

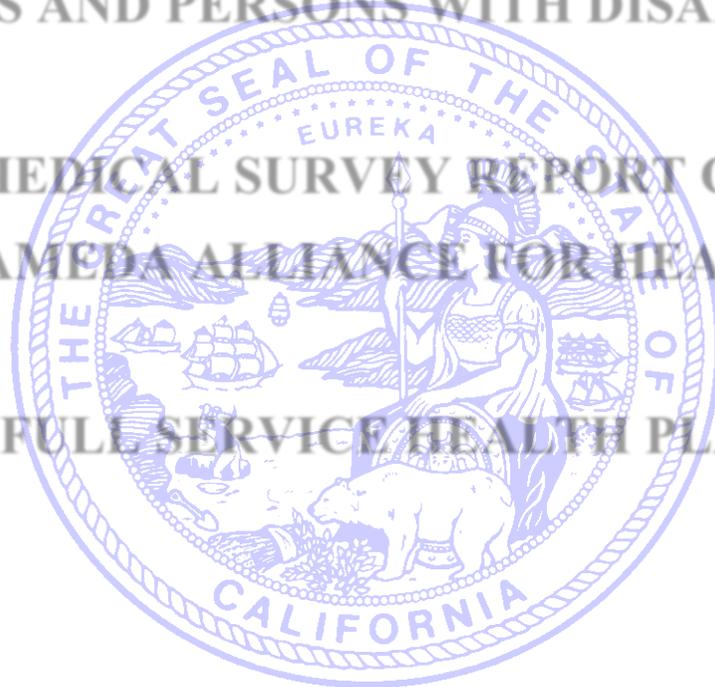
DEPARTMENT OF  
**Managed Health Care**  
**Help Center**

**DIVISION OF PLAN SURVEYS**

**1115 WAIVER**

**SENIORS AND PERSONS WITH DISABILITIES**

**MEDICAL SURVEY REPORT OF  
ALAMEDA ALLIANCE FOR HEALTH  
A FULL SERVICE HEALTH PLAN**



**DATE ISSUED TO DHCS: MARCH 18, 2016**

**1115 Waiver SPD Medical Survey Report  
Alameda Alliance For Health  
A Full Service Health Plan  
March 18, 2016**

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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”)<sup>1</sup> to conduct health plan medical surveys to ensure that members 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 March 20, 2015, the Department notified Alameda Alliance For Health (the “Plan”) that its medical survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department’s medical survey team conducted the onsite portion of the medical survey from June 8, 2015 through June 12, 2015.

### **SCOPE OF MEDICAL SURVEY**

As required by the Inter-Agency Agreement, the Department provides the 1115 Waiver SPD Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the SPD population. This medical survey evaluated the following elements specifically related to the Plan’s delivery of care to the SPD population as delineated by the DHCS-Alameda Alliance For Health Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations:<sup>2</sup>

#### **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 under- and over-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> All references to “Contract” are to the County Organized Health System, Geographic Managed Care, and Two-Plan contracts issued by the DHCS. All references to “Section” are to the Knox-Keene Act of the Health and Safety Code. All references to “Rule” are to Title 28 of the California Code of Regulations.

**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 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 medical survey incorporated review of health plan documentation and files from the period of April 1, 2014 through March 31, 2015.

**SUMMARY OF FINDINGS**

The Department identified **14** potential deficiencies during the current medical survey.

**2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES**

<p>#1</p>	<p><b>The Plan does not consistently make decisions in a timely manner, based on medical necessity determinations, to approve, modify, or deny requests by providers.</b>          DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment – Utilization Management, Provision 3(G) – Timeframes for Medical Authorization; DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 13 – Member Services, Provision 8(E) – Denial, Deferral, or Modification of Prior Authorization Requests; Section 1367.01(h)(1) and (5).</p>
<p>#2</p>	<p><b>For decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response:</b></p> <ul style="list-style-type: none"> <li>• <b>A clear and concise explanation of the reasons for the decision;</b></li> <li>• <b>A description of the criteria or guidelines used; and</b></li> <li>• <b>The clinical reasons for the decision.</b></li> </ul> <p>DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures; DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 13 – Member Services, Provision 4(C) – Written Member Information; Section 1367.01(h)(4).</p>
<p>#3</p>	<p><b>The Plan does not consistently make decisions in a timely manner, based on medical necessity determinations, to approve, modify or deny requests by providers for pharmaceutical treatments.</b>          DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 3(F) – Timeframes for Medical Authorization.</p>
<p>#4</p>	<p><b>The Plan does not have adequate mechanisms to detect for under- and over-utilization of out-of-network specialty referrals and behavioral health services.</b>          DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 1(F) and (G) – Utilization Management Program, and Provision 4 – Review of Utilization Data; Rule 1300.70(b)(2)(H).</p>

<b>CONTINUITY OF CARE</b>	
<b>#5</b>	<p><b>The Plan does not monitor or ensure the timely provision of an Initial Health Assessment for each new member.</b></p> <p>DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 10 – Scope of Services, Provision 3(A) – Initial Health Assessment, Provision 5(A)(1) and (2) – Services for Members under Twenty-One (21) Years of Age, and Provision 6(A)(1) – Services for Adults.</p>
<b>#6</b>	<p><b>The Plan does not consistently ensure the provision of complex case management services.</b></p> <p>DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care, Provision 1(B) and (C) – Comprehensive Case Management Including Coordination of Care Services.</p>
<b>AVAILABILITY &amp; ACCESSIBILITY</b>	
<b>#7</b>	<p><b>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 appointments.</b></p> <p>DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4(B)(1) and (2) – Access Standards; Rule 1300.67.2.2(c)(1); Rule 1300.67.2.2(c)(5)(A) and (B); Rule 1300.67.2.2(d)(3).</p>
<b>#8</b>	<p><b>The Plan does not ensure that during normal business hours, the waiting time for a member to speak by telephone with a Plan customer service representative does not exceed ten minutes.</b></p> <p>DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4 – Access Standards; DHCS-AAH Contract, Exhibit A, Attachment 13 – Member Services, Provision 2(A) – Member Services Staff; Rule 1300.67.2.2(c)(10).</p>
<b>MEMBER RIGHTS</b>	
<b>#9</b>	<p><b>The Plan’s grievance system does not consistently ensure that all expressions of dissatisfaction are captured as grievances and that a written record is made for each grievance received.</b></p> <p>DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Section 1368(a)(4)(B); Rule 1300.68(a)(1); Rule 1300.68(b)(5); Rule 1300.68(d)(8).</p>
<b>#10</b>	<p><b>The Plan’s grievance system does not consistently ensure adequate consideration of exempt grievances and rectification when appropriate.</b></p> <p>DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Section 1368(a)(1); Rule 1300.68(a)(4).</p>
<b>#11</b>	<p><b>The Plan does not consistently ensure that Limited English Proficient members receive coordinated interpreter services at the time of scheduled appointments.</b></p> <p>DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4 – Access Standards, and Provision 14(A) – Linguistic Services; Rule 1300.67.2.2(c)(4).</p>

<b>QUALITY MANAGEMENT</b>	
<b>#12</b>	<p><b>The Plan does not conduct adequate review of potential quality issues to ensure that all problems are being identified and that grievances related to medical quality issues are consistently referred to the Plan’s medical director.</b></p> <p>DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(E) – Grievance System Oversight; Rule 1300.70(a)(1).</p>
<b>#13</b>	<p><b>The Plan does not have effective oversight procedures in place to ensure that providers are continuously fulfilling all delegated responsibilities.</b></p> <p>DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 4(D) – Contract Performance; DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, and Provision 6(B) – Delegation of Quality Improvement Activities; Rule 1300.70(b)(2)(G)(2) and (3); Rule 1300.70(b)(2)(H)(1).</p>
<b>#14</b>	<p><b>The Plan does not maintain a system of accountability for its Quality Improvement System by ensuring that reports to the governing body are sufficiently detailed to identify significant or chronic quality of care issues.</b></p> <p>DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, Provision 2 – Accountability, Provision 3(C) – Governing Body, and Provision 4(B) – Quality Improvement Committee; Rule 1300.70(b)(2)(C).</p>

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

On May 8, 2014, the Department appointed Mark Abernathy of the Berkeley Research Group to serve as the Plan's conservator. The Plan's conversion to a new claims payment system had contributed to a backlog of claims that eventually led to the Plan's failure to maintain a minimum tangible net equity. In addition, the Plan had experienced dramatic growth in membership in January 2014. The conservatorship was overseeing the Plan throughout the majority of the survey review period.

On October 29, 2015, the Department terminated the conservatorship as the Plan had eliminated its backlog of claims and the conservator had sufficiently rehabilitated the Plan such that operations no longer constituted a substantial risk to members. The conservator implemented numerous process changes across all departments that benefited all members, including SPDs. For example:

- To ensure that all SPDs eligible for complex case management are accommodated, the Plan was in the process of hiring more staff in the Case Management Department.
- The Plan established a Compliance Department, spearheaded by the conservator's team, to conduct audits of utilization management denial files on a quarterly basis and uncovered issues with timely processing. The Plan immediately implemented process changes that resulted in improved turnaround times.

## DISCUSSION OF POTENTIAL DEFICIENCIES

### UTILIZATION MANAGEMENT

**Potential Deficiency #1: The Plan does not consistently make decisions in a timely manner, based on medical necessity determinations, to approve, modify, or deny requests by providers.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5– Utilization Management, Provision 3(G) – Timeframes for Medical Authorization; DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 13 – Member Services, Provision 8(E) – Denial, Deferral, or Modification of Prior Authorization Requests; Section 1367.01(h)(1) and (5).

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5 – Utilization Management

3. Timeframes for Medical Authorization

G. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member’s provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member’s interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 13 – Member Services

8. Denial, Deferral, or Modification of Prior Authorization Requests

E. Contractor shall provide required notification to beneficiaries and their authorized representatives in accordance with the time frames set forth in Title 22 CCR Sections 51014.1 and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made, not to exceed 14 calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in Exhibit A, Attachment 5, Provision 3, Contractor shall notify the Member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide written notification of the decision to Members no later than 28 calendar days from the receipt of the original request.

If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 5, Provision 3, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

Section 1367.01(h)(1) and (5)

(h) In determining whether to approve, modify, or deny requests by providers prior 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:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

#### **Documents Reviewed:**

- Plan Policy MED-UM-0001: UM Authorization Process (older version updated May 2014; redlined version revised 12/01/14)
- Plan Policy (proposed): Timeliness of UM Decisions (04/13/15)
- DMHC Change Log (05/05/15)
- Utilization Management: Inpatient and Outpatient Corrective Action Plan (undated)
- 51 denial files (04/01/14 – 03/31/15)

**Assessment:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 3(G) and Section 1367.01(h)(1) specify timeframes that the Plan must abide by when approving, modifying, or denying requests from providers based on medical necessity. For routine prior authorizations, the Plan must not exceed five working days from receipt of information reasonably necessary to make a determination. However, Provision 3(G) of the DHCS contract imposes an additional cap on the maximum number of days the Plan has to render a decision, regardless of whether necessary information has been received. It indicates that the Plan can take no longer than 14 calendar days from receipt of the request to render a decision. However, the decision may be deferred for an additional 14 calendar days if requested by the member or requesting provider, or the Plan can substantiate that additional information is needed and is in the best interest of the member. For any deferrals, Section 1367.01(h)(5) requires the Plan to notify the provider and enrollee of the anticipated date of the decision. DHCS-Alameda Alliance

For Health Contract, Exhibit A, Attachment 13, Provision (8)(E) requires the Plan to provide written notification of a deferral to the member no later than 28 calendar days from receipt of the request.

To assess compliance with these timeliness standards, the Department examined key policies and procedures, reviewed a random sample of denial files, as well as considered the Plan's internal audit results.

### **1. Policies and Procedures**

In light of the interventions brought on by the conservatorship, the Plan submitted two versions of *MED-UM-0001: UM Authorization Process*, the primary utilization management policy that was in place during the survey review period. A comparison of both the older and the redlined versions of this policy indicate that neither version included timeframes for processing routine prior authorization requests, including deferral procedures. The redlined version shows deletion of "Section IV. Authorization Processing Timeframes," a table which previously addressed timeframes and deferral procedures. Although removed from the redlined version, this section was inexplicably absent from the older version. To replace the deleted section, the Plan created a separate policy, *Timeliness of UM Decisions*, which separately addresses authorization-processing timeframes. Although only in proposed format and completed one month after the survey review period, this proposed policy demonstrates alignment with the contractual and statutory requirements.

### **2. File Review**

The Department reviewed a random sample 43<sup>3</sup> files that were denied based in whole or in part on medical necessity. In six<sup>4</sup> (14%) prior authorization files, the Plan issued denials beyond five working days from receipt of information reasonably necessary to make a determination.<sup>5</sup> In seven<sup>6</sup> (16%) prior authorization files, the Plan issued denials beyond the 14-calendar day maximum requirement for rendering a decision. For these files, the Plan took anywhere from 17 to 45 calendar days from receipt of the original request to render a decision (averaging approximately four weeks).

The Department noted that in two (2) of the seven (7) deficient files where denials were issued beyond the 14-calendar day requirement, the Plan sent a deferral notice to the member extending the timeframe, as allowable by DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 3(G) and Section 1367.01(h)(5). However, in both cases, the Plan's decision was still made beyond the anticipated decision date indicated in the deferral notice, as well as beyond the maximum 28-calendar day deferral timeframe. For example:

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<sup>3</sup> 51 files were initially reviewed. 8 files were excluded from review because they were not denials that were based in whole or in part on medical necessity. Therefore, 43 remaining files were reviewed for compliance.

<sup>4</sup> Files #4; #6; #8; #25; #27; #41

<sup>5</sup> In files where additional information was requested or the decision was deferred, and the provider submitted no additional information, the Department used the Plan's deadline for receipt of all information to calculate non-compliance.

