

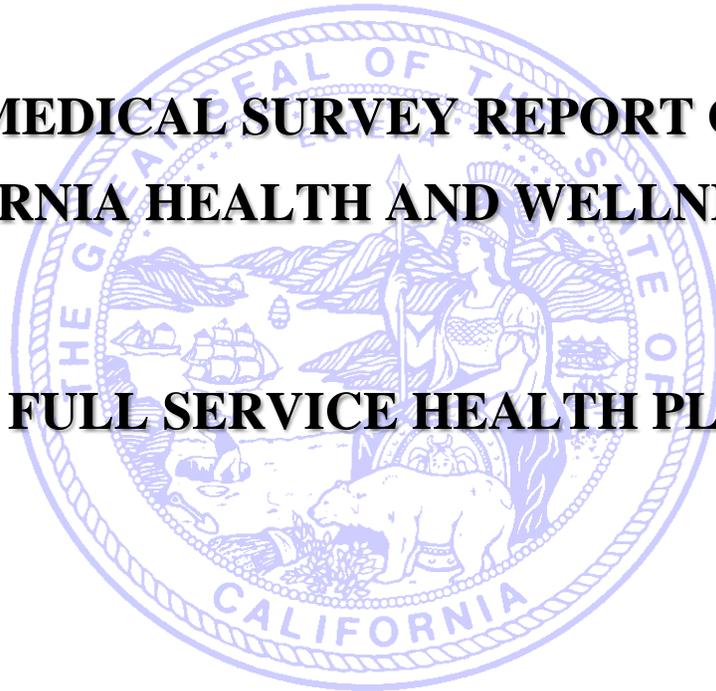
DEPARTMENT OF  
**Managed  
Health Care**  
**Help Center**

**DIVISION OF PLAN SURVEYS**

**1115 WAIVER SENIORS AND PERSONS WITH  
DISABILITIES AND RURAL EXPANSION**

**MEDICAL SURVEY REPORT OF  
CALIFORNIA HEALTH AND WELLNESS PLAN**

**A FULL SERVICE HEALTH PLAN**



**DATE ISSUED TO DHCS: MAY 16, 2016**

**1115 Waiver SPD and Rural Expansion Medical Survey Report**  
**California Health and Wellness Plan**  
**A Full Service Health Plan**  
**May 16, 2016**

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## **EXECUTIVE SUMMARY**

The California Department of Health Care Services (“DHCS”) received authorization (“1115 Waiver”) from the federal government to conduct mandatory enrollment of seniors and persons with disabilities (“SPD”) into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The DHCS then entered into an Inter-Agency Agreement<sup>1</sup> 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.

Pursuant to Welfare and Institutions Code section 14005.27 and authorized under AB 1467, Medi-Cal managed care expanded to Medi-Cal beneficiaries residing in 28 rural California counties. The DHCS entered into an Inter-Agency Agreement with the Department<sup>2</sup> to perform medical surveys of each health plan participating in the Rural Expansion. Mandatory enrollment of Medi-Cal beneficiaries from Fee-For-Service into Medi-Cal managed care began in September 2013.

On June 17, 2015, the Department notified California Health and Wellness 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 August 10, 2015 through August 14, 2015.

### **SCOPE OF MEDICAL SURVEY**

As required by the Inter-Agency Agreements, the Department provides the 1115 Waiver SPD and Rural Expansion Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the SPD and Rural Expansion populations. This medical survey evaluated the following elements specifically related to the Plan’s delivery of care to the SPD and Rural Expansion populations as delineated by the DHCS California Health and Wellness Plan Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations:<sup>3</sup>

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

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

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

<sup>2</sup> The Inter-Agency Agreement (Agreement Number 13-90168) was approved on June 11, 2014.

<sup>3</sup> All references to “Contract” are to the County Organized Health System, Geographic Managed Care, and Two-Plan contracts issued by the DHCS. All references to “Section” are to the Knox-Keene Act of the Health and Safety Code. All references to “Rule” are to Title 28 of the California Code of Regulations.

**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.

**III. Availability and Accessibility**

The Department evaluated Plan operations to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes, and are addressing reasonable patient requests for disability accommodations.

**IV. Member Rights**

The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for Primary Care Physician selection and assignment, and to evaluate the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

**V. Quality Management**

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care.

