

DEPARTMENT OF
Managed Health Care
Help Center

DIVISION OF PLAN SURVEYS

CAL MEDICCONNECT

**MEDICAL SURVEY REPORT OF
COMMUNITY HEALTH GROUP**

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: DECEMBER 31, 2015

**Cal MediConnect Medical Survey Report
Community Health Group
A Full Service Health Plan
December 31, 2015**

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
DISCUSSION OF POTENTIAL DEFICIENCIES	5
CONTINUITY OF CARE	5
ACCESS AND AVAILABILITY	14
MEMBER RIGHTS	16
QUALITY MANAGEMENT	26
APPENDIX A. MEDICAL SURVEY TEAM MEMBERS	31
APPENDIX B. PLAN STAFF INTERVIEWED	32
APPENDIX C. LIST OF FILES REVIEWED	33

EXECUTIVE SUMMARY

The Department of Health Care Services (DHCS) received authorization (“CMS APPROVAL”) from the federal government to conduct a Duals Demonstration Project (“Cal MediConnect”) to coordinate the delivery of health and long term care services to beneficiaries within California who are eligible for benefits under both Medicare and Medicaid. Starting in April 2014, DHCS began phase in enrollment of Cal MediConnect beneficiaries in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. The Department of Managed Health Care (DMHC) and the DHCS then entered into an Interagency Agreement¹ whereby the DMHC will be responsible for conducting medical survey audits related to the provision of Medicaid-based services provided to Cal MediConnect enrollees. Medical Surveys pursuant to this Agreement are conducted once every three years.

On April 8, 2015, the Department notified Community Health Group Partnership Plan (the “Plan” or “Community Health Group”) that its medical survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department’s medical survey team conducted the onsite portion of the medical survey from June 22, 2015 through June 26, 2015.²

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreement, the Department provides the Cal MediConnect Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the provision of Medicaid-based services for 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 Plan’s applicable three-way contract with DHCS and CMS (the Cal MediConnect Three-Way Contract), the Knox-Keene Act, and Title 28 of the California Code of Regulations:

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.

¹ The Inter-Agency Agreement (Agreement Number 13-90167) was approved on October 21, 2013.

² Pursuant to the Knox-Keene Health Care Service Plan Act of 1975, codified at Health and Safety Code section 1340, *et seq.*, Title 28 of the California Code of Regulations section 1000, *et seq.* and the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) Cal MediConnect Three-Way Contract and amendments. All references to “Cal MediConnect Three-Way Contract” or “Three-Way Contract” are to the Cal MediConnect Three-Way Contract between CMS, DHCS, and the Plan, and amendments thereto. All references to “Section” are to the Health and Safety Code unless otherwise indicated. All references to the “Act” are to the Knox-Keene Act. All references to “Rule” are to Title 28 of the California Code of Regulations unless otherwise indicated. .

II. Continuity of Care

The Department evaluated Plan operations to determine whether Medicaid-based services are effectively coordinated both inside and outside the network, and whether the Plan complies with its oversight responsibilities when continuity of care activities are performed by delegated entities. The Department also verified that the Plan takes steps to facilitate coordination of Medicaid-based services with other services delivered under the Cal MediConnect, 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 or grievances made by individuals who experience difficulty accessing services due to a disability.

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 and implements corrective action to improve quality of care, and maintains a system of accountability to ensure quality of care as it relates to the provision of Medicaid-based services. The Department also evaluated the Plan's system and processes related to quality improvement and quality management, including its oversight of any delegated quality management responsibilities or processes.

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

SUMMARY OF FINDINGS

The Department identified **10** potential deficiencies during the current medical survey.

2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES

CONTINUITY OF CARE	
1	The Plan does not complete Health Risk Assessments (HRAs) in accordance with established requirements. Community Health Group Cal MediConnect Three-Way Contract, Section 2.8.2.; Duals Plan Letter 13-002
2	The Plan does not ensure that the Interdisciplinary Care Team (ICT) is person-centered and built on the enrollee’s specific preferences and needs. Community Health Group Cal MediConnect Three-Way Contract, Section 2.5.1.8.
3	The Plan’s ICPs do not integrate information from the HRA and ICT, provide measurable objectives, or meet timeliness standards. Community Health Group Cal MediConnect Three-Way Contract, Section 2.5.1.9.; Community Health Group Cal MediConnect Three-Way Contract, Section 2.8.
4	The Plan does not conduct adequate oversight of delegated entities to ensure sufficient access and availability of provider services. Cal MediConnect Three-Way Contract, Section 2.9.9.
5	The Plan does not ensure that written or oral expressions of dissatisfaction are considered a grievance, and therefore does not adequately acknowledge, review, and respond to enrollee grievances. Community Health Group Cal MediConnect Three-Way Contract, Section 2.14.2; Section 1368(a)(1); Section 1368(a)(4)(A); Section 1368(b)(1)(A); Section 1368.01(a) and (b); 28 CCR 1300.68.01(a)(1)-(2); 28 CCR 1300.68(a); Rule 1300.70(a)(1) and (b)(1)(B).
6	The Plan did not demonstrate that it adequately ensures the availability of interpreter services in languages required under Cal MediConnect. Community Health Group Cal MediConnect Three-Way Contract, Section 2.9.7.3.
7	The Plan does not ensure the availability of enrollee materials in alternative formats. Community Health Group Cal MediConnect Three-Way Contract, Section 2.11.1.2.3.; Community Health Group Cal MediConnect Three- Way Contract, Section 2.17.5.9.

QUALITY MANAGEMENT	
8	<p>The Plan does not address Long-Term Services and Supports (LTSS) and Cal MediConnect transportation services in its quality improvement program with respect to monitoring and improvement efforts, and integration with physical health care.</p> <p>Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.3.2.6.</p>
9	<p>The Plan did not include a copy of its final NCQA accreditation report in its annual QI reports.</p> <p>Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.3.3.5.</p>
10	<p>The Plan does not have a health information system that analyzes and reports quality performance data.</p> <p>Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.4.1.1.; Rule 1300.70(c)</p>

OVERVIEW OF THE PLAN’S EFFORTS TO SUPPORT CAL MEDICONNECT ENROLLEES

As of June 1, 2015, the Plan has enrolled approximately 5,497 Cal MediConnect beneficiaries in San Diego County. To help support these enrollees, the Plan has participated in a collaborative that includes Long Term Service and Support providers and other health plans. The Plan has stated that they work closely with providers such as the Aging and Independent Services of San Diego County, and local Community Based Adult Service Centers.

DISCUSSION OF POTENTIAL DEFICIENCIES

CONTINUITY OF CARE

Potential Deficiency #1: The Plan does not complete Health Risk Assessments (HRAs) in accordance with established requirements.

Contractual/Statutory/Regulatory Reference(s): Community Health Group Cal MediConnect Three-Way Contract, Section 2.8.2.; Duals Plan Letter 13-002.³

Community Health Group Cal MediConnect Three-Way Contract, Section 2.8.2.

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, Dual 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.

Duals Plan Letter 13-002

MCPs will contact enrollees within the required assessment timeframes through a variety of communication methods that will include documented efforts to contact each enrollee, and at least include a letter followed by two phone calls or in-person visits.

