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EXECUTIVE SUMMARY

On March 27, 2013, the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) entered into the Coordinated Care Initiative Memorandum of Understanding (MOU). The MOU authorized DHCS to conduct a demonstration project to assess the effectiveness of integrating delivery of health care services covered by Medicare with delivery of long-term care and other services covered by Medicaid (“Medi-Cal” in California) for individuals within California who are eligible for both Medicare and Medicaid benefits. In preparation for the MOU, in January 2012, DHCS had solicited health care service plans; DHCS sought plans that could develop a comprehensive network of health care service and social service providers and thereby deliver and coordinate all Medicare and Medicaid covered benefits for dual eligible individuals under a capitated model of financing (a “Cal MediConnect” plan). Blue Cross of California Partnership Plan, Inc. (Plan) was one of the health care service plans selected to offer a Cal MediConnect plan for eligible beneficiaries residing in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. A three-way contract between Plan, DHCS and CMS by which the Plan undertook to offer a Cal MediConnect plan (Cal MediConnect Three-Way Contract) was approved on December 12, 2013.

The Department of Managed Health Care (Department) and DHCS entered into an inter-agency agreement1 (IA Agreement) whereby the Department will be responsible for conducting medical survey audits of Cal MediConnect health plans to examine the health plan operations related to the provision of Medicaid-based services. Medical surveys, pursuant to the IA Agreement, are conducted once every three years, as long as the demonstration continues.

On September 10, 2015, the Department notified 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 November 2, 2015 through November 6, 2015.

SCOPE OF MEDICAL SURVEY

As required by the IA Agreement, the Department provides this Cal MediConnect Medical Survey Report of the Plan to DHCS. The report identifies potential deficiencies in the Plan’s operations supporting the provision of Medicaid-based services to the Cal MediConnect population. This medical survey evaluated the following elements specifically related to the Plan’s delivery of care to the Cal MediConnect population as delineated by the Cal MediConnect Three-Way Contract and the Knox-Keene Health Care Service Plan Act of 1975.2

1 The IA Agreement (Agreement Number 13-90167) was executed on October 21, 2013, and amended on March 21, 2014.
2 The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to “Section” are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et
I. Utilization Management
The Department evaluated Plan operations related to utilization management as it relates to the provision of Medicaid-based services, including implementation of the Utilization Management Program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting over- and under-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

II. Continuity of Care
The Department evaluated Plan operations to determine whether Medicaid-based services are effectively coordinated both inside and outside the network. The Department also verified that the Plan takes steps to facilitate coordination of Medicaid-based services with other services delivered under the Cal MediConnect plan, through the enrollees’ primary care physician and/or interdisciplinary team.

III. Availability and Accessibility
The Department evaluated Plan operations to ensure that its Medicaid-based services are accessible and available to enrollees throughout its service areas within reasonable timeframes, and that the Plan addresses reasonable patient requests for disability accommodations.

IV. Member Rights
The Department evaluated Plan operations to assess compliance with internal and external complaint and grievance system requirements related to the provision of Medicaid-based services. The Department also evaluated 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 as it relates to the provision of Medicaid-based services.

The scope of the medical survey incorporated review of health plan documentation and files from the period of November 1, 2014 through October 31, 2015.

seq. All references to “Rule” are to Title 28 of the California Code of Regulations unless otherwise indicated.
SUMMARY OF FINDINGS

The Department identified five potential deficiencies during the current medical survey.

2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES

<table>
<thead>
<tr>
<th>CONTINUITY OF CARE</th>
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| **1** | The Plan does not consistently complete Health Risk Assessments (HRAs) for new enrollees within the required timeframes.  
Cal MediConnect Three-Way Contract § 2.8.2.3; Cal MediConnect Three-way Contract § 2.8.2.4; DHCS Duals Plan Letter 13-002; DHCS Duals Plan Letter 15-005. |

<table>
<thead>
<tr>
<th>AVAILABILITY &amp; ACCESSIBILITY</th>
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| **2** | The Plan did not establish and execute a work plan to achieve and maintain Americans with Disabilities Act (ADA) compliance, nor did it identify an individual to be responsible for ADA compliance, along with his/her job title.  
Cal MediConnect Three-Way Contract § 2.11.1.2; Cal MediConnect Three-Way Contract § 2.11.1.3. |

