

DEPARTMENT OF
Managed
Health Care
Help Center

DIVISION OF PLAN SURVEYS

**1115 WAIVER SENIORS AND PERSONS WITH
DISABILITIES**

**MEDICAL SURVEY REPORT OF
HEALTH PLAN OF SAN JOAQUIN**

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: MARCH 30, 2016

**1115 Waiver SPD Medical Survey Report
Health Plan of San Joaquin
A Full Service Health Plan
March 30, 2016**

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EXECUTIVE SUMMARY

The California Department of Health Care Services (“DHCS”) received authorization (“1115 Waiver”) from the federal government to conduct mandatory enrollment of seniors and persons with disabilities (“SPD”) into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The DHCS then entered into an Inter-Agency Agreement with the Department of Managed Health Care (the “Department”)¹ to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California’s strong patient-rights laws. Mandatory enrollment of SPDs into managed care began in June 2011.

On April 24, 2015, the Department notified Health Plan of San Joaquin (the “Plan”) that its medical survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department’s medical survey team conducted the onsite portion of the medical survey from July 13, 2015 through July 17, 2015.²

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreements, the Department provides the 1115 Waiver SPD Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the SPD population. This medical survey evaluated the following elements specifically related to the Plan’s delivery of care to the SPD population as delineated by the DHCS-Health Plan of San Joaquin (“HPSJ”) Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations:

I. Utilization Management (“UM”)

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

II. Continuity of Care

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

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

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 Two-Plan and GMC Boilerplate Contracts. 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. All references to “Contract” are to the Two-Plan or GMC Boilerplate contract issued by the Department of Health Care Services.

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 July 1, 2014 through June 30, 2015.

SUMMARY OF FINDINGS

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

2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT	
#1	<p>The Plan has not demonstrated that its nurse and physician reviewers consistently apply the criteria and guidelines for medical necessity decisions. In particular, not all UM staff completed the Plan’s inter-rater reliability testing.</p> <p>DHCS-HPSJ Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 1 – Utilization Management Program and Provision 2 – Pre-Authorizations and Review Procedures</p>
CONTINUITY OF CARE	
#2	<p>The Plan does not ensure follow-up services that reflect the findings or risk factors discovered during enrollees’ Initial Health Assessments (IHAs) and Individual Health Education Behavioral Assessments (IHEBAs).</p> <p>DHCS-HPSJ Contract, Exhibit A, Attachment 10 – Scope of Services, Provision 3 – Initial Health Assessment (IHA)</p>
#3	<p>The Plan does not provide all medically necessary covered services to enrollees until California Children’s Services (CCS) eligibility is confirmed.</p> <p>DHCS-HPSJ Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 3 – Timeframes for Medical Authorization and Attachment 11 – Case Management and Coordination of Care, Provision 9 – California Children Services (CCS)</p>
AVAILABILITY & ACCESSIBILITY	
#4	<p>The Plan does not maintain a program that ensures timely access to health care for Children with Special Health Care Needs (CSHCN).</p> <p>DHCS-HPSJ Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care, Provision 8 – Services for Children with Special Health Care Needs</p>
#5	<p>The Plan cannot demonstrate that it is meeting or monitoring timely access standards for specialists, ancillary providers, mental health providers, or urgent care appointments.</p> <p>DHCS-HPSJ Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4 - Access Standards; Rule 1300.67.2.2(c)(5)</p>
#6	<p>The Plan does not monitor compliance with the required timeframe of enrollees’ first pre-natal visits.</p> <p>DHCS-HPSJ Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3 – Access Requirements</p>