- For enrollees identified by the risk stratification mechanism or algorithm as higher risk, the HRA must be completed within 45 calendar days after coverage date or the documentation must demonstrate that the MCP was unsuccessful in its attempts to perform the assessment. Higher risk means enrollees who are at increased risk of having adverse health outcomes, or worsening of their health and functional status, or whose health conditions require careful monitoring and coordination of multiple medical, LTSS, or behavioral health services, if they do not receive their initial contact by the MCP within 45 calendar days after the coverage date.
- For enrollees in nursing facilities or those identified as lower risk for the purpose of developing ICPs, the assessment tool shall be used within 90 calendar days after coverage date.

Documents Reviewed:

- Plan Policy 7255.36cci: Coordinated Care Initiative (CCI) Health Risk Assessments & Care Management (Revised 01/15)
- 30 Health Risk Assessment (HRA) files (04/01/14 – 03/31/15)

³ Dual Plan Letter 15-005 superseded Duals Plan Letter 13-002, effective August 17, 2015.

Assessment: Community Health Group failed to consistently document its HRA completion deadlines, and timely complete HRAs. To determine the timeframe needed to complete the HRA, the Plan stratifies its new enrollees into high-risk and low-risk categories based on historic enrollee-specific Medi-Cal and Medicare fee-for-service (FFS) utilization data and other data supplied by DHCS and CMS. Plan staff perform the initial HRAs for high-risk enrollees and contract with a vendor to perform the initial low-risk HRAs⁴. A written agreement between the Plan and the vendor outlines the vendor's responsibilities and the Plan's oversight requirements. Plan Policy 7255.36, *Coordinated Care Initiative (CCI) Health Risk Assessments & Care Management*, outlines the HRA process, and includes HRA timeframes that are compliant with the Three-Way Contract and Duals Plan Letter 13-002. However, based on the 30 HRA files reviewed by the Department, the Plan was unable to demonstrate that they consistently followed the contractual requirements related to the documentation of HRA completion deadlines and timely completion of HRAs.

1. The Plan did not appropriately document its HRA activities

HRA files must clearly document content and completion dates as required by Duals Plan Letter 13-002. The Duals Plan Letter states: "MCPs are required to develop a health risk assessment survey tool that will be used to assess an enrollee's current 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 ...". Several of the Plan's HRA files contained unclear documentation of HRA completion activities including multiple conflicting dates and undated HRAs.

Specifically:

- Eleven (11) of 30 files contained HRAs that contained no clear completion date. The dates could only be surmised through review of other documents in the HRA file. (File #s 3,13,19, and 23 through 30)
- One (1) of 30 files documented an HRA completion date, but the Plan could not produce the actual HRA to verify that the document had been completed timely. (File #14.)
- One (1) of 30 files failed to clearly document the date of completion. (File #17)

⁴ After the close of this audit period, the Plan expanded the vendor's responsibilities to also include annual low-risk HRAs.

TABLE 1
Completion of HRA Documentation

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
HRA	30	Completion Date clearly documented in the HRA	17 (57%)	13 (43%)
HRA	30	Plan's ability to provide visual proof of HRA Completion Date	29 (97%)	1 (03%)

2. The Plan did not complete HRAs within the required timeframe

The Plan failed to meet the required HRA completion timeframes for six (6) of nine (9) (67%) high-risk enrollee files and 13 of 21 (62%) low-risk enrollee files reviewed. Specifically, the following deficiencies were noted:

- **High-risk:** Nine (9) of 30 files were initially stratified as high-risk. There are six (6) deficient files where the HRAs were not completed within 45 calendar days. HRAs for the first five (5) deficient files were completed in 160 to 297 days; one (1) file did not contain a completed HRA (File #20). Only three (3) of these nine (9) files were completed within the required 45 days.
- **Low-risk:** Twenty-one (21) of the 30 files were initially stratified as low risk. There are 13 deficient files where the HRAs were not completed within 90 calendar days. Eleven deficient low-risk - HRAs were completed in 94 to 322 days, one (1) deficient file contained an HRA whose date of completion could not be determined (File # 17) and another (1 deficient file) contained no HRA (File #14). Only eight (8) of these 21 files were completed within the required 90 days.

TABLE 2
Completion of HRAs within Required Timeframes

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
HRA – low risk	21	Completion within 90 calendar days	8 (38%)	13 (62%)
HRA – high risk	9	Completion within 45 calendar days	3 (33%)	6 (67%)

During onsite survey interviews, Plan staff acknowledged that it had faced difficulties in meeting HRA completion timelines, particularly at the beginning of the survey review period. In response to these difficulties, the Plan indicated it has implemented a management change and devoted additional resources to the HRA process.

Conclusion: The Community Health Group Cal MediConnect Three-Way Contract, Section 2.8.2., and Duals Plan Letter 13-002 require the Plan to complete HRAs within 45 calendar days after their coverage date for higher risk enrollees and within 90 calendar days after coverage date for lower risk enrollees. The Plan failed to meet the required timeframes for six (6) of nine (9) (67%) high-risk enrollees and 13 of 21 (62%) low-risk enrollees. Therefore, the Department finds the Plan in violation of these contractual requirements.

Potential Deficiency #2: The Plan does not ensure that the Interdisciplinary Care Team (ICT) is person-centered and built on the enrollee's specific preferences and needs.

Contractual/Statutory/Regulatory Reference(s): Community Health Group Cal MediConnect Three-Way Contract, Section 2.5.1.8.

Community Health Group Cal MediConnect Three-Way Contract, Section 2.5.1.8.

2.5.1.8. Interdisciplinary Care Team (ICT). The Contractor shall offer an ICT for each Enrollee, as necessary, which will be developed around the Enrollee and ensure the integration of the Enrollee's medical and LTSS and the coordination of Behavioral Health Services delivered by a county Behavioral Health agency, when applicable.

2.5.1.8.1. Every Enrollee will have access to an ICT if requested.

2.5.1.8.2. ICT Functions. ICT will facilitate care management, including assessment, care planning, and authorization of services, transitional care issues and work closely with providers listed in Section 2.5.1.8.3.2 to stabilize medical conditions, increase compliance with care plans, maintain functional status, and meet individual Enrollees care plan goals.

2.5.1.8.3. Composition of ICT. ICT must be person-centered: built on the Enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

Duals Plan Letter 13-004⁵

2. Composition of the ICT

The ICT must be person-centered, and built around the member's specific preferences and needs including language and culture, which will ensure integration of the member's medical, behavioral health, and LTSS care. The member has the primary decision-making role in identifying his or her needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for the member.

a. The ICT will be led by professionally knowledgeable and credentialed personnel, and at a minimum will be comprised of the following core members:

⁵ Duals Plan Letter 15-001 supersedes Duals Plan Letter 13-004, effective 3/09/2015.

- i. Member – the Dual and/or his or her authorized representative.
 - ii. Family and/or caregiver, if approved by the member.
 - iii. Care coordinator – A person employed or contracted by the MMP who is a licensed medical professional or is overseen by a licensed medical professional. The care coordinator is accountable for providing care coordination services, which include assessing appropriate referrals and timely two-way transmission of useful member information, obtaining reliable and timely information about services other than those provided by the primary care provider, assisting in the development and maintenance of the Care Plan, participating in the initial assessment, and supporting safe transitions in care for members moving between settings.
 - iv. Primary care provider – A physician or non-physician medical practitioner under the supervision of a physician, who is responsible for supervising, coordinating, and providing initial and primary care to patients, initiating referrals, and maintaining the continuity of patient care.
 - v. Specialist – If a specialist is serving as the member’s primary care provider, he or she must be part of the ICT.
- b. The ICT will include the aforementioned individuals (care coordinator, family and/or caregiver, primary care provider, specialist). The ICT will also include individuals or providers who are actively involved in the care of the member, if approved by the member, when appropriate:
- i. If receiving IHSS, County IHSS social worker.
 - ii. Hospital discharge planner.
 - iii. Nurse.
 - iv. Social worker.
 - v. Nursing facility representative.
 - vi. Specialized providers, such as physician specialists, pharmacists, physical therapists, and occupational therapists.
 - vii. If receiving IHSS, the IHSS provider if authorized by the member.
 - viii. If participating in CBAS, the CBAS provider.
 - ix. If enrolled in the MSSP waiver program, MSSP coordinator.
 - x. Behavioral health service provider.
 - xi. Other professionals, as appropriate.

