DEPARTMENT OF Managed Health Care Help Center

DIVISION OF PLAN SURVEYS

1115 WAIVER SENIORS AND PERSONS WITH DISABILITIES

MEDICAL SURVEY REPORT OF CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

A COUNTY ORGANIZED HEALTH SYSTEM PLAN

DATE ISSUED TO DHCS: APRIL 27, 2015

1115 Waiver SPD Medical Survey Report
Central California Alliance for Health
A County Organized Health System Plan
April 27, 2015

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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[1] with the Department of Managed Health Care (the "Department") to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patient-rights laws. Mandatory enrollment of SPDs into managed care began in June 2011.

On June 19, 2014, the Department notified Central California Alliance for Health ("CCAH" or 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 September 8, 2014 through September 11, 2014.

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 populations. 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-CCAH Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations: [2]

I. Utilization Management

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

II. Continuity of Care

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

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

[2] All references to "Contract" are to the County Organized Health System, Geographic Managed Care, or 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 the Plan's documentation and files from the period of January 1, 2014 through May 31, 2014.[3]

SUMMARY OF FINDINGS

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

2014 SURVEY POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT	
#1	**For decisions to deny, defer, or modify requests for prior authorization, the Plan does not consistently:** • **Provide written notification to members and/or their authorized representative notifying them of the decision;** • **Inform members of their right to a State Hearing; and** • **Include a description of the criteria or guidelines used to make the determination in written notifications to members and providers.** DHCS-CCAH Contract, Exhibit A, Attachment 13 – Member Services, Provisions 8(A) and 8(D)(1)-(3) – Denial, Deferral, or Modification of Prior Authorization Requests; Section 1367.01(h)(4).
AVAILABILITY & ACCESSIBILITY OF SERVICES	
#2	**The Plan does not maintain a network of primary care physicians who are located within 30 minutes or 10 miles of a member's residence.** DHCS-CCAH Contract, Exhibit A, Attachment 6 – Provider Network, Provision 7 – Time and Distance Standard.

[3] DHCS-CCAH Contract amendments pertaining to the SPD population went into effect January 1, 2014.

#3	**The Plan does not take effective action to improve quality of care where deficiencies in appointment availability are identified.** DHCS-CCAH Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-CCAH Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3(A)(2) – Access Requirements; Rule 1300.67.2(f).
#4	**The Plan does not take effective action to improve quality of care where deficiencies in telephone triage or screening services are identified.** DHCS-CCAH Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-CCAH Contract, Exhibit A, Attachment 9 – Access and Availability, Provisions 3(D) and 3(F) – Access Requirements; Rule 1300.70(a)(1).
#5	**The Plan does not ensure that print materials distributed to members contain accurate appointment availability information.** DHCS-CCAH Contract, Exhibit A, Attachment 13 – Member Services, Provision 4(C) – Written Member Information.
MEMBER RIGHTS	
#6	**The Plan does not ensure that grievances related to medical quality of care issues are consistently referred to the Medical Director.** DHCS-CCAH Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(E) – Grievance System Oversight.
#7	**For grievances involving delay, modification, or denial of services based on a determination in whole or in part on medical necessity, the Plan does not consistently state in its written response, the criteria, clinical guidelines, or medical policies used in reaching the determination.** DHCS-CCAH Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68(d)(3)-(4).
QUALITY MANAGEMENT	
#8	**The Plan does not maintain a system to ensure accountability for delegated quality improvement activities, including the continuous monitoring and evaluation of the delegated functions.** DHCS-CCAH Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and Provision 6(B)(3) – Delegation of Quality Improvement Activities; Rule 1300.70(b)(2)(G)(3).

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

The Plan has instituted the following to support its SPD population:

1. The Plan has worked with the Department to update its annual provider appointment availability survey to ensure that it produces a statistically reliable and useful measure of appointment wait times.

2. The Plan has reported SPD specific data for a number of its Quality Improvement Program activities as well as Utilization Management (UM) elements. This includes data relevant to HEDIS Quality Improvement Projects such as Asthma Health Outcomes, and Diabetes Care and Monitoring Use of Persistent Medication. In addition, the Plan has reported SPD specific data for several UM elements, including outpatient visits, emergency department visits, re-admissions, and inpatient utilization.

3. For complex case management, the Plan has designated three nurses for the SPD population from a total of eight complex case managers.

4. The Plan assumes that all new SPD enrollees are high risk and strives to complete their health risk assessments within 45 days. This allows new enrollees to be rapidly referred to complex case management as needed. It also avoids the initial assignment of some enrollees to low risk only to discover later that these enrollees were, in fact, high risk and could have benefited by earlier referral to complex case management.

5. The Plan enhanced its UM, care management, and pharmacy management processes to allow for the electronic submission of authorization requests via the website's provider portal, electronic receipt and upload of members' health risk assessments, electronic receipt and import of hospital census information, and electronic notification to PCPs of members' hospital admissions. These redesign efforts have aligned the Plan's UM process with the Care Transitions Program and have assisted the Plan with better managing inpatient reviews and prior authorizations.

6. The Plan established the Alternatives to Inpatient Care Program, a collaborative effort between Alliance staff, hospitals, community physicians, and other providers, to maximize appropriate use of skilled nursing facilities (SNF), restorative care units, and other sub-acute facilities in place of the acute hospital setting. The Plan performs evaluations to assess the effectiveness of these interventions. This program was conducted in conjunction with the SNF Pilot Program (with 11 participating facilities in the Plan's service area), which allows direct admission to a SNF of appropriately identified members from the emergency room, physician offices, and long-term care facilities. The Plan educated hospital emergency department staff and physicians to improve appropriate identification of members for this program. Additional facilities are being considered in Los Banos and Dos Palos to serve Merced members in rural areas.

