

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
BLUE CROSS OF CALIFORNIA
dba ANTHEM BLUE CROSS
A FULL SERVICE HEALTH PLAN**

DATE ISSUED TO DHCS: SEPTEMBER 3, 2014

**1115 Waiver Survey Report of the SPD Enrollment
Blue Cross of California
dba Anthem Blue Cross of California
A Full Service Health Plan
September 3, 2014**

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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 DHCS then entered into an Inter-Agency Agreement with the Department of Managed Health Care (the “Department”)¹ 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 of SPDs into managed care began in June 2011.

On August 29, 2013, the Department notified Anthem Blue Cross (the “Plan”) that its Medical Survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department’s survey team conducted the onsite portion of the Medical Survey from November 12, 2013 through November 15, 2013.² Additional file review was subsequently conducted at the Plan’s Woodland Hills corporate office on December 9, 2013.

SCOPE OF SURVEY

This written Summary Report of Medical Survey Findings is provided to the DHCS pursuant to the Inter-Agency Agreement, and identifies 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.

² Pursuant to the Knox-Keene Health Care Service Plan Act of 1975, codified at Health and Safety Code section 1340, *et seq.*, Title 28 of the California Code of Regulations section 1000, *et seq.* and the Department of Health Care Services Two-Plan and GMC Boilerplate Contracts. All references to “Section” are to the Health and Safety Code unless otherwise indicated. All references to the “Act” are to the Knox-Keene Act. All references to “Rule” are to Title 28 of the California Code of Regulations unless otherwise indicated. All references to “Contract” are to the Two-Plan or GMC Boilerplate contract issued by the Department of Health Care Services.

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 September 1, 2012 through August 31, 2013.

SUMMARY OF FINDINGS

The Department identified **nine** potential survey deficiencies during the current Medical Survey.

2013 SURVEY POTENTIAL DEFICIENCIES³

UTILIZATION MANAGEMENT

#1

The Plan’s Utilization Management Notice of Action (NOA) letters do not consistently include:

- **a clear and concise explanation of the reasons for the decision;**
- **a description of the criteria or guidelines used;**
- **the clinical reasons for decisions regarding medical necessity; and**
- **the name and telephone number of the health care professional responsible for the decision.**

Section 1367.01 (h)(4); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 5, Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures.

AVAILABILITY and ACCESSIBILITY

#2

The Plan does not implement prompt investigation and corrective action when compliance monitoring discloses that the Plan’s provider network is not sufficient to ensure timely access to care.

Rule 1300.67.2.2(d)(3); and DHCS Two-Plan and GMC Contract, Exhibit A,

³ The *Discussion of Potential Deficiencies* section of this report contains a discussion of these deficiencies.

#3	<p>The Plan’s provider directory does not, at minimum, display the level of access available at each provider site as either “Basic Access” or “Limited Access” for provider sites that service a high volume of SPDs where a Physical Accessibility Review was conducted.</p> <p>DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 10(A) – Site Review; DHCS MMCD Policy Letter 12-006; and DHCS MMCD Policy Letter 11-009.</p>
MEMBER RIGHTS	
#4	<p>The Plan does not establish and maintain a grievance system that consistently ensures:</p> <ul style="list-style-type: none"> • adequate consideration and rectification of enrollee grievances; and • written acknowledgment and response for grievances not resolved by close of the next business day. <p>Section 1368(a)(1); Rule 1300.68(d)(8); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1 – Member Grievance System.</p>
#5	<p>The Plan’s responses to grievances involving a determination that the requested service is not a covered benefit do not consistently specify the provision in the contract, evidence of coverage, or member handbook that excludes the service.</p> <p>Section 1368(a)(5); Rule 1300.68(d)(5); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1 – Member Grievance System.</p>
#6	<p>The Plan does not immediately inform members of the right to contact the Department when filing grievances requiring expedited review.</p> <p>Section 1368.01(b); Rule 1300.68.01(a)(1); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1 – Member Grievance System.</p>
#7	<p>The Plan does not ensure that written member information materials, including notices pertaining to enrollee grievances, are translated into identified threshold languages.</p> <p>Rule 1300.68(b)(3); DHCS Two-Plan Contract, Exhibit A, Attachment 9, Access and Availability, Provisions 14(B)(2) – Linguistic Services; and DHCS GMC Contract, Exhibit A, Attachment 9, Access and Availability, Provision 14(C)(2) – Linguistic Services.</p>
#8	<p>The officer of the Plan who is designated as having primary responsibility for the grievance system does not continuously monitor and review the operation of the system to identify emerging patterns for quality improvement.</p> <p>Rule 1300.68(b)(1); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provisions 1 – Member Grievance System, and 2(C) – Grievance System Oversight.</p>

QUALITY MANAGEMENT

#9

The Plan's Quality Assurance program does not consistently ensure that problems are identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.

Rule 1300.70(a)(1); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement.

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

Utilization Management:

The Plan has developed a well-established Utilization Management Program that provides for the prevention and monitoring of over- and under-utilization of services for its SPD members. The Plan collaborates with its delegated provider groups to ensure that emergency room usage, inpatient days, and readmission rates are kept to a minimum, to the extent possible. Some of the programs implemented in recent years (2012 to present) to achieve utilization management goals for its SPD membership include:

- *Participating Medical Group (PMG) Bonus Program*
The Plan directly involves individual delegates and provides an incentive-based system. The program is designed to improve utilization data regarding readmission rates, emergency room usage, and inpatient utilization (hospital days), without compromising quality of care.
- *Enterprise/State Readmission Initiative*
The Plan performs stratification of its members who are at risk for readmission, provides case management and disease management to members with special medical and behavioral health needs, and addresses access barriers to care.
- *Multidisciplinary and County-Based Case Management*
The Plan utilizes a team approach to manage high-risk members with special needs. "Geo Care Teams" are comprised of care coordinators, nurses, social workers, managers, physicians, professional educators, and behavioral health specialists. Currently, there are five county-based Geo Care Teams, two of which are assigned to Los Angeles County.

In addition to the above programs, the Plan implemented the following initiatives designed to benefit all Plan enrollees, including SPDs:

- Beginning with the fourth quarter of 2011, the Plan implemented two quality projects—Depression Screening and Behavioral Health Collaboration. The following project goals were established:
 - 1) Goal #1: 95% of members (adult and children) enrolled in complex case management will be screened for depression.
 - 2) Goal #2: 95% of members identified as high risk for depression will have this addressed in their care plan. Documentation will include: a) discussion with the

member for referral to a behavioral health program (internal or external), b) collaboration with the member's primary care physician, c) indication of whether or not the member is undergoing current treatment for depression, and d) notation if the member declines referral to a behavioral health program.

- In addition to the utilization of national policies, the Plan is revising and developing new medical policies specifically designed for California, based on local provider feedback.
- The Plan conducts a provider satisfaction survey on an annual basis to determine primary and specialist care satisfaction with the Plan's UM Program. Specifically, provider input regarding ease with obtaining authorizations, timeliness of authorizations, and overall satisfaction are measured.
- The Plan has established and implemented a program that proactively identifies members with two or more inappropriate emergency room visits and initiates an evaluation to determine the need for case management.
- The Plan conducts a medication adherence analysis to identify members at risk for medication non-compliance and determines an appropriate course of action to intervene and facilitate compliance.
- The Plan instituted a "Knowledge Library," an electronic portal that houses job aids and processes for all utilization management and case management staff. The purpose of the library is to facilitate access to job workflow, staff processes, and internal policies. By standardizing processes, the goal is to increase job efficiency and enhance productivity.
- The Plan conducts physician inter-rater reliability assessments to promote consistent use of adopted clinical review criteria.
- Beginning in 2013, the Plan has conducted a biannual "Prevention of Unnecessary Emergency Room Usage Analysis" to measure the effectiveness of complex case management in decreasing unnecessary emergency room admissions.