Documents Reviewed:

- Plan Policy 7292: Interdisciplinary Care Team (revised 01/14)
- 30 ICP/ICT files (04/01/14 – 03/31/15)

Assessment: The Plan does not tailor its ICTs to each enrollee’s specific needs and preferences, and the Plan does not have a process to include additional providers or individuals that are actively involved in the care of the enrollee, when appropriate. The Community Health Group Cal MediConnect Three-Way Contract, Section 2.5.1.8., requires the Plan to ensure the “integration of the Enrollee’s medical and LTSS and the coordination of Behavioral Health Services.” The Section also requires that each enrollee’s ICT be “person-centered: built on the Enrollee’s specific preferences and needs.” Duals Plan Letter 13-004 sets forth the personnel

who should at the minimum comprise the ICT, but also states that additional individuals “who are actively involved in the care” of the enrollee should be included in the ICT, if approved by the enrollee. Despite these person-centered requirements for ICTs, with the exception of the Case Manager, the enrollee, and the PCP, the composition of the Plan’s ICT is fixed. All ICTs are comprised of the Plan’s Chief Medical Officer, Director of Utilization, Corporate Quality Director, and Behavioral Health Manager. The Plan does not include individuals and providers specific to the enrollee’s needs and preferences, as appropriate. Further, the ICT does not include specialized providers, who may be of vital importance to enrollees, nor does it include representatives of the Long Term Services and Supports (LTSS) provider community. The Plan was unable to demonstrate any actions taken to encourage the participation of these individuals in the Interdisciplinary Care Team.

TABLE 3
Person-Centered ICT

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Individual Care Plans	30	ICP includes coordination of carved out and linked services, as appropriate	8 (27%)	22 (73%)
Individual Care Plans	30	ICP signed by enrollee or authorized representative	2 (7%)	28 (93%)

Conclusion: The Community Health Group Cal MediConnect Three-Way Contract, Section 2.5.1.8., requires the Plan to ensure the integration of the enrollee’s medical, LTSS, and behavioral health services. The Section also requires that the ICT be person-centered, based upon the enrollee’s specific preferences and needs. The Plan uses an ICT with a fixed membership rather than one tailored to each enrollee. As a result, the ICTs do not include evidence that the individual healthcare needs of the enrollee are consistently taken into consideration, in violation of Section 2.5.1.8 of the Three-Way Contract, and DPL 13-004. Therefore, the Department finds the Plan in violation of its contractual requirements.

Potential Deficiency #3: The Plan’s ICPs do not integrate information from the HRA and ICT, provide measurable objectives, or meet timeliness standards.

Contractual/Statutory/Regulatory Reference(s): Community Health Group Cal MediConnect Three-Way Contract, Section 2.5.1.9.; Community Health Group Cal MediConnect Three-Way Contract, Section 2.8.

Community Health Group Cal MediConnect Three-Way Contract, Section 2.5.1.9.

2.5.1.9. Individual Care Plan (ICP). Contractor will develop an ICP for each Enrollee. Contractor will engage Enrollees and/or their representatives in the design of the ICPs. ICPs will include:

2.5.1.9.1. Enrollee goals and preferences;

2.5.1.9.2. Measurable objectives and timetables to meet medical, Behavioral Health services, and LTSS;

2.5.1.9.3. Timeframes for reassessment and updating of care plan, to be done at least annually or if a significant change in condition occurs;

2.5.1.9.4. If the Enrollee is receiving Behavioral Health services, the ICP will also include:

2.5.1.9.4.1. The name and contact information of the primary county or county-contracted Behavioral Health provider;

2.5.1.9.4.2. Attestation that the county Behavioral Health provider and PCP have reviewed and approved the ICP; and

2.5.1.9.4.3. Record of at least one (1) case review meeting that included the county Behavioral Health provider and includes date of meeting, names of participants, evidence of creation or adjustment of care goals, as described in the plans' models of care reviewed and approved by the National Committee on Quality Assurance (NCQA)

Community Health Group Cal MediConnect Three-Way Contract, Section 2.8.

2.8.2.1. The HRA will serve as the starting point for the development of the ICP.

2.8.3.1. ICPs will be developed within thirty (30) working days of HRA completion.

Duals Plan Letter 13-004

ICT functions will include, at a minimum:

a. Develop and implement a Care Plan with member and/or caregiver participation.

...

Care Plans will include:

...

b. Measurable objectives and timetables to meet medical needs, behavioral health, and long term support needs as determined through the assessment process, In-Home Supportive Services (IHSS) assessment results, Multipurpose Senior Services Program (MSSP) and Community-Based Adult Services (CBAS) records, behavioral health utilization, other data, self and provider referrals, *and input from members of the ICT*, as appropriate. [Emphasis added.]

...

Duals Plan Letter 13-002

The HRA will serve as the starting point for the individual care plan (ICP) which will be developed for each enrollee that demonstrates a need for an ICP and will include enrollee goals and preferences, measurable objectives and timetables to meet medical, behavioral health, and LTSS needs.

Documents Reviewed:

- Plan Policy 7255: Medical Case Management/UM (Revised 03/14)
- Plan Policy 7255.1a: Complex Case Management Program (03/14)
- Plan Policy 7255.36cci: HRA Policy (01/15)
- 30 ICP/ICT files (04/01/14 – 03/31/15)

Assessment: The Community Health Group Cal MediConnect Three-Way Contract, Section 2.8.2.1., states that “the HRA will serve as the starting point for the development of the ICP.” Item 3.1, requires that “ICPs will be developed within thirty (30) working days of HRA completion.”

Plan staff stated that a number of the ICPs should have been considered as “drafts,” although nothing in the files indicate which ICPs should be so identified. As a result, the Department could not consider any files to be in draft form as part of its review of the 30 files containing ICPs.

1. ICPs were not developed within thirty (30) working days of HRA completion

Of the 30 files reviewed, 18 ICPs were not developed within the required 30 working days of HRA completion, as specified by Section 2.8.2.1 of the Three-Way Contract:

- Seven (7) ICPs were completed without or prior to HRA completion. (File #s 4, 5, 8, 16, 20, 22, 24.)
- Eight (8) ICPs were not developed within 30 working days after HRA completion. (File #s 7, 14, 15, 19, 27, 28, 29, and 30.) These eight (8) ICPs were completed within 33 to 245 working days of HRA completion and were developed outside of the required timeframe.
- One (1) ICP was undated and completion date could not be determined. (File #17)
- Two (2) ICPs were missing from the file, and thus could not be considered as completed timely (File #13 and File# 21)

2. The Enrollees’ HRAs and ICTs did not adequately inform the development of the ICPs

The ICP should be developed from information obtained through the HRA and ICT. The Community Health Group Cal MediConnect Three-Way Contract, Section 2.8., specifies, “the HRA will serve as the starting point for the development of the ICP.” Duals Plan Letter 13-004 requires that ICPs include “input from members of the ICT, as appropriate.”

