

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**

**MOLINA HEALTHCARE OF CALIFORNIA**

**A FULL SERVICE HEALTH PLAN**

**DATE ISSUED TO DHCS: JANUARY 24, 2014**

**1115 Waiver Survey Report of the SPD Enrollment  
Molina Healthcare of California  
A Full Service Health Plan  
January 24, 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 Department of Managed Health Care (the “Department”) entered into an Inter-Agency Agreement with the DHCS<sup>1</sup> to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California’s strong patient-rights laws. Mandatory enrollment began in June 2011.

On June 21, 2013, Molina Healthcare of California (the “Plan”) was notified that its Medical Survey had commenced and was requested to provide the Department with the necessary pre-on-site data and documentation. The Department’s survey team conducted the onsite portion of the Medical Survey from September 16, 2013, through September 19, 2013.<sup>2</sup>

### SCOPE OF SURVEY

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

#### **I. Utilization Management**

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

#### **II. Continuity of Care**

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

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

<sup>2</sup> 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 June 1, 2012 through May 31, 2013.

**SUMMARY OF FINDINGS**

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

**2013 SURVEY POTENTIAL DEFICIENCIES<sup>3</sup>**

<b>UTILIZATION MANAGEMENT</b>	
<b>#1</b>	<b>The Plan does not have utilization review mechanisms in place that allow for monitoring of its delegates for potential under and over-utilization of services.</b> Rule 1300.70(b)(2)(H); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 5, Utilization Management, Provision 1(F) – Utilization Management Program.
<b>#2</b>	<b>The Plan does not consistently ensure that denial letters include a clear and concise explanation of the reasons for the plan’s decision.</b> Section 1367.01(h)(4); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 5, Utilization Management, Provision 2(D) – Pre-Authorization and Review Procedures; and DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 13, Member Services, Provision 4(C) – Written Member Information.
<b>CONTINUITY OF CARE</b>	
<b>#3</b>	<b>The Plan does not ensure that its primary care providers review the individual health education behavioral assessment tool (IHEBA) at least annually with each member.</b> DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 10, Scope of Services, Provision 8(A)(10) – Services for All Members.
<b>AVAILABILITY &amp; ACCESSIBILITY OF SERVICES</b>	
<b>#4</b>	<b>The Plan does not have a mechanism to ensure that the first prenatal visit for a pregnant member will be available within two weeks of request.</b> Rule 1300.67.2(f); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Access and Availability, Provision 3(B) – Access Requirements.
<b>#5</b>	<b>The Plan does not take appropriate and effective corrective action to ensure that individual physicians and/or provider groups meet appointment availability and after-hours standards.</b> Rule 1300.67.2.2(d)(2)(A); Rule 1300.70(a)(1) and (3); and DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Access and Availability, Provisions 3 – Access Requirements, and 4 – Access Standards.
<b>#6</b>	<b>The Plan does not have sufficient specialists to serve its Medi-Cal members, including its SPD members, in Sacramento County.</b> Rule 1300.67.2 (e); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Access and Availability, Provision 1 – General Requirement.

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

<b>MEMBER RIGHTS</b>	
<b>#7</b>	<p><b>The Plan does not implement and maintain a grievance system that consistently includes:</b></p> <ul style="list-style-type: none"> <li>• <b>an adequate appeals process to ensure that clinical issues are resolved by an identified licensed health care professional who has not participated in any other prior decisions related to the grievance, and that the rationale for the decision is clearly documented; and</b></li> <li>• <b>an adequate intake process to ensure that inquiries and expressions of dissatisfaction are appropriately documented and identified.</b></li> </ul> <p>Section 1367.01(e); Section 1368(a)(1); Rule 1300.68(a)(1); Rule 1300.68(d)(8); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provisions 2(D) and (G)(1)(2)(3) – Grievance System Oversight.</p>
<b>#8</b>	<p><b>The Plan does not ensure that written member-informing materials, including grievance acknowledgment and resolution letters, are translated into identified threshold languages.</b></p> <p>Section 1367.04(b)(1)(B)(iv); Section 1367.04(b)(1)(C)(i); DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 9, Access and Availability, Provision 14 (B)(2) – Linguistic Services; and DHCS Two-Plan Contract and GMC Contract, Exhibit A, Attachment 13, Member Services, Provision 4(C)(1) – Written Member Information.</p>
<b>QUALITY MANAGEMENT</b>	
<b>#9</b>	<p><b>The Plan’s Quality Assurance program does not ensure that effective action is taken to improve care where deficiencies are identified.</b></p> <p>Rule 1300.70(a)(1) and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement.</p>

## **OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES**

**Utilization Management:** The plan contracts with Independent Practice Associations (IPAs) to provide care for its members. There is a comprehensive oversight for each IPA (delegation oversight) including audits that measure each of the metrics monitored.

**Continuity of Care:** The Plan takes appropriate measures to ensure that new SPD enrollees have an initial risk assessment and are provided with an opportunity to continue care with their existing providers when possible.