7. The Plan developed and enhanced existing utilization reports to better understand utilization patterns, develop strategies to address inappropriate utilization, and monitor the impact of interventions.

8. The Plan established the Telephonic Care Transition Program. This initiative centers on the identification of, and interventions for, high-risk patients, with the aim to reduce hospital readmission rates by coordinating post-discharge communication between the inpatient care team, primary care team, community services, and the patient's support person. Its goals are to decrease hospital readmission rates and improve discharge planning and transition from the hospital setting to the home. Strategies include post-hospitalization medication reconciliation and a PCP visit within 10 business days post hospital discharge. Patients with diagnoses such as congestive heart failure, myocardial infarction, pneumonia, and chronic obstructive pulmonary disease are served by this program.

DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

Potential Deficiency #1: For decisions to deny, defer, or modify requests for prior authorization, the Plan does not consistently:

- **Provide written notification to members and/or their authorized representative notifying them of the decision;**
- **Inform members of their right to a State Hearing; and**
- **Include a description of the criteria or guidelines used to make the determination in written notifications to members and providers.**

Contractual/Statutory/Regulatory Reference(s): DHCS-CCAH Contract, Exhibit A, Attachment 13 – Member Services, Provisions 8(A) and 8(D)(1)-(3) – Denial, Deferral, or Modification of Prior Authorization Requests; Section 1367.01(h)(4).

<u>DHCS-CCAH Contract, Exhibit A, Attachment 13 – Member Services, Provisions 8(A) and 8(D)(1)-(3)</u>

8. Denial, Deferral, or Modification of Prior Authorization Requests
   A. Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

   D. Contractor shall provide for a written notification to the Member and the Member's authorized representative on a standardized form, approved by DHCS, informing the Member of all the following:
      1) The Member's right to, method of obtaining, and time limit for requesting a State Hearing to contest the denial, deferral, or modification action and the decision the Contractor has made, the reason(s) for the action and the specific regulation(s) or plan authorization procedures supporting the action.
      2) The Member's right to represent himself/herself at the State Hearing or to be represented by legal counsel, friend or other spokesperson.
      3) The name and address of Contractor and the State Department of Social Services (DSS) toll-free telephone number for obtaining information on legal service organizations for representation.

<u>Section 1367.01(h)(4)</u>

(4) 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…Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations. [Emphasis added.]

Documents Reviewed:

- Plan Policy 404-1201: Authorization Request Process (06/18/13)
- Four Appeals files (01/01/14 – 05/31/14)
- Plan's response to DMHC onsite request #27/29 – Request for NOAs (09/09/14)
- Plan's email response to DMHC post-onsite request for missing NOA letters (10/01/14, 10/23/14, 10/27/14)

Assessment: Plan Policy 404-1201: Authorization Request Process states:

2. Communications Regarding Determination to Medi-Cal Members…
   b. A Notice of Action Letter (NOA), regarding a decision to deny, delay, modify or terminate a requested service…will be mailed to the member…A NOA also specifies the following:

      - The action taken by the Alliance (Denial, Delay, Modification or Termination);
      - A clear and concise explanation of the reason for the Alliance decision;
      - Details containing descriptions of criteria, or guidelines including a citation of the specific regulations or Alliance authorization procedures supporting the action and the clinical reasons for the decision regarding medical necessity used when making deferral, denial or modification of requests;
      - The direct line phone numbers of decision makers in NOA letters when communicating with providers;
      - The member's right to a fair hearing including;
      - The method by which a fair hearing may be obtained; and
      - Time limit for fair hearing…

3. Communications Regarding Decisions to Providers…
   b. Denial, delay, or modification of an authorization request:
      Communication of the decision…will include:
      - A clear and concise explanation of the reasons for the plan's decision
      - A description of the criteria or guidelines used as a basis for the Plan's decision…

This policy is consistent with the DHCS-CCAH Contract, Exhibit A, Attachment 13, Provisions 8(A) and 8(D)(1)-(3) as it requires the Plan to notify members in writing of the Plan's decision to deny, delay, modify, or terminate a requested service. The Plan's letter to the member must also provide information on the State Hearing process. In addition, the policy mirrors Section 1367.01(h)(4) as the Plan must provide members and providers with a description of the criteria

or guidelines used as a basis for the Plan's decision. The three appeals files[4] reviewed by the Department revealed that the Plan does not consistently send members written notification of the Plan's decisions or State Hearing information. Also, the Plan does not include a description of criteria or guidelines used in its decisions to members and providers.

The Plan does not consistently send NOA letters to members.
In two of three (67%) appeals files reviewed, the Department found that the Plan did not send a NOA letter to the member. On September 10, 2014, the Department requested copies of NOA member letters from the Plan for File #8 and File #12. On October 27, 2014, the Plan's written response to the Department's request stated:

> Upon review of the case[s] it was recognized that there was a designation on the authorization in our system as a post service request. Post-service requests are treated like a provider request and therefore a NOA would not have been sent to the member. There should have been a NOA to the member in this situation. UM staff were in-serviced this afternoon to correct the practice.

The Department subsequently requested further clarification from the Plan, and in its written response, the Plan stated, "Cases 8 and 12 were mistakenly classified as post-service requests. They were not post-service requests, and therefore, it was a mistake that the NOA was not sent." Due to the misclassification of these files as provider post-service requests rather than prior authorization requests, members did not receive written notification of the Plan's prior authorization denials and were not informed of their right to a State Hearing.