Of the 30 files reviewed, 25 contained evidence that HRA information did not form the basis of the ICPs. Some files are listed below more than once below due to multiple issues:

- Ten (10) enrollee files contained evidence of medical, behavioral health, or LTSS issues that were not mentioned in the ICP (Files #s 3, 4, 8, 10, 12, 26, 27, 28, 29, 30) For example:

- *File #27*: The ICP contained advice on how to handle stress but ignored issues related to blood sugar testing, which had been noted in the HRA.
- *File #10*: This enrollee had pending back surgery. The surgery was mentioned in the file but not addressed in the ICP.
- *File #26*: This enrollee stated she needed “lots of help with transportation” in the HRA; however, transportation was not addressed in the ICP.
- *File #8*: This enrollee was identified via HRA as having a behavioral health diagnosis and taking psychotropic medication. Behavioral health was not mentioned in the initial ICP.
- Seven (7) ICPs were completed without or prior to HRA completion (File #s 4, 5, 8, 16, 20, 22, 24) One (1) ICP was missing from the file, and thus considered deficient on all elements (File #21)
- Fourteen (14) files contained minimal information in the ICPs, such as preventive screening, flu shots, or boilerplate language on hypertension and diabetes. (File #s 3, 7, 13, 14, 15, 16, 17, 18, 20, 22, 24, 27, 29, 30.) Diagnoses disclosed on the HRA, but not mentioned in the ICP included organ transplant (File #13) and treatment with an injectable biologic drug for rheumatoid arthritis (File #15).

3. ICPs contained no measurable objectives or timetables

The Community Health Group Cal MediConnect Three-Way Contract, Section 2.5.1.9., requires that the ICP contain “[m]easurable objectives and timetables” to meet medical and behavioral health services and LTSS. These measurable objectives and timetables should be “determined through the assessment process, In-Home Supportive Services (IHSS) assessment results, Multipurpose Senior Services Program (MSSP) and Community-Based Adult Services (CBAS) records, behavioral health utilization, other data, self and provider referrals, and input from members of the ICT, as appropriate.” (See Duals Plan Letter 13-004.) Of the 30 files reviewed, 25 contained no measurable objectives or timetables that were determined through these records or processes.

TABLE 4
ICP Completions

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
ICP/ICT files	30	ICP completed within 30 working days of HRA completion	12 (40%)	18 (60%)
		ICP integrates HRA information	5 (17%)	25 (83%)
		ICP contains measureable objectives and timetables.	5 (17%)	25 (83%)

Conclusion: The Community Health Group Cal MediConnect Three-Way Contract, Section 2.5.1.9., requires the Plan to develop an ICP for each enrollee and that the ICP contain measurable objectives and timetables. Community Health Group Cal MediConnect Three-Way Contract, Section 2.8., requires that information from the HRA be used in developing the ICP and that the ICP be developed within 30 working days of HRA completion. The Department's file review demonstrated that 19 of 30 files failed to include an ICP that was developed within 30 working days of HRA completion. In addition, 25 of the 30 files contained no evidence that HRA information was integrated into the ICP, and 25 of the 30 files did not contain measurable objectives and timetables. Therefore, the Department finds the Plan in violation of these contractual requirements.

ACCESS AND AVAILABILITY

Potential Deficiency #4: The Plan does not conduct adequate oversight of delegated entities to ensure sufficient access and availability of provider services.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract, Section 2.9.9.

Cal MediConnect Three Way Contract, Section 2.9.9.

2.9.9. Subcontracting Requirements

2.9.9.1. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.9.9.2. Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall evaluate the prospective First Tier, Downstream or Related Entity's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements per 42 C.F.R. §§ 422.504(i), 423.505(i), 438.230(b)(3), (4) and Title 22 CCR Section 53867 and this Contract.

2.9.9.3. All contracts entered into with First Tier, Downstream and Related Entities shall be in writing and in accordance with the requirements of the 42 C.F.R. § 438.230(b)(2), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28, CCR Section 1300 et seq.; WIC Section 14200 et seq.; Title 22, CCR Section 53800 et seq.; and other applicable federal and state laws and regulations, including the required contract provisions between the Contractor and First Tier, Downstream and Related Entities in Appendix C.

2.9.9.4. The Contractor remains fully responsible for functions delegated and for ensuring adherence to the legal responsibilities under the Contract, as described in Appendix C, except that the Contractor's legal responsibilities under this Contract for the provision of LTSS shall be limited as set forth in WIC Sections 14186 through 14186.4.

2.9.9.5. The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are

required to meet the same federal and state financial and program reporting requirements as the Contractor. Additional required contract provisions between the Contractor and First Tier, Downstream and Related Entities is contained in Appendix C.

Documents Reviewed:

- 2015 Quality Improvement Program Description
- 2014 Corporate Quality Improvement Work Plan
- 2015 Corporate Quality Improvement Work Plan
- 2014 Annual Quality Improvement Program Summary
- Compliance Committee/Delegation Oversight Committee meeting minutes (09/29/14, 11/16/14, 12/17/14, 02/26/15)
- Clinical Quality Improvement Committee (CQIC), meeting minutes (August 2014, February 2015, May 2014, November 2014)
- Corporate Quality Improvement Committee meeting minutes (December 2014, March 2014, September 2014)
- Service Quality Improvement Committee (SQIC) meeting minutes (07/11/14, 09/12/14, 09/30/14, 12/17/14)
- Service Quality Improvement Committee Complaint Analysis (1st, 2nd, 3rd, 4th Quarter 2014)

Assessment: The Plan was unable to demonstrate adequate oversight of Plan service providers. None of the documents submitted by the Plan detail a systematic and structured oversight processes for In-Home Supportive Services (IHSS), Community Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) or non-emergency transportation providers. Interviews with Plan staff confirmed that the Plan does not have a process for oversight of these services.

The Community Health Group Cal MediConnect Three-Way Contract, Section 2.9.9.5., states that the Plan “is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities.” The Plan’s *2015 Quality Improvement Program Description* confirms this requirement, stating:

The Quality Improvement Program functions include, but are not limited to:

- Implement a multidimensional and multi-disciplinary QIP that effectively and systematically monitors and evaluates the quality and safety of clinical care and quality of service rendered to members.
- Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members.
- Conduct effective oversight of delegated providers. [Emphasis added.]

Despite the language in its *QIP Program Description*, the Plan’s delegation oversight committees and processes do not include oversight of access and availability concerning IHSS, CBAS, MSSP, or non-emergency transportation services. The Plan has established a

Compliance and Delegation Oversight Committee to provide “a formalized mechanism to monitor and act on all delegated activities.” The Committee meets at least quarterly and reports to the Corporate Quality Improvement Committee (CQIC) and other appropriate committees as needed. *Meeting Minutes* of the Compliance & Delegation Oversight Committee, the Clinical Quality Improvement Committee, and the Service Quality Improvement Committee (SQIC) did not include any reference to or discussion of, IHSS, CBAS, or MSSP, with regard to access and availability of services or to any other topic.

SQIC Complaint Analysis reports routinely included complaints concerning non-emergency transportation, but there is no evidence of resultant follow-up actions or activities, and no analysis of, or investigation into, these grievances. Additionally, while the Plan’s *2015 Corporate Quality Improvement Work Plan* addresses the Plan’s oversight responsibilities of delegated entities who provide utilization management and credentialing services, there is no mention of oversight and monitoring of delegated entities who provide IHSS, CBAS, MSSP, or non-emergency transportation services.