**Member Rights:** The Plan dedicated significant effort toward ensuring that all educational literature and informational literature sent to enrollees is available in all threshold languages. The Plan's Cultural and Linguistics Department contracted with an external vendor for such translation services. This vendor not only translates requested documents, handbooks, EOCs, etc., it also puts each document through several over-reads by staff other than the initial translator to ensure that the translation is accurate. Each final translated document is sent to the Plan with an attestation to its accuracy.

**Quality Management:** The Plan tracks several SPD-specific measures, which it reviews through the Quality Management committee.

## 2013 MOLINA HEALTHCARE 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 does not have utilization review mechanisms in place that allow for monitoring of its delegates for potential under and over-utilization of services.**

**Statutory/Regulatory/Contract Reference(s):** Rule 1300.70(b)(2)(H); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 5, Utilization Management, Provision 1(F) – Utilization Management Program.

Rule 1300.70(b)(2)(H) states that “A plan that has capitation or risk-sharing contracts must:

1. Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the plan shall have systems in place to monitor QA functions.
2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services.”

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

1. Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:
  - F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

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

- 14 utilization management initial denial letters from appeals files that were included as part of the random sample of standard grievances and appeals (for the review period June 1, 2012 through May 31, 2013)
- The Plan’s delegate audit tool

- Audit results from three provider groups, including a corrective action plan and results for one provider group

**Assessment:** The Plan contracts with approximately 27 provider groups that receive capitated payments from the Plan for the provision of both primary and specialty care services. Primary care physicians refer enrollees to specialists within the network and are responsible for tracking specialty referrals. However, the Plan does not obtain or require submission of specialty referral reports from any of the provider groups. Because the Plan cannot track, trend, and analyze data, it does not monitor for potential under-utilization of specialty services.

An interview with the Medical Director and utilization management staff confirmed that the Plan recognizes the possibility of under-utilization of specialty services among contracted provider groups that are capitated. The Plan conducts an audit of each contracted provider group annually; however, the audit tool used does not include elements designed to assess the appropriateness of specialty referrals, completion of those referrals, and whether or not follow-up occurs after completion of a referral.

Further, although the Plan utilizes HEDIS measures and hospital utilization data for monitoring preventive health utilization, these measures do not include the monitoring of specialty referrals, including the length of time needed to access specialists.

Rule 1300.70(b)(2)(H) requires that each plan with capitated providers must have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services. DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 5, Utilization Management, Provision 1(F) – Utilization Management Program further requires the Plan to establish a specialty referral system to track and monitor referrals, including the timeliness of the referrals. Because the Plan does not monitor its delegates to ensure appropriate and timely referrals to specialists, follow-up with appointments, and communication of specialty consultative reports to the primary care physicians, it cannot demonstrate that delegates' quality assurance/utilization management mechanisms are adequate and that specialists are utilized when medically appropriate. Therefore, the Department finds the Plan in violation of these regulatory and contract requirements.

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**Potential Deficiency #2: The Plan does not consistently ensure that denial letters include a clear and concise explanation of the reasons for the plan's decision.**

**Statutory/Regulatory/Contract Reference(s):** Section 1367.01(h)(4); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 5, Utilization Management, Provision 2(D) – Pre-Authorization and Review Procedures; and DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 13, Member Services, Provision 4(C) – Written Member Information.

Section 1367.01(h)(4) states, in pertinent part, "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.”

DHCS Two-Plan 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.

DHCS Two-Plan Contract, Exhibit A, Attachment 13 – Member Services

4. Written Member Information

C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor’s group needs assessment and approved by DHCS. The written Member information shall ensure Members’ understanding of the health plan processes and ensure the Member’s ability to make informed health decisions.

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

- 14 utilization management initial denial letters from appeals files that were included as part of the random sample of standard grievances and appeals (for the review period June 1, 2012 through May 31, 2013)

**Assessment:** The Department reviewed 14 appeals files where the initial denial letters were reviewed. Of the 14 files, nine (64%) initial denial letters were not written in a manner that could be understood by the layperson reader. To the Plan’s credit, 13 of the 14 initial denial letters did cite the medical necessity criteria used in making the determination; however, only technical terminology was used in the description of criteria used and therefore those letters could not be understood by the layperson reader. For example:

- File #12: This case involved a 16 year old girl who was born with cerebral palsy and bulbar (brain stem impairment for cranial nerves) issues. The parent reported that the child had been on *PediaSure* (a nutritional supplement) her entire life because although she has never been able to chew, she could still swallow. The parent requested continuation of the use of *PediaSure*. The request was ultimately partially denied in that only three months of the formula were authorized. The initial denial indicated that the guideline for use requires the presence of a gastrointestinal tube (feeding tube). However, this reason for the denial was not in a language that a lay person could understand, especially given the fact that child had been on *PediaSure* since birth due to her inability to swallow solid foods (without a feeding tube) and such nutrition supplementation may be covered by Medi-Cal or CCS. The Plan failed to consider the predicament and confusion the parents would face due to the denial and offered no other reasonable supplemental alternatives or any other direction to help guide the parent in obtaining the appropriate services for their disabled child, such as a specialty consult with a pediatric gastroenterologist or pediatric nutritionist.