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

**SUMMARY OF FINDINGS**

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

**2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES**

<b>AVAILABILITY &amp; ACCESSIBILITY</b>	
<b>#1</b>	<p><b>The Plan does not consistently ensure and monitor an appropriate network of specialists.</b>            DHCS-CHWP Contract, Exhibit A, Attachment 6 – Provider Network, Provision 2 – Network Composition; DHCS-CHWP Contract, Exhibit A, Attachment 6 – Provider Network, Provision 6 – Specialists.</p>
<b>#2</b>	<p><b>The Plan does not maintain and periodically review a log of exempt grievances.</b>            DHCS-CHWP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1; Section 1368(a)(4)(B)(i)-(vi); Rule 1300.68(d)(8).</p>
<b>#3</b>	<p><b>The Plan does not consistently provide immediate notification to complainants of their right to contact the Department regarding expedited appeals.</b>            DHCS-CHWP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68.01(a)(1).</p>
<b>#4</b>	<p><b>The Plan does not implement and maintain procedures to make reasonable efforts to provide oral notice of expedited appeal decisions.</b>            DHCS-CHWP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 6(E) – Responsibilities in Expedited Appeals.</p>
<b>#5</b>	<p><b>The Plan does not consistently refer grievances related to medical quality of care issues to its medical director.</b>            DHCS-CHWP Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 6(E) – Medical Director; DHCS-CHWP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(E) – Grievance System Oversight.</p>
<b>#6</b>	<p><b>The Plan does not consistently monitor, evaluate, and take effective action to address needed improvements in the quality of care delivered by its providers.</b>            DHCS-CHWP Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; Rule 1300.70(a)(1).</p>

## DISCUSSION OF POTENTIAL DEFICIENCIES

### AVAILABILITY AND ACCESSIBILITY

#### **Potential Deficiency #1: The Plan does not consistently ensure and monitor an appropriate network of specialists.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-CHWP Contract, Exhibit A, Attachment 6 – Provider Network, Provision 2 – Network Composition; DHCS-CHWP Contract, Exhibit A, Attachment 6 – Provider Network, Provision 6 – Specialists.

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

#### 2. Network Composition

Contractor shall ensure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, supportive paramedical personnel, and an adequate number of accessible inpatient facilities and service sites within each service area.

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

#### 6. Specialists

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with Title 22 CCR Section 53853(a) and W & I Code section 14182(c)(2).

#### **Documents Reviewed:**

- Plan Policy CA.CONT.04 Provider/Patient Ratios (11/01/13)
- “Update on Our Network” (07/10/14)
- Plan Policy CA.QI.04 Evaluation of Practitioner Availability (03/19/15)
- Access and Availability Report (March 2015)
- Quality Improvement Committee Minutes (06/23/14, 08/25/14, 09/29/14, 12/01/14, 01/26/15)
- Board of Directors Minutes (08/11/14, 11/19/14, 02/19/15, 05/07/15)

**Assessment:** To demonstrate an adequate network of specialists, the Plan provided a July 2014 report entitled Update on Our Network, which included geographical access reports and accompanying analyses for Butte County and Imperial County. This was a complete analysis which identified shortages that needed to be filled, by specialty, in the two counties. The next step was to perform this type of analysis for all 19 counties, but additional analytics were not mentioned until the beginning of 2015. Plan staff stated during interviews that they had been creating geoaccess reports on a monthly basis since July 2014, in order to determine shortages of specialists in each county. However, with the exception of the special presentation on Butte and Imperial counties, the Plan was unable to provide additional geoaccess reports with dates prior to July 2015 during the onsite review.

In late 2014, the Plan hired a chief operating officer and a new contracting manager to identify gaps in the specialty network and create action plans to fill these identified gaps more quickly. The Department reviewed meeting minutes of both the Quality Improvement Committee (QIC)

and Board of Directors to determine the process for identifying problems with accessibility and what action the contracting department and the QIC had taken.

#### QIC Minutes

- June 23, 2014: Provider network item stated “[n]etwork was ‘adequate’ for regulators at Go-Live, but [enrollment] growth has continued” and a recommendation was made to “add data capture of defining high volume specialists for addition of SPD members.” There was no documentation of analysis and no geographical access reports were included.
- August 25, 2014: No mention of network development.
- September 29, 2014: Included discussion about the specialist provider network and that there was an ability to use single case agreements to access care.
- December 1, 2014: Under “Provider Network Development & Contracting,” it was noted that the Plan did not have enough specialists in the certain areas (cardiology, dermatology, gastroenterology, obstetrics and gynecology (OB/GYN), ophthalmology, and orthopedics). An action required the director of contracting to “look into modifying contracts to get more of the hard to access specialties.”
- January 26, 2015: Reports indicated that most counties were at or greater than 80% covered for specialists, with the exception of El Dorado (80% of the necessary specialists accessible to the membership in the service area).