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<th>MEMBER RIGHTS</th>
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| **3** | The Plan did not acknowledge receipt of an enrollee grievance regarding Medicaid based services in a timely manner and did not include all required information in letters acknowledging grievances regarding Medicaid based services.  
Cal MediConnect Three-Way Contract § 2.14.2.1.1 (As amended); Cal MediConnect Three-Way Contract § 2.14.2.1.2.1; Cal MediConnect Three-Way Contract § 2.15.3.3.3 (As amended); Section 1368, subdivision (a)(4)(A). |
| **4** | The Plan does not have a system to maintain records of referrals and resolutions of all Multipurpose Senior Services Program (MSSP) grievances and appeals.  
Cal MediConnect Three-way Contract § 2.1.5; DHCS All Plan Letter 15-002. |

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<th>QUALITY MANAGEMENT</th>
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| **5** | The Plan’s governing body did not meet, during the survey period, on a quarterly basis to oversee its quality assurance program responsibilities.  
Cal MediConnect Three-Way Contract § 2.16.3.1; Rule 1300.70, subdivision (b)(2)(C). |
OVERVIEW OF THE PLAN’S EFFORTS TO SUPPORT CAL MEDICONNECT ENROLLEES

Cal MediConnect:
To address the needs of Cal MediConnect enrollees the Plan has added and expanded its services, including the following:

- The Plan has established a community connector program under the umbrella of case management. These non-clinical staff act as extenders to case managers to assist enrollees in using managed care benefits (e.g., they may assist enrollees with completion of Health Risk Assessments over the phone, deliver forms, conduct research to find enrollee contact information, explain Plan services).

- The Plan added a psychiatrist to its staff who works with interdisciplinary teams.

- The Plan performs outreach to a local shelter for homeless persons and provides case management services.
DISCUSSION OF POTENTIAL DEFICIENCIES

CONTINUITY OF CARE

Potential Deficiency 1: The Plan does not consistently complete Health Risk Assessments (HRAs) for new enrollees within the required timeframes.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-way Contract § 2.8.2.3; Cal MediConnect Three-way Contract § 2.8.2.4; DHCS Duals Plan Letter 13-002; DHCS Duals Plan Letter 15-005.

Cal MediConnect Three-Way Contract § 2.8.2.3 and § 2.8.2.4

2.8.2. Health Risk Assessment (HRA). In accordance with all applicable federal and state laws WIC Section 14182.17(d)(2), the CMS Model of Care requirements, Duals Plan Letter 13-002, Contractor will complete HRAs for all Enrollees.

2.8.2.3. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as higher-risk, the Contractor will complete the HRA within forty-five (45) calendar days of enrollment in accordance with DHCS Dual Plan Letter 13-002.

2.8.2.4. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as lower-risk, the Contractor will complete the HRA within ninety (90) calendar days of enrollment in accordance with DHCS Dual Plan Letter 13-002.

DHCS Duals Plan Letter 13-002, Page 4, Policy and Requirements Section, under Subsection B. Health Risk Assessment

MCPs [Medi-Cal managed care plans] are required to develop a health risk assessment survey tool that will be used to assess an enrollee's current health risk within 45 calendar days of coverage for those identified by the risk stratification mechanism or algorithm as higher risk, and within 90 calendar days of coverage for those identified as lower risk for the purpose of developing individualized care management plans.

DHCS Duals Plan Letter 15-005, Page 4, Requirements Section, under Subsection B. Health Risk Assessment

MMPs [Medicare-Medicaid plans] are required to develop a health risk assessment survey tool to assess an enrollee’s current health risk within 45 calendar days of enrollment for those enrollees identified through the risk stratification as higher risk, and within 90 calendar days of coverage for those identified as lower risk.