#7	<p>The Plan has not established standards for geographic distribution of hospitals, emergency services facilities, or ancillary care facilities.</p> <p>DHCS-HPSJ Contract, Exhibit A, Attachment 6 – Provider Network, Provision 2 - Network Composition, Provision 5 - Emergency Services and Attachment 9 – Access and Availability, Provision 7 – Emergency Care</p>
MEMBER RIGHTS	
#8	<p>The Plan did not consistently acknowledge enrollee grievances and appeals in writing within five calendar days of receipt.</p> <p>DHCS-HPSJ Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 - Member Grievance System, Provision 2 – Grievance System Oversight; Rule 1300.68(d)(1)</p>
#9	<p>The Plan does not consistently ensure adequate consideration of standard enrollee grievances.</p> <p>DHCS-HPSJ Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 - General Requirement, Attachment 14 – Member Grievance System, Provision 1 - Member Grievance System; Rule 1300.68(a)(4); Rule 1300.70(a)(1)</p>
#10	<p>The Plan does not appropriately categorize exempt grievances.</p> <p>DHCS-HPSJ Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 - General Requirement; Attachment 14 – Member Grievance System, Provision 2A; Rule 1300.68(d)(8); Rule 1300.70(a)(1)</p>
QUALITY MANAGEMENT	
#11	<p>The Plan’s Quality Assurance Program does not 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.</p> <p>DHCS-HPSJ Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 1 – Utilization Management Program and Provision 2 – Pre-Authorizations and Review Procedures</p>

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

- The Plan is National Committee for Quality Assurance (NCQA) Accredited.
- The Chief Medical Officer is directing the Plan's quality management/quality improvement operations.
- The Plan has implemented a Clinical Program Department with analytics capacity to support the Quality Management Program.
- The Plan added coverage for mild to moderate behavioral disorders, and has delegated Quality Improvement to an NCQA Accredited Managed Behavioral Health Organization.
- The Plan implemented a coordinated care approach with County Behavioral Health Services for patients hospitalized with medical conditions who have coexisting serious mental health conditions.
- A process improvement approach is evident in individual Plan projects to improve quality.
- The Plan created a dedicated pediatric California Children's Services (CCS) unit within its Utilization Management Department.

DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

Potential Deficiency #1: The Plan has not demonstrated that its nurse and physician reviewers consistently apply the criteria and guidelines for medical necessity decisions. In particular, not all UM staff completed the Plan's inter-rater reliability testing.

Contractual/Statutory/Regulatory Reference(s): DHCS-HPSJ Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 1 – Utilization Management Program and Provision 2 – Pre-Authorizations and Review Procedures

DHCS-HPSJ Contract, Exhibit A, Attachment 5 – Utilization Management

1. Utilization Management Program

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

A. Qualified staff responsible for the UM program. . . .

C. Contractor shall ensure [sic] that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.

D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or [sic] adoption of specific criteria used by the Contractor. . . .

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

2. Pre-Authorizations and Review Procedures

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements: . . .

B. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan medical director, in collaboration with the Plan Pharmacy and Therapeutics Committee (PTC) or its equivalent.

C. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. . . .

Documents Reviewed:

- Medical Review Criteria – (02/20/15)
- HPSJ Utilization Management FY 2015 Work Plan (undated)

Assessment: The DHCS-HPSJ Contract requires that the Plan “shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services.” The Contract also requires the Plan to ensure its review procedures have “a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.” [Emphasis added.]

The Plan employs annual inter-rater reliability (IRR)³ testing of its nurse and physician reviewers to review consistent application of criteria used for UM decisions. The *Health Plan of San Joaquin Utilization Management FY 2015 Work Plan* states under the heading of “Planned Activities”: “The Medical Management department conducts IRR tests annually on all UM staff. These tests are conducted using MCG guidelines.” This same document states under the heading “Goals”: “Conduct annual inter-rater reliability studies for all staff.” and “Ensure all staff have a passing rate of at least 90 %.”

The Plan’s policy, *Medical Review Criteria* states: “Inter-rater Reliability Testing and UM file review will be conducted at least annually to assess determinations made by UM staff, including physician advisors and Medical Directors, to evaluate the consistency in applying criteria. If the report findings indicate that there is inconsistency in criteria application corrective education and/or individual action plans will be implemented in an effort to improve consistency.”