<sup>6</sup> Files #4; #6; #8; #12; #25; #27; #41

- *File #6:* The Plan received the request on May 19, 2014. The Plan sent a deferral notice on May 28, 2014 with an anticipated decision date of June 13, 2014 pending receipt of additional information. Additional information was received on May 31, 2014. However, a denial decision was not made until June 24, 2014 (36 calendar days from receipt of the original request, 16 working days from receipt of additional information, and 12 calendar days from when the Plan indicated a deferral decision would be made). In addition, the member did not receive written notification of the decision until June 26, 2014 (38 calendar days from receipt of the original request), in further violation of DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 13, Provision 8(E).
- *File #41:* In this file, the Plan issued both a request for additional information to the provider as well as a deferral notice to the member. The Plan received the request on April 21, 2014, and sent a request for additional information on April 23, 2014. The request for additional information stated, "If [vendor] does not receive this information by 04/25/2014, this will result in an automatic denial of this request for lack of clinical information." No additional information was received. The Plan then sent a deferral notice on May 6, 2014. The deferral notice stated:

You can expect a decision on your treatment request within 14 calendar days from 04/21/2014 when your treatment request was received. The requested decision is being deferred because the plan decided that a deferral is in your best interests to collect necessary information; receive consultation from an expert reviewer; or to conduct an additional exam or test. You may expect the decision from us on or before 05/05/2014. You will be notified in writing if another 14 day deferral is indicated (28 days total).

However, the deferral notice is particularly confusing because it indicates that a decision will be made within 14 calendar days from receipt of the request (May 5, 2014), but the letter itself is dated May 6, 2014 (one day *after* the anticipated decision date). Furthermore, the Plan did not actually render a denial decision until June 5, 2014 (45 calendar days from receipt of the original request, 21 working days from the deadline for receipt of additional information, and 30 calendar days from when the Plan indicated a deferral decision would be made). The member was never notified that another 14-day deferral was indicated, and written notification of the decision was not received until June 6, 2014 (46 calendar days from receipt of the original request), in further violation of DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 13, Provision 8(E).

The Department also noted that the Plan does not always appear to make clear the distinction between requests for additional information and formal deferrals. For example, when formal deferrals are sent, as noted in File #41 described above, the deferral notice includes a header titled, "NOTICE OF ACTION About Your Treatment Request (Deferral)." The word "deferral" is clearly indicated. However, in two (2) of seven (7) deficient files where the Plan requested additional information from the requesting provider, the deadline for receipt of additional

information indicated was beyond the 14-calendar day timeframe required for rendering a decision. Therefore, it is unclear whether this extension for receipt of additional information was intended to serve as a deferral. For example:

- *File #12:* The Plan received the request on April 18, 2014 and sent a request for additional information on April 22, 2014. The request for additional information stated, “If [vendor] does not receive this information by 05/19/2014, this will result in an automatic denial of this request for lack of clinical information.” However, the deadline indicated for receipt of additional information is 31 calendar days from receipt of the original request, which is beyond the 14-calendar day timeframe the Plan has to render a decision. It is unclear whether the Plan meant for this letter to serve as a deferral notice, in which case, the deadline still would have been beyond the 28-calendar timeframe to notify the member of the decision. The Plan ultimately made a denial decision on May 27, 2014 (39 calendar days from receipt of the original request, and exactly 5 working days from the deadline for receipt of additional information, which was never submitted by the provider).
- *File #25:* The Plan received the request on May 20, 2014 and sent a request for additional information on May 23, 2014. The request for additional information stated, “If [vendor] does not receive this information by 6/6/2014, this will result in an automatic denial of this request for lack of clinical information.” However, the deadline indicated for receipt of additional information is 17 calendar days from receipt of the original request, which is beyond the 14-calendar timeframe the Plan has to render a decision. It is unclear whether the Plan meant for this letter to serve as a deferral notice. The Plan ultimately made a denial decision on June 22, 2014 (33 calendar days from receipt of the original request, and 11 working days from the deadline for receipt of additional information which was never submitted by the provider).

### **3. Internal Audits**

In light of the interventions brought on by the conservatorship, the Plan produced a document, *Utilization Management: Inpatient and Outpatient Corrective Action Plan*, that captures the results of internal audits performed by the Plan to monitor timeframes for utilization management processing. It states:

Internal audits performed by the Alliance Compliance Department during the periods of CY Q3 and Q4 2014 to [sic] revealed significant deficiencies in the process for both Inpatient and Outpatient Utilization Management (UM) as it relates to turn-around times (TATs) and member and/or provider notification. The department implemented numerous corrective actions to correct the deficiency. . . .

The document also presents a table that is inclusive of deficiencies identified, corrective actions implemented, and results of a February 2015 audit designed to re-measure the effectiveness of implemented corrective actions. A relevant excerpt from the table is included as follows:

UM Unit	Deficiency	Corrective Action Plan	February 2015 Audit Results as Result of Corrective Action Plan
Inpatient	Denial decisions from medical director were never rendered in timely manner in accordance with Health and Safety Code and contractual obligations	Workflow instated [sic] in the unit lead triages the medical directors' reviews on daily basis	80% of sampled inpatient decisions were rendered timely
Outpatient	Denial decisions from medical directors were occasionally delayed	Daily authorization expiration report created; unit lead uses to triage due dates urgency and due date	88.9% of sampled outpatient decisions were rendered timely

The Plan's re-measurement compliance rates (80% and 88.9% for inpatient and outpatient, respectively) appear to be consistent with the Department's own file review findings. The efforts made by the Plan to remedy those identified deficiencies are further demonstrative of the Plan's own awareness concerning utilization management timeliness issues.

**TABLE 1**  
**Timeliness of UM Denials**

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Denial Letters	43	Decision made within 5 working days from receipt of all information reasonably necessary to make a determination	37 (86%)	6 (14%)
		Decision made with 14 calendar days from receipt of the request	36 (84%)	7 (16%)

**Conclusion:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 3(G) and Section 1367.01(h)(1) specify timeframes that the Plan must abide by when approving, modifying, or denying requests from providers based on medical necessity. For routine prior authorizations, the Plan must not exceed five working days from receipt of information

reasonably necessary to make a determination. The DHCS contract imposes an additional cap on the total number of days the Plan has to render a decision, regardless of whether necessary information has been received. It indicates that the Plan can take no longer than 14 calendar days from receipt of the request to render a decision. However, the decision may be deferred for an additional 14 calendar days if requested by the member or requesting provider, or the Plan can substantiate that additional information is needed and is in the best interest of the member. For any deferrals, Section 1367.01(h)(5) requires the Plan to notify the provider and enrollee of the anticipated date of the decision. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 13, Provision (8)(E) requires the Plan to provide written notification of a deferral to the member no later than 28 calendar days from receipt of the request.

The Department's findings revealed that in 14% of prior authorization files reviewed, the Plan issued denials beyond five working days from receipt of information reasonably necessary to make a determination. In addition, in 16% of the files reviewed, the Plan issued denials beyond 14 calendar days from receipt of the request. In cases where deferral notices were sent, the Plan's decision was still made beyond the anticipated decision date indicated in the deferral notice. The Department also noted that the Plan does not always appear to make clear the distinction between requests for additional information and formal deferrals, as the deadline for receipt of additional information indicated is often times beyond the 14-calendar day timeframe required for rendering a decision. The Plan's internal audits revealed findings consistent with those of the Department, and efforts made by the conservatorship to update Plan policies and implement corrective action demonstrate the Plan's awareness of non-compliance. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

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**Potential Deficiency #2: For decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response:**

- **A clear and concise explanation of the reasons for the decision;**
- **A description of the criteria or guidelines used; and**
- **The clinical reasons for the decision.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures; DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 13 – Member Services, Provision 4(C) – Written Member Information; Section 1367.01(h)(4).

DHCS-Alameda Alliance For Health 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-Alameda Alliance For Health Contract, Exhibit A, Attachment, 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.

Section 1367.01(h)(4)

(h) In determining whether to approve, modify, or deny requests by providers prior 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.

**Documents Reviewed:**

- Utilization Management Program Description (2014)
- Notice of Action – denial letter template (revised 11/06/13)
- Notice of Action – deferral letter template (revised 10/28/14)
- Utilization Management: Inpatient and Outpatient Corrective Action Plan (undated)
- 51 denial files (04/01/14 – 03/31/15)

**Assessment:** Section 1367.01(h)(4) requires the Plan's responses regarding decisions to deny, delay, or modify health care services in whole or in part on medical necessity to be communicated to the enrollee in writing and 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. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 2(D) similarly requires that reasons for decisions be clearly documented. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 13, Provision 4(C) additionally indicates that written member information shall ensure members' understanding of health plan processes and ensure the member's ability to make informed health decisions.

To assess compliance with these standards, the Department reviewed a random sample of 43<sup>7</sup> files that were denied based in whole or in part on medical necessity. The Department determined that 23<sup>8</sup> (53%) denial letters did not include one or more of the three required components prescribed by Section 1367.01(h)(4). Specifically, 23 denial letters did not include a clear and concise explanation of the reasons for the Plan's decision, nine (9) denial letters did not include a description of the criteria or guidelines used, and 20 denial letters did not include the clinical reasons for the decision. For example:

- *File #31:* This file involved the denial of an MRI of the shoulder. The denial letter stated:

This request is denied because:

Information received by fax was reviewed. The history is shoulder pain. This test would be needed if the member had pain that did not go away after trying physical therapy, and medication that reduces swelling, for four weeks or more, or the pain is getting worse while under treatment, or such treatment should not be done. This decision was based on the CareCore National, LLC criteria for CPT 73221 - MRI of upper extremity joint (hand, wrist, elbow or shoulder) without dye.

Although the letter provided both the title and a clear description of the criteria, it did not include the clinical reason for how the member did not specifically meet the criteria. The letter only indirectly implied that the member had not tried physical therapy and had not taken medication to reduce swelling, without reference to the member's specific condition or lack of information substantiating that the criteria had been met. Therefore, in addition to not containing a clinical reason for the denial, overall, the letter did not provide a clear explanation of the Plan's reason for the denial.

- *File# 37:* This file involved a member whose last two days of a 13-day inpatient hospitalization stay was denied. The denial letter stated:

This inpatient hospitalization no longer meets acute inpatient hospitalization criteria and therefore the authorization has been denied.

Alameda Alliance for Health makes determinations for admissions and lengths of stay in an acute inpatient hospitalization setting for medically necessary treatment based on MCG Guidelines (formerly Milliman Care Guidelines), a nationally recognized set of clinical guidelines. The Alameda Alliance for Health Medical Director has reviewed the medical documentation received and has determined based on the MCG guideline: Pancreatitis, with Common Duct Stone ORG: M-251 (ISC) and Atrial

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<sup>7</sup> 51 files were initially reviewed. 8 files were excluded from review because they were not denials that were based in whole or in part on medical necessity. Therefore, 43 remaining files were reviewed for compliance.

<sup>8</sup> Files #2; 3; 4; 7; 9; 10; 11; 12; 21; 22; 25; 26; 31; 32; 34; 36; 37; 38; 40; 41; 46; 49; 51

Fibrillation ORG: M-505 (ISC). The patient was hemodynamically and neurologically stable without signs sepsis. The patient is able to tolerate a regular diet and pain is controlled. Therefore, the authorization for an acute inpatient hospital stay has been denied effective March 9, 2015.

Although the letter referenced the title of the guideline used, there was no clear description of the specific criteria used for a continued hospital stay. The letter did attempt to provide the clinical reason for the denial by referencing specifics of the member's condition, but since the criteria was not described, it was unclear how the member did not specifically meet the criteria. In addition, the letter used language (e.g., hemodynamically stable) that would be challenging for the layperson to understand.

The Department also identified one noteworthy trend and observed that some denial letters appeared to include a near regurgitation of the actual criteria language, but without a clear explanation describing how the member's condition specifically did not meet the criteria. For example:

- *File #22:* This file involved the denial of an imaging study of the heart muscle, the myocardium. The letter included technically challenging language that stated:

This letter is in response to a request for authorization Myocardial Perfusion Imaging with SPECT – Multiple Studies by your physician received on 4/9/2014.

The Alameda Alliance for Health Medical Director and CareCore National Group carefully reviewed the request and the clinical information provided. The request for 78452 Myocardial Perfusion Imaging with SPECT – Multiple Studies has been denied.

The Alameda Alliance for Health has adopted CareCore National Evidence-Base Healthcare Solutions criteria for radiology benefits. In accordance with CareCore National Criteria for Imaging 78452 Myocardial Perfusion Imaging with SPECT – Multiple Studies the procedure is indicated when:

Evaluation prior to non-cardiac surgery [One of the following]

A. With current cardiac symptoms [One of the following]

1. Prior documentation of coronary artery disease – See section II
2. No prior documentation of coronary artery disease – See section V

B. Without current cardiac symptoms

1. Intermediate or high risk non-cardiac surgery [One of the following]

- a. Inability to reach four mets on treadmill exercise stress testing
- b. If able to reach four mets on treadmill exercise stress testing, one of the following must be documented

- i. Creatinine 2.0 or greater
- ii. Diabetes
- iii. Congestive heart failure
- iv. Known coronary artery disease

Upon review of the clinical information it was noted that you have not met the above criteria. Therefore, the request for a [insert procedure name] has been denied at this time. Please call your physician for further discussions and alternative therapies.

Although the letter listed the criteria used, it did not include the clinical reasons for how the member specifically did not meet the criteria. In addition, the criteria referenced “sections II and V” which were not included as attachments with the letter. The final paragraph also included template language that was not customized to fit the member’s case (“insert procedure name”). Therefore, overall, the letter was not clear and concise.

- *File #25:* This file involved the denial of a CT scan of the abdomen and pelvis. The denial letter included lengthy and technically challenging language that stated:

This letter is in response to a request for authorization of a CT scan of the abdomen and pelvis with contrast (special dye) for abdominal pain (789) by your physician.

The Alameda Alliance for Health Medical Director and CareCore National Group (radiology utilization management program) carefully reviewed the request and the clinical information provided. The request for CT scan of the abdomen and pelvis with contrast has been denied.

The Alameda Alliance for Health uses CareCore National Evidence-Based Healthcare Solutions criteria for radiology benefits. In accordance with CareCore National P&P: 74177 CT of abdomen and pelvis with contrast, a CT of the abdomen and pelvis is indicated for one or more of the following:

1. The member has complaint associated with abdominal or pelvic pain with a normal or non-diagnostic ultrasound with one of the following:
  - a. Tenderness
  - b. Evidence of inflammatory reaction and infection with one of the following:
  - c. Temperature of >100.9
  - d. WBC >11.5
  - e. Muscular rigidity/guarding
  - f. Abdominal distention on exam
2. The member has weight loss of 10 pounds more than 5% body weight in a year or less with all:

- a. Negative colonoscopy
- b. Chest x-ray non-diagnostic for cause of weight loss
- c. Normal thyroid function tests (TSH, T3 and T4)
- d. Normal renal function tests (BUN and creatinine)
3. The member needs evaluation of symptoms after any abdominopelvic surgery.
4. The member has suspected aneurysm (weakening of the artery wall).
5. The member has a suspected bowel or uropathy (bladder) obstruction.
6. The member has known or suspected cancer/mass/infection
7. The member has known or suspected pancreatitis or pseudo cyst (cyst of the pancreas)
8. The member has a palpable mass with a non-diagnostics ultrasound
9. The member has a fever of unknown origin
10. The member has abdominal and or pelvic trauma.
11. The member needs evaluation of abdominal and pelvic anatomy
12. The member needs planning for radiation for therapy

Upon review of the clinical information, it was noted that the documentation does not meet the above criteria. Therefore, the request for a CT scan of the abdomen and pelvis with contrast has been denied at this time. Please call your physician for further discussion and alternatives.