Documents Reviewed:

• Plan policy titled: CA MMP Health Risk Assessment (Approved September 24, 2015)
• Department On-site Request #78: Plan’s email response to untimely HRAs (11/06/15)
• 74 HRA Files out of the Universe of 1,435 files (enrollment dates 01/01/15 – 08/01/15)

Assessment:
The Cal MediConnect Three-Way Contract, §§ 2.8.2.3. and 2.8.2.4, require the Plan to stratify new enrollees as higher-risk or lower-risk, and to perform initial HRAs within 45 days of enrollment for higher-risk enrollees, and within 90 days of enrollment for lower-risk enrollees. DHCS Duals Plan Letters 13-002 and 15-005 (13-002 was effective before the survey period until superseded by 15-005 on August 17, 2015) provide additional guidance to plans on how to implement the HRA process requirements of the Cal MediConnect Three-Way Contract. Both Duals Plan Letters confirm that the Plan is required to develop a HRA survey tool to assess an enrollee’s current health risk within 45 calendar days of coverage for those identified as higher risk, and within 90 calendar days of coverage for those identified as lower risk.

The Plan’s policy titled CA MMP Health Risk Assessment, acknowledges the Cal MediConnect Three-Way Contract requirements as follows:

PROCEDURE:
A. All new members must have an initial HRA completed within the time period specified by the state based on the member’s risk classification.
   1) Members identified as higher-risk must have an initial HRA completed within 45 days of coverage date.
   2) Members who are nursing facility residents or who are identified as lower-risk or community well must have an initial HRA completed within 90 days of coverage date.

The Department selected and reviewed a random sample of 74 initial HRA files with enrollment dates of January 15, 2015, through July 1, 2015, for adherence to contract requirements. The Department found that the Plan failed to consistently complete HRAs for new enrollees within required timeframes. Of the 74 files, 36 files (49%) were not completed according to required timeframes as follows:
• Higher-risk: 56 files were initially stratified as higher-risk. The Plan did not complete 28 of the 56 (50%) HRAs for these enrollees within 45 calendar days. The non-compliant cases took from 46 to 181 calendar days (mean = 93.8 days; median = 88.5 days).
• Lower-risk: 18 files were initially stratified as lower-risk. In one case the enrollee declined the HRA for approximately six months; because the delay was due to enrollee choice, the Plan was deemed compliant for this case. The Plan did not complete 8 of the 18 HRAs (44%) within 90 calendar days. The non-compliant cases took from 103 to 215 days (mean = 132.4 days; median = 115.0 days).
During onsite interviews, Plan staff indicated that the Plan was aware of the untimely HRAs. Plan staff asserted that a weekly report that details the number and timeliness of HRAs completed has been reviewed and the Plan has recently developed an enterprise-wide audit tool for monitoring HRA documentation.

### TABLE 1
Timely Completion of HRA

<table>
<thead>
<tr>
<th>FILE TYPE</th>
<th>NUMBER OF FILES</th>
<th>ELEMENT</th>
<th>COMPLIANT</th>
<th>DEFICIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher-Risk Enrollees HRA Files</td>
<td>56</td>
<td>HRAs completed within 45 days of enrollment</td>
<td>28 (50%)</td>
<td>28 (50%)</td>
</tr>
<tr>
<td>Lower-risk Enrollees HRA Files</td>
<td>18</td>
<td>HRAs completed within 90 days of enrollment</td>
<td>10 (56%)</td>
<td>8 (44%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9 completed within required timeframe, 1 delay due to enrollee</td>
<td></td>
</tr>
<tr>
<td>All HRA Files Reviewed</td>
<td>74</td>
<td>HRAs completed within time required by contract</td>
<td>38 (51%)</td>
<td>36 (49%)</td>
</tr>
</tbody>
</table>

**Conclusion:** The Cal MediConnect Three-Way Contract, §§ 2.8.2.3 and 2.8.2.4, outline the timeframe for plans to complete HRAs for higher-risk and lower-risk enrollees. Duals Plan letters 13-002 and 15-005 further confirm these timeframes. Review of the Plan’s HRA files showed that the Plan did not consistently complete HRAs within the required timeframes. Therefore, the Department finds the Plan in violation of these contractual requirements.

### AVAILABILITY AND ACCESSIBILITY

**Potential Deficiency 2:** The Plan did not establish and execute a work plan to achieve and maintain Americans with Disabilities Act (ADA) compliance, nor did it identify an individual to be responsible for ADA compliance, along with his/her job title.

**Contractual/Statutory/Regulatory Reference(s):** Cal MediConnect Three-Way Contract § 2.11.1.2; Cal MediConnect Three-Way Contract § 2.11.1.3.