However, the Plan failed to ensure that all key UM staff were tested for IRR during the review period, and therefore could not ensure that its nurse and physician reviewers were consistently applying criteria and guidelines in UM decisions. In a report of IRR results that the Plan shared with the Department during the onsite survey:

- five out of the eight (63%) of physician reviewers did not complete the IRR case studies
- one out of 16 nurse reviewers did not complete the IRR case studies

The Chief Medical Officer conceded that some of the clinical reviewers failed to complete the IRR testing and provided the Department with the following current corrective activities:

- Medical Director to engage individual(s) who did not complete the IRR testing;
- Conduct remedial training with staff who did not pass and retest them to ensure competency; and
- Establish completion date for UM staff who failed to take the test (e.g., on vacation, on leave) during the assessment period and follow up as necessary.

Conclusion: DHCS-HPSJ Contract, Exhibit A, Attachment 5, Provisions 1 and 2 require the Plan to use appropriate processes for utilization review; to have written criteria or guidelines based on sound medical evidence for utilization review; and to consistently apply, regularly

³ Inter-rater reliability is a measure of the degree to which different reviewers agree in their assessment decisions. To ensure that clinicians are making appropriate and consistent determinations – based on their clinical judgment and/or their use of established criteria or standards where these are available – two or more reviewers assess a sample of cases. Results of the reviews are compared, discrepancies analyzed, and corrective actions (e.g., reviewer education, clarification of criteria) implemented as needed.

review, and update these criteria. Although the Plan has established a process for inter-rater reliability testing, the Department found that not all UM reviewers had completed the testing. Because the Plan failed to demonstrate that all utilization reviewers consistently apply the criteria or guidelines used for utilization review decisions, the Department determined that the Plan is in violation of this contractual requirement.

CONTINUITY OF CARE

Potential Deficiency #2: The Plan does not ensure follow-up services that reflect the findings or risk factors discovered during enrollees' Initial Health Assessments (IHAs) and Individual Health Education Behavioral Assessments (IHEBAs).

Contractual/Statutory/Regulatory Reference(s): DHCS-HPSJ Contract, Exhibit A, Attachment 10 – Scope of Services, Provision 3 – Initial Health Assessment (IHA).

DHCS-HPSJ Contract, Exhibit A, Attachment 10 – Scope of Services

3. Initial Health Assessment (IHA)

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

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

B. Contractor shall ensure that the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10) using an age appropriate DHCS approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.

Documents Reviewed:

- Plan Policy QA22: Initial Health Assessments (Revised 05/11)
- DHCS Medical Record Review Survey 2012 Medi-Cal Managed Care

Assessment: DHCS-HPSJ Contract, Exhibit A, Attachment 10 – Scope of Services, Provision 3. – Initial Health Assessment (IHA) states that the Plan “is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.” Plan Policy QA22: *Initial Health Assessments*, on page 3, states, “Risks identified from the IHA and IHEBA must be followed up with appropriate interventions and documented in the medical record.” In addition, on page 4, the policy states: “The plan of care must include all follow-up activities,” however, the policy contains no provisions for ensuring this follow-up, nor does it provide for any monitoring of follow-up services. Plan staff stated that they do not receive enrollees' IHAs or IHEBAs and have no way of knowing the findings. They pointed to the medical record reviews that occur every three years for primary care physicians as the way the Plan would monitor follow-up of IHAs and IHEBAs. However,

the *DHCS Medical Record Review Survey 2012* tool used for the medical record reviews has no area to score or evaluate these specific follow-up activities.