Although the denial letter listed the criteria used, the language itself included much medical jargon that was not concisely explained in layman's terms (e.g., WBC >11.5, abdominopelvic surgery, non-diagnostics ultrasound). Furthermore, the letter did not include the clinical reasons for how the member's condition specifically did not meet the criteria. The member would not have been able to discern which of the criteria were not met.

In onsite interviews, Plan staff indicated that recent efforts brought on by the conservatorship had primarily addressed improvements to decision-making turnaround times and not the quality of denial letters. Plan staff acknowledged that improvements were warranted but would require much staff training. Plan staff confirmed that there were currently no formal mechanisms in place for evaluating the clarity of denial letters.

**TABLE 2**  
**UM Denial Letters**

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Denial Letters	43	Clear and concise explanation	20 (47%)	23 (53%)
		Description of the criteria or guidelines used	34 (79%)	9 (21%)
		Clinical reasons	23 (53%)	20 (47%)

**Conclusion:** Section 1367.01(h)(4) requires the Plan’s responses regarding decisions to deny, delay, or modify health care services in whole or in part on medical necessity to be communicated to the enrollee in writing and 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. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 2(D) similarly requires that reasons for decisions be clearly documented. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 13, Provision 4(C) additionally indicates that written member information shall ensure members’ understanding of health plan processes and ensure the member’s ability to make informed health decisions.

The Department’s findings revealed that in 53% of files reviewed, the denial letters did not include one or more of the three required components prescribed by Section 1367.01(h)(4). In addition, the Department identified one noteworthy trend and observed that some denial letters included a near regurgitation of the actual criteria language but failed to indicate how the member’s condition specifically did not meet the criteria. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

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**Potential Deficiency #3: The Plan does not consistently make decisions in a timely manner, based on medical necessity determinations, to approve, modify, or deny requests by providers for pharmaceutical treatments.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 3(F) – Timeframes for Medical Authorization.

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5 – Utilization Management

3. Timeframes for Medical Authorization

F. Pharmaceuticals: 24 hours on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto.

**Documents Reviewed:**

- Plan Policy MED-RX-0002a: Prior Authorization Review Process (older version approved 11/07/12; redlined version revised 04/13/15)
- Plan Policy (proposed): Timeliness of UM Decisions
- DMHC Change Log (05/05/15)
- 63 Medi-Cal pharmacy denial files (04/01/14 – 03/31/15)

**Assessment:** The Department reviewed a random sample of 63 Medi-Cal pharmacy denial files. Twenty files were removed from the sample because the denials were not based in whole or in part on medical necessity.<sup>9</sup> In 10 out of the remaining 43 pharmacy denials (23%),<sup>10</sup> the Plan took longer than 24 hours to render a decision.

During onsite interviews, Plan staff acknowledged that timely processing of pharmacy requests had been identified as an area needing improvement during the review period. This prompted the Plan to contract with a pharmacy benefit management vendor in January 2014. The vendor was delegated to perform utilization management functions, including requesting and obtaining additional information from providers. Beginning January 2015, the Plan assumed responsibility for ensuring providers responded promptly to requests for additional information.

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 3(F) requires the Plan to make prior authorization decisions for pharmaceuticals within 24 hours of the Plan's receipt of the request. As the Plan does not consistently respond to pharmacy requests within 24 hours, the Department finds the Plan in violation of this contractual requirement.

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**Potential Deficiency #4: The Plan does not have adequate mechanisms to detect for under- and over-utilization of out-of-network specialty referrals and behavioral health services.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 1(F) and (G) – Utilization Management Program, and Provision 4 – Review of Utilization Data; Rule 1300.70(b)(2)(H).

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

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<sup>9</sup> Files #3, 4, 13, 14, 16, 17, 18, 19, 22, 28, 34, 46, 47, 49, 56, 58, 59, 63, 64, 68

<sup>10</sup> Files #5, 6, 11, 15, 31, 33, 37, 39, 41, 69

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 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. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5 – Utilization Management

1. Utilization Management Program

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. This specialty referral system should include non-contracting providers.

Contractor shall ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures.

G. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

4. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request.

Rule 1300.70(b)(2)(H)

(H) A plan that has capitation or risk-sharing contracts must:

2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible underutilization of specialist services and preventive health care services.

**Documents Reviewed:**

- Plan Policy MED-UM-0004: Over and Under Utilization (revised 04/07/14)
- Utilization Management Program Description (2014)
- Quality Improvement Program Description (2014)
- Quality Improvement Program Description (2015)
- Managed Behavioral Health Administrative Services Agreement Among The Alameda Alliance For Health, Beacon Health Strategies LLC, and College Health IPA, Inc. (executed August 2013)

- Plan Response to DMHC Request #48: DMHC Follow Up Audit Request for OON (email received 06/17/15)
- Outpatient Denial Rates (09/10/14)
- AAH Inpatient Barometer Report – Acute Utilization By Line of Business (09/16/14)
- Medical Services Update to HCQC (10/16/14)
- Medical Services Overview Report (12/05/14)
- Non OB Acute Admits (02/04/15)
- Utilization Management Metrics (02/05/15)
- MCAL Utilization Trend by Groups (02/20/15)

**Assessment:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 4 requires the Plan’s Utilization Management Program to include mechanisms to detect both under- and over-utilization of health care services. Review of Plan documents as well as interviews with Plan staff revealed that the Plan does not monitor utilization patterns for the following: 1) out-of-network specialty (OON) referrals, and 2) behavioral health services.

### **1. Out-of-Network Specialty Referrals**

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 1(F) requires the Plan to track and monitor referrals requiring prior authorization, including those with non-contracting providers. The Plan’s policy, *MED-UM-0004: Over and Under Utilization*, similarly requires the Plan to generate and review reports regarding referrals to specialty care providers. On page 1, it states:

On at least an annual basis, utilization reports (i.e., acute bed days, LOS, admissions, readmissions, ER visits, *referrals to specialty care providers* and generic pharmaceutical utilization, etc.) will be analyzed for comparisons against benchmarks and goals (by each LOB and combined) to detect any potential over- or under-utilization. [Emphasis added.]

While the Plan submitted reports to the Department that demonstrate robust monitoring of inpatient stays and readmissions (e.g. acute bed days, admissions per thousand, emergency room readmission rates, etc.), no documentation was submitted to demonstrate the tracking of OON referrals as required by the Plan’s policy. The lack of tracking of OON referrals is especially relevant because in onsite interviews, Plan staff indicated that due to the increased enrollment experienced in January 2014, as well as the loss of a significant number of providers in the network, there was an increase in demand to see OON providers. The potential over-utilization of OON providers could prove costly for the Plan if not monitored.

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 1(G) further requires the integration of utilization management activities into the Quality Improvement System (QIS), including a process to integrate reports on appeals and denials for review by appropriate QIS staff. Therefore, in an onsite request, the Department inquired whether the Plan evaluates the number of OON referral requests denied, appealed, and overturned, and if so, how often this data is reviewed. In its written response, the Plan stated, “We do not review these

internally as part of a larger, comprehensive process but plan to as part of the Continuity of Care subgroup.”

In onsite interviews, Plan staff acknowledged that during the survey review period, monitoring for over- and under-utilization of services was not being monitored as robustly as it should have been and that data collected was not being measured against local and national benchmarks. Plan staff conceded that the Plan began tracking denials and appeals in May 2015 (two months after the survey review period) and has yet to begin tracking referrals to specialty providers.

## **2. Behavioral Health Services**

The Plan contracts with Beacon to provide behavioral health services for members on a capitated basis. Rule 1300.70(b)(2)(H) requires the Plan to have a mechanism to detect and correct under-service when it has capitation or risk-sharing contracts. The Plan’s *Utilization Management Program Description (2014)* includes a section that specifically addresses the monitoring of under- and over-utilization of behavioral health services. On page 20, it states:

The Director of Utilization Management monitors patterns of over and under-utilization. Data is reviewed at the monthly CMC meeting and when a pattern of under or over utilization is identified an analysis of barriers is conducted and potential interventions are identified. Data is then re-evaluated to determine the efficacy of the interventions.

The Director of Utilization Management also monitors individual member utilization data and identifies cases to be presented at formal weekly case conference with a CHIPA physician advisor. When a concern over potential over or under-utilization for a specific member is identified, the clinical team under the direction of the Director of UM, develops a plan to address the utilization issue which may include referral to CHIPA Case Management and/or the Alliance’s Case Management or Disease Management programs, CHIPA physician peer to peer with the inpatient attending physician, referral to the California county mental health authority for additional services and supports or, for dual eligible members, referral for Long Term Support Services (LTSS), etc.

However, the Plan was unable to provide either Plan- or Beacon-generated utilization reports to demonstrate monitoring of over- and under-utilization. In onsite interviews, Plan staff indicated that utilization reports submitted by Beacon were not specific enough to be rendered useful. Therefore, the Plan recently implemented joint operations meetings to review utilization patterns specific to the Plan’s population.

**Conclusion:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 4 requires the Plan’s Utilization Management Program to include mechanisms to detect both under- and over-utilization of health care services. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 1(F) requires the Plan to track and monitor referrals requiring prior authorization, including those with non-contracting providers. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 5, Provision 1(G) further requires the integration of utilization management activities into the QIS, including a process to integrate

reports on appeals and denials for review by appropriate QIS staff. Rule 1300.70(b)(2)(H) requires the Plan to have a mechanism to detect and correct under-service when it has capitation or risk-sharing contracts. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4, Provision 1 requires the Plan to implement an effective QIS in accordance with the standards in Rule 1300.70.

The Department's review revealed that while the Plan submitted reports that demonstrate robust monitoring of inpatient stays and readmissions, no documentation was submitted to demonstrate the tracking of OON specialist referrals. The Plan also does not evaluate the number of OON referral requests that have been denied, appealed, or overturned to integrate use of these reports with quality improvement activities. Furthermore, while the Plan contracts with Beacon to provide behavioral health services to members on a capitated basis, the Plan was unable to provide useful reports to demonstrate monitoring of over- and under-utilization. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

## CONTINUITY OF CARE

**Potential Deficiency #5: The Plan does not monitor or ensure the timely provision of an Initial Health Assessment for each new member.**

**Contractual/Statutory/Regulatory References:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 10 – Scope of Services, Provision 3(A) – Initial Health Assessment, Provision 5(A)(1) and (2) – Services for Members under Twenty-One (21) Years of Age, and Provision 6(A)(1) – Services for Adults.

### DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 10 – Scope of Services 3. Initial Health Assessment (IHA)

An IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.

A. Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

### 5. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.

Contractor shall ensure that appropriate diagnostic and treatment services are initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

A. Provision of IHAs for Members under Age 21

- 1) For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.
- 2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

#### 6. Services for Adults

##### A. IHAs for Adults (Age 21 and older)

- 1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

#### **Documents Reviewed:**

- Plan Policy Template (no policy #): Initial Health Assessment (drafted April 2015)
- Pre-Onsite Survey Questionnaire (04/09/15)

**Assessment:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 10, Provision 3(A) requires the Plan to cover and ensure the provision of an Initial Health Assessment (IHA) for each new member. The IHA is a complete history and physical examination that enables a provider of primary care services to comprehensively assess the member's health needs and identify those members whose health needs require coordination with appropriate community resources and other agencies. Provision 5(A)(1) and (2) of the DHCS contract specifies timeframes for completion of the IHA for members under the age of 21 (within 60 calendar days from enrollment for members under 18 months; within 120 calendar days from enrollment for members 18 months and older). Similarly, Provision 6(A)(1) of the DHCS contract specifies timeframes for completion of the IHA for members age 21 and older (within 120 calendar days from enrollment).

Prior to the onsite survey, the Department requested that the Plan complete a *Pre-Onsite Questionnaire* which contained questions designed to elicit a general overview of key Plan operations. On page 26, the Plan was asked to describe its procedures for how SPDs are informed and encouraged to get their IHAs, and whether the Plan makes any reasonable attempts to contact SPDs for scheduling. In its written response, the Plan stated:

The Alliance informs all new members, including SPD members, about the importance of a well-visit within 120 days of joining the plan through the New Member Welcome Letter included in the new member packet. During this visit, providers are asked to conduct both the IHA and IHEBA. *The Alliance did not make additional attempts to contact SPD Members and schedule an IHA during the audit period.* Beginning April 1, 2015, the Alliance will encourage SPD Members who are contacted by phone regarding their Health Risk Assessment of the importance of scheduling a well visit with their PCP. Each attempt will be documented in the Alliance database for case management, TruCare. [Emphasis added.]

During onsite interviews, Plan staff acknowledged that IHA completion was not monitored during the survey review period. The Plan was thereby unable to provide the IHA completion rate for its SPD membership. The Plan's Medical Director indicated that this was an area of oversight but affirmed that the Plan has identified the appropriate Current Procedural Terminology (CPT) codes that represent IHA completion. These codes will be used in the future to query the claims system to retrieve data to track IHA completion. The Plan intends on using this data to provide feedback to providers to promote compliance.

While outside the scope of survey review period, the Plan submitted a draft policy that was created in April 2015 (one month after the end of the survey review period). The policy, *Initial Health Assessment*, demonstrates alignment with the contractual requirements regarding timely completion of IHAs. The policy additionally addresses monitoring activities and on page 3 states:

**Compliance with IHA:**

On an quarterly basis, AAH pulls claims and encounters with specific visit codes above for primary care providers to identify the percentage of their newly assigned members who had a visit within 120 days of being newly assigned.

If the provider is in the lowest quartile, the QI Department reaches out to the provider and educates them on the importance of doing an IHA/IHEBA. Aggregate results are shared with the Quality/Utilization Advisory Committee annually.

**Conclusion:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 10, Provision 3(A) requires the Plan to ensure the provision of an IHA for each new member. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 10, Provision 5(A)(1) and (2), and Provision 6(A)(1) specify timeframes for completion of the IHA for members under and over the age of 21. During onsite interviews, Plan staff acknowledged that IHA completion was not monitored during the survey review period. Although the Plan has developed a policy that addresses IHA completion and monitoring, these procedures were not in place during the relevant review period. Therefore, the Department finds the Plan in violation of these contractual requirements.