Continuity of Care:

The Plan has emphasized the importance of the Initial Health Assessment (IHAs) for its SPD members and has taken the following measures to increase the number of IHAs completed in a timely manner:

- The Plan hired additional staff and formed geographic care teams (multidisciplinary "Geo Care Teams" comprised of care coordinators, nurses, social workers, managers, physicians, professional educators, and behavioral health specialists) that go into the community to educate and encourage members to obtain their IHAs by scheduling appointments with their primary care physicians. These teams also visit primary care offices to educate providers and their staff regarding the need to increase compliance through outreach to members.
- All Geo Care Teams meet to discuss identified barriers that prevent members from obtaining the IHA, including transportation issues.

- The Plan notifies members and providers regarding the importance of completing the IHA through education newsletters.
- The Plan offers financial incentives to providers to promote compliance with IHA completion within 45 days of enrollment.

In addition to prioritizing the completion of IHAs, the Plan has made the following efforts to improve coordination of care for its SPD members:

- The Plan recruited additional primary care physicians and specialists to address access issues within the network.
- The Plan recently instituted a new program utilizing specialists to train primary care physicians in the identification and evaluation of members who need more timely referrals to specialists.
- The Plan instituted a policy whereby primary care physicians can refer members to out-of-network providers if specialists are indicated within the network but unavailable, with no associated cost to members.
- The Plan has a policy that ensures that members who are referred to the Complex Case Management Program have their initial case management assessments completed within 30 days of enrollment.
- The Plan has developed the Anthem CA Risk Assessment survey tool designed to identify barriers and assess risk factors associated with its SPD members (socioeconomic, structural, housing, transportation, social support, health literacy, etc.). The survey will be conducted via telephone or in person.

Quality Management:

- The Plan has developed a quality management program comprised of dedicated quality management staff. The Plan has allocated significant resources to improving its historically low HEDIS scores and performance, recently hiring 11 quality management registered nurses, 3 quality management managers, 1 vice president for quality, a data analyst, and outreach associates to educate providers regarding medical record maintenance and documentation.
- The Plan is currently addressing issues with its information system that has in the past contributed to inadequate retrieval/collection of appropriate data for HEDIS scoring.
- The Plan deploys nurses to high volume participating medical group offices to improve data reporting through standardization of processes, enhanced provider participation, and increased education/training.
- A provider incentive program, which will be based on county-specific HEDIS scores, is being developed for 2014 to improve accuracy of encounter data. Included in the

planning are discussions about directing incentives to individual providers rather than to provider medical groups. Previous financial incentives provided to participating medical groups did not impact HEDIS scores. Score cards will be published so that all involved staff can see their progress within the program.

- The Plan ensures adequate representation of the SPD population in UM and QI committees by including network physicians who work directly with the SPD population.

Member Rights:

- The Plan provides staff training on cultural sensitivity to encourage awareness of the unique needs of the SPD population. The Plan currently makes available certified bilingual English/Spanish member services representatives who can both field questions and translate information for members during a single point of contact.

Availability and Accessibility:

- The Plan contracted with the Harris Family Center for Disability and Health Policy to provide training for call center staff prior to the implementation of the SPD enrollment. The training program, “Serving Seniors and Persons with Disabilities—A Training Module,” was provided in April 2011. The training focused on several topics, including concerns and challenges SPDs face with navigating through the managed care system, communication and language etiquette when dealing with SPDs, education on use of the California Relay System for people who are deaf or hard of hearing, and physical accessibility to provider offices.
- The Plan’s Evidence of Coverage is written at the appropriate reading level. It uses clear, understandable language and avoids healthcare jargon. The Customer Care Center telephone/TTY numbers and the Anthem NurseLine telephone /TTY numbers are easily identifiable on every other page of text.

2013 BLUE CROSS OF CALIFORNIA: DISCUSSION OF POTENTIAL DEFICIENCIES

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 Deficiency #1: The Plan’s Utilization Management Notice of Action (NOA) letters do not consistently include:

- **a clear and concise explanation of the reasons for the decision;**
- **a description of the criteria or guidelines used;**
- **the clinical reasons for decisions regarding medical necessity; and**
- **the name and telephone number of the health care professional responsible for the decision.**

Statutory/Regulatory/Contract References: Section 1367.01 (h)(4); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 5, Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures.

Section 1367.01 (h)(4) states, “In determining whether to approve, modify, or deny requests by providers to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification.

The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or

modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 of Title 22 of the California Code of Regulations.”

DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 5 – Utilization Management

2. Pre-Authorizations and Review Procedures

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

D. Reasons for decisions are clearly documented.

Supporting Documentation: The Department requested and reviewed the following documentation:

- 20 appeals files (September 1, 2012 through August 31, 2013)

Assessment: As part of its routine process for evaluating the Plan’s grievance system, the Department selected a random sample of 66 standard grievances and appeals filed during the survey review period of September 1, 2012 through August 31, 2013. The Department isolated all Utilization Management (UM) appeals from the sample, which consisted of 22 files, and requested the initial NOA letters along with all supporting documentation for each file. Review of 20 files was conducted to assess the Plan’s authorization process regarding the provision of medically necessary services.⁴

The Denial, Modification and Delay Letters do not Consistently Contain a Clear and Concise Explanation, a Description of Criteria or Guidelines Used, or the Clinical Reasons for the Decision

Of the 20 appeals files reviewed, 12 files represented initial denials made by the Plan’s internal UM Department. The remaining eight files represented initial denials made by various provider groups delegated by the Plan to perform UM review and preauthorization of health care services. Nine of the 20 files (45%) did not contain either a clear or concise reason for the denial, a description of the criteria or guidelines used, or the clinical reasons for the decision.^{5,6} The following examples are demonstrative of these failures:

- *File #1:* This case involved a request for continued rental/use of high frequency chest wall oscillation (HFCWO) equipment, which was previously approved for one month by the Plan’s provider group. The NOA letter states, “Not medically indicated ... This authorization has been denied by the UR Committee ... to request a free copy of the criterion used to make this decision, please call 626-282-0288.” However, the letter did not provide a clinical basis to explain why the service was not medically indicated. Further, there was no description of the criteria used, only a reference as to where it could be obtained.

⁴ Two appeals files were initially denied based on lack of information rather than medical necessity and therefore were not assessed by this standard.

⁵ Of these nine grievances, eight were received by the Plan and one was received by a delegated provider group.

⁶ See TABLE 1: UM Medical Necessity Denials.

- *File #8:* This case involved an enrollee who had a power wheelchair for the past eight years with documented use of “independent mobility around his home and the community.” It is unknown how the power wheelchair was originally paid for eight years ago, but the member was requesting a replacement since the old one was worn out. The Plan initially denied the request on January 7, 2013, stating, it was “not medically necessary. This case has been sent for specialty review. We will make a decision in 14 days from the date we received the initial request per Wheeled Mobility Devices, Power Operated Vehicles Guideline CG-DME-31...You may appeal this decision ...”

This initial denial reason did not provide a clinical basis explaining why the service was not medically indicated, or explicitly state how the member’s condition failed to meet the referenced criteria. Nor is the letter clear. First, it states that the member does not meet the criteria, but, at the same time, indicates that the case will be pended for specialty review and a decision will be rendered within 14 days.