The Plan does not consistently include a description of the criteria or guidelines it used to make its determination in NOA letters to members and providers.
While only one out of three members received an NOA letter, the Plan sent NOA letters to each of the three providers. The Department reviewed all four letters to ascertain compliance with the requirements set forth in Section 1367.01(h)(4) and found that none of the letters contained descriptions of the criteria or guidelines the Plan used to make its determinations. For example:

- *File #8*: This case involved the denial of a request for extension of wheelchair rental. The NOA letter sent to the provider stated:

  > Per member's PT notes, member is now ambulating up to 150 feet with walker. The continued authorization of the requested wheelchair would be counter intuitive as the member is walking with a walker and there is no documentation implying that she is unsafe nor is there a documented history of falls. Furthermore, she continues to receive PT and is still progressing. Therefore, the requested wheelchair is denied.

[4] The Department indirectly assesses the Plan's prior authorization review process through an examination of grievances and appeals filed during the survey review period. A random sample of grievances and appeals files are selected, from which all appeals are isolated and reviewed specifically for the initial denial process. The Department identified and reviewed four appeals files. File #19 was not an appeal and was excluded from review. The remaining three appeals files were reviewed for compliance with the contractual and statutory requirements.

Although the Plan references physical therapy notes to establish the member's status and condition, the NOA letter does not include a description of the specific criteria or guideline the Plan used to deny the request.

- *File #12*: This case involved the denial of oxygen supplement to treat a diagnosis of sleep apnea. The NOA letter sent to the provider stated:

  > The documentation sent with this request does not support medical necessity. The clinical notes sent with this request state that you have been diagnosed with sleep apnea. Supplemental oxygen is not considered the appropriate way to treat this diagnosis per medical guidelines. Please have member contact their PCP to explore other options for her treatment (including possible sleep study and CPAP consideration.)

  Although the Plan indicates that an oxygen supplement is inappropriate to treat the member's sleep apnea, the NOA letter does not include a description of the specific criteria or guideline the Plan used to deny the request.

- *File #18*: This case involved the denial of additional physical therapy sessions. The NOA letter sent to the provider stated:

  > Per Milliman Guidelines, documentation provided does not support the medical necessity for additional physical therapy. Member is encouraged to follow up with his PCP for other options. Thank You.

  The NOA letter sent to the member stated:

  > [Provider] has asked the Alliance to approve 12 Additional Physical Therapy Visits. This request is denied by the Alliance for the following reason: You have received approximately 46 visits of physical therapy for your condition. The documentation provided to the Alliance does not support the medical necessity for additional physical therapy per Milliman Guidelines for your diagnosis. Please follow up with your physician to explore other treatment options.

  Although the Plan cites Milliman Guidelines in both NOA letters, neither letter included a description of the specific criteria or guideline the Plan used to deny the request. Moreover, the member's letter did not include any State Hearing information.

DHCS-CCAH Contract, Exhibit A, Attachment 13, Provision 8(A) requires the Plan to notify members of a decision to deny, defer, or modify requests for prior authorization by providing written notification as specified in Section 1367.01. Section 1367.01(h)(4) requires the notifications to include a description of the criteria or guidelines the Plan used to make its determination. DHCS-CCAH Contract, Exhibit A, Attachment 13, Provision 8(D)(1)-(3) additionally requires the written notification to include State Hearing information should the

member choose to contest the Plan's decision. Based on the Department's review of the appeals files, it was found that the Plan did not consistently provide members with NOA letters notifying them of the Plan's decision or of their right to a State Hearing. Furthermore, none of the NOA letters reviewed included a description of the criteria or guidelines the Plan used to make its determination. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

AVAILABILITY AND ACCESSIBILITY

Potential Deficiency #2: The Plan does not maintain a network of primary care physicians who are located within 30 minutes or 10 miles of a member's residence.

Contractual/Statutory/Regulatory Reference(s): DHCS-CCAH Contract, Exhibit A, Attachment 6 – Provider Network, Provision 7 – Time and Distance Standard.

DHCS-CCAH Contract, Exhibit A, Attachment 6 – Provider Network

7. Time and Distance Standard
   Contractor shall maintain a network of Primary Care Physicians that are located within 30 minutes or ten (10) miles of a Member's residence unless the Contractor has a DHCS approved alternative time and distance standard.

Documents Reviewed:

- Plan Policy 300-5050: Geographic Accessibility Standards (06/20/13)
- Member Distribution Dashboard (05/31/14)
- Plan Response to DMHC Pre-Onsite Request: Access & Availability GeoAccess Reports (undated)
- Plan Response to DMHC Onsite Request #1: GeoAccess Narrative (undated)

Assessment: DHCS-CCAH Contract, Exhibit A, Attachment 6, Provision 7 requires the Plan to maintain a network of PCPs who are located within 30 minutes or 10 miles of a member's residence. Prior to the onsite survey, Department staff requested the Plan to provide documentation that demonstrates compliance with this accessibility standard. Specifically, the Department requested copies of the Plan's GeoAccess reports, which would identify the location of providers in relation to members. The Plan's written response to the Department's request stated that it "does not have any Geoaccess [sic] reports during the survey period."

Plan Policy 300-5050: Geographic Accessibility Standards states, "The Alliance shall maintain a network of providers which complies with all regulatory and contractual requirements relating to geographic accessibility." The policy includes a section titled, "Ongoing Monitoring of Geographic Accessibility," but the section pertains to the monitoring of provider terminations and identification and recruitment of potential non-contracted providers that would be utilized to ensure compliance when needed. While the Plan is aware that it must comply with geographic accessibility standards, it lacks monitoring policies to ensure that the requisite standards are met.

Additionally, during the onsite survey, the Department requested the Plan to provide geographic access monitoring reports. The Plan's written response to the request indicated:

> The Alliance does not have any GeoAccess reports but does have a Member Distribution Dashboard that has been used to review the geographic distribution of members and PCPs. This report was presented to the Access Initiative on March 18, 2014. The current version of the Member Distribution Dashboard shows by zip code the number of providers and members. The report can also show the number of member/provider links within a zip code and the number of members that are linked to providers outside of their respective zip codes.