#### Board of Directors Minutes

- August 11, 2014: Did not mention network development activities.
- November 19, 2014: A presentation was made where the speaker indicated that the Plan “ha[s] demonstrated [its] commitment to making improvements within [its] network gaps in [its] existing service areas and [is] continuing to go into the right direction.” The minutes also included a compliance report, which stated that one of the four highest risks to the Plan was the specialty network.
- February 19, 2015: There was a discussion on the “challenges of recruiting specialists as the climate in healthcare evolves” and an overview of the gaps in their 19 counties.
- May 7, 2015 (draft): There was an update on the Plan’s progress of adding specialists. Plan staff explained that they “are working closely with nursing homes and long term providers and that we are continuing to fill specialty gaps.” In addition, the Plan has “been working with quality to strengthen the contracted network and will continue this on an ongoing basis.”

The Network Development and Contracting Report Summary of May 2015 states: “since 1-15-15, we closed 15 specialty/service gaps (<60% member access).” Reporting to the QIC since the beginning of 2015 indicated that the Plan was now measuring specialty gaps by area and taking the necessary steps to fill gaps as the opportunities allow. In March 2015, the Plan reported that 19 percent of the overall membership had access to less than 60 percent of the Plan’s specialty service categories (Network Summary, March 16, 2015).

DHCS-CHWP Contract, Exhibit A, Attachment 6, Provision 2 requires the Plan to ensure and monitor an appropriate provider network of specialists. DHCS-CHWP Contract, Exhibit A, Attachment 6, Provision 6 requires the Plan to maintain adequate numbers and types of specialists within its network to accommodate the need for specialty care. During the

Department's review of the Plan's access reports and onsite interviews with Plan staff, it was determined that there was an insufficient number of specialists available during the survey review period. Although the Plan started to identify and fill gaps in specialty areas in the beginning of 2015, inactivity during the first half of the survey review period, as well as continued shortages of specialists in rural counties, demonstrated that the Plan did not ensure an appropriate network of specialists. Therefore, the Department finds the Plan in violation of these contractual requirements.

## MEMBER RIGHTS

### **Potential Deficiency #2: The Plan does not maintain and periodically review a log of exempt grievances.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-CHWP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1; Section 1368(a)(4)(B)(i)-(vi); Rule 1300.68(d)(8).

#### DHCS-California Health and Wellness Plan Contract, Exhibit A, Attachment 14 – Member Grievance System

##### 1. Member Grievance System

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).

#### Rule 1300.68

Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

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

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

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

#### Rule 1300.68(d)(8)

(8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written

acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in Subsection (b).

**Documents Reviewed:**

- Policy CA.QI.11: Grievance System Description (undated)
- Policy CA.QI.11.01: Grievance Process (undated)
- Exempt Grievance Log (06/01/14 – 05/31/15)
- Email response from Plan (07/23/15)
- Email response from Plan (09/17/15)

**Assessment:** Plan Policy CA.QI.11.01: Grievance Process states:

All grievances and appeals shall be recorded in a log (see below for exempt, separate log) which shall be periodically reviewed through the QI Program... For grievances exempt from acknowledgement requirements (grievances received over the phone, facsimile, email or through the Plan website and resolved within the next business day, which do not include coverage, medical necessity or experimental or investigations disputes a separate log will be maintained and shall include the following:

- a. Date of the call
- b. Name and identification number of the complainant
- c. Nature of the grievance
- d. Resolution of the grievance
- e. Representative who took the call and resolved the grievance

To assess compliance with these standards, in its pre-onsite request, the Department requested a log of all exempt grievances identified by the Plan during the review period. The Plan was unable to submit this log in its pre-onsite submission and in a written response stated, “We had no exempt grievance report. We have now implemented a system to track and report those exempt grievances[,] unfortunately that was not in place during the look back period. We can provide greater detail once you are onsite.”

During the first day of the onsite survey, the Plan produced the log of exempt grievances. The Plan’s Director of Member & Provider Services explained that Plan staff had retroactively gone through all member inquiries made during the review period and manually extracted those calls that should have been captured as exempt grievances. Plan staff confirmed that during the review period, the Plan did not distinguish exempt grievances from general inquiries, and as such, no log with the required components was periodically reviewed by the Plan for the identification of trends. However, as of July 15, 2015, the Plan implemented a new process by where all exempt grievances are now flagged, enabling the Plan to capture all exempt grievances in a separate log for review. In its written response to the Department, the Plan stated, “As of 7/15/15 we are able to track Exempt Grievances allowing us to identify issues for reporting to the Appeals & Grievances team.”

