Agency Agreement (Agreement Number 10-87255) was approved on September 20, 2011.

III. Availability and Accessibility

The Department evaluated Plan operations to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes, and are addressing reasonable patient requests for disability accommodations.

IV. Member Rights

The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for Primary Care Physician (PCP) selection and assignment, and to evaluate the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

V. Quality Management

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care.

The scope of the survey incorporated review of health plan documentation and files from the period of June 1, 2011 through May 31, 2012.

SUMMARY OF FINDINGS

The Department identified **one** potential survey deficiency during the current Medical Survey.

2012 SURVEY POTENTIAL DEFICIENCIES²

MEMBER RIGHTS	
#1	The Plan does not consistently ensure adequate consideration of enrollee grievances. Section 1368(a)(1); DHCS 2-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1: Member Grievance System

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

In November 2010, California obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) authorizing, among other provisions, mandatory enrollment of Medi-Cal eligible SPDs into Medi-Cal managed care plans (e.g., two-plan and geographic managed care (GMC) models) in 16 participating counties including Los Angeles County. Beginning June 2011, under the Section 1115 Waiver, DHCS began a phased-in mandatory enrollment of SPDs into managed care plans over a 12-month period in participating counties. The Plan is one of the managed care plans selected by DHCS to serve the SPDs. The Plan has an estimated 106,759 SPD members.

In anticipation of the influx of SPD members, the Plan implemented several safeguards and interventions in 2011 in efforts to support the transitions of SPD members including, but not limited to, the following:

- Recruited 59 FTEs to support the Plan's Call Center.
- Solicited support from other departments (e.g., Human Resources) to support the Call Center.
- Provided overtime opportunities for Call Center staff to handle member callbacks, thereby enabling an increased call volume.
- Extended Call Center hours from 8:00 a.m. – 5:00 p.m. to 7:00 a.m. – 7:00 p.m.
- Added a new SPD member unit with a toll-free number in the Member Services Department. Added three Member Services staff dedicated to the Medicare population.
- Increased the number of member materials available in alternative formats to improve understanding and readability among members---e.g. audiotape, braille, font type 14-16.
- Added a Member Services Specialist/Navigator position responsible for resolving member coordination for complex cases

² The *Discussion of Potential Deficiencies* section of this report contains a discussion of these deficiencies.

- Introduced a Pay-for-Performance program that rewards provider groups for exceeding performance standards in five domains, including member satisfaction.
- Developed an online Community Resources Directory (CRD) to assist the Plan's physician network in making referrals to local agencies. Over 100 new agencies serving seniors and people with disabilities were added to the CRD in 2011.
- Enhanced the Plan's ancillary and tertiary provider network.
- Recruited eight additional utilization management clinical staff and increased use of temporary workers.
- Recruited six case managers specifically for the SPD population to monitor patients with high-risk potential.
- Implemented the E-consult program, which is designed to improve member access to specialists through timely electronic exchange of clinical information and telephonic consultation between primary care and specialty physicians.
- Sponsored a collaborative effort with 10 network provider sites to improve access, care coordination, and patient engagement in compliance with the National Committee on Quality Assurance's (NCQA) medical home standards.
- Established an auto-approval process for SPD services and expansion of the types of services frequently prescribed for SPD members that are amenable to auto-approval (e.g., colonoscopies, incontinence supplies, and lifetime authorizations of specific services for selected members).
- Heightened fraud and abuse oversight for pharmacy benefits and services.

2012 L.A. CARE: DISCUSSION OF POTENTIAL DEFICIENCIES

The Department identified potential deficiencies, by survey area.

UTILIZATION MANAGEMENT

In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s utilization management processes including:

- a. The development, implementation, and maintenance of a utilization management program.
- b. The mechanism for managing and detecting over- and under-utilization of services.
- c. The methodologies and processes used to handle prior authorizations appropriately while complying with the requirements specified in the contract as well as in state and federal laws and regulations.
- d. The methodologies and processes used to evaluate utilization management activities of delegated entities.