The Plan's Member Distribution Dashboard shows the number of members and providers within each zip code. However, there is no measurement of the proportion of members who are within 30 minutes or 10 miles of at least one PCP.

DHCS-CCAH Contract, Exhibit A, Attachment 6, Provision 7 requires the Plan to maintain a network of PCPs who are located within 30 minutes or 10 miles of a member's residence. The Plan was unable to demonstrate that it monitors its provider network to comply with this requirement. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #3: The Plan does not take effective action to improve quality of care where deficiencies in appointment availability are identified.

Contractual/Statutory/Regulatory Reference(s): DHCS-CCAH Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-CCAH Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3(A)(2) – Access Requirements; Rule 1300.67.2(f).

<u>DHCS-CCAH Contract, Exhibit A, Attachment 4 – Quality Improvement System</u>

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.

<u>DHCS-CCAH Contract, Exhibit A, Attachment 9 – Access and Availability</u>

3. Access Requirements
   Contractor shall establish acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2 and as specified below. DHCS will review and approve standards for reasonableness. Contractor shall ensure that Contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the provider serves only

Medi-Cal Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

(2) Standards for Timely Appointments:

Members must be offered appointments within the following timeframes:

a) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
b) Urgent appointment for services that do require prior authorization – within 96 hours of a request;
c) Non-urgent primary care appointments – within ten (10) business days of request;
d) Appointment with a specialist – within 15 business days of request;
e) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

Rule 1300.67.2(f)

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

Documents Reviewed:

- Plan Policy 300-8030: Monitoring Network Compliance with Accessibility Standards (10/08/13)
- Plan Policy 401-1509: Accessibility (12/02/13)
- Provider Access Appointment Availability Audit (2013)
- Follow-up documentation for 20 providers randomly selected from those who were non-compliant with one or more appointment standards as measured by the Plan's Annual Provider Access Appointment Availability Audit (2013)
- Plan Response to DMHC Pre-Onsite Request: Access Related CAPs (undated)

Assessment: DHCS-CCAH Contract, Exhibit A, Attachment 9, Provision 3(A)(2) requires the Plan to communicate, enforce, and monitor providers' compliance with standards for timely appointments, including non-urgent primary care appointments and urgent care appointments that do not require prior authorization. Plan Policy 300-8030: Monitoring Network Compliance with Accessibility Standards describes the process for providing written notice to all contracted providers and provider groups that fail to meet one or more of the Timely Access standards. Policy 300-8030 states:

> 2.a. In the event the quarterly compliance monitoring or annual accessibility survey discloses the Alliance's network is not sufficient to ensure timely access, the Access Initiative shall investigate and implement corrective action, including taking all necessary and appropriate actions to identify the cause of the identified timely access deficiencies and steps to bring the network into compliance.

> …Provider Services will provide written notice to all contracted providers affected by a corrective action. The written notice 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 Alliance's corrective action.
>
> The [Provider Services Network Manager (PSNM)] shall conduct quarterly monitoring of any provider affected by a corrective action to ensure their compliance with the corrective action plan. If after the first 3 months, the provider is not in compliance with the standards, the Chief Medical Officer will also follow up with the provider. If after two quarters the provider still fails to comply with the standards, the Chief Medical Officer will present the matter to the Peer Review and Credentialing Committee (PRCC).
>
> 2.b. Provider Services will provide written notice of deficiency to any provider group that fails to meet one or more of the timely access standards described in [Rule 1300.67.2.2], based on the results from the timely access survey. The written notice will identify which standard or standards were not met. The PSNM will conduct annual monitoring and trending of provider groups receiving a deficiency letter. If a provider trends for two consecutive years with the same deficiency, the PSNM will present the issue to the Access Initiative to determine the appropriate next steps to bring the provider into compliance.

Further, Plan Policy 401-1509: Accessibility outlines the Plan's procedures for monitoring timely appointment standards as required by Exhibit A, Attachment 9, Provision 3(A)(2). Policy 401-1509 provides:

> 5. In the event that the quarterly compliance monitoring or annual accessibility survey discloses the provider network is not sufficient to ensure timely access, the Access Initiative shall investigate and implement corrective action and provide a written notice to all contracted providers affected by the corrective action as stated in Policy 300-8030 – Monitoring Network Compliance with Accessibility Standards.

Each year, the Plan conducts a Provider Access Appointment Availability Audit to monitor provider compliance with timely access standards. In 2013, 338 providers and provider groups responded to this audit. Forty out of 338 (12%) providers and provider groups received a "fail" score to one of the two appointment wait time standard questions below:

- Q3: Routine non-urgent Appointment: When is the next available date with any practitioner in the office for a routine non-urgent appointment?
- Q7: Urgent Care Appointment (no prior authorization): What is the average length of time to obtain an urgent care appointment?

The Department randomly selected 20 out of 40 deficient providers to evaluate the Plan's follow-up and providers' corrective actions. An interview with Plan staff revealed that the Plan's Provider Services Senior Network Advisor called each non-compliant provider and sent

deficiency letters to 18 of the 19 providers.[5] The following is an example of the deficiency letter:

> …[Y]our office participated in our annual timely access survey...This letter is to advise you that your office was noted to have a deficiency in meeting one of the standards.
>
> Members must be able to access urgent care appointments for services that do not require prior authorization within 24 hours upon request. Your response to this inquiry is that urgent care appointments for services within 24 hours are not available at your office, thereby not meeting the standard.
>
> Every effort to accommodate our members within the stated timeframe must be made. We strongly encourage you to make the necessary changes to ensure compliance...