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**Potential Deficiency #6: The Plan does not consistently ensure the provision of complex case management services.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care, Provision 1(B) and (C) – Comprehensive Case Management Including Coordination of Care Services.

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care

1. Comprehensive Case Management Including Coordination of Care Services

Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.

B. Complex Case Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include, at a minimum:

1. Basic Case Management Services
2. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3. Intense coordination of resources to ensure member regains optimal health or improved functionality
4. With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually

C. Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical data, and any other available data, as well as self and physician referrals. Complex case management services for SPD beneficiaries must include the concepts of Person-Centered Planning.

**Documents Reviewed:**

- Plan Policy MED-CM-0001: Complex Case Management (CCM) Identification, Screening, Assessment and Triage (revised 03/05/13)
- Plan Policy MED-CM-0002: Complex Case Management Plan Development and Management (revised 12/05/12)
- Plan Policy MED-CM-0003: Complex Case Management Plan Evaluation and Closure (revised 12/05/12)
- Plan Policy MED-CM-0004: Referrals To and From Complex Case Management (CCM) (revised 12/05/12)
- Plan Policy MED-UM-0002: Coordination of Care (older version revised 04/07/14; redlined version revised 04/13/15; updated version revised 04/13/15)
- Comprehensive Case Management Program Description (2013)
- Alameda Alliance For Health Chart (03/25/15)
- Plan Response to DMHC Request #47: DMHC Follow Up to Complex Case Management (received 06/17/15)
- Plan Response to DMHC Request #47: CCM Members Identified and Enrolled During and Post Audit Period (06/15/15)
- Plan Response to DMHC Request #47: Complex Case Management Member Selection Process (received 06/17/15)

**Assessment:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 11, Provision 1 requires the Plan to ensure the provision of comprehensive medical case management to each member. These services can be provided through either basic or complex case management activities based on the medical needs of the member. Both basic and complex case management are provided by the primary care provider (PCP) in collaboration with the Plan, although complex case management requires more intense coordination of resources and involvement by a multidisciplinary case management team to manage acute or chronic illnesses, including emotional and social support issues.

To evaluate the Plan's provision of comprehensive case management to its members, the Department examined key documents as well as interviewed Plan staff. The Department's review revealed the following concerns regarding the provision of complex case management services, specifically: 1) no annual program evaluation, 2) low member participation, 3) timeliness of referrals, and 4) lack of PCP education and collaboration.

### **I. No Annual Program Evaluation**

The Plan's *Comprehensive Case Management Program Description (2013)* requires an annual evaluation of the Plan's complex case management program. On pages 21-22 it states:

#### **D. Annual Complex Case Management Program Evaluation**

The Chief Medical Officer and the Director of Case and Disease Management collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the HCQC for review and feedback. The HCQC makes recommendations for corrective action interventions to improve program performance, as appropriate. The Director of Case and Disease Management is responsible for implementing the interventions under the oversight of the Chief Medical Officer.

However, as of the dates of the onsite survey in June 2015, there was no documentation to substantiate that the Plan had conducted an annual review of its policies and program description as required, or that the results of the annual program evaluation had been reported to the HCQC for review and feedback.

The Plan submitted numerous documents to demonstrate evidence of a robust case management program, including its *Comprehensive Case Management Program Description (2013)* as well as four policies specifically pertaining to complex case management.<sup>11</sup> The four policies address

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<sup>11</sup> Plan Policy MED-CM-0001: Complex Case Management (CCM) Identification, Screening, Assessment and Triage; Plan Policy MED-CM-0002: Complex Case Management Plan Development and Management; Plan Policy MED-CM-0003: Complex Case Management Plan Evaluation and Closure; Plan Policy MED-CM-0004: Referrals To and From Complex Case Management (CCM)

various topics concerning complex case management such as referral processes, criteria for identification and screening, and care plan development and evaluation. However, the Department noted that three policies were last revised on December 5, 2012, and one policy was last revised on March 5, 2013. The program description itself was for the year 2013. Given the relevant review period for the scope of the survey, the Department inquired about the most recent revision dates for these documents. In its written response, the Plan stated, "All 4 policies were last updated December 2013 and there have been no program changes since then."

## **2. Low Member Participation**

During onsite interviews, the Department inquired about the Plan's criteria for identifying members who are eligible for receiving complex case management. Plan staff explained that filters are used to tighten the eligibility criteria. One of the criteria used is the Plan's "Care Analyzer Resource Utilization Band" (RUB). For example, applying a RUB of "4" limits the potential number of eligible members to approximately 10,000. However, the Plan applies a RUB of "5" to limit the potential number of eligible members to approximately 5,000 to target only those members who are the most vulnerable and at the highest risk. Plan staff indicated that it would be a huge undertaking to case manage even this many members due to its limited resources such as staffing capacity. Therefore, additional criteria are applied.

To gauge the number of members receiving complex case management as well as the number of members *eligible* for receiving complex case management, the Department requested that the Plan provide this data for the relevant survey review period. The Plan generated a report, *CCM Members Identified and Enrolled During and Post Audit Period*, which included the following data:

(A) Unique Members Identified for CCM 4/1/2014-3/31/2015	403
(B) Unique Members from (A) w/ CCM Case Created 4/1/2014-3/31/2015	189
(C) % of Members (B/A)	47%

The data suggests that the Plan initiated a case for almost half of all members identified as eligible for receiving complex case management. However, review of the raw data in the report indicates that as of the onsite survey, only nine members were actively receiving complex case management services, three of which were SPDs.<sup>12</sup> The extremely low participation level presents a concern as the Plan serves approximately 210,887 Medi-Cal members, 25,602 of which are SPDs.

The Department identified one significant trend and noted that in 199 of the 403 members identified as eligible for complex case management, the "Case Closed Reason" column in the report indicated "Unable to contact member." In onsite interviews, Plan staff confirmed that the

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<sup>12</sup> Nine members were identified as actively receiving complex case management services as indicated by the "IN\_PROGRESS" notation in the "Current Case Status" column on the spreadsheet. The report reflects data as of the June 15, 2015 (report generation date).

inability to contact eligible members has been a significant challenge despite the Plan's outreach efforts.

The Plan's policy, *MED-CM-0001: Complex Case Management (CCM) Identification, Screening, Assessment and Triage*, delineates outreach procedures for contacting members eligible for complex case management. On page 5, it states:

3. The Case Manager will outreach the member at least 2 times via phone.
  - a. Initial member telephonic outreach will be made during working hours Monday through Friday from 8:00 AM-5:00 PM within the priority standards outlined above. If unable to reach the member, a follow up attempt will be made again using the priority standards and documented within the Member Contact Attempt structured note. If still not able to reach the member, a letter will be mailed to the member as a third attempt using the priority standards. The letter is contained within TruCare as a template letter, called Unable to Contact Letter. For each of these attempts, a task will be created to follow up on the attempted contact, called Member Contact Follow Up. Case Manager may close case if member is unable to contact. See case closure section[.]

However, the report does not consistently document outreach attempts made by the Plan nor provide any details regarding the dates and/or times of the telephone calls. While the Plan's policy does not specify any time intervals for outreach or case closure, the Department noted wide variations in timeframes from when the member was first identified as eligible for complex case management to when the case was closed due the inability to contact the member. For example:

- *Line #13 on log (000001635):* This member was first identified by the Plan as eligible for complex case management on June 2, 2014. The member subsequently appeared on the July 11, 2014 and August 12, 2014 monthly eligibility reports. The case was created on September 24, 2014. The case was closed on June 8, 2015 (one year from referral). However, there were no documented outreach attempts although the "Case Closed Reason" stated, "Unable to contact member."
- *Line #23 on log (000010571):* The member was first identified by the Plan as eligible for complex case management on November 11, 2014. The case was created on December 2, 2014. The case was closed on December 12, 2014 (one month from referral). However, there were no documented outreach attempts although the "Case Closed Reason" stated, "Unable to contact member."

### **3. Timeliness of Referrals**

The Plan's policy, *MED-CM-0004: Referrals To and From Complex Case Management (CCM)*, specifies the following referral processing timeframes on page 4:

1. The CM designee processes referral requests within one working day from receipt of the request for CCM services.

2. Recipients of the CCM Referral shall open the referral according to the CM designee case priority classification:
  - a. Urgent – referral opened within 24 hours referral opened within 1 working day
  - b. Routine – referral reviewed within 5 days
  - c. Report – referrals will be reviewed with 30 days

As indicated in the previous section, three SPDs were identified as actively receiving complex case management services. However, none of these cases were processed within the timeframes delineated in the Plan’s policy. For example:

- *Line #76 on log (000056307):* This member was first identified by the Plan as eligible for complex case management on June 2, 2014. The member subsequently appeared on the July 11, 2014 and August 12, 2014 monthly eligibility reports. The case was created on September 4, 2014 (94 calendar days from initial referral; 23 calendar days from the last eligibility report).
- *Line #146 on log (000106667):* This member was first identified by the Plan as eligible for complex case management on August 12, 2014. The case was created on September 8, 2014 (27 calendar days from referral).
- *Line #253 on log (000192129):* This member was first identified by the Plan as eligible for complex case management on January 20, 2015. The member subsequently appeared on the February 11, 2015 monthly eligibility report. The case was created on February 17, 2015 (28 calendar days from initial referral; 6 calendar days from the last eligibility report).

#### **4. Lack of PCP Education or Collaboration**

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 11, Provision 1(B) requires the Plan’s complex case management services to be provided by the PCP in collaboration with the Plan. The Plan’s policy, *MED-UM-0002: Coordination of Care*, emphasizes the primary role of the PCP in coordinating members’ care. On page 1, it states:

##### Primary Care Physician (PCP) Role

Continuity and Coordination of care is ensured through the Primary Care Physician (PCP) who is formally designated as having primary responsibility for coordinating the member’s overall health care. The PCP has the responsibility and authority to direct and coordinate the members’ services. These responsibilities include: 1) act as the primary case manager for all assigned members, 2) Assess the acute, chronic and preventive needs of each member, and 3) Employ disease management protocols to manage member’s chronic health conditions.

However, during onsite interviews, Plan staff indicated that during the survey review period, no provider education was conducted to inform PCPs about the components of the Plan's Comprehensive Case Management Program. PCPs were not assisted with initiating complex case management services as lists of eligible members were not provided by the Plan. Plan staff indicated that they intend on developing strategies to foster a more robust provider education program and increase case management referrals and support for PCPs.

**Conclusion:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 11, Provision 1 requires the Plan to ensure the provision of comprehensive medical case management to each member. These services can be provided through either basic or complex case management activities based on the medical needs of the member. Both basic and complex case management are provided by the PCP in collaboration with the Plan. Provision 1(B) specifies the minimum requirements of complex case management services, including the coordination of resources and involvement by a multidisciplinary case management team to manage acute or chronic illnesses, including emotional and social support issues. Provision 1(C) requires the Plan to develop methods to identify members who may benefit from complex case management services using a variety of utilization data and other sources.

The Department's review revealed the following concerns regarding the provision of complex case management services, specifically: 1) no annual program evaluation, 2) low participation of members, 3) timeliness of referrals, and 4) lack of PCP education and collaboration. While the Plan has robust policies and procedures in place that specifically address the various topics concerning complex case management such as referral processes, criteria for identification and screening, and care plan development and evaluation, only nine members (three of which were SPDs), were identified as receiving complex case management. Therefore, the Department finds the Plan in violation of these contractual requirements.

## AVAILABILITY AND ACCESSIBILITY

**Potential Deficiency #7: 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 appointments.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4(B)(1) and (2) – Access Standards; Rule 1300.67.2.2(c)(1); Rule 1300.67.2.2(c)(5)(A) and (B); Rule 1300.67.2.2(d)(3).

### DHCS-Alameda Alliance For Health 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.

## B. Standards for Timely Appointments

Members must be offered appointments within the following timeframes:

1. Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
2. Urgent appointment for services that do require prior authorization – within 96 hours of a request[.]

### Rule 1300.67.2.2(c)(1)

(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

### Rule 1300.67.2.2(c)(5)(A) and (B)

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G);

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (G);

### Rule 1300.67.2.2(d)(3)

(3) 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.

### **Documents Reviewed:**

- Plan Policy AAH-CMP-0024: Monitoring of Access & Availability Standards (effective 03/31/15)
- Plan Policy MED-DEL-0025: Appointment Access & Availability (effective 03/31/15)
- 2014 Appointment Availability & After-Hours Audits – The Myers Group
- Summary of Timely Access Report – Measurement Year 2014 (03/31/15)
- Provider Appointment Availability Survey Results Summary (2014)
- Alameda Alliance for Health Request for Corrective Action Plan – Community Health Center Network (03/23/15)
- Corrective Action Request – Beacon Health Strategies (02/18/15)
- DMHC Change Log (05/05/15)

**Assessment:** Rule 1300.67.2.2(c)(1) requires the Plan to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee’s condition consistent with good professional practice. The Plan must establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. 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.

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9, Provision 4(B)(1) and (2) and Rule 1300.67.2.2(c)(5)(A) and (B) specify the following standards for timely urgent care appointments:

- Urgent care appointments not requiring prior authorization must be offered within 48 hours of the request.
- Urgent care appointments requiring prior authorization must be offered within 96 hours of the request.

To measure compliance with these standards, the Plan conducted a provider appointment and availability survey for the 2014 measurement year. The survey, conducted by the Myers Group (an external vendor), targeted all Plan providers (PCPs and specialists), including directly contracted providers and delegated groups. Daytime telephone interviews were conducted with providers to determine adherence to appointment wait time standards. The Plan’s *Summary of Timely Access Report – Measurement Year 2014* incorporates the results of the Myers Group’s findings with the Plan’s own internal analysis and corrective actions taken. On page 5, it defines a “failing” compliance rate as 65% or less.

The Department reviewed the *2014 Appointment Availability & After-Hours Audits – The Myers Group* report. The following observations were noted regarding low rates of compliance for both PCP and specialist urgent care appointments:

- There was a significant decrease (17.8%) in the compliance rate for PCP urgent care appointments not requiring prior authorization from 2013 to 2014.

<b>Urgent Care Appointments (PCP)</b>	<b>2014</b>	<b>2013</b>
Appointments <u>not</u> requiring prior authorization – within 48 hours of request	61.9%	79.7%

- For two consecutive years, the compliance rates for specialist urgent care appointments (for those that do and do not require prior authorization) fell below the Plan’s 65% standard.