Cal MediConnect Three-Way Contract § 2.11.1.2 and § 2.11.1.3.
2.11  Enrollee Access to Services

2.11.1  General.  The Contractor must provide services to Enrollees as follows:

2.11.1.2.  Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollee with disabilities from obtaining all Covered Services from the Contractor by:

2.11.1.3.  The Contractor must identify to DHCS the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The Contractor must also establish and execute a work plan to achieve and maintain ADA compliance.

Documents Reviewed:

- Anthem Medicare-Medicaid Plan, Cultural and Linguistics Policies and Procedures # CA_CL 01; Subject: Cultural and Linguistics Program (Approved September 30, 2015)
- Anthem Medicaid Provider Network Policies and Procedures #CA_PNXX_033; Subject: Access to Care Standards (Approved 26, 2012)
- Anthem Blue Cross Cal MediConnect Plan Santa Clara County Provider Manual (Effective January 1, 2015)
- 2015 Medicaid QM Workplan CA (Approved March 18, 2015; Revised September 28, 2015)

Assessment:

In a review of Plan documents, the Department found no evidence of a work plan or identification of a responsible representative to achieve and maintain the Plan’s ADA compliance. The Cal MediConnect Three-Way Contract, Section 2.11.1.3, states that the Plan must “establish and execute a work plan to achieve and maintain ADA compliance …” and “identify to DHCS the individual in its organization who is responsible for ADA compliance … and his/her job title.”

The Plan did not provide an ADA work plan, as requested by the Department prior to the on-site visit. In a review of other submitted Plan documents, the Department found only brief mentions of the Plan’s ADA compliance objectives and procedures. For instance, the Plan’s California Medicare-Medicaid Plan 2015 Quality Management (QM) Program Description states, at page 35, that its complaints and appeals department has a responsibility to “ensure that the appeal process and all member services and interactions are communicated and administered in a culturally and linguistically competent manner … and accommodate those individuals with disabilities consistent with the requirements of the American Disabilities Act (ADA) of 1990.” No specifics are noted as to how this process is to be achieved. Likewise, the Cal MediConnect Santa
Clara County Provider Manual describes, at page 37, the actions providers must take to meet ADA requirements, but does not describe how the Plan will monitor and ensure compliance.

The Department requested the name and title of the individual responsible for the Plan’s ADA compliance in a pre-onsite document request, but Plan staff was unable to provide this information. In response to the Department’s additional on-site request for this material, the Plan provided a job description for a staff vice president for privacy and compliance. The job description addresses general issues of compliance but does not specifically address the ADA or issues related to enrollee access to services (including communications and physical access).

**Conclusion:** Cal MediConnect Three-Way Contract, §§ 2.11.1.3 and 2.11.1.4, requires that the Plan establish and execute a work plan to achieve and maintain ADA compliance and to designate an individual responsible for ADA compliance, along with his/her name and job title. The Plan did not provide evidence of a work plan, nor did it identify an individual responsible for ADA compliance. Therefore, the Department finds the Plan in violation of this contractual requirement.

**MEMBER RIGHTS**

**Potential Deficiency 3:** The Plan did not acknowledge receipt of an enrollee grievance regarding Medicaid based services in a timely manner and did not include all required information in letters acknowledging grievances regarding Medicaid based services.

**Contractual/Statutory/Regulatory Reference(s):** Cal MediConnect Three-Way Contract § 2.14.2.1.1 (As amended); Cal MediConnect Three-Way Contract § 2.14.2.1.2.1; Cal MediConnect Three-Way Contract § 2.15.3.3.3 (As amended); Section 1368, subdivision (a)(4)(A).

Cal MediConnect Three-Way Contract § 2.14.2.1.1. (As amended) and 2.14.2.1.2.1

2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, pursuant to the Knox-Keene Health Care Services Plan Act of 1975, and the regulations promulgated thereunder, WIC Section 14450 and CCR, Title 22, Section 53260.