Further, the denial letter also cited the California Code of Regulations, Title 22, Section 14105, but this regulation appears unrelated. Overall, the explanation given to the parents along with the reference used for the denial of the request were not clear.

- File #39: A member has a pulmonary condition and is confined to a wheel chair. She requested a highly specialized “High Frequency Chest Wall Oscillation Air-pulse Generator System.” However, the reason for the denial included highly technical medical terminology that is difficult for a lay reader to understand.

Section 1367.01(h)(4) requires that responses regarding decisions to deny, delay, or modify health care services 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 Contracts, Exhibit A, Attachment 5, Utilization Management, Provision 2(D) – Pre-Authorization and Review Procedures, and DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 13, Member Services, Provision 4(C) – Written Member Information further require that the decision for the denial be clearly documented and all written information be provided to members at a sixth grade reading level or as determined appropriate to ensure members’ understanding of the health plan processes so that informed health decisions can be made. Because the Plan’s initial denial letters were not clear and concise and included technical terminology that could not be understood by the layperson reader, the Department finds the Plan in violation of these statutory and contractual requirements.

#### **CONTINUITY OF CARE**

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

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

**Potential Deficiency #3: The Plan does not ensure that its primary care providers review the individual health education behavioral assessment tool (IHEBA) at least annually with each member.**

**Statutory/Regulatory/Contract Reference(s):** DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 10, Scope of Services, Provision 8(A)(10) – Services for All Members.  
DHCS Two-Plan and GMC Contracts, Exhibit A – Attachment 10 – Scope of Services

8. Services for All Members
  - A. Health Education

- 10) Contractor shall ensure that all new Members complete the individual health education behavioral assessment within 120 calendar days of enrollment as part of the initial health assessment; and that all existing Members complete the individual health education behavioral assessment at their next non-acute care visit. Contractor shall ensure: 1) that primary care providers use the DHCS standardized “Staying Healthy” assessment tools, or alternative approved tools that comply with DHCS approval criteria for the individual health education behavioral assessment; and 2) that the individual health education behavioral assessment tool is: a) administered and reviewed by the primary care provider during an office visit, b) reviewed at least annually by the primary care provider with Members who present for a scheduled visit, and c) re-administered by the primary care provider at the appropriate age-intervals.”

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

- Policy and Procedure QM 10: Initial Health Assessment (IHA) (11/20/12)

**Assessment:** The Plan’s Policy and Procedure, QM 10: Initial Health Assessment (IHA), describes the process for administering the IHA, including the Individual Health Education Behavioral Assessment (IHEBA), which is to accompany the IHA. Regarding criteria for the IHEBA, the policy states,

- The practitioner must review the completed assessment with the member during an office visit; provide interventions for prioritized, identified risks; record intervention codes, dates and initial on the form.
- Re-administer the assessment when the member enters a new age category, annually for adolescents (12-17), and every 3-5 years for adults (18 years and older).

However, the policy does not indicate that the primary care provider will specifically review the assessment at least annually with members who present for a scheduled visit, as required by the DHCS contract.

The DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 10, Scope of Services, Provision 8(A)(10) – Services for All Members requires each plan to ensure that the IHEBA be reviewed at least annually by the primary care provider with members who present for scheduled visits. The Plan has no formal process for oversight of providers’ fulfillment of these responsibilities (e.g., incorporating it into part of the provider site audits). Because the Plan has established no mechanism to ensure that the IHEBA is being reviewed at least annually with members, the Department finds the Plan in violation of this requirement.

## 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 #4: The Plan does not have a mechanism to ensure that the first prenatal visit for a pregnant member will be available within two weeks of request.**

**Statutory/Regulatory/Contract References:** Rule 1300.67.2(f); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Access and Availability, Provision 3(B) – Access Requirements.

Rule 1300.67.2(f) states, “Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.”

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

#### 3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers’ compliance with these requirements.

B. Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

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

- Policy and Procedure QM 09: Access to Health Care (5/15/13)

**Assessment:** The Plan’s Policy and Procedure, QM 09: Access to Health Care, indicates that a member’s first prenatal visit will be made available within less than or equal to five working days of the request. In an interview, the Manager of Quality Improvement Compliance confirmed the Plan’s standard of five working days for the availability of the first prenatal visit. However, she indicated that the Plan does not monitor this. Therefore, the Plan does not have a process in place to monitor whether a pregnant member obtains an appointment within five days (per the Plan’s own policy) or even within two weeks of her request for a first prenatal visit (as required by DHCS).

DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Access and Availability, Provision 3(B) – Access Requirements requires each plan to ensure that the first prenatal visit for a pregnant member will be available within two weeks of the request. Because the Plan does not have a mechanism to monitor timeliness of a pregnant member’s first prenatal visit and cannot

demonstrate that appointments are available within two weeks of the member's request, the Department finds the Plan in violation of this contractual requirement.