Conclusion: The Community Health Group Cal MediConnect Three-Way Contract, Section 2.9.9.5, requires the Plan to conduct adequate oversight of its First Tier, Downstream and Related Entities. The Plan has failed to demonstrate adequate oversight and monitoring of delegated entities that provide IHSS, CBAS, MSSP, or non-emergency transportation services. Therefore, the Department finds the Plan in violation of this contractual requirement.

MEMBER RIGHTS

Potential Deficiency #5: The Plan does not ensure that written or oral expressions of dissatisfaction are considered a grievance, and therefore does not adequately acknowledge, review, and respond to enrollee grievances.

Contractual/Statutory/Regulatory Reference(s): Community Health Group Cal MediConnect Three-Way Contract, Section 2.14.2; Section 1368(a)(1); Section 1368(a)(4)(A); Section 1368(b)(1)(A); Section 1368.01(a) and (b); 28 CCR 1300.68.01(a)(1)-(2); 28 CCR 1300.68(a); Rule 1300.70(a)(1) and (b)(1)(B).

Community Health Group Cal MediConnect Three-Way Contract, Section 2.14.2.

2.14.2. Internal (plan level) Grievance

An Enrollee may file an Internal Enrollee grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Contractor or its providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee grievances, including grievances regarding reasonable accommodations and access to services under the ADA.

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*, WIC Section 14450 and CCR, Title 22, Section 53260. [Emphasis added.]

- 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;
 - 2.14.2.1.2.2. Timely review of each Enrollee grievance;
 - 2.14.2.1.2.3. Response, electronically, orally or in writing, to each Enrollee grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the grievance;
 - 2.14.2.1.2.4. Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the grievance to each Enrollee grievance whenever Contractor extends the Appeals timeframe or Contractor refuses to grant a request for an expedited Appeal;
 - 2.14.2.1.2.5. Availability to Enrollees of information about Enrollee Appeals, as described in Section 2.15, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability; and
 - 2.14.2.1.2.6. Procedures to ensure that decision makers on grievances were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:
 - 2.14.2.1.2.6.1. A grievance regarding denial of expedited resolutions of an appeal.
 - 2.14.2.1.2.6.2. Any grievance or appeal involving clinical issues.

Community Health Group Cal MediConnect Three-Way Contract, Definition of Terms

1.62 Medi-Cal Grievance Process – A complaint from an enrollee related to Medi-Cal benefits and services pursuant to Welfare and Institutions Code Section 14450 and California Health and Safety Code Sections 1368 and 1368.1.

Section 1368(a)(1)

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

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Section 1368(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.

Section 1368(b)(1)(A)

(b)(1)(A) After either completing the grievance process described in subdivision (a), or participating in the process for at least 30 days, a subscriber or enrollee may submit the grievance to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a health care service plan contract, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or to participate in the process for at least 30 days before submitting a grievance to the department for review.

Section 1368.01

(a) The grievance system shall require the plan to resolve grievances within 30 days.
(b) The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance. Paragraph (4) of subdivision (a) of Section 1368 shall not apply to grievances handled pursuant to this section.

28 CCR 1300.68.01(a)(1)-(2)

(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:
(1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.
(2) A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.

28 CCR 1300.68(a)

(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:
(1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for

reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

(2) "Complaint" is the same as "grievance."

Rule 1300.68(d)(1)-(4)

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

(1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance.

(2) The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance.

(3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in Subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

(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. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

Rule 1300.70(a)(1) and (b)(1)(B).

(a) Intent and Regulatory Purpose.

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

(b) Quality Assurance Program Structure and Requirements.

(1) Program Structure.

To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

(B) quality of care problems are identified and corrected for all provider entities

Documents Reviewed:

- Plan Policy 5510: Member Grievance Policy (revised April 2015)
- Plan Policy 6063: Documentation/Resolution of Members' Concerns (revised April 2015)
- Member Services Log – Non-Emergency Transportation (01/01/15 – 03/31/15)
- Quality of Care Complaints Not Previously Reported (04/01/14 – 03/31/15)

- Member Services Inquiries (04/10/14 – 05/10/14)
- Member Service Inquiries (08/01/14 – 09/03/14)
- Customer Service Desktop Process – Complaint and Grievance Process (no date given)
- Customer Service Desktop Process – Proper Case Classification (no date given)
- Customer Service Desktop Process – Quality of Care Rapid Response (no date given)
- Corrective Action Response (CAR) – Complaints/Grievances (06/19/15)

Assessment: The Plan fails to meet its legal and contractual obligations to appropriately identify grievances, and instead classifies enrollee grievances as “complaints” or “inquiries.” As a consequence, the Plan also fails to meet its obligation to send written acknowledgements, conduct investigations, resolve issues, and send written resolutions to enrollees. Because these cases were not identified as grievances, the Plan also did not track and trend for the purpose of uncovering systemic problems, in order to provide opportunities for quality improvement. By handling these matters as “complaints” or “inquiries” instead of grievances, enrollees with actual grievances were deprived of significant consumer protections under the Cal MediConnect Three-Way Contract, and the incorporated protections of the Knox-Keene Act.

Under the Cal MediConnect Three-Way Contract, the Medi-Cal grievance process is triggered by a “complaint from an enrollee related to Medi-Cal benefits and services pursuant to Welfare and Institutions Code Section 14450 and California Health and Safety Code Sections 1368 and 1368.1.” The Regulations supporting the Health and Safety Code define a grievance as “a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee’s representative.” (Rule 1300.68(a)(1).) A “complaint” is the same as a “grievance.” (Rule 1300.68(a)(2).)

The Plan’s policy language also defines a complaint as a type of grievance, and distinguishes an enrollee complaint from an enrollee “inquiry.” Policy 5510 – *Member Grievances and Appeals (revised 03/14)* defines a complaint as “a type of grievance; a written or oral expression of dissatisfaction communicated by a member, or agent of a member, which, according to the member, involves an issue other than quality of clinical care,⁶ and is not a request to change a decision to deny, delay, or modify health care services or coverage.” Policy 5510 defines an inquiry as “a request for clarification of a benefit or process or request for information. An inquiry is not a grievance.”

The Plan’s obligation to maintain a system to adequately address grievances is addressed in the Community Health Group Cal MediConnect Three-Way Contract, Section 2.14.2., which allows Cal MediConnect enrollees to:

... [F]ile an Internal Enrollee grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Contractor or its providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee grievances, including grievances regarding reasonable accommodations and access to services under the ADA.

⁶ Quality of clinical care issues are addressed in another section of the Plan’s Policy 5510.

Further, the contract (2.14.2.2.1) requires the Plan to:

... [E]stablish 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 Service Plan Act of 1975, WIC Section 14450 and CCR, Title 22, Section 53260.

Plan Policy 5510, *Member Grievance Policy*, confirms these requirements, stating, “CHG shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance.” The policy further states, “CHG provides written acknowledgment of grievances within five (5) calendar days of receipt The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name, telephone number and address of the CHG representative who may be contacted about the grievance.”

The Department identified the following issues with regard to the Plan’s receipt, review, and resolution of enrollee grievances.

1. Failure to Consider Expressions of Dissatisfaction and the Misclassification of Grievances as Complaints or Inquiries

Despite multiple requests, the Plan initially produced no grievance files for the Department’s review, indicating that the Plan had received no grievances during the survey period. This raised concerns over the accuracy of the Plan’s grievance tracking, because the Plan began a phased-in enrollment of Cal MediConnect beneficiaries in April 2014, had served over 3,700 enrollees by the end of 2014, and approximately 5,600 by May 2015. An investigation revealed that the Plan had not appropriately identified and classified enrollee expressions of dissatisfaction as grievances. During interviews with Plan staff, the Plan also disclosed that it had not consistently classified expressions of dissatisfaction related to external Long Term Services and Supports (LTSS) as grievances.