POTENTIAL DEFICIENCIES:

Based on the Department’s review, there were no potential deficiencies identified in the area of Utilization Management.

CONTINUITY OF CARE

In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s continuity of care processes including:

- a. The methodologies and processes used to coordinate medically necessary services within the provider network.
- b. The coordination of medically necessary services outside the network (specialists).
- c. The coordination of special arrangement services including, but not limited to, California Children’s Services, Child Health and Disability Prevention, Early Start and Regional Centers.
- d. Compliance with continuity of care requirements in Section 1373.96 of the Health and Safety Code.

POTENTIAL DEFICIENCIES:

Based on the Department’s review, there were no potential deficiencies identified in the area of Continuity of Care.

AVAILABILITY AND ACCESSIBILITY

In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s processes to support access and availability including:

- a. The availability of services, including specialists, emergency, urgent care, and after hours care.
- b. Health plan policies and procedures for addressing a patient’s request for disability accommodations.

POTENTIAL DEFICIENCIES:

Based on the Department’s review, there were no potential deficiencies identified in the area of Availability and Accessibility.

MEMBER RIGHTS

In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s member rights processes including:

- a. Compliance with requirements for a complaint/grievance system. Examination of a sufficient number of SPD member grievance files to ensure an appropriate audit confidence level.
- b. PCP selection and assignment requirements.
- c. Evaluation of available interpreter services and member informing materials in identified threshold languages.
- d. The health plan’s ability to provide SPDs access to the member services and/or grievance department in alternative formats or through other methods that ensure communication.

Deficiency # 1: The Plan does not consistently ensure adequate consideration of enrollee grievances.

Statutory/Regulatory/Contract Reference:

Section 1368(a)(1); DHCS 2-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1: Member Grievance System

Supporting Documentation:

- Policy#: MS-009 - Complaint Process for Members, revision date 4/20/10
- Policy#: UM-114 - Appeals Processes for Members, revision date 1/20/11
- 64 SPD Grievance files

Assessment:

The Department’s assessment included a review of the Plan’s SPD member grievance files. In six (6) out of sixty-four (64) files, the Department found that the Plan did not address all of the issues presented by the enrollee’s grievance.

Section 1368(a)(1) requires that health plan grievance systems ensure adequate consideration of enrollee grievances and rectification when appropriate. The Department’s file review indicated

that in certain circumstances, as described below, the Plan's resolution letter to the enrollee did not address all of the issues initially presented by the member when the member filed the grievance. For example, the member would complain or discuss three issues when initially contacting the Plan's customer service department. When the Plan ultimately sent a resolution letter to the enrollee regarding the resolution of the grievance, the letter would only address one or two issues of the three issues. Below are case studies demonstrating the Plan's failure to resolve all of the issues presented by the enrollee.

Relevant Case Summaries:

- (1) Case# 98282—Member filed a grievance regarding a denial to see an ophthalmologist for cataracts and a denial for a prescription medication. The resolution letter to the member focused only the prescription issue. There was no evidence suggesting the Plan ever resolved the member's issue regarding referral to an ophthalmologist.
- (2) Case #90068— Member called the Plan expressing three different grievance issues: a change of an approved medication supply from a 60 day supply to a 90 day supply, case management services previously asked for and a request for wound supplies and a soft air mattress. The resolution letter to the member only addressed the air mattress and stated that the Plan would "look into" the wound care request. The Plan did not address the member's request for a case manager or fully address the medication supply.
- (3) Case# 92739- The member stated that he had not completed his therapy sessions due to an assault at the clinic while awaiting his transportation. Although the resolution letter stated that the Plan forwarded a complaint to the Provider Network Operations Department for outreach and education in regards to the incident, the resolution letter did not confirm the facilitation of enrollee appointment or the completion of therapy sessions.
- (4) Case # 92932—Member obtained a prescription from a pharmacy but paid out of pocket because the member did not have his/her ID card. The member requested reimbursement through the plan's grievance process. Although the Plan's notes indicate steps were taken to reimburse the member for the medications, the resolution letter did not fully address the member's reimbursement issue.
- (5) Case# 89118—Member contacted the plan because he/she had to pay out of pocket for a prescription at a pharmacy. Plan notes indicated the plan representative contacted the member's dad to go back to the pharmacy for reimbursement; however, the resolution letter provided to the enrollee did not address the reimbursement issue or the resolution of the matter.
- (6) Case #87245— Member submitted a grievance with complaints regarding pharmacy services and access to a specialist. The member complained that he was dropped by his oncologist and was unable to obtain his prescriptions. Plan notes indicate the member's concerns were investigated and the member's request to continue care with his Hematologist/Oncologist was granted. In the resolution letter to the enrollee, the Plan explained that it was unable to contact the member and that the prescription issue was resolved. The Plan did not explain the Oncologist issue to the member.