2.14.2.1.2. The Contractor must maintain written records of all grievance activities, and notify CMS and DHCS of all internal grievances. The system must meet the following standards:

2.14.2.1.2.1 Timely acknowledgement of receipt of each Enrollee grievance.
Cal MediConnect Three-Way Contract § 2.15.3.3.3 (As amended)

2.15.3.3 Contractor shall implement and maintain an Enrollee internal Appeals system, which includes oversight of any First Tier, Downstream or Related Entity, in accordance with all applicable federal and state laws and regulations, including but not limited to the following: [¶]

2.15.3.3.3 Internal Contractor Appeal processes, in accordance with the Knox-Keene Act and the regulations promulgated thereunder, as applicable, and external Appeal processes in accordance with the DMHC’s Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with Health & Safety Code section 1374.30) and the regulations promulgated thereunder, and the fair hearing standards for Medi-Cal managed care, Title 22, CCR, sections 51014.1, 51014.2, 53894 and 53858.

Section 1368, subdivision (a)(4)(A)

(a) Every plan shall do all of the following:

(4)(A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:

(i) That the grievance has been received.
(ii) The date of receipt.
(iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

Documents Reviewed:

- Anthem Medicare-Medicaid Plan, Grievance and Appeals Policies and Procedures OSC 11.0; Subject: Grievance Process: Members (Approved October 1, 2015)
- Two standard grievance files (01/01/15 – 08/31/15)

Assessment:

The Cal MediConnect Three-way Contract, § 2.14.2.1.2, requires that plans timely acknowledge receipt of each enrollee grievance. What is timely acknowledgment for grievances concerning Medicaid based services is specified by the Knox-Keene Act because Cal MediConnect Three-way Contract, § 2.14.2.1.1, requires the Plan to “maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, pursuant to the Knox-Keene Health Care Services Plan Act of 1975 . . ..” Section 1368, subdivision (a)(4)(A), of that Act specifies the required timeframe and contents for a written acknowledgement, stating “[p]rovide for a written acknowledgment within five calendar days of the receipt of a grievance . . ..” The written acknowledgement must “advise the complainant of the following: (i) That the grievance has been received. (ii) The date of receipt. (iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.”
The Plan’s policy, *Grievance Process: Members*, confirms this requirement in its description of the Plan’s internal process, stating, “a health plan associate sends a written acknowledgment of the member’s grievance within five (5) calendar days of the date stamped as the received date for the grievance.”

The Department reviewed two standard grievance files (File 1, and File 2), which represent the universe of grievance files involving Medicaid based services for the survey review period. The Department determined that one acknowledgment letter (File 2) was not sent within the required five-day timeframe; it was acknowledged six days after receipt of the grievance. The Department also found that the acknowledgment letters in both files failed to include the date of receipt of the grievance, and neither included the name, telephone number, and address of the Plan representative who could be contacted about the grievance. In lieu of a specific staff name, the acknowledgment letters were signed, “Appeals and Grievances Coordinator.”

Plan staff acknowledged that specific grievance and appeals staff names are not included in the letter because “any staff has access to the grievance.”

**Conclusion:** The Cal MediConnect Three-Way Contract, § 2.14.2, requires timely acknowledgment of each grievance, and requires the Plan to operate a grievance system that complies with the Knox-Keene Act. Section 1368, subdivision (a)(4)(A), requires that an acknowledgment be sent within five calendar days of the receipt of a grievance and that it include the date of receipt and the name, telephone number and address of the Plan representative who may be contacted about the grievance. In the two grievances, involving Medicaid based services submitted to the Plan during the survey review period, one acknowledgment letter was not sent within five days and neither letter included the date of receipt of the grievance and the Plan representative’s name and contact information. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

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**Potential Deficiency #4:** The Plan does not have a system to maintain records of referrals and resolutions of all Multipurpose Senior Services Program (MSSP) grievances and appeals.

**Contractual/Statutory/Regulatory Reference(s):** California MediConnect Three-way Contract § 2.1.5; DHCS All Plan Letter 15-002.

California MediConnect Three-way Contract § 2.1.5
2. Contractor Responsibilities

2.1 Compliance: The Contractor must, to the satisfaction of CMS and DHCS:

2.1.5 Comply with all applicable administrative bulletins and plan letters issued by DHCS.
DHCS All Plan Letter 15-002, Page 4, Policy Section, under Subsection C. MCP and MMP Responsibilities

During the 19-month period, MCPs and MMPs shall keep records of both referrals and resolutions of all MSSP beneficiary complaints, grievances, and appeals that are received internally and from MSSP sites.