Plan staff confirmed that an enrollee “inquiry” should not be classified as such if it contains any expression of dissatisfaction. (See Plan Policy 5510.) However, the Plan conducted an internal investigation of its inquiries when staff recognized that the Plan had been potentially misclassifying grievances. In the *Member Service Inquiries Log (08/01/14 – 09/03/14)*, Plan staff determined that of the 13 calls the Plan reviewed, 10 calls (77%) were misclassified as inquiries that should have been classified as grievances. In addition, in the *Member Service Inquiries Log (04/10/14 – 05/10/14)*, Plan staff determined that of the 18 calls reviewed, seven (7) calls (39%) were misclassified as inquiries that should have been classified as grievances.

Due to the Plan’s incomplete documentation and reporting, it is unknown how many of the Plan’s misclassified grievances concerned Medicaid based services provided to Cal MediConnect enrollees. However, the Plan admitted that it followed improper procedures with

Cal MediConnect enrollees, resulting in the misclassification of enrollee grievances. When expressions of dissatisfaction are not appropriately handled, an actual grievance that might have prompted a clinical review would not be handled as such, thus potentially violating the requirements of Rule 1300.70 (a)(1) and (b)(1)(B). Below are some examples of the Plan's misclassification of grievances as "complaints" or "inquiries." During the onsite portion of the survey, upon request the Plan produced a document entitled *Member Services Log – Non-Emergency Transportation (01/01/15 – 03/31/15)*. The document revealed that the Plan incorrectly classified grievances regarding non-emergency transportation services as "complaints." Seventeen of these misclassified grievances related specifically to Cal MediConnect enrollees. No action was taken to elevate these complaints for further review, and the Plan did not follow up on the complaints by conducting a more thorough investigation and documenting such follow-up. The following Cal MediConnect non-emergency transportation service issues were classified as "complaints" by the Plan, but not identified as grievances:

- *File #1:* The enrollee called Member Services upset that the taxi company informed him that they do not have a payment voucher for that day. Member had an appointment scheduled for that morning and was worried because this request was previously scheduled. Member stated that he would file a formal complaint because he was not happy with the services. There was no documentation that the Member Services representative offered to assist him with filing a grievance, or provided the member with information regarding how to file a grievance. There was additionally no notation that the Member Services representative forwarded the member's concerns to the appropriate grievance and appeals staff.
- *File 2:* The enrollee called with two issues, one of which was transportation related, and notes in the file indicate that the enrollee was upset. The enrollee was almost through her allotment of 15 taxi rides that were available through Cal MediConnect. She was advised her to call her primary care provider (PCP) and ask how she might obtain more rides and also call MTS (transportation service) to request more tickets. The enrollee agreed with the suggestions provided by Plan staff, and the case was closed.

The Plan provided no documentation that any further actions were taken with regard to the calls that were classified as complaints and/or inquiries rather than grievances. Because the Plan did not classify the grievances adequately, it did not elevate grievances for review, investigation, and follow-up.

During interviews, Plan staff acknowledged that they have been misclassifying grievances. When queried about complaint logs that contained quality of care issues, staff stated, "Those were the ones that were supposed to be elevated to a manager and move to [the appeals manager]." Plan staff also acknowledged that because grievances were misclassified, they were not elevated for review, investigation, and follow-up. Plan staff produced a *Corrective Action Response* document (dated 06/19/15), which commits the Plan to update current call codes, train and educate Customer Service staff, implement a daily audit of all complaints and grievance issues; implement a biweekly audit reviewing a randomized sample of inquiry issues, and implement a quality of care rapid response process.

During interviews, Plan staff acknowledged that it had systematically misclassified grievances, but that it had made recent efforts to develop new procedures. The Plan developed new desktop procedures one week prior to the onsite visit. The following Plan documents set forth the Plan's new procedures:

- Plan Document: Customer Service Desktop Process – Complaint and Grievance Process
- Plan Document: Customer Service Desktop Process – Proper Case Classification
- Plan Document: Customer Service Desktop Process – Quality of Care Rapid Response

2. Failure to send written acknowledgements, conduct investigations, resolve issues, and send written resolutions to enrollees

The Community Health Group Cal MediConnect Three-Way Contract, Section 2.14.2.1.2., requires the Plan to provide, for each grievance, “timely acknowledgement of receipt ... timely review ... response, electronically, orally or in writing ... within a reasonable time, but no later than thirty (30) days after the Contractor receives the grievance; and expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the grievance”

Because the Plan did not identify enrollee complaints and inquiries containing expressions of dissatisfaction as grievances, these cases did not progress through the grievance system. As a result, enrollees were deprived of vital rights and information including:

- A written, oral or electronic acknowledgements of receipt of the grievance pursuant to Section 1368(a)(4)(A), Rule 1300.68(d)(1);
- The right to receive adequate consideration and rectification of grievances, including review of the grievance by qualified Plan personnel pursuant to Section 1368(a)(1) and Rule 1300.68(d)(2);
- The right to receive a clear and concise explanation for the Plan's decision, for either standard or expedited grievances, within the required timeframes pursuant to Section 1368(a)(5), Section 1368.01(a), Rule 1300.68(a)(1), Rule 1300.68(d)(3)-(4), Rule 1300.68.01(a)(2); and
- Information pertaining to the right to appeal the decision to the Department pursuant to Section 1368.01(b), Section 1368(a)(5), Section 1368(b)(1)(A), Rule 1300.68.01(a)(1), and Rule 1300.68(d)(3)-(4).

As stated above, Plan staff produced a *Corrective Action Response* document (dated 06/19/15), to address some of its grievance system issues.

Conclusion: The Community Health Group Cal MediConnect Three-Way Contract, Section 2.14.2., requires that the Plan have a system in place for addressing enrollee grievances and that the Plan shall establish and maintain a grievance process under which enrollees may submit their grievances. The Department determined that the Plan has been misclassifying member grievances as “complaints” and “inquiries,” and not properly addressing them through the grievance system. The Section also requires that the Plan acknowledge review and respond to

grievances within required timeframes. The Department found that the Plan has not been elevating inquiries and complaints with expressions of member dissatisfaction as grievances. As a result, the Plan does not provide a prompt acknowledgement to each grievance, adequate investigations are not conducted, and members do not receive written resolutions. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Potential Deficiency #6: The Plan did not demonstrate that it adequately ensures the availability of interpreter services in languages required under Cal MediConnect.

Contractual/Statutory/Regulatory Reference(s): Community Health Group Cal MediConnect Three-Way Contract, Section 2.9.7.3.

Community Health Group Cal MediConnect Three-Way Contract, Section 2.9.7.3.

2.9.7.3. Linguistic Capability of Employees: Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).

Documents Reviewed:

- Plan Policy# 7400: Language Assistance Program (Linguistic Services), (revised 03/14)
- Community Health Group San Diego Medi-Cal Group Needs Assessment Executive Summary (10/17/11)
- Cultural and Linguistics Program from the 2014 QI Program Description (approved 04/23/13)
- Corporate Quality Improvement Work Plan (2014, 2015)
- Cultural and Linguistics Program Questionnaire (2015)
- Accuracy of Translations (2015)
- Process utilized by the plan to ensure the accuracy of translations (internal and external) (2015)

Assessment: The Plan does not adequately assess, identify, and track the linguistic capability of its Spanish language interpreters. The Community Health Group Cal MediConnect Three-Way Contract, Section 2.9.7.3., requires that plans “assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).”