Conclusion: DHCS-HPSJ Contract, Exhibit A, Attachment 10 – Scope of Services, Provision 3. – Initial Health Assessment (IHA) requires the Plan to ensure follow-up health care services that address the findings or risk factors discovered during an enrollee’s IHA and IHEBA. The Plan’s only stated approach to monitoring provision of these follow-up services is medical record reviews occurring during periodic site visits. This approach is unsatisfactory because the tool used by the Plan for these reviews contains no items to assess follow-up health care services that address the findings or risk factors discovered during IHAs and IHEBAs. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #3: The Plan does not provide all medically necessary covered services to enrollees until California Children’s Services (CCS) eligibility is confirmed.

Contractual/Statutory/Regulatory Reference(s): DHCS-HPSJ Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 3 – Timeframes for Medical Authorization and Attachment 11 – Case Management and Coordination of Care, Provision 9 – California Children Services (CCS).

DHCS-HPSJ Contract, Exhibit A Attachment 5 – Utilization Management

3. Timeframes for Medical Authorization

- A. Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.
- B. Post-stabilization: Response to request within 30 minutes or the service is deemed approved in accordance with Title 22 CCR Section 53855 (a), or any future amendments thereto.
- C. Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.
- D. Concurrent review of authorization for treatment regimen already in place: Within five (5) working days or less, consistent with urgency of the Member’s medical condition and in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.
- E. Retrospective review: Within 30 calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.
- F. Pharmaceuticals: 24 hours on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto.
- G. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member’s provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member’s interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. . . .

DHCS-HPSJ Contract, Exhibit A Attachment 11 – Case Management and Coordination of Care

9. California Children Services (CCS)

Services provided by the CCS program are not covered under this Contract. Upon adequate diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which: . . .

4) Ensure that Contractor continues to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed.

Documents Reviewed:

- CCS Deferred Report
- Memorandum of Understanding with Stanislaus County California Children's Service CCS
- Plan Policy UM41: California Children's Services (Effective date: 02/14)
- Plan document, Coordination and Identification of CCS Eligible Children (undated)

Assessment: DHCS-HPSJ Contract requires the Plan to continue “to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed.” The Plan’s *Memorandum of Understanding (MOU) with Stanislaus County California Children's Service CCS* explicitly states as one of the Plan’s responsibilities:

“Arrange for medically necessary care during the period after referral and prior to the CCS eligibility determination. . . .” Plan Policy *UM41: California Children's Services* does not explicitly state this requirement. The policy, on page 7, states:

1. In the event that CCS, for any reason, appears to delay in the referral to CM or authorization of services, and the Plan Medical Director determines that any prolonged delay could impede the care to the member, HPSJ CM will make the necessary arrangements, keeping the CCS CM informed as to the actions taken. HPSJ will ensure that the providers are CCS paneled.

The above language fails to comply with the Plan’s MOU with CCS, and Attachment 11, Provision 9, because it allows for the Plan Medical Director to have discretion regarding arranging for the necessary care pending a delay by CCS.

The Plan submitted an unsigned, undated document in response to a request prior to the onsite survey, which outlines the current process for coordination of care with CCS, including the role of a dedicated pediatric review unit:

9. All medically necessary diagnostic and other services essential to establish that the member has a CCS eligible condition are approved and provided through the plan while awaiting CCS eligibility determination.

The document also contains, as one of the steps “to prevent a delay in care”: “5. Tracking of the cases that are deferred to CCS for eligibility determination and the SARs [service authorization requests].”

During onsite interviews, Plan staff were asked if cases are ever deferred beyond 28 days, and they confirmed that longer delays do occur. The Plan submitted a report, *CCS Cases Deferred* that further demonstrates the lack of contractual compliance. According to the DHCS-HPSJ Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 3 – Timeframes for Medical Authorization, the Plan should treat these requests as denials. However, the Plan does not treat these deferrals as denials even when they extend beyond 28 days and are for services that are medically necessary as well as a Plan benefit (if not covered by CCS). According to the *Coordination and Identification of CCS Eligible Children* document, while the Plan is awaiting CCS eligibility determinations, it does not approve any services it deems as lacking urgency. Without a denial, the member receives no Notice of Action (NOA) or appeal rights. If CCS denies the services, only then does the Plan actually issue the authorization(s).