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**Potential Deficiency #5: The Plan does not take appropriate and effective corrective action to ensure that individual physicians and/or provider groups meet appointment availability and after-hours standards.**

**Statutory/Regulatory/Contract References:** Rule 1300.67.2.2(d)(2)(A); Rule 1300.70(a)(1) and (3); and DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Access and Availability, Provisions 3 – Access Requirements, and 4 – Access Standards.

Rule 1300.67.2.2(d)(2)(A) states, “Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan’s provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan’s quality assurance program shall address:

(2) Compliance monitoring policies and procedures, filed for the Department’s review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:

(A) Tracking and documenting network capacity and availability with respect to the standards set forth in subsection (c).”

Rule 1300.70(a)(1) and (3) states, “(1) 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. (3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.”

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

3. Access Requirements

Contractor shall establish acceptable accessibility requirement in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers’ compliance with these requirements.

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:

- Policy and Procedure QM 09: Access to Health Care (5/15/13)

- Template letter to groups/individual providers that have not met one or more of the timely access standards and/or one or more of the after-hours telephone standards.
- Template letter to the same groups/individual providers that have not met one or more of the timely access standards and/or one or more of the after-hours telephone standards in the subsequent year.

**Assessment:** The Plan's Policy and Procedure, QM 09: Access to Health Care, describes a process in which the Plan utilizes a vendor to conduct an annual provider appointment and after-hour availability survey on a statistically valid sample size of the primary care physicians and specialists in the network. The survey data is analyzed to assess level of compliance. The policy states,

“...Providers who are identified with noncompliance to timely appointments or after-hour availability standards, as delineated above, will be immediately investigated and corrective action will be implemented as appropriate. The corrective action plan will include evaluation findings, the cause or barriers to the results, and necessary implementation for improvements and compliance to the timely access standards...”

In order to further reinforce the impact and the process outcome of implemented corrective action notification, practitioners and provider offices that failed to meet any of the timely access standards during the evaluation or measurement year will be automatically added onto the subsequent year's survey population, regardless of its valid sampling technique...”

Plan staff stated in interviews that in order to inform physicians of the requirements regarding appointment availability and after-hours standards, it distributes informing materials to provider offices. If it is discovered in the survey that any given provider does not meet some or all of the Timely Access Regulation requirements, the Plan's Quality Improvement staff indicated that a letter is sent to physician's office, advising of the specific standards that were not met and requesting improvements be made. The Plan provided an example of a letter, which stated,

“Please ensure to provide timely access and services to well-child preventive care visit appointments. MHC's wait time standard for well-child preventive care visit appointment is within 7 working days from the request.”

The office would then be routinely included in the subsequent year's survey by default or continued monitoring. If an office still does not meet some or all of the requirements in the subsequent year, the Plan then requires that the office manager sign a statement indicating that corrective actions have been taken. The statement reads,

“This is to verify that the above Practitioner/Provider office has reviewed the Access Standards and Survey and Survey Evaluation records, acknowledged the survey findings and needed improvements and complied to meet Molina's Access Standards.”

However, the Plan does not actually require the provider office to develop a corrective action plan, report on what corrective actions have been taken specifically to remedy the problem, or follow-up on the effectiveness of the corrective actions in regards to ensuring compliance with

appointment access and the after-hours standards. Further, the Plan does not monitor progress or compliance in between the annual surveys to ensure that standards are being met or that the non-compliant office demonstrates sustained improvement.

Rule 1300.67.2.2(d)(2)(A) requires each plan to have policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility and availability to meet wait time standards. Rule 1300.70(a)(1) and (3) further requires each plan to 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. It also specifies that the plan must address service elements such as access and availability of care. DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Access and Availability, Provisions 3 – Access Requirements, and 4 – Access Standards require the Plan to enforce and monitor compliance with access standards and requirements. Because the Plan does not take effective action to ensure that deficient provider offices comply with access standards, it cannot demonstrate that its provider network is sufficient to provide accessibility, availability, and continuity of covered health care services to members. Therefore, the Department finds the Plan in violation of these regulatory and contractual requirements.

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**Potential Deficiency #6: The Plan does not have sufficient specialists to serve its Medi-Cal members, including its SPD members, in Sacramento County.**

**Statutory/Regulatory/Contract References:** Rule 1300.67.2 (e); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Access and Availability, Provision 1 – General Requirement.

Rule 1300.67.2 (e) states, “A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral.”

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

1. General Requirement

...Contractor shall ensure Members access to specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided in accordance with Title 22 CCR Section 53853(a) and consistent with all specified requirements.

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

- Member to Total Physicians Report (Q1/2013)

**Assessment:** The Member to Total Physicians Report (Q1/2013) indicates that the Plan served a combined total of 318,771 enrollees in Los Angeles, Riverside/San Bernardino, Sacramento, and San Diego counties. The report showed that in Sacramento County, where there were 39,143 members, the Plan did not have any of contracts with any of the following specialists: oral surgeons, colorectal surgeons, radiology: therapeutic or geriatricians. In addition, the Plan

contracts with only one of each of the following specialties: dermatology, rheumatology, genetics, and emergency medicine. In interviews, Plan staff stated that intensive recruitment efforts have been underway in an attempt to expand the network. When necessary, the Plan arranges for a member to be seen by an out of network provider.