The file lacked documentation indicating that a subsequent decision was made 14 days later as the NOA letter indicated. However, the provider did appeal the initial denial on January 24, 2013 (17 days later). The provider described the patient’s mobility problems and functional limitations, indicating that the patient lived alone and was independent in bathing, grooming and dressing, yet was slow and severely limited in ambulation, using a single cane with frequent loss of balance, falling at least one time per month. The Plan upheld the initial denial stating:

Records show this scooter is for community use. You live alone. You are independent in dressing, bathing, and toileting, grooming and light meal preparation. There is no proof you are not able to walk in your home or that a walker has been considered to improve your gait in the home. In making this decision, the health plan clinical guideline on Mobility Devices...

Although the Plan attempted to explain how the member’s physical limitations failed to meet the guideline, the criteria itself was not clearly described. Further, the additional information from the provider regarding the member’s severe limitations in ambulation is not addressed. Therefore, while the letter is comprehensible, it is not clear whether the Plan adequately considered the member’s limitation when applying the guidelines because the letter does not accurately represent the member’s mobility problems.

The Denial, Modification and Delay Letters do not Consistently Contain the Name and Telephone Number of the Health Care Professional Responsible for the Decision

The Department separately reviewed the denial notification processes of both the Plan and its delegated entities to ensure that the name and direct phone number, or extension, of the physician reviewer was included on all denial communications sent to the requesting provider. The Department concluded that eight of the 20 files (40%) demonstrated non-compliance with this standard.⁷ Those eight files were derived from the provider group denials.

⁷ See TABLE 1: UM Medical Necessity Denials.

Review of the eight denial letters issued by the Plan’s delegated provider groups revealed inconsistencies and demonstrated non-compliance with Section 1367.01(h)(4). For example, File #5, the provider group issued both a separate fax and written letter notifying the requesting physician of the denial. The faxed notification included language directing the provider on how to contact the physician reviewer and stated the following:

The Medical Director is also available to discuss the decision determination with the physician:

Monday through Friday
 8:30 AM – 4:00 PM
 (408) 937-3615

However, in violation of Section 1367.01(h)(4) the fax does not contain the name of the actual physician reviewer who was responsible for the denial.

In addition to the fax, a formal letter is also sent to inform the requesting provider of the denial. However, this written communication also does not include either the name or direct telephone number (or extension) of the physician reviewer. The only telephone numbers referenced are the State’s Ombudsman Office and a general number to the Plan’s Customer Service Department. Therefore, the letter includes language geared more towards the member with instructions on how to file an appeal, rather than the requesting physician who would need to contact the provider group, not the Plan.

TABLE 1
UM Medical Necessity Denials

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
UM Denials	20	NOA letter includes a clear and concise explanation, a description of the criteria or guidelines used, and the clinical reasons for the decision	11 (55%)	9 (45%)
UM Denials	20	NOA letter includes the name and telephone number of the health care professional responsible for the decision	12 (60%)	8 (40%)

The Department finds the Plan in violation of the following regulatory and contractual requirements:

Section 1367.01 (h)(4) requires responses regarding decisions to deny, delay, or modify health care services requested by providers to include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 5, Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures similarly require reasons for decisions to be clearly documented.

Review of NOA denial letters indicate that the Plan does not consistently provide a clear and concise reason for the denials (45% non-compliance rate). The Department found denial letters based on medical necessity that did not clearly state the clinical basis for the member not meeting the criteria cited, and although the guidelines are referenced, they are not explained. Additionally, letters that deny services based on medical necessity, but also indicate that the case will be pended for specialty review and a subsequent decision are inconsistent and ambiguous. Moreover, this inconsistency results in unnecessary delays when no subsequent decision is ever made, as the enrollee and provider are unlikely to immediately appeal.

Section 1367.01(h)(4) requires that any written communication to health care providers include the name and telephone number of the health care professional responsible for the decision.

The Plan does not ensure that its delegated entities responsible for performing UM review and preauthorization of health care services include the name and telephone number of the health care professional responsible for the denial decision so that the physician can readily make contact, if necessary (40% non-compliance rate for denial letters overall; 100% non-compliance rate for denial letter from delegates).

CONTINUITY OF CARE
<p>In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's continuity of care processes including:</p> <ul style="list-style-type: none">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.

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 Deficiency #2: The Plan does not implement prompt investigation and corrective action when compliance monitoring discloses that the Plan’s provider network is not sufficient to ensure timely access to care.

Statutory/Regulatory/Contract References: Rule 1300.67.2.2(d)(3); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 9, Access and Availability, Provision 4 – Access Standards.

Rule 1300.67.2.2(d)(3) states, “A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan’s provider network is not sufficient to ensure timely access as required by this section, including but not limited to, taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all contracted providers affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan’s corrective action.”

DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 9 – Access and Availability

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers’ compliance with these standards.

Supporting Documentation: The Department requested and reviewed the following documentation:

- 2012 Provider Access, Availability and Provider Satisfaction Comprehensive Analysis – Medi-Cal and Healthy Families HMO Programs (1/13/13)
- Annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) Quantitative Results (2012 and 2013)
- Plan response to the Department’s question, “What is the Plan doing to improve appointment availability times?” (11/20/13)
- Policy #CA_PNXX_033: Access to Care Standards (9/26/12)

Assessment: The Plan uses several methods to monitor appointment accessibility for its members, including, but not limited to, an annual member satisfaction survey (Consumer Assessment of Healthcare Providers and Systems), an annual provider satisfaction survey, as

well as an evaluation of access related enrollee grievances. However, the Department discovered that while these monitoring efforts are in place, no effective action is taken to improve timely access to appointments when potential deficiencies are uncovered.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS results for the Plan’s annual member satisfaction survey included the following results for 2012 and 2013:

- “Getting Care Quickly” – Members were asked to respond to the following two questions: “Got appointment for urgent care as soon as needed?” and “Got appointment for non-urgent care as soon as needed?” The combined percentage of members surveyed responding “usually” or “always” was 68.3% in 2012 and 70.7 % in 2013. This data placed the Plan in the 10th percentile of all Medi-Cal plans as reported in the NCQA Quality COMPASS National Average for both years.
- “Getting Needed Care” – Members were asked to respond to the following two questions: “How often is it easy to get an appointment with a specialist?” and “How often is it easy to get tests, treatment or care you need via the health plan?” The combined percentage of members surveyed responding “usually or always” was 60.3% in 2012 and 64% in 2013. This data placed the Plan in the 10th percentile of all Medi-Cal plans as reported in the NCQA Quality COMPASS National Average for both years.

Provider Satisfaction Survey

The annual provider satisfaction survey, “2012 Provider Access, Availability and Provider Satisfaction Comprehensive Analysis – Medi-Cal and Healthy Families HMO Programs,” included an analysis for both primary and specialty care appointment access. Results were based on 452 primary care physicians, which represent approximately 10% of the Plan’s primary care population, but more than 70% of the total membership of the Medi-Cal program. Survey results for primary care access to appointments were as follows:

Primary Care Physician Appointment Type	% Compliant
Urgent (within 24 hours)	94.8%
Non Urgent Sick (within 48 to 72 hours)	75%
Preventive Care under 21 years (within 14 days)	84.1%
Preventive Care over 21 years (within 14 days)	85.8%
Prenatal (within 7 days)	74.5%
Wait Time (15 minutes)	66.7%
Triage [return phone call during business hours] (≤30 minutes)	77.9%
Overall	80.1%

The Plan’s performance goal for each type of appointment availability listed above was 95%. However, the Plan’s overall compliance was 80.1%, which is 14.9% below the Plan’s goal.