The Plan’s policies and procedures do not describe the methods by which the linguistic capabilities of its bilingual employees, interpreters, and contracted staff are assessed, identified, and tracked. In response to the Department’s onsite request for further information, the Plan prepared and submitted a document to the Department post-onsite titled *Process utilized by the plan to ensure the accuracy of translations (internal and external)*. The document states that the Plan’s Vietnamese, Arabic, and Tagalog translations are performed by an external translation service, Language Translation, Inc., which employs certified translators and maintains a 3-step quality assurance process. Documents translated into these languages are also subject to additional proofreading by the Plan.

The Plan's Spanish language translations are not performed by Language Translation, Inc. The post-on-site document prepared for the Department states that Spanish translations "are done by a CHG employee who holds a Bachelor's Degree from Mexico and who is a native speaker of the Spanish language. Once completed, all Spanish translations are reviewed by another employee who is also a College Graduate from Mexico and who is a native Spanish speaker." During interviews, Plan staff stated that Spanish translations and interpretations do not undergo a standardized quality assurance process by certified personnel. Plan staff further acknowledged that the Plan does not have a formal assessment process to assess the proficiency of its bilingual personnel. When queried about the process that the Plan uses to identify qualified bilingual personnel, a Plan staff supervisor stated, "someone whose Spanish is as good as mine." Plan staff conceded, "It's an informal process." The Plan indicated that it had identified this as an area in which it needed to implement formal guidelines.

Conclusion: Community Health Group Cal MediConnect Three-Way Contract, Section 2.9.7.3., requires that the Plan assess, identify, and track the linguistic capability of interpreters, bilingual employees, and contracted staff. The Department determined that the Plan has not designed nor implemented a formal process for assessing, identifying, and tracking the linguistic capabilities of its bilingual Spanish personnel. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #7: The Plan does not ensure the availability of enrollee materials in alternative formats.

Contractual/Statutory/Regulatory References: Community Health Group Cal MediConnect Three-Way Contract, Section 2.11.1.2.3.; Community Health Group Cal MediConnect Three-Way Contract, Section 2.17.5.9.

Community Health Group Cal MediConnect Three-Way Contract, Section 2.11.1.2.3.

2.11.1.2.3. Ensuring that Enrollees with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the Enrollee and include but are not limited to:

2.11.1.2.3.1. Providing large print (at least 16-point font) [emphasis added] versions of all written materials to Enrollees with visual impairments ...

Community Health Group Cal MediConnect Three-Way Contract, Section 2.17.5.9

2.17.5.9. The Contractor must ensure that all information provided to Enrollees and potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood and that is:

2.17.5.9.1. Made available in large print (at least 16 point font) [emphasis added] to Enrollees as an alternative format, upon request;

Documents Reviewed:

- Plan Policy #7400: Language Assistance Program (Linguistic Services), (revised 03/14)

Assessment: The Plan was unable to provide evidence that it ensures the availability of large print (at least 16-point font) to enrollees as an alternative format. The Community Health Group Cal MediConnect Three-Way Contract, Section 2.11.1.2.3.1. and Section 2.17.5.9.1. require the Plan to provide “large print (at least 16-point font)” versions of all written materials to enrollees with visual impairments. The Plan’s policies and procedures do not specify the font size for enrollee communications in large size print. Plan Policy 7400, *Language Assistance Program (Linguistic Services)*, states:

Services for the Visually Impaired

CHG accommodates the needs of the visually impaired member in accessing printed material upon request. Requests for enlarged print or audio recordings, including those related to grievance procedures, forms and grievance response information are coordinated through Member Services. CHG provides these services through the Braille Institute Universal Media Services.

The Plan did not produce documentation indicating the font size it uses in its written materials for visually impaired enrollees, despite the Department’s request. During interviews, in response to questioning concerning the specific font size the Plan uses for its large print documents, Plan staff stated that they “would have to go back to the policy” in order to provide a response to the Department. They further stated that the Plan’s *Evidence of Coverage* document does not specify the size of large print materials, by indicating that it is customized according to the enrollee.

Conclusion: The Community Health Group Cal MediConnect Three-Way Contract, Section 2.11.1.2.3.1. and Section 2.17.5.9.1. require the Plan to provide large print (at least 16-point font) versions of all written materials to members with visual impairments. The Plan’s policies and procedures do not cite the specific font size used for enrollee communications in large size print, and the Plan could not produce any other materials indicating the font size used for these enrollees. Therefore, the Department finds the Plan in violation of this contractual requirement.

QUALITY MANAGEMENT

Potential Deficiency #8: The Plan does not address Long-Term Services and Supports (LTSS) and Cal MediConnect transportation services in its Quality Improvement Program with respect to monitoring and improvement efforts, and integration with physical health care.

Contractual/Statutory/Regulatory Reference(s): Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.3.2.6.

Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.3.2.6.

2.16.3.2.6. Address all aspects of health care, including specific reference to Behavioral Health services and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care.

Documents Reviewed:

- 2014 Quality Improvement Program Description
- 2015 Quality Improvement Program Description
- Transportation/CBAS QS Complaints/Grievance (01/01/15 – 03/31/15)
- Corporate QIC February 2015 meeting materials
- Member Services Log Non-Emergency Transportation (01/01/15 – 03/31/15)
- 30 HRA files (04/01/14 – 03/31/15)

Assessment: The Plan failed to demonstrate that it integrates LTSS services, non-emergency medical transport, and non-medical transport into its Quality Improvement Program. Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.3.2., requires the Plan to “[a]ddress ... LTSS, with respect to monitoring and improvement efforts, and integration with physical health care.” Although the Plan makes specific reference to behavioral health in its program descriptions, no mention is made of LTSS services, non-emergency medical transport (e.g., ambulance or medivan), and non-medical transport (e.g., taxi or bus). The Plan provided no evaluation of the effectiveness of LTSS and/or transportation services in the annual *Quality Improvement Program Evaluation*, and there was no discussion of it at the *Corporate Quality Improvement Committee Meeting Minutes* in which the annual Quality Improvement (QI) Program was presented and approved.

The Plan was asked repeatedly during interviews if these aspects of care (LTSS services, non-emergency medical transport, and non-medical transport) were addressed in the Plan’s QI Program. Plan staff responded that these components were not part of the QI Program, stating that the QI Program only provides for the detection of events that would trigger a review for potential quality issues (PQI)⁷. However, the Department asserts that quality issues (quality of care and quality of service) could stem from usage of LTSS and transportation services.

Although Plan staff stated in interviews that the Plan had established a policy regarding non-medical transport, the Plan could not produce a non-medical transport policy upon request. Plan staff indicated that enrollees receive 30 trips per year—however; Plan staff provided conflicting information as to whether the benefit was for one-way or round-trip transport. However, the Plan stated that when enrollees exceed this benefit limit, the Plan routinely grants an exception. Despite this stated practice, the Department found evidence that such exceptions were not always

⁷ Potential Quality Issues (PQI) include cases, providers, processes or quality concerns identified through enrollee grievances, sentinel events (e.g., mortalities), data analysis, provider site visits, and other sources that issues that require investigation.

granted, as evidenced by the following member “complaint”⁸ from the *Member Services Log Non-Emergency Transportation*:

Mbr called upset because she states that she will almost be done with her 15 taxis that she has available through CMC. Advice [sic] her to call her PCC and inform them about how she can continue to obtain more. I also advise her to call MTS to ask for an application so she can apply for MTS if she qualifies then she can with one week in advance to req MTS tickets for her appts [sic]

Thus, the Plan provided no established written policy on non-medical transport, and the transport documentation that the Plan did provide demonstrates that the Plan did not adhere to its asserted transportation practices.