DHCS-CHWP Contract, Exhibit A, Attachment 14, Provision 1 requires the Plan to implement and maintain a member grievance system in accordance with Rule 1300.68. Rule 1300.68 requires all health care service plans to establish a grievance system pursuant to the requirements of Section 1368. In addition, Section 1368(a)(4)(B) and Rule 1300.68(d)(8) require that the Plan maintain a log of all exempt grievances and to periodically review the log. Although the Plan retroactively extracted all exempt grievances and produced a log for the Department during the onsite survey, the Plan did not actively maintain a log with the required components and periodically review the log during the review period. Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

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**Potential Deficiency #3: The Plan does not consistently provide immediate notification to complainants of their right to contact the Department regarding expedited appeals.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-CHWP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68.01(a)(1).

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

1. Member Grievance System

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

Rule 1300.68.01(a)(1)

(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.

**Documents Reviewed:**

- Plan Policy CA.QI.11 Grievance System Description
- 8 Expedited Appeal Files

**Assessment:** The Plan's policy, Grievance System Description, states:

C. Expedited Grievances

3. When the Plan receives notice of a case requiring expedited review, the Plan will immediately notify the member, or their representative or the provider filing on the member's behalf, in writing of their right to notify the DMHC of the grievance and to request interpretation, translation, and disability access services at no cost to the member. Notice may also be accomplished by a documented telephone call.

During onsite review of eight expedited appeal files, seven files (88%)<sup>4</sup> did not include documentation that the Plan immediately informed enrollees of their right to notify the Department. During onsite interviews, the QI Manager stated it is the Plan's practice to inform enrollees of their rights during initial telephone discussions of the grievance, but there has not been a requirement that staff document this notification.

DHCS-CHWP Contract, Exhibit A, Attachment 14, Provision 1 requires the Plan to implement and maintain a member grievance system in accordance with Rule 1300.68.01. When an expedited grievance is filed with the Plan, Rule 1300.68.01(a)(1) requires the Plan to immediately notify the complainant of the right to contact the Department regarding the grievance. The Plan may notify the complainant of this right either in writing or with a documented telephone call. As seven out of eight expedited grievance appeal files did not include evidence of this notification to the complainants, the Department finds the Plan in violation of these contractual and regulatory requirements.

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**Potential Deficiency #4: The Plan does not implement and maintain procedures to make reasonable efforts to provide oral notice of expedited appeal decisions.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-CHWP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 6(E) – Responsibilities in Expedited Appeals.

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

6. Responsibilities in Expedited Appeals

Contractor shall implement and maintain procedures as described below to resolve expedited appeals. When Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

E. Contractor must make a reasonable effort to provide oral notice of expedited appeal decision.

**Documents Reviewed:**

- Plan Policy CA.QI.11 Grievance System Description (May 2015)
- California Health and Wellness Plan Medi-Cal Contract 13-90157 – Imperial County (effective 11/01/13)
- 8 Expedited Appeal Files

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<sup>4</sup> Files #2, 3, 4, 5, 6, 7, 8

**Assessment:** The Plan's Grievance System Description policy and procedure states:

4. Expedited appeals must be resolved and notification made as quickly as the member's health condition requires. The Plan will make reasonable efforts to provide oral notice of expedited appeal resolution to the member and the DMHC immediately after the Appeal decision and written notice will not exceed seventy-two (72) hours after Plan receives the Appeal request, whether the Appeal was made orally or in writing.

DHCS-CHWP Contract, Exhibit A, Attachment 14, Provision 6(E) requires the Plan to implement and maintain procedures to make a reasonable effort to provide oral notice of its expedited appeal decisions. While the Plan's policy, cited above, contains this contractual requirement almost verbatim, the policy merely restates the Plan's contractual obligations. The policy does not set forth specific procedures that the Plan will implement to ensure that its contractual duties are performed. In addition, during onsite review of eight expedited appeal files, the Plan was unable to demonstrate that reasonable efforts were made to provide oral notice of expedited appeal decisions in seven files (88%).<sup>5</sup> Therefore, the Department finds the Plan in violation of this contractual requirement.