Rule 1300.67.2 (e) and DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 9, Access and Availability, Provision 1 – General Requirement require that each plan ensure accessibility to medically required specialists. Because the Plan does not ensure accessibility for a number of key specialties in Sacramento County, the Department finds the Plan in violation of these regulatory and 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 #7: The Plan does not implement and maintain a grievance system that consistently includes:**

- **an adequate appeals process to ensure that clinical issues are resolved by an identified licensed health care professional who has not participated in any other prior decisions related to the grievance, and that the rationale for the decision is clearly documented; and**
- **an adequate intake process to ensure that inquiries and expressions of dissatisfaction are appropriately documented and identified.**

**Statutory/Regulatory/Contract References:** Section 1367.01(e); Section 1368(a)(1); Rule 1300.68(a)(1); Rule 1300.68(d)(8); and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provisions 2(D) and (G)(1)(2)(3) – Grievance System Oversight.

Section 1367.01(e) states, in pertinent part, “No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.”

Section 1368(a)(1) states, “Every plan shall do all of the following: (1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each 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(a)(1) states, in pertinent part, “‘Grievance’ means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee’s representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.”

Rule 1300.68(d)(8) states, “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 resolution, and the plan 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

##### 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.

- D. Procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues. To this end, Contractor shall ensure that any grievance involving the appeal of a denial based on lack of Medical Necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues shall be resolved by a health care professional with appropriate clinical expertise in treating the Member’s condition or disease.
- G. Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance and is a health care professional with clinical expertise in treating a Member’s condition or disease if any of the following apply:
- 1) A denial based on lack of medical necessity;
  - 2) A grievance regarding denial of expedited resolutions of an appeal; and
  - 3) Any grievance or appeal involving clinical issues.

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

- Policy and Procedure PO 20: Member Appeals Process (1/28/13)
- 14 appeals files that were included as part of the random sample of 67 standard grievances and appeals files (for the review period June 1, 2012 through May 31, 2013)
- 100 of 504 randomly selected entries from the Plan’s Member Services Call Log from targeted code categories – e.g., access/availability, authorizations/referrals, and member related (for the week of May 20-24, 2013)

**Assessment:** The Department randomly selected 67 standard grievances and appeals files for review. Of those 67 files, 14 appeals files were identified for denials based on lack of medical necessity. All 14 appeals files were reviewed by the Department.

In addition, the Department reviewed a targeted sampling of 100 entries (from targeted code categories) from the Plan's Member Services Call Log to examine the Plan's grievance intake process.

The Department identified the following issues related to both the Plan's Appeals and Member Services Intake processes:

#### Appeals Process

The Plan's Policy and Procedure, PO 20: Member Appeals Process, states, in pertinent part, "The Grievance and Appeals Coordinator forwards the appeal to the Medical Claims Review Coordinator (MCR) for review by a healthcare professional with appropriate clinical expertise in treating the member's condition or disease..."

Although all 14 appeal files documented the "specialty" of the clinical reviewer, the name of specific reviewer was not indicated. Therefore, the person who made the final decision cannot be traced back to any one given clinician. Because of this, the Department was unable to determine whether the final resolution of the appeal was made by someone who had not participated in any prior decisions related to the grievance. Furthermore, all 14 appeal files contained no documentation of the reviewer's basis for the final decision.

When Plan staff were queried regarding the absence of the clinical reviewer's name and documented rationale for his/her decision, they explained that the Plan utilizes a multi-specialty consulting group of approximately 17 physicians from all major specialties. The multi-specialty consulting group reviews all clinical appeals. The Plan indicated that the consultants utilize a review form to document and communicate the rationale behind their decisions. However, when the Department requested copies of the completed forms for each of the 14 appeals, the Plan was unable to produce these forms or provide any other documentation to substantiate that the appeals case had been reviewed by appropriate clinical professionals.

#### Member Services Intake Process

Review of the Plan's grievance log for the one-year survey review period revealed that the Plan did not maintain a log of "one-day" grievances – grievances received over the telephone (that were not coverage disputes, disputed healthcare services involving medical necessity or experimental or investigation treatment) that were resolved by the close of the next business day. Plan staff confirmed in an interview that there were in fact no one-day grievances.