The Plan also surveyed 116 randomly selected specialty care providers to assess the availability of non-urgent appointments within 15 business days of the request. The results were as follows:

Specialty	% Compliant
Allergy & Immunology	100.0%
Cardiovascular Disease	73.9%
Gastroenterology	69.2%
Neurology	87.5%
Ophthalmology	80.6%
Orthopedic Surgery	92.9%
Otolaryngology	80.0%
Pulmonary Disease	75.0%
Overall	80.2%

Overall compliance related to specialty appointments was 80.2%, which was a 38% increase in compliance from the 2011 survey. Results for gastroenterology were particularly low with 69.2% compliance with appointment availability, and only 30.8% compliance with in office wait time.

The Plan's policy, "Access to Care Standards," states:

If a provider is deemed non-compliant, Anthem will notify the provider in writing of their noncompliant status, and provide corrective action information. Follow-up surveys include noncompliant providers to ensure providers on a corrective action plan are following the established standards. Providers that continue to remain non-compliant maybe subject to additional corrective actions with the possibility of termination as set forth in their Anthem Participating Provider Agreement.

In light of the survey results for the both the member satisfaction (CAHPS) and provider satisfaction surveys, the Department requested the Plan to provide documentation of any corrective actions that had been taken with providers who did not meet the Plan's timely access requirements. To the credit of the Plan, it provided documentation of a corrective action plan implemented for a physician whom the Plan identified as having numerous appointment availability related grievances. However, no documentation of any provider notifications or corrective action efforts were submitted as a result of the provider satisfaction survey findings. In response to the Department's concerns, the Plan provided the following written response regarding future actions that would be taken to ensure provider compliance with appointment access standards:

Policy #CA_PNXX_033 (III. Monitoring Access to Care) will be amended to include detailed procedures on how the plan will use the access and availability provider survey data not meeting performance standards. Below are procedures under consideration for our action plan:

1. Providers with deficiencies will be contacted (within a certain timeframe after survey results are available) to substantiate deficiencies and document corrective action if necessary.
2. Providers with substantiated deficiencies will be re-surveyed after a certain timeframe from initial contact to verify corrective action.
3. A defined incremental enforcement procedure will be followed for providers with repeat deficiencies.
4. Broaden the distribution of the survey results to several leadership positions in each Regional Health Plan.
5. A recurring educational webinar offered to providers on these standards.
6. A tracking database implemented to document and track outreach efforts, findings, re-surveys, webinar attendance, and providers with repeat deficiencies.

Rule 1300.67.2.2(d)(3) requires the Plan to “implement prompt investigation and corrective action when compliance monitoring discloses that the Plan’s provider network is not sufficient to ensure timely access as required by this section, including but not limited to, taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies.” DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 9, Access and Availability, Provision 4 – Access Standards also requires compliance with this Rule. Although the Plan conducts annual surveys to assess both provider and member satisfaction with timely access standards, the Plan does not implement a procedure for prompt investigation and corrective action when problems are identified. Therefore, the Department finds the Plan in violation these regulatory and contractual requirements.

Potential Deficiency #3: The Plan’s provider directory does not, at minimum, display the level of access available at each provider site as either “Basic Access” or “Limited Access” for provider sites that service a high volume of SPDs where a Physical Accessibility Review was conducted.

Statutory/Regulatory/Contract References: DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 10(A) – Site Review; DHCS MMCD Policy Letter 12-006; and DHCS MMCD Policy Letter 11-009.

DHCS GMC Contract, Exhibit A, Attachment 4 – Quality Improvement System

10. Site Review

A. General Requirement

Contractor shall conduct Facility Site and Medical Record reviews on all Primary Care Provider sites in accordance with the Site Review Policy Letter, MMCD Policy Letter 02-02 and Title 22, CCR, Section 53856. Contractor shall also conduct Facility Site Physical Accessibility reviews on Primary Care Provider sites, and all provider sites which serve a high volume of SPD beneficiaries, in accordance with the Site Review Policy Letter, MMCD Policy Letter 10-016 and W & I Code 14182(b)(9).

DHCS MMCD Policy Letter 12-006 states, in pertinent part, “Plans are to make the results of FSR Attachment C available to members through their websites and provider directories. The information provided must, at a minimum, display the level of access results met per provider site as either *Basic Access or Limited Access*. Additionally, Plans must indicate whether the site has Medical Equipment Access as defined in the FSR Attachment C and identify whether each provider site has or does not have access in the following categories: parking, building exterior, building interior, exam room, restroom and medical equipment (height adjustable exam table and patient accessible weight scales).” [Emphasis added].

DHCS MMCD Policy Letter 11-009 establishes policy and guidelines for use of standardized physical accessibility indicators in all provider directories to assist SPDs in locating physically accessible provider sites.

Supporting Documentation: The Department requested and reviewed the following documentation:

- Provider Directory on the Plan’s website
- Provider Directory (hardcopy)

Assessment: Review of the Plan’s Provider Directory, online and a hardcopy, demonstrates that a description of specific accessibility indicators (parking, building exterior, building interior, restroom, exam room, and medical equipment) are provided for each site that has undergone Attachment C of the Facility Site Review. The use of a legend with corresponding codes (P, EB, IB, R, E, T) is explained in the introductory section of the directory. However, there is no indication of whether each site meets the minimum standards for either “Basic Access” or “Limited Access” as required in Policy Letter 12-006.

DHCS Two-Plan and GMC Contract, Exhibit A, Attachment, Quality Improvement System, Provision 10(A) – Site Review requires the Plan to conduct Facility Site Physical Accessibility reviews on primary care provider sites, and all provider sites which serve a high volume of SPDs. DHCS MMCD Policy Letter 12-006 requires the Plan to make the results of FSR Attachment C available to members through their websites and provider directories by, at a minimum, displaying the level of access results met as either Basic Access or Limited Access. Although the Plan provides a specific description of accessibility indicators, the minimum requirement of either “Basic Access” or “Limited Access” is not displayed. Therefore, the Department finds the Plan in violation contractual requirements.

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

Potential Deficiency #4: The Plan does not establish and maintain a grievance system that consistently ensures:

- **adequate consideration and rectification of enrollee grievances; and**
- **written acknowledgment and response for grievances not resolved by close of the next business day.**

Statutory/Regulatory/Contract References: Section 1368(a)(1); Rule 1300.68(d)(8); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1 – Member Grievance System.

Section 1368(a)(1) states, in pertinent part, that the Plan’s grievance system “shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.”

Rule 1300.68(d)(8) states, in pertinent part, “Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The Plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of the resolution, and the plan’s representative’s name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in Subsection (b).”

DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14 – Member Grievance System

1. Member Grievance System

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

Supporting Documentation: The Department requested and reviewed the following documentation:

- 29 standard grievances/appeals files (September 1, 2012 through August 31, 2013)
- 29 exempt (one-day) grievance files (September 1, 2012 through August 31, 2013)
- Exempt Grievance Log consisting of 69 randomly selected exempt grievances (September 1, 2012 through August 31, 2013)
- Policy #CA_GAMC_015 – Grievance Process: Members (3/27/13)
- Policy (no number assigned) – Member Grievance and Complaint Escalation Process (implementation date TBD)

Assessment: To evaluate the Plan's handling of members' grievances, the Department randomly selected and reviewed a sample of 29 standard grievances/appeals files and 29 exempt (one-day) grievances files. The Department concluded that the Plan does not have reasonable procedures in place to ensure adequate consideration and rectification of grievances. Furthermore, grievances that are incorrectly identified as exempt because they are not resolved by the close of the next business day, do not receive the required written acknowledgment and resolution letters.