Conclusion: DHCS-HPSJ Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care, Provision 9 – California Children Services (CCS) requires the Plan provide all medically necessary covered services to enrollees while they are awaiting CCS eligibility determination. The presence of over 100 deferrals indicates a lack of compliance with this provision. Therefore, the Department finds the Plan in violation of this contractual requirement.

AVAILABILITY AND ACCESSIBILITY

Potential Deficiency #4: The Plan does not maintain a program that ensures timely access to health care for Children with Special Health Care Needs (CSHCN).

Contractual/Statutory/Regulatory Reference(s): DHCS-HPSJ Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care, Provision 8 – Services for Children with Special Health Care Needs.

DHCS-HPSJ Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care
8. Services for Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are defined as “those who have or are at increased risk for a chronic physical, behavioral, developmental, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally”.

Contractor shall implement and maintain a program for CSHCN which includes, but is not limited to, the following:

- A. Standardized procedures for the identification of CSHCN, at enrollment and on a periodic basis thereafter;
- B. Methods for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, and specialized equipment and supplies; these may include assignment to a specialist as PCP, standing referrals, or other methods as defined by Contractor; ...

Documents Reviewed:

- Plan Policy QM 04: Appointment Availability and Access Standards (Effective date 2/96)
- Plan Policy UM 41: California Children’s Services (CCS) (Effective date, 02/01/96)

Assessment: DHCS-HPSJ Contract requires the Plan to implement “[m]ethods “for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, and specialized equipment and supplies; . . .” The Plan does not meet this contractual requirement as evidenced by Plan policy *QM 04: Appointment Availability and Access Standards*, Plan policy *UM41: California Children’s Services (CCS)*, and Plan staff interviews. The Plan policies do not mention timely access standards or monitoring of these services, and Plan staff confirmed that the Plan has not established any standards for timely access in these areas, nor has it implemented a process to monitor and ensure timely access.

Conclusion: DHCS-HPSJ Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care, Provision 8 – Services for Children with Special Health Care Needs requires the Plan to implement methods for ensuring “timely access to pediatric specialists, sub-specialists, ancillary therapists, and specialized equipment and supplies; . . .” The Plan has not established timeliness standards nor does it conduct monitoring to ensure timely access to these services. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #5: The Plan cannot demonstrate that it is meeting or monitoring timely access standards for specialists, ancillary providers, mental health providers, or urgent care appointments.

Contractual/Statutory/Regulatory Reference(s): DHCS-HPSJ Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4 - Access Standards; Rule 1300.67.2.2(c)(5).

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

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers’ compliance with these standards.

A. Appropriate Clinical Timeframes

Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.

B. Standards for Timely Appointments

Members must be offered appointments within the following timeframes:

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

Rule 1300.67.2.2(c)

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

- (A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G);
- (B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (G);
- (C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (G) and (H);
- (D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (G) and (H);
- (E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in (G) and (H);
- (F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in (G) and (H); . . .

Documents Reviewed:

- QM Program Monitors Full R&A Plan Beacon & CHIPA Quarterly Report Status for QOC - FY15 Q1
- Beacon - CHIPA Final Executed Agreement Effective 6_1_14
- Beacon Statement (untitled, 07/28/15)
- Beacon Routine Report HPSJ Q2 2015
- Plan Policy QM04: Appointment Availability and Access Standards (Revised 10/14)
- HPSJ Timely Access Regulation (TAR) Report Submission (Measurement Year 2014)

Assessment: The Plan's *Appointment Availability and Access Standards* policy satisfies the timeframes outlined in Rule 1300.67.2.2

The Plan has held itself to a higher standard for urgent care PCP appointments than required by the Rule. The Plan's rate of compliance for urgent care PCP appointments (i.e., appointment within 24 hours) is 78.8%. While it is probable that the rate of compliance would be higher when using a 48-hour standard, the Plan could not produce data on the percentage of urgent appointments offered within 48 hours.