In interviews, Plan representatives indicated that the Member Services Department serves as the entry point for all calls from members. If a call is determined to be an expression of dissatisfaction or grievance, then it is forwarded to the Grievances & Appeal Unit for review. The Department reviewed 100 of 504 entries from the Plan's Member Services Call Log (for a one-week sampling during the review period) to assess whether Member Services staff were able to distinguish a request for information between an expression of dissatisfaction (grievance). However, review of this log revealed inadequate and minimal documentation of calls by member services representatives. Due to lack of detailed information included, the Department was

ultimately unable to clearly ascertain whether the Plan effectively identifies potential grievances (including one-day grievances or grievances involving potential access or clinical concerns). For example:

- Five callers requested a change of primary care providers. Only one call entry included the reason –“personal preference,” making it clear that this did not involve an expression of dissatisfaction. However, because the other four calls did not provide a reason for the change of primary care provider, the Department was unable to determine whether these calls should have been classified as grievances or not (e.g., if the change in provider had to do with quality of care or access issues, etc.) and should have warranted further investigation.

Additionally, the Department found that member services staff may not have handled all member calls in an appropriate manner. The severity of this concern becomes challenging to evaluate because yet again, inadequate documentation by member service representatives makes it difficult to obtain a full understanding of what the call entailed. For example:

- “CALL REASON: Mbr called for urgent care listings; RESOLUTION: Informed member to contact pcp or go to er; CALL CLOSING – SATISFACTION RESPONSE: Mbr satisfied.”

However, it is unclear whether the member was calling in regards to an actual urgent matter and if so, whether that call should have been routed to appropriate clinical staff for review. The call log does not document the reason for the member’s request and it is unclear whether the Member Services Representative inquired further or not.

Section 1367.01(e) and the DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provisions 2(D) and (G)(1)(2)(3) – Grievance System Oversight require that an appeal involving clinical issues be resolved by a health care professional with appropriate clinical expertise in treating the Member’s condition or disease and that that person must not have participated in any prior decisions related to the grievance. Because the Plan’s appeals files fail to include the name of the clinician who was responsible for making the final determination, and there is no documentation of the basis or rationale for the decision, the Department finds the Plan in violation of these statutory and contractual requirements.

Section 1368(a)(1) requires the Plan to provide reasonable procedures to ensure adequate consideration of enrollee grievances and Rule 1300.68(a)(1) further specifies that when the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. Additionally, Rule 1300.68(d)(8) requires that grievances received over the telephone (that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment) that are resolved by the close of the next business day shall be maintained in a log and that this log be reviewed periodically by the Plan. Because the Plan does not maintain adequate documentation in its Member Services Call Log, it cannot demonstrate that it consistently identifies all cases involving an expression of dissatisfaction as grievances to appropriately handle them. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

**Potential Deficiency #8: The Plan does not ensure that written member-informing materials, including grievance acknowledgment and resolution letters, are translated into identified threshold languages.**

**Statutory/Regulatory/Contract References:** Section 1367.04(b)(1)(B)(iv); Section 1367.04(b)(1)(C)(i); DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 9, Access and Availability, Provision 14 (B)(2) – Linguistic Services; and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 13, Member Services, Provision 4(C)(1) – Written Member Information.

Section 1367.04(b)(1)(B)(iv) states, in pertinent part, “Specification of vital documents produced by the plan that are required to be translated... (iv) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal.”

Section 1367.04(b)(1)(C)(i) states, “For those documents described in subparagraph (B) that are not standardized but contain enrollee specific information, health care service plans shall not be required to translate the documents into the threshold languages identified by the needs assessment as required by this subdivision, but rather shall include with the documents a written notice of the availability of interpretation services in the threshold languages identified by the needs assessment as required by this subdivision.”

DHCS Two-Plan and GMC 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.

DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 13 – Member Services

4. Written Member Information

- C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor’s group needs assessment and approved by DHCS. The written Member information shall ensure Members’ understanding of the health plan processes and ensure the Member’s understanding of the health plan processes and ensure the Member’s ability to make informed health decisions.
  - 1) Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, Provision 13, Linguistic Services.

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

- Cultural and Linguistics Program Description (2013)
- Policy and Procedure HE 03: Communications to Members (5/23/13)
- Policy and Procedure PO 19: Member Grievance Process (1/28/13)
- 67 randomly selected standard grievances and appeals (for the review period June 1, 2012 through May 31, 2013), 9 of which the Plan had identified the enrollee's primary language as a language other than English
- Call Tracking Template for the 9 grievance files the Plan had identified the enrollee's primary language as a language other than English (11/1/13)
- Post-Onsite written correspondence with Plan, Request #44 (9/26/13; 10/8/13)

**Assessment:** The Plan's Cultural and Linguistics Program Description indicates that all health education and member informing materials are translated into the following six threshold languages: Arabic, Chinese, Hmong, Russian, Spanish and Vietnamese.

The Plan's Policy and Procedure, HE 03: Communications to Members, defines member "Informing Materials" as follows,

"Informing materials are vital documents that provide members with essential information about access to and usage of Plan services....Vital documents may include...member rights and grievance information..."

The Plan's Policy and Procedure, PO 19: Member Grievance Process, further speaks to the importance of translated documents, but as it pertains directly to the grievance process and states,

"MHC ensures that all members have access to the grievance process by providing assistance for those with limited English proficiency or with a visual or other communication impairment. Such assistance includes, but is not limited to, translations of grievance procedures, forms, and *letters* [emphasis added] ..."