<b>Urgent Care Appointments (Specialist)</b>	<b>2014</b>	<b>2013</b>
Appointments <u>not</u> requiring prior authorization – within 48 hours of request	61.7%	57.6%
Appointments requiring prior authorization – within 96 hours of request	63.8%	53.0%

- One of the Plan’s delegates, Community Health Center Network (CHCN), had a particularly low rate of compliance for both PCP and specialist urgent care appointments in 2014.

<b>Urgent Care Appointments</b>	<b>2014</b>
Appointments <u>not</u> requiring prior authorization – within 48 hours of request	50.0% (PCP) 56.4% (Specialist)
Appointments requiring prior authorization – within 96 hours of a request	56.5% (Specialist)

The Plan did issue two corrective action plans (CAPs) during the last two months of the survey review period. One CAP was issued to CHCN on March 23, 2015, and another CAP was issued to the Plan’s behavioral health delegate, Beacon, on February 18, 2015. While the Department credits the Plan with these efforts during the latter portion of the survey review period, the low rates of compliance for two consecutive years without immediate action demonstrate the Plan’s lack of prompt investigation to bring its network into compliance, in violation of Rule 1300.67.2.2(d)(2).

In light of the interventions brought on by the conservatorship, the Plan developed a document entitled, *DMHC Change Log*, to track all internal corrective actions implemented by the Plan. The Department noted that the log had already identified compliance with timely urgent care appointments as one of the areas in need of improvement and documented the following:

*Requirement:* Plan monitors compliance with time elapsed appointment standards defined in section 1300.67.2.2.(c) (A-H) including urgent care appointments with no prior authorization within 48 hours

*Corrective Action Plan:* Implement monitoring reports for urgent care appointment access

*Actions Taken:* Created MED-DEL-0025 Appointment Access & Availability P&P; Created AAH-CMP-0024 Monitoring of Access & Availability Standards; revised MED-QM-0024 Provider Access and Availability Survey. Workgroup met on 4/27/15 to discuss possible process changes. Plan to establish process through the Access and Availability committee. Next workgroup meeting scheduled on 5/11/15 to discuss actions and next steps of implementation.

*Target Date for Completion: 6/1/2015*

The Department confirmed that two new policies, *AAH-CMP-0024: Monitoring of Access & Availability Standards*, and *MED-DEL-0025: Appointment Access & Availability*, on March 31, 2015 (the last month of the survey review period.) The Plan's policy, *AAH-CMP-0024: Monitoring of Access & Availability Standards*, demonstrates the Plan's intent on complying with the timely access standards. Aside from conducting annual provider and member satisfaction surveys, the Plan commits to performing more frequent monitoring on a quarterly basis. On page 1, it states:

The Alliance performs ongoing monitoring of its provider network to identify any changes within its network and deficiencies related to Access and Availability. The monitoring process includes the following activities:

...

- 4) Reviewing and evaluating, on at least a quarterly basis, data across the Plan related to accessibility [sic], continuity [sic] of care, and availability of services to identify trends across the Plan's operations. Data is taken from monitoring reports, provider and member surveys, member and provider grievances and appeals, triage or screening services [sic], access to behavioral health services, and advanced access programs.

If the Alliance discovers deficiencies [sic] within the provider through the monitoring [sic] process, prompt investigation and corrective action is implemented to correct the deficiencies [sic]. The Alliance will take all necessary and appropriate actions to maintain compliance of the access and availability standards for its provider network.

**Conclusion:** Rule 1300.67.2.2(c)(1) requires the Plan to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. The Plan must establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. 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. Rule 1300.67.2.2(c)(5)(A) and (B) specify the standards for timely urgent care appointments (within 48 hours for those not requiring prior authorization; within 96 hours for those requiring prior authorization). DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9, Provision 4(B)(1) and (2) require the Plan to ensure the provision of acceptable accessibility standards in accordance with Section 1300.67.2.2 as well as mirror the requirements for timely urgent care appointment standards.

The Department's review of the Plan's provider appointment and availability survey revealed there was a significant decrease (17.8%) in the compliance rate for PCP urgent care

appointments not requiring prior authorization from 2013 to 2014. While rates of compliance for urgent care specialist appointments have risen from 2013, and the Plan did issue CAPs to two of its delegates during the latter portion of the survey review period, the low rates of compliance still fell below the Plan's 65% "failing" standard for two consecutive years without immediate action by the Plan to bring its network into compliance. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

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**Potential Deficiency #8: The Plan does not ensure that during normal business hours, the waiting time for a member to speak by telephone with a Plan customer service representative does not exceed ten minutes.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4 – Access Standards; DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 13 – Member Services, Provision 2(A) – Member Services Staff; Rule 1300.67.2.2(c)(10).

DHCS-Alameda Alliance For Health 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.

DHCS-Alameda Alliance for Health Contract, Exhibit A, Attachment 13 – Member Services  
2. Member Services Staff

A. Contractor shall maintain the capability to provide Member services to Medi-Cal Members or potential members through *sufficient assigned* and knowledgeable staff. [Emphasis added.]

Rule 1300.67.2.2(c)(10)

(10) Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes.

**Documents Reviewed:**

- Plan Policy AAH-CMP-0024: Monitoring of Access & Availability Standards (effective 03/31/15)
- Plan Policy MED-DEL-0025: Appointment Access & Availability (effective 03/31/15)
- Health Care Quality Committee meeting minutes (09/18/14)
- Member Services Dashboard 2014 Blended Customer Service Results – MediCal and Group Care
- DMHC Change Log (05/05/15)

**Assessment:** DHCS-Alameda Alliance for Health Contract, Exhibit A, Attachment 13, Provision 2(A) requires the Plan to maintain the capability to provide member services to Medi-

Cal members through sufficient staff. Rule 1300.67.2.2(c)(10) further specifies that during normal business hours, the waiting time for an enrollee to speak by telephone with a Plan customer service representative knowledgeable and competent regarding the enrollee’s questions and concerns not exceed ten minutes.

Review of the Plan’s Health Care Quality Committee (HCQC) meeting minutes of September 18, 2014 indicate that in the months preceding the survey review period, the Plan experienced a mass increase membership and system related issues that contributed to high volume of member calls. On page 2, it states:

In January 2014 the membership increased by 30k. The increase in grievances in January and February were partly due to the increase in membership as well as internal system issues related to implementation of new data systems. Members were unable to speak with representatives due to high call volume and eligibility issues with the implementation of new systems.

In onsite interviews, the Plan’s Director of Member Services confirmed that the volume of member calls received at the end of 2013 had increased from an average of approximately 18,000 calls per month to 60,000 calls per month in January 2014. The Plan provided its *Member Service Dashboard 2014 Blended Customer Service Results – MediCal and Group Care* report, which included the following data:

Alliance Member Services Staff	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Incoming Calls (MS)	60487	46598	30530	27295	25430	24326	23806	24327	20575	21686	14304	15511
Abandoned Rate (MS)	81.4%	83.4%	65.3%	57.5%	58.8%	55.3%	61.3%	65.3%	43.1%	43.8%	26.5%	25.2%
Answered Calls (MS)	11316	7748	10609	11611	10476	10892	9232	8451	11695	12178	10503	11577
Calls Answered in 30 Seconds (All)	0.7%	1.0%	4.2%	6.1%	6.1%	6.1%	3.9%	3.8%	9.5%	9.5%	22.3%	30.2%

The data demonstrates a high call abandonment rate of 81.4% in January 2014. By April 2014 (first month of the survey review period), the abandonment rate had decreased to 57.5%, and by December 2014, it had decreased further to 25.2%. Nevertheless, from April to October 2014 (also during the survey review period), abandonment rates ranged from 43.1% to 65.3% (an average of 55.0%), indicating that over half of all callers were unable to speak to a Plan representative.

While the Plan did not measure compliance with the ten-minute wait time standard, the Plan’s Director of Member Services acknowledged that during January and February 2014, wait times for members to speak to a Plan representative averaged one hour. Since then, the Plan has directed its focus on addressing the volume of calls and reported that wait times were now averaging approximately 30 seconds to one minute.

In light of the interventions brought on by the conservatorship, the Plan developed a document entitled, *DMHC Change Log*, to track all internal corrective actions implemented by the Plan. The Department noted that the log had already identified compliance with telephone wait times to speak to a Plan representative as one of the areas in need of improvement and documented the following:

*Requirement:* The Plan ensure that, during normal business hours, the wait time for an enrollee to speak by telephone with a Plan customer service representative does not exceed ten minutes

*Corrective Action Plan:* Update P&P to include standard with timeframe; monitor calls routinely to reduce wait times to be less than 10 minutes

*Actions Taken:* Created AAH-CMP-0024 Monitoring of Access & Availability Standards. Workgroup met on 4/27/15 to discuss possible process changes. Plan to establish process through the Access and Availability committee. Next workgroup meeting scheduled on 5/11/15 to discuss actions and next steps of implementation.

*Target Date for Completion:* 6/1/2015

The Department noted that while the Plan's policy, *AAH-CMP-0024: Monitoring of Access & Availability Standards*, did not address the ten-minute wait time standard (as prescribed by the Plan's action plan), the Plan created an alternate policy *MED-DEL-0025: Appointment Access & Availability*, on March 31, 2015 (the last month of the survey review period) which does incorporate this requirement. On page 3, it states, "During normal business hours, the waiting time for members to speak by telephone with an Alliance Member Services representative knowledgeable and competent in addressing member's questions and concerns shall not exceed ten (10) minutes."

**Conclusion:** DHCS-Alameda Alliance for Health Contract, Exhibit A, Attachment 13, Provision 2(A) requires the Plan to maintain the capability to provide member services to Medi-Cal members through sufficient staff. Rule 1300.67.2.2(c)(10) further specifies that during normal business hours, the waiting time for an enrollee to speak by telephone with a Plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns not exceed ten minutes. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9, Provision 4 requires the Plan to ensure the provision of acceptable accessibility standards in accordance with Rule 1300.67.2.2.

The Plan submitted documentation to show that during seven months of the relevant survey review period, abandonment rates ranged from 43.1% to 65.3% (an average of 55.0%). This indicates that over half of all callers were unable to speak to a Plan representative at all (including within ten minutes), demonstrating that the Plan did not have sufficient staff available to address member questions and concerns. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

## MEMBER RIGHTS

**Potential Deficiency #9: The Plan’s grievance system does not consistently ensure that all expressions of dissatisfaction are captured as grievances and that a written record is made for each grievance received.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Section 1368(a)(4)(B); Rule 1300.68(a)(1); Rule 1300.68(b)(5); Rule 1300.68(d)(8).

### DHCS-Alameda Alliance For Health 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.

#### Section 1368(a)(4)(B)

B. Grievances received by telephone, by facsimile, by e-mail, or online through the plan's website pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:

- (i) The date of the call.
- (ii) The name of the complainant.
- (iii) The complainant's member identification number.
- (iv) The nature of the grievance.
- (v) The nature of the resolution.
- (vi) The name of the plan representative who took the call and resolved the grievance.

#### Rule 1300.68(a)(1)

(1) “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(b)(5)

(b) The plan's grievance system shall include the following:

(5) A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to Section 1300.69, and by an officer of the plan or his designee. This review shall be thoroughly documented.

Rule 1300.68(d)(8)

(d) The plan shall respond to grievances as follows:

(8) 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).

**Documents Reviewed:**

- Plan Policy MED-CGR-0001: Member Grievances and Appeals (older version revised 10/27/14; redlined version revised 04/13/15; updated version revised 04/13/15)
- Plan Policy MEM-GEN-0024: Exempt Grievances (effective 04/13/15)
- Email from the Director of Member Services to staff: Informal Complaints (06/03/14)
- Member Grievance Analysis Report – Compliance Department (July 2014)
- Health Care Quality Committee meeting minutes (09/18/14)
- Grievance and Appeals Self Audit Tool (02/09/15)
- DMHC Change Log (05/05/15)
- Member Services Dashboard 2014 – Call Reasons (Medi-Cal and Group Care)
- Member Services Dashboard 2014 – Call Reasons (Medi-Cal and Group Care)
- Exempt Grievance Log (04/01/14 – 03/31/15)
- Standard Grievance Log (04/01/14 – 03/31/15)

**Assessment:** Rule 1300.68(a)(1) defines a grievance as any written or oral expression of dissatisfaction. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. Rule 1300.68(b)(5) requires the Plan to maintain a written record for each grievance received by the Plan.

To first gauge the volume of grievances that the Plan receives and processes, in its pre-on-site request, the Department requested a log of both “standard” and “exempt” grievances for the survey review period. While both considered “expressions of dissatisfaction” (and therefore “grievances”), standard and exempt grievances have slightly different requirements for resolution timeframes and member notification. Standard grievances require resolution within

30 calendar days and warrant written acknowledgment and response to the member. By contrast, exempt<sup>13</sup> grievances, are generally more simplistic in nature and require resolution by the close of the next business day. Exempt grievances do not warrant written acknowledgment and response to the member, but do require maintenance in a log for periodic review.

While the Plan produced a log of 467 standard SPD grievances, the Plan only produced a log of 12<sup>14</sup> exempt SPD grievances. Given the Plan's membership of approximately 25,000 SPDs, the Department was concerned with the low number of exempt grievances reported during the survey review period. During onsite interviews, Plan staff confirmed that not all exempt grievances were captured during the survey review period. Through further investigation, the Department determined that the following factors partially contributed to the Plan's under-reporting of exempt grievances: 1) lack of clear policies and procedures, 2) inadequate staff training, and 3) system implementation issues.

### **1. Policies and Procedures**

The Plan did not have a specific policy or procedure in place to address the identification and handling of exempt grievances during the survey review period. In light of the interventions brought on by the conservatorship, the Plan developed a document entitled, *DMHC Change Log*, to track all internal corrective actions implemented by the Plan. The log identified exempt grievance handling as one of the areas in need of improvement and documented the following:

*Requirement:* Maintain an exempt grievance log that includes the date of the call, the name and id number of the complainant, the nature of the grievance, the resolution, and the representative who took the call and resolved the grievance

*Corrective Action Plan:* Create P&P for exempt grievance process and transition to G&A when not resolved within 1 business day. Update the current process between MS and G&A department to ensure log captures all elements; create monitoring activities (reporting, tracking trending cases)

*Actions Taken:* Updated MED-CGR-0001 to add missing grievance log elements. Workgroup met on 4/22/15 to discuss possible process changes. Next workgroup meeting scheduled on 5/06/15 to discuss actions and next steps of implementation.

*Target Date for Completion:* 6/1/2015

While outside the scope of the survey review period, the Plan submitted its newly implemented policy, *MEM-GEN-0024: Exempt Grievances*, which became effective on April 13, 2015 (two

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<sup>13</sup> Exempt grievances are complaints that are 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.