Providers and provider groups identified by the Plan as having the same deficiency two years in a row received similar letters with the following modified paragraph:

> This letter is to advise you that your office was noted to have a deficiency in meeting one of the standards. It is important to note that this deficiency was noted last year as well.

In the 18 letters reviewed by the Department, the Plan never requested corrective action plans (CAPs) or any evidence of correction from non-compliant providers and provider groups. During onsite interviews, Plan staff confirmed that if a provider is non-compliant two years in a row, the Plan would send a deficiency letter requesting a CAP. However, the Plan's actions to ensure provider compliance was limited to sending deficiency letters detailing the non-compliance and informing providers and provider groups that compliance will be re-measured during next year's audit. Furthermore, the Plan's written request to the Department's pre-onsite request indicated that there were no access related CAPs implemented during the review period.

DHCS-CCAH Contract, Exhibit A, Attachment 9, Provision 3(A)(2) requires the Plan to communicate, enforce, and, monitor providers' compliance with standards for timely appointments. Rule 1300.67.2(f) requires the Plan to have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, including waiting time and appointments. DHCS-CCAH Contract, Exhibit A, Attachment 4, Provision 1 requires the Plan to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers.

The Plan's annual audit revealed that some of its providers and provider groups did not meet appointment availability requirements. In addition, the Plan had knowledge that some had been non-compliant for two consecutive years. However, other than calling and sending deficiency letters, the Plan did not investigate or implement any CAPs to bring these individuals into

[5] One provider misunderstood the urgent care appointment question and was in compliance once he clarified his response.

compliance. Although the Plan identified deficiencies, the Plan failed to take effective action to improve quality of care for its members. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Potential Deficiency #4: The Plan does not take effective action to improve quality of care where deficiencies in telephone triage or screening services are identified.

Contractual/Statutory/Regulatory Reference: DHCS-CCAH Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-CCAH Contract, Exhibit A, Attachment 9 – Access and Availability, Provisions 3(D) and 3(F) – Access Requirements; Rule 1300.70(a)(1).

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

3. Access Requirements
   Contractor shall establish acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2 and as specified below. DHCS will review and approve standards for reasonableness. Contractor shall ensure that Contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.
   D. Telephone Procedures
      Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

   F. After Hours Calls
      At a minimum, Contractor shall ensure that a Physician or an appropriate licensed professional under his/her supervision is available for after-hours calls.

Documents Reviewed:

- Plan Policy 401-1509: Accessibility (12/02/13)
- Provider Access Appointment Availability Audit (2013)

- Follow-up documentation for 20 providers randomly selected from those who were non-compliant with triage standards as measured by the Plan's Annual Provider Access Appointment Availability Audit (2013)
- Plan Response to DMHC Pre-Onsite Request: Access Related CAPs (undated)

Assessment: DHCS-CCAH Contract, Exhibit A, Attachment 9, Provisions 3(D) and 3(F) require the Plan to communicate, enforce, and monitor providers' compliance with timely access standards, including requiring providers to maintain a procedure for triaging members' telephone calls and ensuring that a physician or an appropriate licensed professional under the physician's supervision is available for after-hours calls. Plan Policy 401-1509: Accessibility outlines the Plan's procedures for telephone triage or screening services. It states:

> D. Telephone Triage or Screening Services
> Telephone triage or screening services are provided in a timely manner, appropriate for the member's condition. Triage or screening waiting times do not exceed 30 minutes during business hours.
>
> The minimum telephone triage or screen service shall include the use, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff that will inform the caller:
>
> 1. Regarding the length of wait for a return call from the provider; and
> 2. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

Each year, the Plan conducts a Provider Access Appointment Availability Audit to monitor provider compliance with timely access standards. In 2013, 338 providers and provider groups responded to this audit. Ninety out of 338 (27%) providers and provider groups received a "fail" score to the following question:

- Q15. Does your practice provide a telephone appointment triage or screening services, such as an answering machine or answering service?

The Department randomly selected 20 out of 90 deficient providers to evaluate the Plan's follow-up and providers' corrective actions. Of the 20 providers selected for review, 16 providers did not comply with the triage or screening services requirement.[6] An interview with Plan staff revealed that the Plan's Provider Services Senior Network Advisor called each non-compliant provider. However, the Plan did not send deficiency letters to non-compliant providers requesting the submission of CAPs or evidence of correction. In each of the 16 provider files reviewed, the Plan's documentation indicated, "The provider will be re-measured during the 2014 Timely Access survey."

[6] It was determined that two providers misunderstood the survey question and were found to be in compliance; one provider could not be followed up with because he was no longer operating as a PCP; and another was erroneously classified as deficient.

DHCS-CCAH Contract, Exhibit A, Attachment 9, Provisions 3(D) and 3(F) require the Plan to communicate, enforce, and monitor providers' compliance with standards for telephone procedures and after hour calls. DHCS-CCAH Contract, Exhibit A, Attachment 4, Provision 1 requires the Plan to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers. The Plan's annual audit revealed that some of its providers and provider groups did not meet requirements for telephone procedures and after hours calls. However, other than calling non-compliant individuals, the Plan did not send deficiency letters or implement any CAPs to bring these individuals into compliance. Although the Plan identified deficiencies, the Plan failed to take effective action to improve quality of care for its members. Therefore, the Department finds the Plan in violation of these contractual requirements.

Potential Deficiency #5: The Plan does not ensure that print materials distributed to members contain accurate appointment availability information.

Contractual/Statutory/Regulatory Reference(s): DHCS-CCAH Contract, Exhibit A, Attachment 13 – Member Services, Provision 4(C) – Written Member Information.

<u>DHCS-CCAH Contract, Exhibit A, Attachment 13 – Member Services</u>

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 Covered Services, processes and ensure the Member's ability to make informed health decisions.