## QUALITY MANAGEMENT

**Potential Deficiency #5: The Plan does not consistently refer grievances related to medical quality of care issues to its medical director.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-CHWP Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 6(E) – Medical Director; DHCS-CHWP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(E) – Grievance System Oversight;

DHCS-CHWP Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan  
6. Medical Director

Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:  
E. Resolving grievances related to medical quality of care.

DHCS-CHWP 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.

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<sup>5</sup> Files #2, 3, 4, 5, 6, 7, 8

**Documents Reviewed:**

- Quality Assessment and Performance Improvement Program (QAPI) (03/19/15)
- Plan Policy CA.QI.11 Grievance System Grievance System Description (May 2015)
- 30 SPD Grievance Files

**Assessment:** Plan Policy CA.QI.11 Grievance System Description Policy and Procedure states: “If the grievance is a quality of care or service complaint, it will be routed to the QI Department and Plan Medical Director for investigation and resolution.”

DHCS-CHWP Contract, Exhibit A, Attachment 1, Provision 6(E) requires the Plan to maintain a full time physician as medical director to resolve grievances related to medical quality of care. DHCS-CHWP Contract, Exhibit A, Attachment 14, Provision 2(E) requires the Plan to refer grievances related to medical quality of care issues to the medical director. During onsite review of 30 standard grievance files, five files (17%)<sup>6</sup> contained quality of care issues and should have been forwarded to the Plan’s medical director. As the Plan does not refer all quality of care issues to its medical director for review, the Department finds the Plan in violation of these contractual requirements.

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**Potential Deficiency #6: The Plan does not consistently monitor, evaluate, and take effective action to address needed improvements in the quality of care delivered by its providers.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-CHWP Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; Rule 1300.70(a)(1).

DHCS-CHWP Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1  
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.

Rule 1300.70(a)(1)

(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.

**Documents Reviewed:**

- Potential Quality of Care Severity Levels.pdf
- Plan Policy CC.QI.19 Peer Review Committee and Process (June 2015)

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<sup>6</sup> Files #1, 7, 12, 18, 21

- 7 SPD PQI Files

**Assessment:** The Plan’s Peer Review Committee and Process policy states: “The Plan utilizes a Peer Review process to evaluate the quality of care provided to a member when there is a significant potential for an adverse event, or a significant, severe adverse outcome has occurred.” The Plan’s Potential Quality of Care (QOC) Severity Levels document, incorporated as an attachment to the Peer Review Committee and Process policy, defines severity levels and provides examples of corrective actions. During onsite review of seven SPD PQI files, six files (86%)<sup>7</sup> were found to be non-compliant. For example:

- *File #3:* A 29-year-old inpatient, admitted for diabetic ketoacidosis, sustained a cardiac arrest due to a medication error. The Plan’s medical director reviewed the case and assigned it a Severity Level III (High). Per the Plan’s Potential Quality of Care (QOC) Severity Levels document, Level III is defined as: “Investigation indicates that a particular case has demonstrated a significant potential for serious adverse effects.” However, because a cardiac arrest had occurred, it might have been more appropriate to assign this case a Severity Level IV (Critical), which is defined as: “Investigation indicates that a particular case demonstrated a serious, significant adverse outcome.”

The Plan provided no explanations as to why the incident occurred, whether this incident was preventable, or whether any new processes will be implemented to prevent future occurrences. The corrective action plan in this case was to track and trend this incident. Whether assigned a Level III or a Level IV, based on the Plan’s policy, tracking and trending without any other actions does not appear to be an appropriate CAP for this case. Furthermore, the Plan did not assess the effectiveness of the CAP, evaluate the outcome of the CAP, or conduct reasonable follow-up activities. Contrary to the Plan’s Peer Review Committee and Process policy, this case did not go through the peer review process.

- *File #5:* A 33-year-old morbidly obese male went to the emergency room for severe epistaxis (nose bleed) and systolic blood pressure of mid-200.<sup>8</sup> He has a documented history of methamphetamine and marijuana daily abuse and was admitted to the intensive care unit for cardiac observation for six days. The member promised his doctor that he would follow up with his doctor a few days after discharge, but was found dead in his home. The Plan’s licensed vocational nurse reviewed this case and assigned it a Severity Level I (Low). Per the Plan’s Potential QOC Severity Levels document, Level I is defined as: “Investigation indicates acceptable Quality of Care has been rendered. OR Investigation indicates that a particular case was without significant potential for serious adverse effects, but could become a problem if a pattern developed.” However, as death is a serious, significant adverse outcome, it might have been more appropriate to assign this case a Severity Level IV (Critical), per Plan policy. In addition, this case should have been reviewed by the medical director.