Inadequate Consideration and Rectification of Grievances

Four of 29 standard grievances/appeals files (14%) did not contain documentation to substantiate that members' complaints were fully addressed by the Plan. This practice was more prevalent among exempt grievances, where 14 of 29 files (48%) showed evidence that members' grievances were not fully addressed.⁸ For example, eight exempt grievances involved requests for a change of primary care provider. Although the Plan resolved the grievance to the member's satisfaction by initiating the provider transfer, there was no evidence to show that the underlying cause of the complaint had been investigated. For example:

- *File #18:* The member complained that several Plan providers in Contra Costa County were not accepting new patients, further indicating that she did not wish to go to a clinic for her care. The Plan offered the member the option of seeing several other providers in the service area, thereby resolving the complaint. However, there was no evidence that the Plan had investigated the member's report of access issues regarding PCP availability for those providers that the member had initially contacted.

⁸ See TABLE 2: Standard and Exempt Enrollee Grievances.

- *File #3:* The member called to complain about a provider’s office that placed him on hold on the telephone for too long, resulting in him becoming involuntarily disconnected. The member subsequently called back and got no answer after several rings. The Plan offered a change of provider, which the member declined. There is no evidence in the file that the Plan investigated the specific telephone access issues raised by the member or that the Plan researched whether other members had voiced similar concerns.
- *File #16:* The member injured a foot and scheduled an appointment, which the provider’s office repeatedly cancelled and rescheduled. The member finally showed up as a walk-in and waited five hours to be seen by the provider. The Plan handled the complaint as an exempt grievance and assigned the member to a new provider. However, there was no evidence that the Plan investigated the access issue raised by the member.

TABLE 2
Standard and Exempt Enrollee Grievances

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Grievances/Appeals	29	Adequate consideration and rectification of enrollee grievances	25 (86%)	4 (14%)
Exempt Grievances	29	Adequate consideration and rectification of enrollee grievances	15 (52%)	14 (48%)

Exempt Grievances not Resolved by the Close of the Next Business Day

To perform an assessment of the Plan’s processing of exempt grievances, the Department randomly selected 69 grievances identified by the Plan as “exempt,” meaning they were resolved within one business day and were therefore exempt from the standard requirement of providing written acknowledgment and resolution to members. A cursory examination of grievance receipt and closure dates in the exempt grievance log revealed that 14 of 69 cases (20%) were not resolved by the close of the following business day.⁹ Of the 69 exempt grievances in the log, the Department reviewed 29 files in depth. Eight of 29 cases (28%) were not resolved by the close of the following business day. For example:

- *File #24:* The member contacted the Plan on June 3, 2013 to complain about his primary care physician. The case was closed on June 7, 2013 (three business days later). The issue was not resolved by the next business day and subsequently

⁹ See TABLE 3: Exempt Grievances.

handled as a standard grievance. A written acknowledgment or resolution letter of the grievance was not sent to the member.

- *File #26:* The member contacted the Plan on February 13, 2013 to inquire on the status of an appeal that had been pending for over 45 days. The case was closed on February 22, 2013 (five business days later). The issue was not resolved by the next business day and subsequently handled as a standard grievance. A written acknowledgment or resolution letter of the grievance was not sent to the member.

In interviews, Plan staff indicated that Customer Care Associates (CCA) are responsible for the initial intake of all telephone grievances received in the Customer Care Center (CCC). Rather than consistently forwarding grievances that cannot be resolved by the end of the next business day to the Grievances and Appeals Department for standard processing, some CCAs will hold onto the grievance and continue to work the case, in a good faith attempt to provide the member with assistance. However, Plan staff conceded that these grievances then do not receive the appropriate notification, investigation, and handling that would be required for standard grievances. In an attempt to remedy this, the Plan recently developed a new policy, “Member Grievance and Complaint Escalation Process,” which requires CCAs to forward unresolved grievances to the Grievance and Appeals Department. However, staff training in preparation for implementation of the policy has yet to be conducted.

TABLE 3
Exempt Grievances

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Exempt Grievances	69	Resolution by the close of the next business day	55 (80%)	14 (20%)

Section 1368(a)(1) requires the Plan to implement reasonable procedures to ensure adequate consideration and rectification of enrollee grievances. Rule 1300.68(d)(8) requires the Plan to send written acknowledgment and response for all grievances other than for those received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day. DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System – Member Grievance System requires the Plan to comply with this Rule. Review of enrollee grievances revealed that the Plan does not consistently ensure adequate consideration of grievances (14% non-compliance rate for standard grievances; 48% non-compliance rate for exempt grievances). Although this practice was more prevalent among exempt grievances, CCAs responsible for the processing of “one-day grievances” will conversely hold onto other grievances and continue to work the case even if it cannot be resolved by the end of the next business day, in a good faith attempt to assist the member. However, because these grievances are not consistently forwarded on to the Grievances and Appeals Department, they do not receive appropriate notification, investigation, and handling. Therefore, the Department finds the Plan in violation of these statutory, regulatory, and contractual requirements.

Potential Deficiency #5: The Plan’s responses to grievances involving a determination that the requested service is not a covered benefit do not consistently specify the provision in the contract, evidence of coverage, or member handbook that excludes the service.

Statutory/Regulatory/Contract References: Section 1368(a)(5); Rule 1300.68(d)(5); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1 – Member Grievance System.

Section 1368 (a)(5) states, in pertinent part, “If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, *the decision shall clearly specify the provisions in the contract that exclude that coverage.*” [Emphasis added].

Rule 1300.68 (d)(5) states, in pertinent part, “Plan responses to grievances involving a determination that the requested service is not a covered benefit shall *specify the provision in the contract, evidence of coverage or member handbook that excludes the service.* The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee.” [Emphasis added.]

DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14 – Member Grievance System

1. Member Grievance System

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member’s health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

Supporting Documentation: The Department requested and reviewed the following documentation:

- 29 standard grievances/appeals files (September 1, 2012 through August 31, 2013)

Assessment: The Department randomly selected and reviewed a sample of 29 standard grievances/appeals files. Two of the 29 files included requests for benefits that were not covered by the member’s specific plan design. In each of these two cases, the Plan explained the reason for the denial for the requested services, but failed to specify the provision in the contract, evidence of coverage, or member handbook that excludes the service. For example:

- *File #2:* The member knowingly used an out-of-network provider without securing prior approval from the Plan, even though the Plan’s network of providers included availability of the same specialty services. The Plan’s resolution letter advised

the member that coverage was denied because the provider was not part of the Plan's network; however, the specific contractual provision on which the denial was based was not cited.

- *File #20:* The member requested coverage for the medication, Viagra, a drug not included in the Plan's formulary. The Plan's resolution letter advised the member that coverage was denied because Viagra was not a benefit under the member's plan; however, the specific contractual provision on which the denial was based was not cited.

Section 1368(a)(5) requires the Plan's responses to grievances involving a determination that the requested service is not a covered benefit specify the provision in the contract, evidence of coverage, or member handbook that excludes the service. Rule 1300.68(d)(5) further specifies that the Plan either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System – Member Grievance System requires the Plan to comply with this Rule. In review of the grievance files, the Department found two files that included requests for services not covered by the Plan. In these cases, the Plan explained the reason for the denial of the requested service, but the resolution letter did not specify the provision in the contract, evidence of coverage, or member handbook that excluded the service. Therefore, the Department finds the Plan in violation of these statutory, regulatory, and contractual requirements.