The Department reviewed nine grievance files where the Plan identified the enrollee's primary language as a language other than English (Spanish – 6 files; Arabic – 3 files). However, of the nine files reviewed, only one (11%) contained the acknowledgment and resolution letters in the enrollee's primary language (Arabic). The remaining eight files contained the acknowledgment and resolution letters in only English, although two of the eight files also included a separate insert attachment (translated in the Plan's six threshold languages) that provided guidance on how to receive translation services, if necessary.

In an interview, Plan staff were asked why the insert was included in only two of the files. The Plan's Supervisor of Provider Inquiry indicated that the insert attachment was a relatively new process that the Plan had recently implemented. However, the Department later discovered that these two grievances were actually filed in June and October 2012, respectively, well over one year prior to the survey on-site date.

In an attempt to clarify the Plan's overall process for sending written notification in the enrollee's preferred language, the Department inquired via written correspondence with the Plan following the onsite portion of the survey. The Plan confirmed that they receive member demographic information from a file from the State. However, because this information does not

differentiate a member's "spoken" language from "written" language preference, the Plan does not assume that this is the member's written language preference. Therefore, the Plan will not automatically send written informing materials based on this data. Instead, a further step is taken to clarify the member's written preference at the time of grievance intake. The Plan stated,

"In our current process, when the member files a grievance, the member's written language preference is captured during the grievance intake....Whenever a member files a grievance the Member Services Representative will ask the member what their written language preference is and document that in the grievance template...."

The members referenced in the [nine] cases above did not request written correspondence to be sent to them in another language. The standard protocol during the initial intake of the grievance is to ask the member what their written language preference is...."

However, review of the "Call Tracking Template" for each of the nine files did not substantiate that Member Services Representatives initiate asking about the member's written language preference. Although all files included a screenshot that included the member's primary language as obtained from the state, the files did not consistently document the member's written language preference, as indicated by the Plan's stated process above. For example:

- Only two files contained a separate "LANGUAGE" field for the Member Services Representative to actually input/type information into. Therefore, the Department cannot substantiate that the Plan is asking the member for this information with each grievance intake. Even still, this does not differentiate a member's "spoken" language from "written" preference.
- Only one file (File #57) documented the member's "written" language preference. This was done so in the body of the call text and stated, "Used Arabic Interpreter #661256 to speak with the member. Please send all correspondence in Arabic." This was the only file where the member did actually receive the grievance acknowledgment and resolution letters in his threshold language. (Note: This is inconsistent with the Plan's statement above which indicated that none of the nine members requested written correspondence to be sent in an alternate language).
- For another file (File #37), it was documented that an Arabic interpreter was used during the call. The member's demographic information (Arabic) was indicated in a screenshot. However, the grievance acknowledgement and resolution letters were sent in English, even though there was no documentation indicating that the member had specified a written language preference of English, rather than the threshold language Arabic.

Section 1367.04(b)(1)(B)(iv) requires the translation of vital documents, including notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal. Section 1367.04(b)(1)(C)(i) indicates that for other documents that are not required to be translated, written notice of the availability of interpretation services translated in each of the threshold languages shall be included instead. DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 9, Access and Availability, Provision 14 (B)(2) – Linguistic Services further refines these requirements by specifying the translation of grievance

acknowledgment and resolution letters in identified threshold languages. The Plan receives member identifying demographic data from the State for members. Although the Plan indicated it does not routinely send out grievance notifications in a member's identified threshold language because Member Services Representatives go a step further to clarify the member's written language preference, file review indicated that this is not being done consistently. Therefore, the Department finds the Plan in violation of these statutory 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 to address needed improvements in quality.
- b. Verifying that health plans maintain a system of accountability for quality within the organization.
- c. Verifying that health plans remain ultimately accountable even when Quality Improvement Plan activities have been delegated.

**Potential Deficiency #9: The Plan's Quality Assurance program does not ensure that effective action is taken to improve care where deficiencies are identified.**

**Statutory/Regulatory/Contract Reference(s):** 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:

- Quality Improvement Program Evaluation (2012)
- Utilization Management Program Evaluation Synopsis (2012)
- 14 files that were identified by the Plan for potential quality of care (PQI) issues (for the review period June 1, 2012 through May 31, 2013)
- Quality Improvement Committee Minutes (2012)

**Assessment:** The Plan's 2012 Quality Improvement Program Evaluation includes the Utilization Management Program Evaluation Synopsis report. Beginning on page 52, this synopsis includes a section titled "DHCS Monitor" and indicates that the Plan's acute bed days/K goal is less than or equal to 250. The report includes the following statistics for the past year:

**Goals/Analysis**

Bed days goals ( $\leq 250$ ) for  
Acute Bed days for 1<sup>st</sup> Quarter – 341  
Acute Bed days for 2<sup>nd</sup> Quarter – 325  
Acute Bed days for 3<sup>rd</sup> Quarter – 367.6  
Acute Bed days for 4<sup>th</sup> Quarter – 343.7

Therefore, the actual bed days for each quarter consistently exceeds the goal by almost 100 bed days/K, showing no signs of improvement over the course of the year. The report further states that a high percentage of "catastrophic" cases (18 of 28) were SPD enrollees and that in the 4<sup>th</sup> quarter, "we had several SPD complex members requires [sic] longer Hospital stay."