When an MCP [Medi-Cal managed care health plan] or MMP [Medicare-Medicaid Plans] receives a complaint from a beneficiary or from an MSSP provider, the MCP or MMP shall keep a record of all complaints, grievances, and appeals using an internal tracking system. MCPs and MMPs shall develop the tracking system.

Assessment:
All Plan Letter 15-002 requires the Plan to “keep records of both referrals and resolutions of all MSSP (Multipurpose Senior Services Program) beneficiary complaints, grievances, and appeals that are received internally and from MSSP sites … using an internal tracking system.”

The Plan’s policies do not delineate a system for maintaining records of grievances and appeals for MSSP sites. During interviews, Plan staff confirmed that they currently do not have a procedure to follow up with MSSP sites regarding receipt and resolutions of MSSP grievances and appeals.

Conclusion: All Plan Letter 15-002 requires the Plan to keep a record of all MSSP complaints, grievances, and appeals using an internal tracking system. The Plan has not implemented a system in which they maintain records of referrals and resolutions of all MSSP grievances and appeals. Therefore, the Department finds the Plan in violation of this requirement.

QUALITY MANAGEMENT

Potential Deficiency 5: The Plan’s governing body did not meet, during the survey period, on a quarterly basis to oversee its quality assurance program responsibilities.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.16.3.1; Rule 1300.70, subdivision (b)(2)(C).

Cal MediConnect Three-Way Contract, Section 2.16.3.1.
2.16. Quality Improvement [QI] Program
2.16.3. QI Program Structure
2.16.3.1. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor’s service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and
external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart D, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA health plan accreditation requirements in 28 CCR Section 1300.70.

Rule 1300.70, subdivision (b)(2)(C)
(b) Quality Assurance [QA] Program Structure and Requirements.

(2) Program Requirements.

In order to meet these obligations each plan’s QA program shall meet all of the following requirements:

(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...

Documents Reviewed:

- Blue Cross of California Board of Directors’ Meeting Minutes with Attachments (12/08/14, 03/12/15, 09/08/15)
- Resolutions of the Board (06/23/15)
- Anthem Blue Cross of California Partnership Plan 2015 Medicaid Quality Management Program Description
- Response to Pre-onsite Document Request: Blue Cross of California Partnership Plan Board Meeting Minutes (09/23/15)

Assessment: The Plan’s Board of Directors did not conduct quarterly meetings as required; specifically, it failed to meet during the third quarter of the survey review period. Cal MediConnect Three-Way Contract, § 2.16.3.1, requires the Plan to, “meet the quality management and improvement criteria described in the most current NCQA health plan accreditation requirements in 28 CCR Section 1300.70.” Rule 1300.70, subdivision (b)(2), in turn, requires the Plan’s governing body to “meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities.”

The Plan’s 2015 Medicaid Quality Management Program Description states, “[the] Health Plan Board of Directors (Board) has responsibility for organizational governance and in this capacity is the governing body of the Quality Management Program.” It further states that the Plan’s Chief Medical Officer is “Responsible for the Quality Management and Improvement program and reports program activities and updates to the Board of Directors quarterly.”

The Plan responded to the Department’s request for meeting minutes of Board of Directors’ with a document, which stated:
“The June meeting was canceled and combined with the September meeting.”

The Plan submitted three sets of board minutes to the Department for the December 8, 2014, March 12, 2015, and September 8, 2015 meetings.

The September 8, 2015, minutes included a report from the Chief Medical Officer on quality management activities from Q1 and Q2 of 2015. Minutes approved at this meeting were from the previous meeting, noted as March 12, 2015.

During interviews, the CMO stated he “was not sure” why the Board only met three times rather than four. In response to whether the Board had somehow discharged its quarterly responsibility in an alternative meeting, the Plan submitted a document titled, Resolutions of the Board, dated June 23, 2015, which contains agreed upon resolutions covering financial and legal obligations. There is no mention of quality management activities in the document.