QUALITY MANAGEMENT

In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s Quality Management processes including:

- a. Verifying that health plans monitor, evaluate, and take effective action to maintain quality of care and to address needed improvements in quality.
- b. Verifying that health plans maintain a system of accountability for quality within the organization.
- c. Verifying that health plans remain ultimately accountable even when Quality Improvement Plan activities have been delegated.

POTENTIAL DEFICIENCIES:

Based on the Department’s review, there were no potential deficiencies identified in the area of Quality Management.

A P P E N D I X A

A. SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Rodel Pena	Survey Team Lead
Jennifer Childress	Associate Analyst
MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS	
Laurence Ikeda, MD	Quality Management
Lana Cotner RN, MBA	Utilization Management
Patty R Nelson, RN, MS	Language Assistance Program & Access and Availability
Bruce Hoffman, MBA	Grievances and Appeals
Rose Leidl, RN	File Review

A P P E N D I X B

B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED FROM: L.A. CARE	
Elaine Batchlor	Chief Medical Officer
Steven Krivit	Interim Compliance Officer
Steven Gobi	Associate Counsel
Jennifer Sayles	Medical Director
Joseph Wanski	Medical Director
Sarita Mohanty	Medical Director, Medical Management
Russ Billimoria	Senior Director, Medical Management
Nicole Moussa	Pharmacy Operations Supervisor
Makilah Hubbert	Pharmacy Technician
Adriana Tapia	Pharmacy Auditor
Susan Leong	Director, Pharmacy and Formulary
Joanne Garlow	U.M. Oversight Specialist
Murleen Ryder	UM Oversight & Compliance Specialist
Juana Valdez	Lead, Grievance & Appeals
Kimberly Williams	Medical Management Director
Diana McIntyre	UM Medical Management Manager
Laura Linebach	Director, Q.I.
Christine Chueh	QI Specialist
Maria Casias	QI Specialist
Lynnette Hutcherson	Sr. Medical Management Director
Maria Wilks	Manager, QI/Clinical Studies
Edward Calles	Sr. Manager, Contracting & Network Analysis
Angie Lageson	Provider Relations Manager
Gwendolyn Cathey	Project Specialist
Nai Kasick	Director, Health Education, Cultural & Linguistics
Lenna Monte	Manager, Cultural & Linguistics
Maribel Ferrer	Sr. Director, Member & Medicare Services
Elena Stern	Director of Communications & Marketing
Allen Freymuth	Sr. Manager Claims
Maryam Maleki	Compliance Advisor
Tiffany Fleet	Compliance Coordinator
Allen Freymuth	Acting Director Claims

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Susan Williams	Auditor, Credentialing
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Marilyn Ventura	QI Specialist
Kathleen Rice	Medical Management
Vivian Vitug	Pharmacy
Lisa Daly	QI Specialist
Michelle Brochu	Vice President, Project Management, CompCare

A P P E N D I X C

C. LIST OF FILES REVIEWED

Note: The statistical methodology utilized by the Department is based on an 80% Confidence Level with a margin of error of 7%. Each file review criterion is assessed at a 90% compliance rate.

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Grievance and Appeals-SPD	64	The Department identified the sample size based upon its standard File Review Methodology. The SPD grievance file universe from June 1, 2011 to May 31, 2012 was 611.