Potential Deficiency #6: The Plan does not immediately inform members of the right to contact the Department when filing grievances requiring expedited review.

Statutory/Regulatory/Contract References: Section 1368.01(b); Rule 1300.68.01(a)(1); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1 – Member Grievance System.

Section 1368.01(b) states, in pertinent part, "When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance."

Rule 1300.68.01(a)(1) states, in pertinent part, "Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include: (1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call."

DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14 – Member Grievance System

1. Member Grievance System

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

Supporting Documentation: The Department requested and reviewed the following documentation:

- 4 expedited appeals files (September 1, 2012 through August 31, 2013)
- Policy #CA_GAMC_015 – Grievance Process: Members (3/27/13)
- Policy #CA_GAMC_051 – Appeals Member (12/17/12)

Assessment: Review of Plan policies indicate that the Plan has procedures in place to notify members of their right to contact the Department in the event of filing expedited grievances or appeals. For example:

The Plan's policy, "Grievance Process: Members," states:

Expedited grievances are acknowledged immediately telephonically, if possible. At this time they are informed of the limited amount of time available to present evidence. *The member is also immediately notified of the right to contact DMHC regarding their grievance*, without participating in the plan's grievance process prior to applying to the DMHC for review of an urgent grievance. In addition a written acknowledgement is sent to the member and DMHC. [Emphasis added.]

The Plan's policy, "Appeals Member," similarly states,

If the Medical Director determines the request is for medical care or treatment in which the application of the time period for making a standard determination would be detrimental to the member, the G&A associate[:]

- Immediately notifies the member by telephone, if possible, that the request was received. *The member is also notified of the right to contact the DMHC regarding their appeal* without participating in Anthem Blue Cross Medicaid's appeal process prior to applying to DMHC for review of an expedited appeal. [Emphasis added.]

The Plan identified four expedited appeals processed during the survey review period. The Department reviewed all four cases and discovered that in all four cases, the Plan did not

“immediately” inform members of the right to contact the Department regarding the filing of the urgent grievance.¹⁰ Although the Plan sent letters to the members acknowledging receipt of the urgent grievance, and the letters provided the statement required under Section 1368.02(b), the letters were sent via U.S. Postal Service, which generally requires two to three days for delivery. There was no documented phone call to substantiate that the member had been immediately notified by the Plan of the right to contact the Department. In interviews, Plan staff acknowledged that such a practice did not exist.

TABLE 4
Expedited Grievances

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Expedited Grievances	4	Members are immediately informed of the right to notify the Department of the grievance	0 (0%)	4 (100%)

Section 1368.01(b) and Rule 1300.68.01(a) require the Plan to provide members with immediate notification of the right to contact the Department regarding the filing of an expedited or urgent grievance. DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1 – Member Grievance System requires the Plan to comply with this Rule. Because the Plan did not immediately advise members who filed expedited grievances of their right to contact the Department (100% non-compliance rate), the Department finds the Plan in violation of these statutory, regulatory, and contractual requirements.

Potential Deficiency #7: The Plan does not ensure that written member information materials, including notices pertaining to enrollee grievances, are translated into identified threshold languages.

Statutory/Regulatory/Contract References: Rule 1300.68(b)(3); DHCS Two-Plan Contract, Exhibit A, Attachment 9, Access and Availability, Provisions 14(B)(2) – Linguistic Services; and DHCS GMC Contract, Exhibit A, Attachment 9, Access and Availability, Provision 14(C)(2) – Linguistic Services.

Rule 1300.68(b)(3) states, in pertinent part, “The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access

¹⁰ See TABLE 4: Expedited Grievances.

to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.”

DHCS Two-Plan Contract, Exhibit A, Attachment 9 – Access and Availability

14. Linguistic Services

B. Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential members:

2) *Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters.* Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor’s Service Area, and by the Contractor in its group needs assessment. [Emphasis added.]

Supporting Documentation: The Department requested and reviewed the following documentation:

- Policy #CA_GAMC_015 – Grievance Process: Members (3/27/13)
- Language Assistance Program Quick Reference Guide (December 17, 2008)
- Plan’s Contract with CyraCom for over the phone interpretation services
- Notification cover letter to all member correspondence stating, “We can translate this at no cost. Call the Customer Service number on your ID card.”
- Member Services Guide – Evidence of Coverage (effective July 2012)
- 10 Cultural & Linguistics related grievances (September 1, 2012 through August 31, 2013)
- 29 standard grievances/appeals files (September 1, 2012 through August 31, 2013)

Assessment: Review of Plan policies and documents indicate that the Plan has a comprehensive Language Assistance Program (LAP) that serves the cultural and linguistic needs of members. The Plan contracts with several external vendors for the provision of translation and interpretation services, maintains clear policies and procedures for assisting members with accessing translation and interpretation services, and has certified bilingual staff in English and Spanish, as needed. The Plan also advises members regarding availability of telephone relay services or other communicative devices.

The Plan has vital documents translated in the following seven threshold languages: Arabic, Chinese, Hmong, Khmer, Russian, Spanish, and Vietnamese. When sending correspondence to its members, the Plan includes a cover letter with the following statement written in English and eleven other languages: “We can translate this at no cost. Call the Customer Service number on your ID card.” In addition to standard member informing materials, the templates for the grievance letters are translated as well.

To validate the effectiveness of the Plan’s LAP program, and also to gauge the nature of potential member complaints involving difficulties with accessing cultural and linguistic (C&L) services, the Department requested that the Plan pull all C&L related grievances for the survey

review period. The Plan identified 13 C&L grievances for its SPD members, and the Department reviewed ten of them. Review of these ten files did not reveal any barriers for accessing translation or interpretation services. Rather, the grievances were more so related to general complaints of discrimination due to a variety of reasons. However, for one case in particular, the Department noted that the grievance resolution letter was written in English even though the member's language preference was Chinese. For example:

- *File #8:* The member filed a complaint about the rude treatment by her physician and the office assistant towards non-English speaking members and wanted to switch her primary care physician. The Plan's resolution letter was written in a combination of both English and Chinese, with the template language written in Chinese. However, the most critical component of the letter, the resolution itself, was written in English and stated:

This is in regards to the unsatisfactory interaction you encountered at [your doctor's] office. In the grievance it was indicated [the doctor] and her office staff is rude to 'non-English' patients.

We contacted [the doctor's] office and spoke to [the assistant]; we informed him of your concerns regarding the [doctor] and office staff behavior. [The assistant] advised there was an unsatisfactory interaction during your office visit on January 26, 2013. [The assistant] would not comment on the interaction but did state [the doctor] would prefer for you to seek a different primary care provider (PCP).

System research you have been assigned to [a new doctor] as your new PCP effective February 1, 2013. You may contact [the new PCP] at [telephone number] to request an appointment to prevent any delays in treating your health.

The case file noted that the member's language preference was Chinese, which is identified as one of the Plan's seven threshold languages. Although file review indicated that additional correspondences to the member, including the acknowledgment letter and other attachments to the resolution letter (information related to State Fair Hearing rights, Department contacts, and County Consumer hot lines) were provided in Chinese, the most essential component of the grievance resolution letter was not translated in the threshold language as required.

The Department's review of 29 standard grievances/appeals files produced three cases where the member's language preference was identified as one of the Plan's threshold languages. However, in two of these cases, the grievance resolution letters included the similar scenario as described above where the standard template was translated in the threshold language, but the case resolution details were not.