Conclusion: The Cal MediConnect Three-way Contract requires the Plan to implement an effective quality improvement system in accordance with the standards in Rule 1300.70. Subdivision (b)(2) of Rule 1300.70 requires the Plan’s governing body to meet on a quarterly basis. The Plan’s Board of Directors did not meet and did not receive updates on quality management between March 2015 and September 2015. Therefore, the Plan is in violation of these contractual and regulatory requirements.
## APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

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<thead>
<tr>
<th>DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS</th>
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<tbody>
<tr>
<td>Jeanette Fong</td>
</tr>
<tr>
<td>Frances Yang, MD</td>
</tr>
<tr>
<td>Gene Beed, MD</td>
</tr>
<tr>
<td>Sharon A. Shueman, PhD</td>
</tr>
<tr>
<td>Annalisa Almendras, PsyD.</td>
</tr>
<tr>
<td>Gene Beed, MD</td>
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</tbody>
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## APPENDIX B. PLAN STAFF INTERVIEWED

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Alaina Howland</td>
<td>Program Director Beacon Health Options - BH</td>
</tr>
<tr>
<td>Allison Lam</td>
<td>Manager I, Case Management &amp; CBAS</td>
</tr>
<tr>
<td>Barbara Holmes</td>
<td>Staff VP Operational Compliance</td>
</tr>
<tr>
<td>Beth Sharma</td>
<td>Healthcare Mgmt. Services I Anthem, Inc.</td>
</tr>
<tr>
<td>Christina Menchaca</td>
<td>Director Grievance &amp; Appeals</td>
</tr>
<tr>
<td>David Nolan</td>
<td>General Manager Medicare and Medi-Cal Services for CA</td>
</tr>
<tr>
<td>Dezarai Santiago</td>
<td>Process Expert II Grievances &amp; Appeals</td>
</tr>
<tr>
<td>Fran Shockley</td>
<td>Director I Healthcare Management Services</td>
</tr>
<tr>
<td>Janice McCormick</td>
<td>Clinical Quality Program Director</td>
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<tr>
<td>Jeff Lesesne</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Judy Bumpus</td>
<td>Mgr II Credentialing</td>
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<tr>
<td>Karla Enrequez</td>
<td>Director Enterprise Credentialing</td>
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<tr>
<td>Kathleen King</td>
<td>Mgr Provider Network Mgt.</td>
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<td>Kathryn Duarte</td>
<td>Regulatory Compliance Director</td>
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<tr>
<td>Kendra Fowler</td>
<td>Program Manager Pharmacy</td>
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<tr>
<td>Lakesha Sylvester</td>
<td>Regulatory Oversight Consultant – G&amp;A</td>
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<tr>
<td>Lisa Hayes</td>
<td>Director I Customer Care</td>
</tr>
<tr>
<td>Marisa Feler</td>
<td>Director Delegation Oversight</td>
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<td>Mark Talavera</td>
<td>Medical Director</td>
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<td>Matt Straveler</td>
<td>Mgr II Customer Care</td>
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<td>Nicole Dorsey</td>
<td>Quality Director</td>
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<tr>
<td>Sonya Daniels</td>
<td>Director Grievances &amp; Appeals</td>
</tr>
<tr>
<td>Tammie Pitkin</td>
<td>Director Contracting Administration</td>
</tr>
<tr>
<td>Terry Ho</td>
<td>Nurse Medical Mgmt. Ltd.</td>
</tr>
<tr>
<td>Trisha Singh</td>
<td>UM Director Beacon Health Options - BH</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Type of Case Files Reviewed</th>
<th>Sample Size (Number of Files Reviewed)</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Grievances and Appeals</td>
<td>2</td>
<td>Two (2) standard grievance files were identified by the Plan during the review period. Both files were reviewed.</td>
</tr>
<tr>
<td>Potential Quality Issues (PQIs)</td>
<td>1</td>
<td>One (1) PQI was identified by the Plan during the review period. The sole file was reviewed.</td>
</tr>
<tr>
<td>UM Medical Necessity Denials</td>
<td>1</td>
<td>One UM medical necessity denial was identified by the Plan during the review period. The sole file was reviewed.</td>
</tr>
<tr>
<td>Health Risk Assessments</td>
<td>74</td>
<td>The Plan identified 1,435 files during the review period. Based on the Department’s File Review Methodology, a random sample of 74 files were reviewed.</td>
</tr>
<tr>
<td>Individualized Care Plan</td>
<td>30</td>
<td>The Plan identified 1,435 files during the review period. Based on the Department’s File Review Methodology, a random sample of 30 files were reviewed.</td>
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