The report includes the following proposed interventions:

1. Continue twice weekly reviews with Med Dir on all in-patients cases additionally have access to Med Dir to discuss between reviews
2. Continue pro-active discharge planning upon admission and assess readiness for d/c
3. Continue to refer all 3 day or longer stays for WHC's in addition to members identified in rounds.
4. Increase collaboration with PCP's and IPA's to meet all discharge needs

However, for each quarter, the list of interventions was simply a continuation of the same interventions that had demonstrated no proven effectiveness during previous quarters.

Although there were a few cases of unexpected re-admissions in the PQI file review, the number was too small to detect any trends. Review of Quality Improvement Committee minutes did not indicate any systematic approaches or analyses geared towards identifying the underlying cause for over-utilization of high bed days. Further, there was also no analysis of re-admissions within 30 days or identification or discussion of cases where unexpected hospital events may have occurred. Therefore, because the Plan did not have a systematic approach for thoroughly investigating the root cause of the problem, it did not implement a corrective action plan to effectively improve the quality of care issue identified.

Rule 1300.70(a)(1) and DHCS Two-Plan and GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement require that effective action be taken to improve care where deficiencies are identified. Because the Plan identified a significant quality of care issue but conducted no analysis of the root causes to determine and implement effective action to improve the problem identified, the Department finds the Plan in violation these regulatory and contractual requirements.

**A P P E N D I X A**

**APPENDIX A. SURVEY TEAM MEMBERS**

<b>DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS</b>	
Jeanette Fong	Survey Team Lead, (916) 255-3367
<b>MANAGEDHEALTHCARE UNLIMITED, INC. TEAM MEMBERS</b>	
Pamela Simpson, RN	Member Rights Surveyor
Ruth Martin, MBA, MPH	Access and Availability of Services Surveyor
Martin Glasser, MD	Utilization Management Surveyor
Lawrence Ikeda, MD	Quality Management and Continuity of Care Surveyor

**A P P E N D I X B**

**APPENDIX B. PLAN STAFF INTERVIEWED**

**Key Plan officers and staff interviewed during the onsite survey at the Plan:**

Richard Chambers	Plan President
Teri Lauenstein	VP, Plan Chief Operations Officer
James Novello	VP, Government Contracts
Deborah Miller	VP, Healthcare Services
Dr. Richard Bock	Chief Medical Officer
Greg Hamblin	Chief Medical Financial Officer
Katherine Davidson	AVP, Healthcare Services
Jennifer Rasmussen	Director, Care Management
Susan Corvalan	Manager, Healthcare Services
Susan Garvin	Manager, Services Delegation Oversight
Alona Velando	Manager, Healthcare Services
Dr. James Cruz	Medical Director
Jennifer Leung	Director, Pharmacy
Joy Bland	Director, Quality Improvement
Liza Castillo	Manager, Healthcare Services
Shirley Kim	Manager, Quality Improvement Compliance
Erlinda Castillo	Supervisor, Quality Improvement Compliance
Victoria Luong	Director, Molina Institute
Jill McGougan	Cultural & Linguistic Specialist II
Amritha Roser	Health Educator III
Marianne Maciel	Director, Health Management
Alvina Ter-galstanyan	Director, Provider Services
Steve Soto	Regional Director, Provider Contracting
Karyn Appel	Manager, Member Services
Tamara Gates	Director, Provider Member Network Ops
Adriana Gutierrez	Manager, Provider Member Inquiry
Steven Haggard	Supervisor, Provider Inquiry
Hilario Wilson	Director, Member Services
Veronica Rodriguez	Supervisor, Member Services
Neeta Alengadan	Supervisor, Member Services
Yasamin Hafid	Director, Compliance
Michelle Miranda	Compliance Specialist

Pam Gordon	Compliance Specialist
Michael Grimpo	Compliance Analyst
Ashley Williams	Compliance Coordinator
Keri Premmer	Compliance Specialist
Janette Glaspie	Compliance Specialist

**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.*

<b>Type of Case Files Reviewed</b>	<b>Sample Size (Number of Files Reviewed)</b>	<b>Explanation</b>
<b>Standard Grievances and Appeals</b>	67	The Department randomly selected a sample of 67 of the 426 standard grievances and appeals files identified by the Plan during the survey review period.
<b>Member Services Inquiry Log</b>	100	The Department randomly selected a sample of 100 of the 504 entries from the Plan's Member Services Call Log (for the week of May 20-24, 2013).
<b>Potential Quality Issues</b>	14	The Department selected all 14 of the 14 PQI files identified by the Plan during the survey review period.
<b>Utilization Management Denials</b>	14	The Department selected all 14 appeals from the 67 randomly selected standard grievances and appeals files.