<sup>14</sup> 14 files were initially reviewed. 2 files were excluded from review because they were not member complaints. Therefore, 12 remaining files were reviewed.

weeks after the end of the survey review period). The policy demonstrates alignment with the requirements of Section 1368(a)(4)(B) and Rule 1300.68(d)(8).

## **2. Staff Training**

The under-reporting of exempt grievances is also evident though the Plan's training efforts conducting early on during the survey review period to address this issue. In light of the interventions brought on by the conservatorship, Plan staff indicated that much staff education and re-training took place to increase the accuracy of exempt grievance reporting by member services representatives (MSRs). The Plan provided an email dated June 3, 2014 (two months into the survey review period) that was sent to all MSRs who handle the initial intake of member calls. The email included direction from the Plan's Director of Member Services regarding immediate process changes on how to appropriately identify and classify exempt grievances.

The Department attempted to identify concrete examples of expressions of dissatisfaction that may not have been classified as grievances by MSRs during the survey review period. Therefore, the Department requested the Plan's inquiry log but in its written response, the Plan stated, "There is no inquiry log that documents each call." Rather, the Plan provided its *Member Services Dashboard* which only included raw data and percentages for the number of calls received for each call reason category. However, without documented case notes for each inquiry, the Department was unable to verify whether calls captured as "Change of PCP/Medical Home," "Care Coordination," or "Pharmacy," for example, were true inquires as opposed to expressions of dissatisfaction. Nevertheless, due to the Plan's acknowledgement that exempt grievances were under-reported, and the Plan's inability to produce the inquiry log which would have documented these grievances, the Plan is in violation of Rule 1300.68(b)(5) which requires the Plan to maintain a written record for each grievance received, and Rule 1300.68(d)(8) which requires the Plan to maintain a log of all exempt grievances.

## **3. System Issues**

The Department reviewed the Plan's *Member Grievance Analysis* report, which partially attributes the under-reporting of exempt grievances to implementation of the Plan's new system that tracks grievance data. While the report provides an analysis of grievance data for the two quarters proceeding the survey review period, the summary is still relevant to the scope of the current survey as it reports that implementation of the new system began during the pertinent review period. On page 6, it states:

Prior to this analysis, these grievances were tracked within the Diamond system. After the transfer to the HealthSuite system, much of the data capture and reporting had to be reconfigured in the new system, and this disabled the capture of grievances as before. As of May 25, 2014, these are now being identified and tracked in the HealthSuite system for reporting and analysis by Member Services.

Therefore, the capturing of exempt grievances in the Plan's current system did not begin until May 25, 2014 (almost two months after the survey review period commenced). The *Member Grievance Analysis* was reviewed by the Plan's HCQC, who made further made note of the Plan's system issues in the September 18, 2014 meeting minutes. On page 2 of the meeting

minutes, it stated, “Members were unable to speak with representatives due to high call volume and eligibility issues with the implementation of new systems.”

**Conclusion:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14, Provision 1 requires the Plan to implement and maintain a Member Grievance System in accordance with Rule 1300.68. Rule 1300.68(a)(1) defines a grievance as any written or oral expression of dissatisfaction. Rule 1300.68(b)(5) requires the Plan to maintain a written record for each grievance received by the Plan. Section 1368(a)(4)(B) and Rule 1300.68(d)(8) delineate specific requirements for exempt grievance handling, including maintenance of those grievances in a log for periodic review.

Given the Plan’s membership of approximately 25,000 SPDs, the Department was initially concerned with the low number of exempt grievances reported during the survey review period (only 12). During onsite interviews, Plan staff confirmed that not all exempt grievances were captured during the survey review period. Through further investigation, the Department determined that the following factors partially contributed to the Plan’s under-reporting of exempt grievances: 1) lack of clear policies and procedures, 2) inadequate staff training, and 3) system implementation issues. Furthermore, the Plan was unable to produce its inquiry log, which would have included documentation of all under-reported grievances received by the Plan, including those that would have been classified as exempt and potentially maintained in a separate log for periodic review. Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

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**Potential Deficiency #10: The Plan’s grievance system does not consistently ensure adequate consideration of exempt grievances and rectification when appropriate.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Section 1368(a)(1); Rule 1300.68(a)(4).

DHCS-Alameda Alliance For Health 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.

Section 1368(a)(1)

(a) 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)(4)

(4) "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

**Documents Reviewed:**

- Plan Policy MED-CGR-0001: Member Grievances and Appeals (older version revised 10/27/14; redlined version revised 04/13/15; updated version revised 04/13/15)
- Plan Policy MEM-GEN-0024: Exempt Grievances (effective 04/13/15)
- Grievance and Appeals Self Audit Tool (02/09/15)
- DMHC Change Log (05/05/15)
- Exempt Grievance Log (04/01/14 – 03/31/15)
- 29 Standard grievance files (04/01/14 – 03/31/15)
- 20 Expedited grievance files (04/01/14 – 03/31/15)
- 14 Exempt grievance files (04/01/14 – 03/31/15)

**Assessment:** Section 1368(a)(1) requires that the Plan establish and maintain a grievance system that ensures adequate consideration of member grievances and rectification when appropriate. To assess compliance with this standard, the Department reviewed a random sample of grievance files as well as examined key policies and procedures.

**1. File Review**

The Department reviewed a random sample of standard, expedited, and exempt grievance files. The Department determined that non-compliance with Section 1368(a)(1) was limited to exempt grievances specifically. In four (33%) of 12<sup>15</sup> exempt grievances reviewed, the Plan failed to adequately resolve the member's grievance. For example:

- *File #3:* Documented case notes by the Plan's member services representative (MSR) indicate that the member called to express concern that her Plan identification card showed a 2008 effective date rather than a 2014 effective date. With the assistance of an interpreter from the Plan's vendor, the MSR attempted to educate the member on the interface between Medicare and Plan coverage. The MSR documented the call as follows:

UPSET THAT HER AAH CARD DOES NOT SAY EFFECTIVE 2014  
IT SHOWS 2008 WHICH IS WHEN SHE STARTED. CALL  
THROUGH IEC VIETAMESE INTERPT, I EXPLAINED MBR HAS  
MEDICARE PRIMARY AND THHOSE [sic] CARD SHOULD BE

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<sup>15</sup> Fourteen files were initially reviewed. Two files were excluded from review because they were not member complaints. Therefore, 12 remaining files were reviewed.

SHOWN FIRST AND THEN HER MEDICAL AND AAH CARD. MBR DID NOT UNDERSTAND. I EXPLAINED THAT IF A DR WAS REFUSING TO SEE HER SHE NEEDS TO CONTACT MEDICARE.

The member's documented confusion by the end of the phone call provides indication that the Plan did not fully resolve the member's complaint. Rule 1300.68(a)(4) defines "resolved" as meaning that the grievance has reached a final conclusion with respect to the member's grievance. However, from the member's perspective, no resolution had been reached. There was no documented follow-up attempt to ensure that the member understood the explanation and realized that no action needed to be taken, or indication that the case had been referred to the Grievance and Appeals Department so that the Plan could provide a written resolution to the member, which may have aided with increasing the member's understanding.

- *File #7:* Documented case notes by the Plan's MSR indicate that the member called approximately one week in advance to schedule an Arabic interpreter for a hospital appointment. However, no interpreter showed up on the day of the appointment. When the member contacted the Plan by telephone to express dissatisfaction, the MSR could only confirm the date the member had made the request, but was unable to determine why the interpreter was not present for the appointment. The MSR apologized to the member and said the issue would be investigated and reported to management. While the apology and assurances made to the member may have resolved the grievance from the member's perspective, there was no documentation indicating that these issues had actually been forwarded to management for further investigation.
- *File #8:* Documented case notes by the Plan's MSR indicate that the member called one week in advance to schedule a Spanish interpreter for her oncology appointment. She contacted the Plan by telephone on the day of her appointment to confirm that an interpreter would be present. However, the MSR could only locate notes that indicated the request was pending. The MSR contacted the Plan's language service vendor and was told by the vendor that the Plan had been alerted that an interpreter would not be available. The member expressed dissatisfaction to the MSR and indicated that an interpreter had not shown up for her prior appointment the previous week. The member indicated that she could not understand why the Plan could not provide an interpreter to her appointments since she provides enough advanced notice. The member further indicated that her appointments were very important.

The Plan's *Exempt Grievance Log* indicates that the case was resolved with an apology from the MSR. However, this resolution appears inadequate given the fact that the member was complaining not only about one isolated incident, but rather two instances with difficulties scheduling an interpreter. Further consideration and rectification of the grievance would have been appropriate in this case such as escalation to a manager or follow-up with the Plan's language service vendor.

- *File #12:* Documented case notes by the Plan's MSR indicate that the member reported that a Cantonese interpreter had not showed up for her last two dermatology appointments. As a result, she was unable to have surgery and there was a delay in her treatment. The member also indicated that the interpreter does not always interpret everything that the doctor says. The MSR documented the resolution of the call as follows:

WHAT THE RESOLUTION WAS: ADVISED MBR HAS THE OPTION TO FILE A COMPLAIN[T] AND WE WILL FURTHER INVESTIGATE THE ISSUE. ALSO EXPLAINED TO MBR THAT INTRP IS A COURTESY SERVICE TO OUR MBR[S]. MBR CAN ALSO GIVE A CALL 1 OR 2 DAYS AHEAD TO CHECK THE AVALIBILITY [sic]. MBR SAID SHE WANTS TO THINK ABOUT IT AND CALL BACK TO FILE A FORMAL COMPLAIN[T].

Although the member was already expressing dissatisfaction, the MSR advised the member of the option of filing a complaint to have the issue further investigated. The MSR also indicated that interpretation services were a courtesy service offered to members. This resolution appears inadequate given the fact that the lack of interpreter for two appointments had already delayed the member's care. In addition, the resolution did not address the member's complaint that the interpreter does not always interpret everything that the doctor says. Therefore, not all issues received adequate consideration and rectification as appropriate.

## **2. Policies and Procedures**

In light of the interventions brought on by the conservatorship, the Plan developed a document entitled, *DMHC Change Log*, to track all internal corrective actions implemented by the Plan. The Department noted that the log had already identified compliance with the requirements of Section 1368(a)(1) as one of the areas in need of improvement and documented the following:

*Requirement:* Plan ensure adequate consideration and rectification of enrollee grievances when appropriate.

*Corrective Action Plan:* Revise G&A P&P to include in procedure that there is adequate consideration and rectification of enrollee grievances when appropriate. Process already includes member grievance statement filed orally or in writing

*Actions Taken:* Updated MED-CGR-0001 P&P to include requirement

*Target Date for Completion:* 4/15/2015

*Completion Date:* 4/13/2015

While outside the scope of the survey review period, the Department reviewed the Plan's redlined version of policy, *MED-CGR-0001: Member Grievances and Appeals*, which was

revised on April 13, 2015 (two weeks after the end of the survey review period). The redlined version incorporates use of the following statement, “The G&A Unit considers and rectifies member’s grievance statements as a part of the grievance and appeal review process.”

However, given the fact that the Department’s findings were limited to exempt grievances exclusively, the Department sought out to examine the Plan’s exempt grievance policy. As noted in Deficiency #9, the Plan did not have a specific policy or procedure in place to address exempt grievances during the survey review period. The Plan submitted its newly implemented policy, *MEM-GEN-0024: Exempt Grievances*, which became effective on April 13, 2015 (two weeks after the end of the survey review period). While outside the scope of the review period, the policy does address the Plan’s efforts to investigate each complaint. On page 2 it states:

Member Services staff will investigate the complaint and provide resolution to member within the close of the next business day. If the complaint cannot be resolved within the close of the next business day, the complaint will be forwarded to the G&A Unit to process as a formal grievance.

However, while each of the examples presented above were “closed” within the one business day, the cases were not fully “resolved” and therefore may not have met the conditions for exempt grievance processing, had they received adequate consideration and rectification as appropriate.

**TABLE 3**  
**Exempt Grievances**

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Exempt Grievances	12	Adequate consideration and rectification when appropriate	8 (67%)	4 (33%)

**Conclusion:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14, Provision 1 requires the Plan to implement and maintain a Member Grievance System in accordance with Rule 1300.68. Section 1368(a)(1) requires the Plan to establish and maintain a grievance system that ensures adequate consideration of member grievances and rectification when appropriate. Rule 1300.68(a)(4) defines “resolved” to mean that the grievance has reached a final conclusion with respect to the member’s submitted grievance, and there are no pending member appeals within the Plan’s grievance system, including entities with delegated authority.

The Department’s findings revealed that in 33% of exempt grievance files reviewed, the Plan did not consistently ensure adequate consideration and rectification when appropriate. While grievances were closed within the one business day, the Plan did not ensure that the cases were fully resolved. Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

**Potential Deficiency #11: The Plan does not consistently ensure that Limited English Proficient members receive coordinated interpreter services at the time of scheduled appointments.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4 – Access Standards, and Provision 14(A) – Linguistic Services; Rule 1300.67.2.2(c)(4).

DHCS-Alameda Alliance For Health 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.

14. Linguistic Services

A. Contractor shall comply with Title 22 CCR Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries and potential members receive 24-hour oral interpreter services at all key points of contact, as defined in Paragraph D of this provision, either through interpreters, telephone language services, or any electronic options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.

Rule 1300.67.2.2(c)(4)

(4) Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointment for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.

**Documents Reviewed:**

- 2015 Cultural and Linguistic Services Program Description (updated 12/29/14)
- Plan Policy MED-CL-0003: Language Assistance Services (redlined version revised 04/13/15)
- Plan Policy MED-CL-0011: Compliance Monitoring of Cultural and Linguistic Services Program (effective 02/13/15)
- 3 exempt grievance files (04/01/2014 – 03/31/15)

**Assessment:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9, Provision 14(A) requires the Plan to ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal members receive 24-hour oral interpreter services at all key points of contact, and that lack of interpreter services do not impede or delay timely access to care. Rule 1300.67.2.2(c)(4) further indicates that interpreter services be coordinated with scheduled appointments to ensure the provision of interpreter services at the time of the appointment.

The Plan's policy, *MED-CL-0011: Compliance Monitoring of Cultural and Linguistic Services Program*, indicates that one of the ways that the Plan monitors its Cultural and Linguistic Services Program is through internal review of grievance data. On page 1, it states:

Alameda Alliance for Health ("Alliance") monitors the established Cultural and Linguistic Services Program as a part of the Alliance's Quality Improvement Program. As part of the examination, all processes related to providing cultural and linguistic services are monitored including:

- *Member and provider grievances and complaints related to cultural and linguistic services;*

...