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<sup>7</sup> Files #1, 3, 4, 5, 6, 7

<sup>8</sup> An average systolic blood pressure should be less than 120 mmHg.

The corrective action plan in this case was to track and trend this incident and did not address all issues. As this was a serious incident, tracking and trending without any other actions does not appear to be an appropriate CAP for this case. Furthermore, the Plan did not assess the effectiveness of the CAP, evaluate the outcome of the CAP, or conduct reasonable follow-up activities. Contrary to the Plan's Peer Review Committee and Process policy, this case did not go through the peer review process.

DHCS-CHWP Contract, Exhibit A, Attachment 4, Provision 1 requires the Plan to implement an effective quality improvement system in accordance with the standards set forth in Rule 1300.70. The Plan is required to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all of its providers. Rule 1300.70(a)(1) requires the Plan to document that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. While the Plan identifies quality issues, the cases are often not reviewed by appropriate personnel, and the assigned severity levels are inconsistent with the Plan's definitions. Further, corrective actions and follow-ups assigned from those reviews are not always appropriate for the nature of the issue. The most common CAP was to track and trend the offending provider. There was no evidence in the file that tracking and trending was effective or that the Plan followed-up on it. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements

<b>APPENDIX A. MEDICAL SURVEY TEAM MEMBERS</b>
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<b>DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS</b>	
Jeanette Fong	Medical Survey Team Lead
Cindy Liu	DMHC Survey Counsel
<b>pmpm Consulting Group of WeiserMazars TEAM MEMBERS</b>	
Deirdre Hiatt	Utilization Management Surveyor
James Hendrickson, MD	Quality Management & Continuity of Care Surveyor
Gerry Long	Availability & Accessibility Surveyor
Tony Browne	Member Rights Surveyor

**APPENDIX B. PLAN STAFF INTERVIEWED**

<b>PLAN STAFF INTERVIEWED</b>	
Dr. Greg Buchert	CEO
Jeff Grahling	COO
Dr. Farid Hassanpour	Chief Medical Director (CMD)
Erik Korolev	VP, Network Development
Frances Morris	VP, Quality Improvement (QI)
Garrett Leaf	VP, Finance
Kathryn Kaestner	VP, Medical Management (MM)
Dwight Pattison	Interim Sr. Director, Quality Improvement (QI)
Al Scott	Director, Contracting
Amy Cornett	Director, Behavioral Health Compliance
Antwain Tabb	Director, Customer & Member Services
Darien Smith	Director, Provider Services
Darren Isaak	Director, Medical Management (MM)
Ellen Duke	Director, Behavioral Health Network Management
Joe Judd	Director, Behavioral Health Medical Management
Karen Dager	Director, Pharmacy
Kellie Todd	Director, Marketing
Kim Porter	Director, Claims & Contract Support
Larry Fox	Director, Credentialing
Norman Sedgwick	Director, Human Resources
Paula Ackerman	Director, Case Management (CM)
Dr. Ramiro Zuniga	Medical Director
Sandra Rose	Director, Health Program
Timothy Cereceres	Director, Utilization Management (UM)
Cecilia Tauro	Manager Referral Services
Erin Gee	Manager, Quality Improvement (QI)
Gelmy Ruiz	Manager, Compliance
Karin Bartley	Manager, Case Management (CM)
Sarah Triano	Manager, Special Needs Program
Susan Mahonga	Manager, Vendor Management
Tina Launhardt	Manager, Credentialing

**APPENDIX C. LIST OF FILES REVIEWED**

*Note: The statistical methodology utilized by the Department is based on an 80% confidence level with a 7% margin of error. Each file review criterion is assessed at a 90% compliance rate.*

<b>Type of Case Files Reviewed</b>	<b>Sample Size (Number of Files Reviewed)</b>	<b>Explanation</b>
<b>Standard Grievances &amp; Appeals</b>	31	The Plan identified a universe of 48 files during the review period. Based on the Department’s File Review Methodology, a random sample of 31 files was reviewed.
<b>Expedited Grievances &amp; Appeals</b>	8	All eight expedited appeals were reviewed.
<b>Potential Quality Issues</b>	7	All seven potential quality issues were reviewed.
<b>UM Medical Necessity Denials</b>	70	The Plan identified a universe of 711 files during the review period. Based on the Department’s File Review Methodology, a random sample of 70 files was reviewed.