Conclusion: The Community Health Group Cal MediConnect Three-Way Contract 2.16.3.2.6. requires that the Plan address monitoring and improvement efforts for LTSS as well as integration of LTSS with physical health care. Based on a review of Plan documents, the Department determined that the Plan did not address LTSS in its Quality Improvement Program with respect to monitoring and improvement efforts and integration with physical health care. The Plan also does not have a consistent policy for non-medical transportation. Concerns in these areas are not consistently identified as PQI as part of the Plan’s QI process. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #9: The Plan did not include a copy of its final NCQA accreditation report in its annual Quality Improvement Reports.

Contractual/Statutory/Regulatory Reference(s): Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.3.3.5.

Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.3.3.5.
2.16.3.3.5. Contractor shall develop an [sic] QI report for submission to DHCS and CMS on an annual basis. The annual report shall include ... [c]opies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the Contractor’s Medi-Cal line of business

Documents Reviewed:

- 2014 Quality Improvement Program Description
- 2015 Quality Improvement Program Description
- 2013 Annual Quality Improvement Program Summary
- 2014 Annual Quality Improvement Program Summary

⁸ As addressed in a separate deficiency, deficiency No. 5, the enrollee complaint should have triggered the Plan’s contractual obligation to address it through the Plan’s formal grievance process.

Assessment: Although the Plan is NCQA (National Committee for Quality Assurance) accredited, the Plan did not submit a copy of an NCQA report with its Plan documents. The Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.3.3.5., requires the Plan to develop an annual “QI report for submission to DHCS and CMS ... [that] include[s] copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA)” The Plan’s Corporate Quality Director confirmed during an interview that the NCQA Report was not included in the annual Quality Improvement Report.

Conclusion: The Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.3.3.5. requires that a copy of the Plan’s NCQA final report be included in the Plan’s annual Quality Improvement Report; however, the report was not included. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #10: The Plan does not have a health information system that analyzes and reports quality performance data.

Contractual/Statutory/Regulatory Reference(s): Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.4.1.1; Rule 1300.70(c)

Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.4.1.1.
2.16.4.1.1 The Contractor shall engage in performance measurement and performance improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. The Contractor’s QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 422.516(a), 422.152, and 423.514 for Parts C and D, respectively.

28 CCR 1300.70(c)

In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department.

Documents Reviewed:

- 2014 Quality Improvement Program Description
- 2015 Quality Improvement Program Description
- 2013 Annual Quality Improvement Program Summary
- 2014 Annual Quality Improvement Program Summary

Assessment: The Plan represented that it had generated a series of performance measurement reports that it had not generated. The Plan lacked the technical capability to generate these reports, and further lacked the quality improvement processes to analyze the data that was purportedly generated.

Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.4.1.1., requires the Plan to conduct “performance measurement and performance improvement projects ...” and to establish “a health information system to collect, analyze, and report quality performance data” Both the Plan’s 2014 and 2015 *Quality Improvement Program Description* (at pg. 30) state that the Plan generated the following reports:

- Longitudinal profiles of treatment or services furnished to enrollees with a specific diagnosis;
- Profiles of referral services ordered by each primary care practitioner;
- Statistical reports on the prevalence of different conditions or diagnoses among a specific group of enrollees, such as Medicare beneficiaries.

The Plan could not provide any of these reports to the Department upon request. Plan staff stated that the reports had never been created. Plan staff further indicated that although the Plan collects encounter data from its providers, and has in-house informatics and coding expertise, its Quality Improvement Program’s health information system does not collect, analyze, and report quality performance data. No end user within the Quality Improvement Department has the ability to generate the reports that the *Quality Improvement Program Description* asserts are generated. No end user has access to SQL (a language used for communicating with databases and generating reports), nor is there any alternative method for staff to quickly produce reports. There is also no process in place for Quality Improvement staff to review and analyze the data that was purportedly generated in these reports. The 2014 *Quality Improvement Program Summary* did not mention these reports, or the Plan’s inability to generate them.

Conclusion: Community Health Group Cal MediConnect Three-Way Contract, Section 2.16.4.1.1., requires the Plan to conduct performance measurements and to utilize a health information system to collect, analyze, and report quality performance data. The Plan did not create several key performance measure reports, contrary to assertions in its *Quality Improvement Program Descriptions*. Therefore, the Department finds the Plan in violation of this contractual and regulatory requirement.

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Jennifer Friedrich	Medical Survey Team Lead
Rodel Pena	Plan Surveys' Manager
MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS	
Gene Beed, MD	Quality Management Surveyor and Continuity of Care Surveyor
Sharon Ostach, LCSW	Utilization Management Surveyor
Patricia Schano, M.Ed.	Availability & Accessibility and Language Assistance Surveyor
Annalisa A. Almendras, Psy.D.	Member Rights Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED FROM COMMUNITY HEALTH GROUP	
Edward Hutt, M.D.	Chief Medical Officer
Adla Tessier, M.D.	Medical Officer
Ann Warren, MAM	Chief Regulatory and Human Resources Officer
Carole Anderson, R.N., M.Ed.	Director of Corporate Quality
Colleen Moran, R.N.	Director of Utilization Management
Noreen Koizumi, PharmD.	Pharmacy Director
David Ritchie	Director of Contracting
Nora Pintado	Director of Claims
Heidi Arndt, M.A., M.H. A.,	Chief Information Officer (past Compliance Officer)
Kathy Mangiapane, PharmD.	Pharmacist
George Scolari	Behavioral Health Program Manager
Lolita Pintado-Samaniego,	Appeals Manager
Pedro Cota	Customer Services Manager
Sandra Coleman	Credentialing Services Manager
Judith Fernandez	Enrollment Manager
Mauricio Osorio, MEC	Informatics Manager
Allan Sombillo,	EDI/Applications Manager
John Agustin	Systems Manager
Cristina Alvarado	Claims Manager
Marcella Lopez, M.P.H.	Preventive Services Supervisor
Natalia Castellano	Claims Audit Supervisor
Marcella Lopez, M.P.H.	Preventive Services Supervisor
Natalia Barajas	CCS Specialist Lead
Victor Gonzalez	Community Services Specialist
Charlene Wilburn, R.N.	Corporate Quality Analyst
Marianne Arcaina, R.N.	Corporate Quality Analyst
Elizabeth Martinez	Compliance Analyst

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.

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
HRA/IHA	30	The Plan identified a universe of 2,367 files during the review period. Based on the Department's File Review Methodology, a random sample of 30 files were reviewed.
Potential Quality Issues	11	The Plan identified a universe of 11 PQI files during the review period. The Department reviewed all the PQI files
Standard Grievances	0	The Plan identified zero (0) files during the review period.
Inquiries	0	The Plan identified zero (0) files during the review period.
Exempt Grievances	0	The Plan identified zero (0) files during the review period.
Standard Appeals	0	The Plan identified zero (0) files during the review period.
Expedited Appeals	0	The Plan identified zero (0) files during the review period.
UM Medical Necessity Denials	0	The Plan identified zero (0) files during the review period.