In its annual TAR Report submission to the Department, the Plan did not submit data on specialist services, mental health services, or ancillary services. In interviews, the Plan's Director of Quality Improvement confirmed that the Plan did not gather data on specialists or ancillary appointments for Measurement Year 2014, stating, "We do not have the data you are looking for." The Plan expects to collect specialist data for Measurement Year 2015.

In response to the Department's request for evidence of monitoring of timely access to mental health services, the Plan issued documents purportedly showing "the percentage of time appointments were met within the 10 business day standard for routine services for referrals when members accepted Beacon's offer for assistance in booking appointments" The Plan stated: "Data of both HPSJ counties are combined in this report." The range of percentages reported was from 50% to 100% with a median of 60%. It is important to note that the Plan simply reported a percentage for each month from July 2014 to April 2015. When the Department asked the Plan to provide a report that provides data regarding members who call in due to difficulties getting an appointment, the Plan stated: "That level of detail is not being captured and reported by Beacon." The Plan did not report total appointments booked, or how

many enrollees booked appointments using Beacon's assistance versus how many enrollees self-booked, so it is not possible to determine from the data given what percentage of all behavioral health appointments these rates reflect. Plan staff stated in interviews that in most cases members self-book appointments, in which case these data represent only a small proportion of all appointments booked and may not offer an accurate, representative assessment of the percentage of appointments that met the 10-business day standard across all behavioral health appointments. The Plan's policy, *Appointment Availability and Access Standards* states:

As a delegated entity Beacon has implemented policies and procedures and are responsible for monitoring BHP's access appointment availability, afterhours access, provider geographic network accessibility and practitioner satisfaction surveys. Beacon shall measure compliance with state regulatory and DHCS contractual requirements, NCQA standards MBHP Accreditation standards at least annually and report to the HPSJ Delegation Oversight Committee.

However, the agreement between the Plan and the behavioral health delegate, *Beacon - CHIPA Final Executed Agreement Effective 6_1_14*, pages 30 – 31 as well as the document, *QM Program Monitors Full R&A Plan Beacon & CHIPA Quarterly Report Status for QOC - FY15 Q1*, which tracks Reports required of Plan delegates, lacks mention of any required reporting of appointment availability statistics. Based on the data provided, the Plan's system for monitoring behavioral health appointment availability is inadequate.

Conclusion: DHCS-HPSJ Contract, Exhibit A, Attachment 9 – Access and Availability. Provision 4 - Access Standards and Rule 1300.67.2.2 require the Plan to offer enrollees appointments that meet defined timeframes. The Plan could not produce evidence that it is meeting or monitoring timely access requirements for urgent care, specialist, mental health, and ancillary appointments. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Potential Deficiency #6: The Plan does not monitor compliance with the required timeframe of enrollees' first pre-natal visits.

Contractual/Statutory/Regulatory Reference(s): DHCS-HPSJ Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3 – Access Requirements.

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

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements. . . .

B. First Prenatal Visit

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

C. Waiting Times

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Paragraph A. Appointments, above.

Documents Reviewed:

- Plan Policy QM 04: Appointment Availability and Access Standards (Effective date 2/96)
- HPSJ 2014 TAR Submission

Assessment: The Plan's Appointment Access and Availability Standards policy complies with the contractual requirements regarding pre-natal appointments, committing the Plan to providing the first visit within 14 calendar days of request.

In response to a Department request for data demonstrating that the Plan monitors wait times for the first pre-natal appointment, the Plan submitted the following statement: "HPSJ currently does not conduct any monitoring on whether pre-natal visits are conducted within 10-days of the member's request. This monitoring activity will be performed at the next scheduled survey."