The Compliance Department monitors the language assistance services of its provider network to ensure they continuously abide by the standards set forth in the Alliance's Department of Health Care Services (DHCS) contract and all state and federal regulatory requirements. *When necessary, corrective action plans (CAPs) are created for providers and monitored to ensure problematic issues are addressed.* [Emphasis added.]

Therefore, while conducting its customary review of grievances and appeals during the survey process, the Department sought out any identifiable trends pertaining to language assistance services. The Department reviewed all 12<sup>16</sup> exempt grievances identified by the Plan during the survey review period and identified three files that exemplified member difficulties accessing interpretation services for scheduled appointments. For example:

- *File #7:* Documented case notes by the Plan's MSR indicate that the member called approximately one week in advance to schedule an Arabic interpreter for a hospital appointment. However, no interpreter showed up on the day of the appointment. When the member contacted the Plan by telephone to express dissatisfaction, the MSR could only confirm the date the member had made the request, but was unable to determine why the interpreter was not present for the appointment. The MSR apologized to the member and said the issue would be investigated and reported to management.
- *File #8:* Documented case notes by the Plan's MSR indicate that the member called one week in advance to schedule a Spanish interpreter for her oncology appointment. She contacted the Plan by telephone on the day of her appointment to confirm that an interpreter would be present. However, the MSR could only locate notes that indicated the request was pending. The MSR contacted the Plan's language service vendor and was told by the vendor that the Plan had been alerted that an interpreter would not be available. The member expressed dissatisfaction to the MSR and indicated that an interpreter had not shown up for her prior appointment the previous week. The member indicated that she could not understand why the Plan could not provide an interpreter to

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<sup>16</sup> Fourteen files were initially reviewed. Two files were excluded from review because they were not member complaints. Therefore, 12 remaining files were reviewed.

her appointments since she provides enough advanced notice. The member further indicated that her appointments were very important.

- *File #12:* Documented case notes by the Plan's MSR indicate that the member reported that a Cantonese interpreter had not showed up for her last two dermatology appointments. As a result, she was unable to have surgery and there was a delay in her treatment. The member also indicated that the interpreter does not always interpret everything that the doctor says. Although the member was already expressing dissatisfaction, the MSR advised the member of the option of filing a complaint to have the issue further investigated. The MSR also indicated that interpretation services were a courtesy service offered to members.

In all three examples described above, there was no documentation in file to substantiate that further investigation had been conducted by the Plan to ensure that the member's issues had been resolved, or that assurances had been made to ensure that these members, as well as others, would have no future difficulties accessing interpretation services for scheduled appointments.

In onsite interviews, the director of the Member Services acknowledged that issues with interpreters were an area of concern during the survey review period but that there was no documented monitoring for quality improvement. Following the survey review period, the Plan is attempting to track and monitor the number of "no-shows" to better quantify the data and address this issue.

**Conclusion:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9, Provision 14(A) requires the Plan to ensure that all monolingual, non-English-speaking, or LEP Medi-Cal members receive 24-hour oral interpreter services at all key points of contact, and that lack of interpreter services do not impede or delay timely access to care. Rule 1300.67.2.2(c)(4) further indicates that interpreter services be coordinated with scheduled appointments to ensure the provision of interpreter services at the time of the appointment. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 9, Provision 4 requires the Plan to ensure the provision of accessibility standards in accordance with Rule 1300.67.2.2 and monitor providers' compliance with these standards. The Department identified three exempt grievances where members had difficulties accessing interpretation services for scheduled appointments, with one case resulting in a delay in treatment. No remediation efforts were taken by the Plan to ensure future compliance. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

## QUALITY MANAGEMENT

**Potential Deficiency #12: The Plan does not conduct adequate review of potential quality issues to ensure that all problems are being identified and that grievances related to medical quality issues are consistently referred to the Plan's medical director.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(E) – Grievance System Oversight; Rule 1300.70(a)(1).

DHCS-Alameda Alliance For Health 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 Title 28, CCR, Section 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. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14 – Member Grievance System

2. Grievance System Oversight

E. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Contractor's medical director.

Rule 1300.70(a)(1)

(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.

**Documents Reviewed:**

- Plan Policy MED-QM-0002: Potential Quality Issues (older version revised 09/10/12; redlined version revised 04/13/15; updated version revised 04/13/15)
- Excerpt from Referral Log (documentation on four grievance cases referred to QI nurse for review)
- Plan Response to DMHC Follow-Up Request: PQI referral Log (email received 07/06/15)
- Potential Quality Issue Log (04/01/14 – 03/31/15)
- 29 Standard grievance files (04/01/14 – 03/31/15)
- 7 Potential quality issue files (04/01/14 – 03/31/15)

**Assessment:** Rule 1300.70(a)(1) requires the Plan to document that quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14, Provision 2(E) specifically requires all grievances related to medical quality of care issues to be referred to the Plan's medical director.

To evaluate compliance with these requirements, the Department examined key policies and procedures, reviewed grievance and potential quality issue (PQI)<sup>17</sup> files, and interviewed Plan staff. The Department's review revealed instances wherein PQIs were not properly identified and included in the *PQI Log*. Thus, PQIs that merited further investigation by the Plan were not referred for formal PQI review. The Plan's failure to properly identify and log PQIs resulted in inadequate tracking and trending of issues.

In onsite interviews, the Department requested that the Plan clarify its PQI review process. Plan staff confirmed that the QI nurse conducts an initial review of all PQIs and only elevates cases to the medical director where quality issues have been confirmed. For cases where the QI nurse does not identify a quality issue, the QI nurse's review is documented and maintained in a "PQI referral log." In an onsite request, the Department inquired whether the Plan has any mechanisms in place to check the accuracy of the QI nurse's determinations (e.g., periodic review of the "PQI referral log," inter-rater reliability testing, etc.). In its written response, the Plan indicated that no such action takes place. While the DHCS contract and regulation do not require that this validation take place, the lack of a check and balance mechanism to ensure the reliability of Plan staff determinations is of a concern to the Department because the Plan identified only seven SPD PQI files (for a SPD membership of approximately 25,000) during the survey review period that warranted a medical director's review.

The Department reviewed a random sample of 29 standard grievance files and identified four<sup>18</sup> grievances that involved potential quality of care issues. These files did not appear in the universe of seven (7) SPD PQI files identified by the Plan during the survey review period. Therefore, the Department requested documentation from the Plan to substantiate that these four files had undergone investigation by clinical staff. The Plan submitted an excerpt from its "PQI referral log" which included documentation that a QI nurse had reviewed each one of the four files. Consistent with the Plan's policy, the QI nurse requested and examined pertinent medical records to investigate the member's allegations. In each file, the QI nurse confirmed that a quality of care issue did not exist and therefore did not refer the file to a medical director for review. However, this is in violation of DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14, Provision 2(E) which requires all grievances related to medical quality of care issues to be referred to the Plan's medical director.

### **1. Tracking and Trending**

The Plan's policy, *MED-QM-0002 – Potential Quality Issues*, addresses the tracking and monitoring of PQIs. On page 3, it states:

7. Documentation, Tracking and Retention.
  - a) Each PQI will be assigned a case number representing the PQI submission date [year-month-day] and receipt sequence, e.g. 060920-01.
  - b) PQIs will be logged in a confidential, access restricted database for tracking, trending and quality monitoring purposes.

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<sup>17</sup> The Plan defines a potential quality issue (PQI) as "an event or pattern of behavior that may indicate significant risk to the health and/or well being of the member or members."

<sup>18</sup> Files #4; #15; #16; #17

- i) Cases identified for tracking and trending will be entered on the PQI tracking log.
- ii) Each new case will be compared to the PQI Log to identify prior cases involving the same member and/or provider.
- iii) Cases identified for tracking and trending will be monitored quarterly and included in reports of PQI activity to the HCQC and/or the PRCC, if indicated.

However, only the seven files encompassing the universe of SPD PQIs identified by the Plan during the survey review period were assigned a case number in the format indicated by the Plan's policy. Therefore, while the Plan's policy suggests robust monitoring activities for identified PQIs, these actions only apply to cases where the QI nurse has *confirmed* quality of care issues and elevated the review to the medical director. By contrast, the policy does not ensure that cases identified in the Plan's "PQI referral log" are tracked and trended. The Plan's failure to track and trend these cases, regardless of the outcome of the QI nurse's determination, precludes the Plan from effectively identifying trends or patterns of practice for specific providers who may frequently be the subject of member dissatisfaction. Therefore, the Plan would be unable to identify any trends that would warrant further investigation and follow-up. For example:

- *File #15*: In this grievance, the member alleged that the skilled nursing facility deferred medications for 15 hours after admission into the facility. As part of the investigation, the QI nurse discovered that the dispensing delay was due to the facility needing to verify the medication and order the medications from an outside pharmacy for delivery. Even though a quality of care issue was not confirmed in this case as the medication delay was not critical, similar complaints from other members regarding this skilled nursing facility over time would raise concerns. Given the potential harm of deferring particular medications that should be administered timely (e.g., antihypertensive medications, time-released medications, and medications affecting blood sugars, etc.), further investigation might be warranted.

## **2. Reliability Testing**

Plan Policy *MED-QM-0002, Potential Quality Issues*, does not describe verification review or interrater reliability (IRR) testing of QI nurse reviewer determinations, including those cases that are not referred to the medical director for formal PQI review. The Plan confirmed in an email communication dated July 6, 2015, that the Plan does not conduct any review (e.g., verification audit, IRR testing) of QI nurse reviewer determinations to verify their appropriateness. The lack of a check and balance mechanism and the failure to ensure the reliability of Plan staff determinations can negatively affect quality of care.

**Conclusion:** Rule 1300.70(a)(1) requires the Plan to document that quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4, Provision 1 requires the Plan to implement an

effective QIS in accordance with Rule 1300.70. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 14, Provision 2(E) specifically requires all grievances related to medical quality of care issues to be referred to the Plan's medical director.

The Department identified four grievances that involved potential quality of care issues. While the Plan submitted documentation to support that a QI nurse reviewed each file and determined that a quality of care issue did not exist, the grievances were not referred to a medical director for review and the Plan had no mechanisms in place to validate the determinations made by QI nurse. Furthermore, these cases were not tracked and trended to ensure that regardless of the outcome of the QI nurse's determination, the Plan effectively identifies trends or patterns of practice that would warrant further investigation. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

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**Potential Deficiency #13: The Plan does not have effective oversight procedures in place to ensure that providers are continuously fulfilling all delegated responsibilities.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 4(D) – Contract Performance; DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, and Provision 6(B) – Delegation of Quality Improvement Activities; Rule 1300.70(b)(2)(G)(2) and (3); Rule 1300.70(b)(2)(H)(1).

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan

4. Contract Performance

Contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with Title 28, CCR, Section 1300.67.3 and Title 22 CCR Sections 53800, 53851 and 53857. Contractor shall ensure the following:

D. Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

DHCS-Alameda Alliance For Health 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 Title 28, CCR, Section 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. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

## 6. Delegation of Quality Improvement Activities

B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:

- 1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
- 2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
- 3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

### Rule 1300.70(b)(2)(G)(2) and (3)

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

- (2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise and budgetary resources.
- (3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.

### Rule 1300.70(b)(2)(H)(1)

(H) 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.

### **Documents Reviewed:**

- Managed Behavioral Health Administrative Services Agreement Among The Alameda Alliance For Health, Beacon Health Strategies LLC, and College Health IPA, Inc. (executed August 2013)
- Plan Policy MED-QM-0040: Delegation of Quality Management (effective 04/13/15)
- Plan Policy (proposed): Delegation Oversight (undated)
- Quality Improvement Program Description (2014)
- Quality Improvement Program Description (2015)
- 2015 Delegated Audit Schedule (06/06/15)
- Alameda Alliance Delegated Entities grid (received 06/17/15)
- Delegation Membership (received 06/17/15)
- Plan Response to DMHC Follow-Up Request: Delegation (email received 06/17/15)
- Plan Response to DMHC Request #45: DMHC Outstanding Requests (email received 06/19/15)

**Assessment:** The Plan delegates various quality improvement functions (e.g., quality improvement, utilization management, credentialing, claims, etc.) to eleven<sup>19</sup> contracted provider groups or vendors. The Department examined Plan documents as well as conducted interviews with Plan staff and determined that the Plan does not have effective oversight procedures in place to ensure that providers are continuously fulfilling all delegated responsibilities. Specifically, the concerns were noted regarding the Plan's lack of: 1) pre-delegation audits, 2) organizational structure, and 3) ongoing monitoring.

### **1. Pre-Delegation Audits**

Rule 1300.70(b)(2)(G)(2) and Rule 1300.70(b)(2)(H)(1) require that the Plan ensure that each contracting provider have the administrative and financial capacity to meet its contractual obligations. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4, Provision 6(B)(1) similarly requires the Plan to evaluate the delegate's ability to perform the delegated activities, but additionally specifies that an initial review be conducted. The Plan's *Quality Improvement Program Description (2014)* is consistent with these requirements and on page 11 states, "Prior to delegation, the Alliance conducts delegation pre-assessments to determine compliance with regulatory and accrediting requirements." However, in its written response to the Department's onsite inquiry regarding which of the delegates had pre-delegation audits performed, the Plan stated:

We submitted Beacon's pre-delegation credentialing report, and 2014 delegation audit reports for CHCN, Kaiser, and March Vision. We have not conducted any other pre-delegation audits. Beacon is NCQA accredited and therefore the plan decided a pre-delegation audit was not needed and only an annual delegation audit the following year (2015). For CareCore, we started our contract on 4/1/14 and plan to audit them later this year. For CHME we started our contract full-capitulation on 11/1/2014 and plan to audit them this year also.

In onsite interviews, the Plan confirmed that it had only conducted delegation audits for three of its eleven delegates. In addition, while the Plan indicated that the pre-delegation credentialing report had been submitted for Beacon, according to the Plan's administrative services agreement, Beacon is delegated by the Plan to perform the following functions related to the provision of behavioral health services: quality management, utilization management, credentialing, rights & responsibilities (including grievances), claims, and case management. However, according to the Plan's response, no other pre-delegation audits were performed for any of the other delegated functions.

The Plan also contracts with CareCore to perform utilization review of radiology service requests. However, according to the Plan's written response above, no pre-delegation audit had been conducted for CareCore although the Plan entered into contract with this vendor in April 2014.