In interviews, Plan staff acknowledged that if the member has an identified language preference other than English or Spanish, only the grievance template is translated into the threshold language, while the case resolution details remain in English. Currently, the Plan will initiate contact with the contracted vendor only if the member requests the contents of the letter to be translated. Beginning 2014, staff indicated that they anticipate more immediate access to the full translation of letters with implementation of its new information system (MAGI).

Rule 1300.68(b)(3) requires the Plan's grievance system to address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. Assistance includes translation of grievance procedures, forms, and plan responses to grievances. DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 9, Access and Availability, Provisions 14(B)(2) or 14(C)(2) – Linguistic Services, requires fully translated written informing materials, including but not limited to grievance acknowledgement and resolution letters. For all monolingual or LEP Members that speak identified threshold or concentration standard languages, the Plan is required to provide translated written informing materials. In the Department's evaluation of the Plan's grievance resolution letters for members who speak identified threshold languages, although the letter template and attachments were fully translated, the case resolution details were not. However, the case resolution details are most relevant in that they provide the member with an understanding of whether or not the grievance was resolved to his/her satisfaction. Therefore, the Department finds the Plan in violation of these regulatory and contractual requirements.

Potential Deficiency #8: The officer of the Plan who is designated as having primary responsibility for the grievance system does not continuously monitor and review the operation of the system to identify emerging patterns for quality improvement.

Statutory/Regulatory/Contract References: Rule 1300.68(b)(1); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provisions 1 – Member Grievance System, and 2(C) –Grievance System Oversight.

Rule 1300.68(b)(1) states, "An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures."

DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14 – Member Grievance System
1. Member Grievance System

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.

C. Procedure for systematic aggregation and analysis of the grievance data and use for Quality Improvement.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Plan Organization Chart (undated)
- Medicaid G&A Team Organizational Chart (undated)
- 29 standard grievances/appeals files (September 1, 2012 through August 31, 2013)
- 29 exempt (one-day) grievance files (September 1, 2012 through August 31, 2013)
- Policy #CA_GAMC_015 – Grievance Process: Members (3/27/13)
- Policy (no number assigned) – Member Grievance and Complaint Escalation Process (implementation date TBD)

Assessment: Review of Plan organization charts indicate that the Staff Vice President of Medicaid Revenue Management is responsible for heading the Grievance and Appeals Department, as well as overseeing the Customer Care Center (CCC). Individual department directors for both departments are responsible for day-to-day operations within their own section, however, both report to the Staff Vice President. Despite the shared leadership of an integral system that relies on Customer Care Associates (CCA) to process the intake of all grievances, retain exempt grievances for handling, and forward standard grievances onto the Grievance and Appeals Department, the two operational units have limited effective interaction. The Department conducted file review of both standard grievances (handled by the Grievances and Appeals Department) and exempt grievances (handled by the CCC). This review revealed that member complaints are not always adequately investigated and resolved in either unit (see Potential Deficiency #4). In addition, some customer service associates in the CCC routinely hold onto exempt grievances beyond the one business day requirement and continue to work cases, rather than forwarding it onto the Grievance and Appeals Department for appropriate standard notification and handling.

The Plan routinely tracks and trend grievances as well as run reports. However, the inability of the Plan's current structure to identify the concerns presented above indicates a lack of sufficient oversight of the grievance system to effectively identify systematic problems, suggesting a need for staff training, process improvement, and continual program auditing. This absence of effective monitoring and oversight of grievance processes creates a challenge for the Plan's

executive management to make appropriate recommendations for quality improvement because systemic problems are not being identified.

In addition, the Plan's policy, "Grievance Process: Members," provides provisions for monitoring oversight and states:

Anthem Blue Cross Medicaid's G&A Department will perform semi-annual internal audits of the grievance files and SFH files to ascertain their compliance with all regulatory and accrediting requirements as relates to the Grievance and Appeals process. Audit requirement expectations and educational resources will be communicated and provided to the staff by the G&A Department. Audit performance data will be analyzed and outliers/problems identified for corrective action by the G&A Department. Audit results will be reported regularly to the applicable quality committee for oversight, recommendations and corrective action as needed.

However, in an interview with the Plan's Director of Grievances and Appeals, she indicated that the audit program was not implemented due to staffing and budget constraints.

Rule 1300.68(b)(1) requires an officer of the plan to have primary responsibility for the Plan's grievance system and continuously review operations to identify any emergent patterns of grievances. DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1 – Member Grievance System, requires compliance with this rule. DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 2 – Grievance System Oversight, requires the analysis of grievance data for quality improvement. Although the Plan's Staff Vice President of Medicaid Revenue Management is responsible for heading both the Grievance and Appeals Department, as well as overseeing the Customer Care Center (CCC), the two operational units have limited effective interaction. As a result, the Department discovered that some customer service associates in the CCC routinely hold onto exempt grievances beyond the one business day requirement and continue to work cases, rather than forwarding them onto the Grievance and Appeals Department for appropriate standard notification and handling. In addition, file review of both standard grievances (handled by the Grievances and Appeals Department), and exempt grievances (handled by the CCC), revealed that member complaints are not always adequately investigated and resolved in either unit (see Deficiency #3). The inability of the Plan's current structure to identify these concerns suggests a lack of sufficient oversight of the grievance system to effectively identify systematic problems so that appropriate recommendations for quality improvement can be made. Therefore, the Department finds the Plan in violation of these regulatory and contractual requirements.

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 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 Deficiency #9: The Plan’s Quality Assurance program does not consistently ensure that problems are identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.

Statutory/Regulatory/Contract References: Rule 1300.70(a)(1); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement.

Rule 1300.70(a)(1) states, “The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.”

DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in 28 CCR 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting...

Supporting Documentation: The Department requested and reviewed the following documentation:

- Policy #US_GAXX_022 – Processing Internal Potential Quality Issues (7/31/13)
- Policy #US_GAXX_021 – Clinical Quality Incident Severity Level Determination (3/27/13)
- Policy #US_QMXX_038 – Second Level Peer Review Process (3/22/13)
- Policy #CA_GAMC_015 – SPD Grievance Process: Members (3/27/13)
- Medicaid Peer Review Committee Severity Level for Clinical Review (2013)
- 34 potential quality issue (PQI)¹¹ files (September 1,2012 through August 31, 2013)

¹¹ Cases, providers, processes or concerns identified through enrollee grievances, sentinel events (e.g., mortalities), data analysis and other sources as having *potential quality issues* that require investigation are often referred to as PQIs.