Documents Reviewed:

- Plan Policy 401-1509: Accessibility (12/02/13)
- Medi-Cal Member Handbook (April 2014)
- Member Newsletter – Living Healthy (September 2014)
- Member Newsletter – Living Healthy (December 2014)
- Plan Response to DMHC Onsite Request #37: Access Follow-Up (09/12/14)

Assessment: DHCS-CCAH Contract, Exhibit A, Attachment, Provision 4(C) requires the Plan's written Member information to "ensure Members' understanding of the health plan Covered Services, processes and ensure the Member's ability to make informed health decisions." The Department reviewed the Plan's member materials to assess how members were informed of timely access standards. Upon review, it was discovered that the Plan's published member materials contained appointment wait time information that is inconsistent with the requirements and standards established in the Plan's contract with the DHCS.

The Plan's April 2014 Medi-Cal Member Handbook (page 4) states:

> **Now that I have a PCP, when can I see my doctor?**

> You should see your doctor within 120 days (4 months) of becoming an Alliance Member. Call your doctor to make an appointment for a new patient exam. It's important to have this exam while you are well. Don't wait until you are sick to see your doctor for the first time. Call soon. *Sometimes it takes a few weeks or a month to get a new patient exam*. [Emphasis added.]

DHCS-CCAH Contract, Exhibit A, Attachment 9, Provision 3(A)(2)(c) requires non-urgent primary care appointments to be scheduled within 10 business days of request. However, the last sentence in the above excerpt indicates that it could take up to a month to get an appointment, which is inconsistent with the Plan's timely appointment standards set forth in its contract with the DHCS.

The Plan's April 2014 Medi-Cal Member Handbook (page 28) states:

> **How long will it take to get an appointment?**
> It will take longer to get an appointment for some kinds of care than others. Here is an idea of how long it might take:
> - *Urgent appointments may be available.* Tell the office if there is a fever, severe pain or other important symptoms. They will use that information to determine how soon you need to be seen.
> - For normal office visits, call at least one week in advance.
> - For prenatal care, call at least 1 week in advance.
> - *For non-urgent care, regular check-ups and immunizations and well child visits, call at least 3-6 weeks in advance*. [Emphasis added.]

DHCS-CCAH Contract, Exhibit A, Attachment 9, Provision 3(A)(2)(a) requires urgent care appointments for services that do not require prior authorization to be scheduled within 48 hours of request. DHCS-CCAH Contract, Exhibit A, Attachment 9, Provision 3(A)(2)(b) requires urgent care appointments for services that require prior authorization to be scheduled within 96 hours of request. However, the member handbook only indicates that "urgent care appointments may be available," which is inconsistent with the Plan's timely appointment standards set forth in its contract with the DHCS. In addition, the Plan's three to six week timeframe to obtain non-urgent care appointments is inconsistent with the Plan's 10 business day requirement set forth in DHCS-CCAH Contract, Exhibit A, Attachment 9, Provision 3(A)(2)(c).

In addition, the Plan's September 2014 member newsletter contained an article titled, "Picking a Primary Care Provider (PCP), Getting in to See Your PCP as a New Member." The article indicates it can sometimes take new patients a few months to get an appointment with a PCP, which again, is inconsistent with the Plan's 10 business day requirement set forth in DHCS-CCAH Contract, Exhibit A, Attachment 9, Provision 3(A)(2)(c).

DHCS-CCAH Contract, Exhibit A, Attachment 13, Provision 4(C) requires the Plan's written Member information to "ensure Members' understanding of the health plan Covered Services, processes and ensure the Member's ability to make informed health decisions." The Department found that the Plan's member handbook and newsletter contained non-urgent primary care and urgent care appointment information that was inconsistent with the Plan's contractual

requirements. Since inaccurate appointment availability information in member materials will lead to the members' confusion, the Department finds the Plan in violation of this contractual requirement.

MEMBER RIGHTS

Potential Deficiency #6: The Plan does not ensure that grievances related to medical quality of care issues are consistently referred to the Medical Director.

Contractual/Statutory/Regulatory/Reference(s): DHCS-CCAH Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(E) – Grievance System Oversight.

DHCS-CCAH Contract, Exhibit A, Attachment 14 – Member Grievance System

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

Documents Reviewed:

- Plan Policy 105-1000: Processing Grievance Cases (11/06/13)
- Plan Policy 105-1001: Grievance Reporting, Quality Improvement and Audits (11/06/13)
- Plan Policy 105-1002: Member Grievance System (10/17/13)
- Plan Policy 401-1301: Potential Quality Issue Review Process (09/30/13)
- 21 Standard Grievance Files (01/01/14 – 05/31/14)
- 29 Exempt Grievance Files (01/01/14 – 05/31/14)
- Plan Response to DMHC Onsite Request #34: Follow-Up on Requested Exempt Grievances (09/10/14)

Assessment: DHCS-CCAH Contract, Exhibit A, Attachment 14, Provision 2(E) requires grievances related to medical quality of care issues be referred to the Plan's Medical Director. Plan Policy 105-1001: Grievance Reporting, Quality Improvement and Audits outlines the responsibility of the grievance coordinator:

> Potential Quality Issue and Quality Improvement Committee
> In compliance with Policy 401-1301 – Potential Quality Issue Review Process, the [Grievance Coordinator (GC)] will electronically forward a Closed Case to relevant quality assurance staff within the Alliance. Following the [Potential Quality Issue (PQI)] review, the Associate Medical Director electronically returns the Case to the GC indicating that the Case was routed and its review "completed."