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<sup>19</sup> Beacon Health Strategies LLC; Community Health Center Network (CHCN); March Vision Care Group, Inc.; Children's First Medical Group (CFMG); PerformRX; CareCore; California Home Medical Equipment, Inc. (CHME); Kaiser; UCSF; Physical Therapy Provider Network; Lucille Packard

In light of the interventions brought on by the conservatorship, the Plan submitted its *2015 Delegated Audit Schedule*, which includes scheduled audit dates for each of the Plan's eleven delegates. However, during the relevant survey review period, with the exception of three delegates, the Plan had not conducted the required monitoring for all delegates.

## **2. Organizational Structure**

DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 1, Provision 4(D) requires the Plan to maintain the organization and staffing in medical, fiscal, and administrative services to effectively conduct the Plan's business. The Plan's *Quality Improvement Program Description (2014)* delineates the critical role of the "Delegate Oversight Manager" in conducting oversight of the Plan's delegates. On page 14 it states:

### **I. Delegated Oversight Manager**

The Delegated Oversight Manager reports to the Chief Operating Officer and is responsible for monitoring all delegated functions of delegates through reports and regular oversight audits. The position acts as a liaison to the delegated groups. The Delegated Oversight Manager is responsible for coordinating and summarizing reports or the Compliance and Delegation Oversight Committee meetings as well as to HCQC as appropriate. The Delegated Oversight Manager works closely with the Quality Management Department.

However, in its written response to the Department's onsite inquiry regarding whom the Delegated Oversight Manager is and how long this individual has been in the position, the Plan stated:

Currently there is no delegation oversight manager. This was a previous position that was established by the Plan. During the audit period this position was not filled. Departments for a short time were all involved in the delegation oversight process. The new proposed structure is that Delegation oversight lies within the Compliance Department.

In onsite interviews, Plan staff clarified that historically, as well as during the survey review period, one staff member from the Plan's Provider Relations Department was charged with performing delegation oversight of all of the Plan's delegated entities. However, the Plan found this arrangement to be ineffective so instead appointed "subject matter experts" from various Plan departments (e.g., utilization management, grievances and appeals, claims, etc.) to be responsible for overseeing the respective areas of review. Unfortunately, this strategy proved ineffective as well because it was too burdensome for any one staff member to assume overall responsibility for one area of review for each of the delegates.

In light of the interventions brought on by the conservatorship, the Plan created a Compliance Department that is currently tasked with performing delegation oversight. During the time of the onsite survey, the Plan indicated that recruitment efforts were currently underway to fill one or two lead positions. The Plan provided its draft policy, *Delegation Oversight*, which outlines the responsibilities of the Compliance Department. However, during the survey review period, there was no clear organizational structure in place to delineate delegation oversight procedures.

### **3. Ongoing Monitoring**

Rule 1300.70(b)(2)(G)(3) requires the Plan to have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated responsibilities. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4, Provision 6(B)(3) similarly requires the Plan to ensure accountability for delegated quality improvement activities by conducting continuous monitoring, evaluation, and approval of the delegated functions. However, during onsite interviews, Plan staff acknowledged that no active monitoring had been conducted during the survey review period as the Plan had not been enforcing the submission of required reports from its delegates.

**Conclusion:** Rule 1300.70(b)(2)(G)(2) and Rule 1300.70(b)(2)(H)(1) require that each contracting provider have the administrative and financial capacity to meet its contractual obligations. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4, Provision 6(B)(1) similarly requires the Plan to evaluate the delegate's ability to perform the delegated activities, but additionally specifies that an initial review be conducted. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 1, Provision 4(D) requires the Plan to maintain the organization and staffing in medical, fiscal, and administrative services to effectively conduct the Plan's business. Rule 1300.70(b)(2)(G)(3) requires the Plan to have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated responsibilities. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4, Provision 6(B)(2) and (3) similarly require the Plan to ensure accountability for delegated quality improvement activities by conducting continuous monitoring, evaluation, and approval of the delegated functions. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4, Provision 1 requires the Plan to implement an effective QIS in accordance with the standards in Rule 1300.70.

However, during the relevant survey review period, the Plan had conducted audits on only three of its eleven delegates, there was no clear organizational system in place to delineate delegation oversight procedures, and the Plan had not been enforcing the submission of required reports from its delegates. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

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**Potential Deficiency #14: The Plan does not maintain a system of accountability for its Quality Improvement System by ensuring that reports to the governing body are sufficiently detailed to identify significant or chronic quality of care issues.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, Provision 2 – Accountability, Provision 3(C) – Governing Body, and Provision 4(B) – Quality Improvement Committee; Rule 1300.70(b)(2)(C).

DHCS-Alameda Alliance For Health 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 Title 28, CCR, Section 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. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

2. Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted physicians and contracted providers in the process of QIS development and performance review. Participation of non-contracting providers is discretionary.

3. Governing Body

Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following:

C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.

4. Quality Improvement Committee

B. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. *The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.* [Emphasis added.]

Rule 1300.70(b)(2)(C)

(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. *Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.* [Emphasis added.]

### Documents Reviewed:

- Quality Improvement Program Description (2014)
- Quality Improvement Program Description (2015)
- Alameda Alliance For Health Chart (effective March 2015)
- Health Care Quality Committee meeting minutes and attachments (05/01/14; 09/18/14; 10/16/14; 12/18/14; 02/18/15)
- Alameda Alliance For Health Quality Improvement (QI) Sub-Committee Charter (05/07/15)
- Sub Committee Proposed Reporting (2015)
- DMHC Change Log (05/05/15)
- DMHC Requests #58 and #66: Board Minutes (received 06/12/15)

**Assessment:** The Plan's *Quality Improvement Program Description (2014)* describes the organizational structure of Plan's Quality Improvement Program. It includes a description of the reporting structure between the Board of Governors (BOG), HCQC, and other committees. Included below are excerpts that specifically highlight the relationship between the BOG and HCQC and draw attention to critical role of the HCQC in assessing the overall effectiveness of the QI program and reporting findings up to the BOG. On pages 7-8, it states:

#### A. Overview

The Alliance Board of Governors (BOG) appoints and oversees the Health Care Quality (HCQC), Peer Review and Credentialing (PRCC), and Pharmacy and Therapeutics (P&T) Committees which, in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QI program.

...

#### B. Board of Governors

The Alliance BOG is appointed by the Alameda County Board of Supervisors and consists of 12 members who represent member, provider, and community partner stakeholders. The BOG is the final decision-making authority for the Alliance QI program. Its duties include:

...

- Receiving a report from the CMO on the agenda and actions of HCQC.

#### C. Health Care Quality Committee (HCQC)

The HCQC is a standing committee of the BOG and meets a minimum of four times per year, and as often as need to follow-up on findings and required actions. The HCQC is responsible for the implementation, oversight, and monitoring of the QI Program and Utilization Management (UM) Program. As it relates to the QI Program, the HCQC recommends policy decisions,

analyzes and evaluates the QI work plan activities, and assesses the overall effectiveness of the QI program. The HCQC reviews results and outcomes for all QI activities to ensure performance meets standards and makes recommendations to resolve barriers to quality improvement activities. Any quality issues related to the health plan that are identified through the CAHPS survey and health plan service satisfaction reports are also discussed and addressed at HCQC meetings. The HCQC oversees all delegation arrangements and reviews summary reports and evaluations the health plan conducts on delegate program descriptions and work plan activities. The HCQC receives reports from the Pharmacy and Therapeutics (P&T) Committee. The HCQC presents to the Board the annual QI program description, work plan and prior year evaluation. Signed and dated minutes are maintained that summarize committee activities and decisions. Minutes are submitted to the California Department of Health Care Services (DHCS) quarterly.

HCQC responsibilities include:

...

- Providing on-going reporting to the BOG;

While the Plan produced *HCQC Meeting Minutes* for the survey review period, no BOG Minutes were produced to substantiate that the BOG reviewed reports from the HCQC. During onsite interviews, Plan staff explained that the Plan was placed in conservatorship one month into the survey review period, and as such, there were no BOG Minutes during the relevant timeframe. Rather, the conservator's designee, who had been involved in all ongoing process changes, met informally with the BOG. Nevertheless, Plan staff acknowledged that prior to and during the survey review period, communications between various committees and business units were not well coordinated, and there was no clear approach for managing information for upper reporting and quality improvement. Therefore, during the survey review period, the HCQC was not well equipped to generate reports that were sufficiently detailed to present significant or chronic quality of care issues to the BOG.

In light of the interventions brought on by the conservatorship, the Plan developed a document entitled, *DMHC Change Log*, to track all internal corrective actions implemented by the Plan. The Department noted that the log had already identified the BOG's role in reviewing quality assurance monitoring reports as one of the areas in need of improvement and documented the following:

*Requirement:* The Plan's Governing Body review regular QA monitoring reports at least quarterly; the reports are sufficiently detailed to include findings and actions taken as a result of the QM Program; the reports are sufficiently detailed to identify any significant or chronic quality of care issues; and the Governing

Body act upon the reports and information provided (e.g., by providing feedback, instructions and recommendations to QM Program staff)

*Corrective Action Plan:* Create lists of QA monitoring reports to be routinely provided quarterly at HCQC for review and feedback. Document any actions taken or follow up and report back at next committee.

*Actions Taken:* Workgroup met on 4/22/15 to discuss possible process changes. Next workgroup meeting scheduled on 5/06/15 to discuss actions and next steps of implementation.

*Target Date for Completion:* 6/1/2015

The Plan produced several documents to substantiate that actions had been taken to improve coordination between Plan committees and strengthen the upward flow of information to the HCQC for reporting to the BOG. For example, the Plan submitted a proposed organizational chart, *Sub Committee Proposed Reporting (2015)*, which showed a drastic change in the reporting structure in comparison to what had been previously indicated in the *Quality Improvement Program Description (2014)*. Previously, the HCQC reported up to the BOG, along with the P&T Committee, PRCC, and Compliance and Delegation Oversight Committee. The only body that reported directly to the HCQC was the Network Performance Work Group. By contrast, the proposed structure shows six<sup>20</sup> entities reporting directly to the HCQC.

In addition, the Plan developed the *Alameda Alliance for Health Quality Improvement (QI) Sub-Committee Charter* in March 2015 (the last month of the survey review period), which documented creation of the “QI Sub-Committee,” one of the six entities that will report directly to the HCQC. On page 1 it states that one of the key responsibilities of this committee is to “[r]eview reports from other subcommittees and, if acceptable, forward for review at the next scheduled HCQC.”

**Conclusion:** DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4, Provision 2 requires the Plan to maintain a system of accountability which includes the participation of the governing body and the designation of a quality improvement committee with oversight and performance responsibility. DHCS-Alameda Alliance For Health Contract, Exhibit A, Attachment 4, Provision 3(C) and Provision 4(B) require the Plan’s governing body to routinely receive written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made. Rule 1300.70(b)(2)(C) requires the Plan’s governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, to each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Reports to the Plan’s governing body must be sufficiently detailed to include findings and actions taken as a result of the QA program. DHCS-Alameda Alliance For Health

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<sup>20</sup> UM Sub Committee; QI Sub Committee; Ongoing Monitoring Workgroup; Coordination of Care; P&T Sub Committee; Access and Language Assistance Program Sub Committee

Contract, Exhibit A, Attachment 4, Provision 1 requires the Plan to implement an effective QIS in accordance with the standards in Rule 1300.70.

During the survey review period, the Plan did not submit documentation to substantiate that the BOG had reviewed reports from the Plan's HCQC, the primary committee charged with oversight and monitoring responsibilities for the Quality Improvement Program. The Department's review determined that while the HCQC met and maintained meeting minutes on a quarterly basis as minimally required, communications between various committees and business units were not well coordinated, and there was no clear approach for managing the upward flow of information to the HCQC. Therefore, during the survey review period, the HCQC was not well equipped to generate reports that were sufficiently detailed to present significant or chronic quality of care issues to the BOG, even without the Plan's conservatorship status. The Plan produced documentation to substantiate that subsequent actions have been taken to improve coordination between Plan committees and strengthen the upward flow of information to the HCQC for reporting to the BOG. However, these process improvements were not initiated until the end of the survey review period and have yet to be fully implemented. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

**APPENDIX A. MEDICAL SURVEY TEAM MEMBERS**

<b>DEPARTMENT OF MANAGED HEALTH CARE</b>	
Jeanette Fong	Medical Survey Team Lead
Cindy Liu	Attorney
<b>MANAGED HEALTHCARE UNLIMITED, INC.</b>	
Dawn Wood, MD	Quality Management/Continuity of Care Surveyor
Rose Leidl, RN	Utilization Management Surveyor
Sharon Ostach	Member Rights Surveyor
Cliff Ridenour	Member Rights Surveyor
Madeline Hommel, MPH	Availability and Accessibility Surveyor

**APPENDIX B. PLAN STAFF INTERVIEWED**

<b>ALAMEDA ALLIANCE FOR HEALTH</b>	
Scott Coffin	CEO
Mark Abernathy	CEO (Conservatorship)
Frank Stevens	COO (Conservatorship)
Lily Boris, MD	Chief Medical Officer
Laurie Nakahira, MD	Medical Director
Matt Levin	Compliance Officer (Conservatorship)
Quinn Nguyen	Director, Clinical Services
Anna Yang	Director, Pharmacy Services
Craig Kellar	Director, Member Services
Claudia Mundy	Director, Quality, Accreditation, Audits, Reports, and Training
Lisa Malvo	Director, Claims
Jennifer Karmelich	Associate Director, Compliance (Conservatorship)
Donna Abrams	Manager, Quality Oversight
Diana Sekhon	Compliance Manager
Linda Ayala	Health Educator
Christine Clark	Case Manager
Vicky Hawkins	Credentialing Manager
Mary Beth Wexler	Clinical Pharmacist

**APPENDIX C. LIST OF FILES REVIEWED**

*Note: The statistical methodology utilized by the Department is based on an 80% confidence level with a 7% margin of error. 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>Utilization Management Denials</b>	51	The Plan identified a universe of 1,068 files during the review period. Based on the Department's File Review Methodology, a random sample of 51 files were reviewed.
<b>Standard Grievances</b>	29	The Plan identified a universe of 467 files during the review period. Based on the Department's File Review Methodology, a random sample of 29 files were reviewed.
<b>Expedited Grievances</b>	20	The Plan identified a universe of 20 files during the review period. Based on the Department's File Review Methodology, all 20 files were reviewed.
<b>Exempt Grievances</b>	14	The Plan identified a universe of 14 files during the review period. Based on the Department's File Review Methodology, all 14 files were reviewed.
<b>Potential Quality Issues</b>	7	The Plan identified a universe of 7 files during the review period. Based on the Department's File Review Methodology, all 7 files were reviewed.