Assessment: Review of Plan policies indicate that the Plan has processes in place for the identification and investigation of potential quality issues (PQIs). The Plan developed severity levels for classifying PQIs, along with descriptions and associated actions to be taken for each level. In order to evaluate the Plan's handling of PQI files, the Department randomly selected 34 PQI files for review. However, in its review, the Department was unable to confirm that the Plan consistently identifies problems, adequately investigates concerns, assigns appropriate severity levels, and takes effective action when indicated. In 8 of 34 files (24%) reviewed (*File #9, File #1, File #25, File #24, File #15, File #13/ File #14, and File #34*), the Department found evidence of the above concerns.¹² For example:

- *File #9:* The member in this case was a known intravenous drug user and was treated in the hospital for osteomyelitis, an inflammation of the bone caused by infection. The member refused counseling or placement in a skilled nursing facility, stating he had not used drugs for five months yet was still sent home with an external intravenous access in place with no close supervision. This is a significant deviation from the standard level of care. The case was identified as a PQI internally through case management and the Plan's first level reviewer assigned a severity level of "C-0," which denotes "no quality issue found." Therefore, further investigation never occurred. However, according to Plan Policy # US_GAXX_022, this should have been deemed a preventable adverse event (PAE). The incident should have been documented on quality of care summary form and forwarded to the Clinical Entity Compliance & Clinical Investigations Department for tracking and further analysis by the Preventable Adverse Event Review Committee (the body responsible for the final severity level determination). In addition, this case should have been referred to the Potential Quality Issue Committee for further action. In an interview with Plan staff regarding this case, the Medical Director and Vice President of Quality Management could offer no explanation or documentation to substantiate the "C-0" severity level misclassification.
- *File #13/ File #14:* Two separate PQI cases were internally referred and opened for this single incident involving both medication and delay in care issues. The member contacted the Plan on August 23, 2012 to report a change of mailing address and provide the Plan with a new mailing address. The member called again shortly thereafter to verify that the address change had been made. The member's medications were shipped on August 29, 2012 (six days after member had verified the address change), but were delivered to the old address. The Plan's representative reordered the medications and shipped them on September 9, 2012 and they were delivered on September 11, 2012. The member was found deceased on September 12, 2012. The case was assigned a severity level of "C-4" to denote "a clinical issue that would be judged by a prudent professional to be mildly beneath the acceptable standards of care." Events in this category reflect care that is minimally outside the acceptable practice standards, and the associated action to be undertaken would be a recommendation sent to the practitioner to preclude similar care incidents from occurring.

¹² See TABLE 5: Potential Quality Issues.

However, the Department could find no documentation in the file to substantiate that an investigation or follow-up attempt was made by the Plan to determine why the medications were sent to the old address, despite the member's proactive notification of an address change, and subsequent verification that the change had been processed. Further, there was no final determination on whether or not the delay in delivery of medications contributed to the member's death. Had the Plan thoroughly investigated the case, this PQI file could have potentially triggered discovery of systemic problems. Specifically, the Plan's system for processing address changes and coordinating with various other operational units (including pharmacy benefit management) directly impacts the delivery of timely vital health care services to its members.

- *File #24:* This case involved a member who was seen in the emergency room following a motorcycle accident. The emergency room physician instructed the member to see his primary care physician for a possible referral to an orthopedic surgeon. The primary care physician saw the member, but refused to issue a referral to an orthopedic surgeon because no records were received from the emergency room. Two months later, the member saw the primary care physician again for a "bump" on his hip. The primary care physician continued to refuse to refer the member to the specialist because the medical records still had not been received. The member was upset and left the provider's office before he could be seen by the primary care physician. However, the PQI file showed no evidence that the primary care physician had requested the member's medical records, although standard practice would be for a provider seeing a patient following an emergency room visit to initiate the request, if the emergency room failed to send them. The file further contained no documented follow-up to show that the Plan had investigated why the emergency room records were never sent by the hospital to begin with.

Deviation from professional standards in this case resulted in lack care coordination and continuity of care, thereby potentially affecting the quality of care for this member. The Plan's reviewer assigned this case a severity level of "C-2" to denote "a communication, administrative, or documentation issue that adversely affected the care rendered to a patient/member." The appropriate follow-up action for this level states, "A recommendation for improvement measure(s) *may be* submitted to the practitioner." [Emphasis added.] However, there was no evidence that the Plan had sent a recommendation to the practitioner. Further, the level assigned to this case does not correspond to the severity of the case. While it is unknown whether the lack of referral to an orthopedic surgeon adversely affected the member's health, the offending provider should have at least been sent notification and education (an action required of severity level C-5) so that similar incidents do not occur in the future.

The remaining four PQI cases similarly demonstrated the recurring concerns described above regarding inappropriate severity leveling of identified problems, inadequate investigation that could lead to the discovery of potential systemic problems, or lack of effective corrective action taken when indicated.

TABLE 5
Potential Quality Issues (PQIs)

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
PQI files	34	Problems are identified, effective action is taken to improve care, and follow-up is planned when indicated	26 (76%)	8 (24%)

Rule 1300.70(a)(1) and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement, require the Plan to identify problems, take effective action to improve care where deficiencies are identified, and plan follow-up where indicated. While the Plan has established processes in place for the identification and investigation of PQIs, including the development of severity levels for classification and associated actions to be taken for each level, file review revealed that the Plan does not consistently investigate concerns to identify underlying system problems, assign appropriate severity levels, and take effective action when indicated (24% non-compliance rate). Therefore, the Department finds the Plan in violation of these regulatory and contractual requirements.

A P P E N D I X A

APPENDIX A. SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS

Jeanette Fong	Team Lead
Rose Leidl, RN	Utilization Management Surveyor
Ruth Martin, MPH, MBA	Availability and Accessibility of Services Surveyor
Bruce Carlin, MD	Quality Management & Continuity of Care Surveyor
Bernice Young	Member Rights Surveyor

A P P E N D I X B

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED FROM: Anthem Blue Cross SPD	
Cindy Metcho	Regulatory Compliance Manager
Teresa Cortez	Business Change Manager – Compliance
Barsam Kasravi, MD	Medicaid Manager Medical Director
Erin Mills	Staff VP Clinical Compliance and Audit
Margaret Mohoric	VP Quality Management
Heidi Solz	Manager Medical Director
Maureen Prowse, MD	Medical Director
Steven Palmer, MD	Medical Director
Robert Millhouse, MD	Physician Advisor Senior
Deborah Zurawik	Clinical Compliance Manager
Dan Shydler	Director I Medicaid Fields Operations
Andrew Gomes	Program Manager
Celestine Hall	Director Medicaid Care Management
Cindy Bradshaw	Manager II Medical Management
Joyce Adams	Manager II, Medical Management
Shannon Cordova	Clinical Compliance Manager
Anne Reiss	Manager II Medical Management
Marisa Feler	Director Delegation Oversight
Paula Oeland	Clinical Compliance Consultant
Christina Underwood	Director Grievance & Appeals
Lakesha Sylvester	Regulatory Oversight Consultant – G&A
Minga Williams	Program Director – Medicaid Member Services
Harry Mapanda	Manager II Claims
Huong Ly	Call Center Manager
Anabel Munoz	Call Center Manager
Grace Ting	Director Health Services – C&L
Gayle Soucier	Clinical Program Development Consultant – C&L
Cynthia de la Torre	Manager II Health Care Services Program – Health Education
Hector Benitez	Care Management Operations
Paul Pakuckas	Director Network Management
Susan James	Business Consultant Senior
Christina Ciciarelli	Director Business System Implementation – Membership

Derek Miranda	Business Analyst – Membership
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A P P E N D I X C

APPENDIX 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
Standard Grievances/Appeals	29	The Department randomly selected a sample of 66 of the 408 standard grievances and appeals files identified by the Plan during the survey review period.
Exempt (One-Day) Grievances	29	The Department randomly selected a sample of 69 of the 733 exempt grievances identified by the Plan during the survey review period
Cultural and Linguistics Grievances	10	The Department selected all 13 of the C&L grievances identified by the Plan during the survey review period.
Expedited Appeals	4	The Department selected all 4 of the expedited appeals identified by the Plan during the survey review period.
Medical Necessity Denials	20	The Department selected all 20 medical necessity appeals from the 66 randomly selected standard grievances and appeals files from the Department's Standard Grievances/Appeals pull.
PQIs	34	The Department randomly selected a sample of 36 of the 63 PQI files identified by the Plan during the survey review period.