Plan Policy 401-1301: Potential Quality Issue Review Process identifies sources from which PQIs can be derived, including "member or provider grievances, appeals, and complaints" and defines a PQI as:

> A deviation or suspected deviation from expected provider performance, clinical care, or outcome of care, which cannot be determined to be justified without additional review…Not all PQIs will be found to be quality of care problems.

Policy 401-1301, consistent with DHCS-CCAH Contract, Exhibit A, Attachment 14, Provision 2(E), requires all PQIs to be forwarded to a Medical Director. In addition, the policy outlines key responsibilities of the Medical Director including: reviewing PQIs, requesting additional information, assigning severity levels if quality issues exist, and making determinations regarding whether to take further action.

The Department randomly selected a sample of 21 standard grievances and 28 exempt grievances[7] for review. Twelve out of 21 standard grievances contained quality of care issues. All 12 standard grievances were appropriately elevated as PQIs and forwarded to the Plan's Medical Director for review. Nine out of 28 exempt grievances contained quality of care issues, but the Plan did not forward any of these PQIs to the Medical Director for review.[8] For example:

- *File #4*: The member was unhappy with the treating neurologist, indicating that the physician's reports were always abnormal, he ordered too many EMGs, and his diagnoses were not accurate. The customer service representative gave the member the contact information for other neurologists in the member's area and closed the case. The member's quality of care concerns regarding the treating neurologist (abnormal reports, too many EMGs, inaccurate diagnoses) were never referred to the Medical Director for investigation.

- *File #11*: The member reported that her PCP refused to prescribe nausea and cholesterol medication for her. Per the member's request, the Plan assigned her to a new PCP. The member's quality of care concern regarding difficulty getting medications was never referred to the Medical Director for investigation.

- *File #18*: The member complained that immediately following surgery, someone whom she believed to be a Plan nurse approached her. The member reported that she was heavily sedated at the time, but was requested by the nurse to sign discharge paperwork. The member felt that she was discharged too soon. The customer service representative informed the member that the Plan does not determine discharge dates or medical treatment, informed her that she could file a grievance directly with the hospital, and closed the case. The member's quality of care concerns regarding premature discharge were never referred to the Medical Director for investigation.

[7] Initially, the Department randomly selected 29 exempt grievance files for review. One file was excluded from review because the grievance was not filed within 180 days from the date of the incident.
[8] File #4; File #7; File #8; File #11; File #17; File #18; File #21; File #23; and File #27.

DHCS-CCAH Contract, Exhibit A, Attachment 14, Provision 2(E) requires that medical quality of care grievances be referred to the Plan's Medical Director. The Plan found quality of care issues in nine out of 28 exempt grievances. However, none of those files were forwarded to the Plan's Medical Director for review. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #7: For grievances involving delay, modification or denial of services based on a determination in whole or in part on medical necessity, the Plan does not consistently state in its written response, the criteria, clinical guidelines, or medical policies used in reaching the determination.

Contractual/Statutory/Regulatory Reference(s): DHCS-CCAH Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68(d)(3)-(4).

DHCS-CCAH 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…Contractor shall notify the Member of the grievance resolution in a written member notice.

Rule 1300.68(d)(3)
The plan shall respond to grievances as follows: The plan's resolution, containing a written response…shall contain a clear and concise explanation of the plan's decision.

Rule 1300.68(d)(4)
For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination.

Documents Reviewed:

- Plan Policy #105-1000: Processing Grievance Cases (11/06/13)
- Plan Policy #105-1002: Member Grievance System (10/17/13)
- 21 Standard Grievance files (01/01/14 – 05/31/14)
- Four Appeals files (01/01/14 – 05/31/14)

Assessment: Plan Policy 105-1002: Member Grievance System states:

> When a UM Appeal decision involving the delay, denial or modification of health care services is upheld, the Complaint Resolution Letter will describe the criteria, clinical guidelines or medical policy used to reach the decision.

To assess compliance with this standard, the Department selected a random sample of 21 standard grievance and appeals files for review. Four appeals files were identified. The Plan

overturned two appeals and upheld two appeals. The Plan's written responses in the two upheld appeals failed to provide the criteria, clinical guidelines, or medical policies the Plan used to reach its decisions. For example:

- *File #12*: The member appealed the denial for an oxygen concentrator to treat abnormal oxygen saturation levels. The denial was upheld by the Plan. The Plan's written response simply stated, "Medical criteria was not met using Milliman Guidelines." The Plan's written response did not include a description of the criteria, clinical guidelines, or medical policies the Plan used to determine how the member's condition did not specifically meet the criteria.

- *File #18*: The member appealed the denial for additional physical therapy visits. The denial was upheld by the Plan because the treating physicians did not submit supplemental information to justify the additional visits. The Plan's written response did not include a description of the criteria, clinical guidelines, or medical policies the Plan used to determine how the member's condition did not specifically meet the criteria.[9]

Rule 1300.68(d)(4) requires the Plan's written responses to grievances involving the delay, modification, or denial of services based on medical necessity to clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination. Rule 1300.68(d)(3) requires the Plan's written response to include a clear and concise explanation of the Plan's decision. DHCS-CCAH Contract, Exhibit A, Attachment 14, Provision 1 requires compliance with these rules. The Department's review of the two upheld appeals revealed that the Plan's written responses did not clearly state the criteria, clinical guidelines, or medical policies it used in making its determinations. As the lack of clear and concise explanations resulted in unclear denials, the Department finds the Plan in violation of these contractual and regulatory requirements.

QUALITY MANAGEMENT

Potential Deficiency #8: The Plan does not maintain a system to ensure accountability for delegated quality improvement activities, including the continuous monitoring and evaluation of the delegated functions.

Contractual/Statutory/Regulatory Reference(s): DHCS-CCAH Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and Provision 6(B)(3) – Delegation of Quality Improvement Activities; Rule 1300.70(b)(2)(G)(3).

<u>DHCS-CCAH Contract, Exhibit A, Attachment 4 – Quality Improvement System</u>

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

[9] Please see Deficiency #1 for a discussion on how the original NOA letters also did not include a description of the criteria or guidelines the Plan used to make its determinations.

for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

6. Delegation of Quality Improvement Activities
   B. Contractor shall maintain a system to ensure accountability for delegated Quality Improvement activities, that at a minimum:
      3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

Rule 1300.70 (b)(2)(G)(3)
(a) Quality Assurance Program Structure and Requirements.
(2) Program Requirements.
(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:
(3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.

Documents Reviewed:

- Managed Behavioral Health Services Agreement (12/04/13)
- Alliance Delegation Review for Behavioral Health Integration (January 2014)
- Delegated Oversight Quarterly Reporting Form – Quality Improvement (First Quarter, 2014)
- Quarterly Reports of Delegated Activity (First Quarter, 2014)
- Plan Policy #105-0004: Delegation Oversight Policy (04/11/14)
- Compliance Committee Meeting Minutes (04/16/14)

Assessment: In January 2014, the Plan contracted with a behavioral health specialty plan. Several functions were delegated to this specialty plan, including quality improvement, UM, member rights and responsibilities, and provider credentialing. The Managed Behavioral Health Services Agreement, an executed contract between the Plan and delegate, requires the delegate to submit a variety of reports to the Plan pertaining to activities related to these delegated functions.

Plan Policy 105-0004: Delegate Oversight assigns delegation oversight responsibilities to its Compliance Committee, who then delegates the functions to various departmental directors within the Plan. In January 2014, the Plan's Quality Improvement Director prepared Alliance Delegation Review for Behavioral Health Integration, a Plan document that contains a list of additional reports the delegate is required to submit on a quarterly basis:

2. [Quality Management & Improvement] Program Evaluation (which includes a written description of all completed and ongoing [Quality Improvement] activities, trending of measures, analysis of results, and evaluation of the program) on a quarterly basis…

3. Report all Sentinel events and other reportable incidents and unexpected deaths from suicide to the Alliance upon discovery, at the completion of the investigation, and on a quarterly basis in aggregate format…

4. Report all Quality of Care concerns that warrant an investigation to the Alliance (upon discovery?) and on a quarterly basis in aggregate format…

5. Report all Provider Preventable Conditions (PPC's) upon discovery and on a quarterly basis in aggregate format…

Plan document, Delegated Oversight Quarterly Reporting Form – Quality Improvement revealed that as of April 2014, the Quality Improvement Director had not received any reports from the behavioral health delegate. Follow-up action on the reporting form stated, "Escalate request by CCAH Compliance Committee." The April 2014 Compliance Committee Meeting minutes indicated, "a conference call with [the delegate] confirmed the necessary annual and quarterly reporting expected from [the delegate] moving forward." However, there was no documentation of additional follow-up concerning the submission of required reports until the Plan emailed the delegate on August 29, 2014. At the time of the Department's onsite survey in September 2014, the first quarter and second quarter reports for 2014 were still unavailable for review.

DHCS-CCAH Contract, Exhibit A, Attachment 4, Provision 1 requires the Plan to implement an effective QIS to monitor and evaluate quality of care issues. DHCS-CCAH Contract, Exhibit A, Attachment 4, Provision 6(B)(3) requires the Plan to ensure accountability for delegated quality improvement activities by continuously monitoring and evaluating delegated functions. 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 quality assurance responsibilities. The delegate's failure to submit required reports and the Plan's failure to follow-up in a timely manner or implement corrective actions demonstrates the Plan's lack of continuous monitoring, evaluation, and oversight of delegated functions. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

APPENDIX A. SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Jeanette Fong	Survey Team Lead, (916) 255-3367
Cindy Liu	Attorney
MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS	
Roger Diemert, MD	Quality Management and Continuity of Care Surveyor
Rose Leidl, RN	Utilization Management Surveyor
Senia Vitale, PhD	Utilization Management Surveyor
Pamela J. Simpson, RN	Member Rights Surveyor
Patricia Schano, MEd	Access and Availability Surveyor
Madeline Hommel	Access and Availability Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED FROM: CENTRAL CALIFORNIA ALLIANCE FOR HEALTH	
Alan McKay	Chief Executive Officer
Rachael Nava	Chief Operating Officer
Dale Bishop, MD	Chief Medical Officer
Kathy Neal, RN	Chief Health Services Officer
Julio Porro, MD	Medical Director
Michelle Stott, RN	Quality Improvement Director
Javier Carrillo	Health Programs Manager
Dana Marcos	Grievance Manager
Stephanie Sonnenshine	Compliance Director
Mary Brusuelas, RN	Utilization Management Director
Eva Balint, MD	Medical Director
Cathy Elliott, RN	Utilization Management Manager, Concurrent Review
Kathy Dean, RN	Utilization Management Manager, Prior Authorization
Kathleen McCarthy	Provider Services Director
Jan Wolf	Member Services Director
Peg Behan, RRT	Quality Improvement Manager
Jenifer Mandella	Compliance Manager
Liza Warren	Care Management Director

APPENDIX C. LIST OF FILES REVIEWED

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

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Standard Grievances	21	The Department reviewed 21 standard grievance files identified during the survey review period.
Exempt Grievances	29	The Department reviewed 29 exempt grievance files identified during the survey review period.
Expedited Grievances	1	The Department reviewed one expedited grievance file identified during the survey review period.
Potential Quality Issues	20	The Department reviewed 20 PQI files from a random sample of 26 files selected from a universe of 38 files identified during the survey review period.
Appeals	4	The Department reviewed the initial denial files of four appeals identified during the survey review period.