Conclusion: DHCS-HPSJ Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3 – Access Requirements requires the Plan to monitor to ensure that the first pre-natal visit for a pregnant enrollee is available within two weeks of the request. The Plan currently does not conduct any monitoring to ensure the offering of pre-natal visits within the required timeframe. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #7: The Plan has not established standards for geographic distribution of hospitals, emergency services facilities, or ancillary care facilities.

Contractual/Statutory/Regulatory Reference(s): DHCS-HPSJ Contract, Exhibit A, Attachment 6 – Provider Network, Provision 2 - Network Composition, Provision 5 - Emergency Services and Attachment 9 – Access and Availability, Provision 7 – Emergency Care.

DHCS-HPSJ 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. . . .

5. Emergency Services

Contractor shall have, as a minimum, a designated emergency service facility, providing care on a 24-hour-a-day, 7-day-a-week basis. This designated emergency service facility will have one or more physicians and one nurse on duty in the facility at all times.

DHCS-HPSJ Contract, Attachment 9 – Access and Availability

7. Emergency Care

Contractor shall ensure that a Member with an emergency condition will be seen on an emergency basis and that emergency services will be available and accessible within the Service Area 24-hours-a-day.

Documents Reviewed:

- Hospital and Ancillary Facilities 2014 3rd Qtr DHCS Network Impact Report
- Hospital and Ancillary Facilities 2014 4th Qtr DHCS Network Impact Report
- Hospital and Ancillary Facilities 2015 1st Qtr DHCS Network Impact Report
- Plan Policy QM 04: Appointment Availability and Access Standards (Effective date, 02/96)

Assessment: The Plan has not established a geographic access standard for hospitals, emergency services facilities, or ancillary care facilities against which it will monitor the geographic distribution of these services to ensure availability. Plan staff stated that this was a policy gap, which they would be correcting. (The Department noted that the Plan has contracted with all available area hospitals.)

Conclusion: DHCS-HPSJ Contract, Exhibit A, Attachment 6 – Provider Network, Provision 2 - Network Composition requires the Plan to ensure and monitor an appropriate provider network. Provision 5 – Emergency Services and Attachment 9 – Access and Availability, Provision 7 – Emergency Care require the Plan to make emergency services available and accessible emergency 24-hours-a-day, 7-days-a-week. However, Plan policies contain no mention of geographic standards against which the Plan will monitor the geographic distribution of these services. Therefore, the Department finds the Plan in violation of these contractual requirements.

MEMBER RIGHTS

Potential Deficiency #8: The Plan did not consistently acknowledge enrollee grievances and appeals in writing within five calendar days of receipt.

Contractual/Statutory/Regulatory/Reference(s): DHCS-HPSJ Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 - Member Grievance System, Provision 2 – Grievance System Oversight; Rule 1300.68(d)(1).

DHCS-HPSJ 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,

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.

A. Procedure to ensure timely acknowledgement, resolution, feedback to complainant. . . .

Rule 1300.68(d)(1)

(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. . . .

Documents Reviewed:

- Plan Policy GRV02: Member Grievance/Complaint Procedures (07/14)
- 42 standard grievances and appeals files (07/01/14 – 06/30/15)
- 2013 Medi-Cal EOC

Assessment: Plan Policy *GRV02: Member Grievance/Complaint Procedures* states: “All Grievances are acknowledged in writing within five (5) calendar days of receiving the Grievance. . . .” The *2013 Medi-Cal EOC* confirms this process, stating: “We will send you a letter within 5 days of receiving your complaint telling you we got your complaint.”

The Department reviewed a sample of 42 standard enrollee grievances and appeals files and determined that the Plan did not consistently acknowledge grievances in writing within five calendar days of receipt. Of the 42 case files, 35 included documentation demonstrating that the Plan sent the required acknowledgment letter to enrollees within five calendar days of receipt. Seven cases⁴ did not meet the five-day requirement. Five of the seven non-compliant files were appeals. In two⁵ of these seven cases, no acknowledgement letters were sent because of “bad addresses” in the Plan database. Delays in the remaining five cases ranged from three to seven days.

TABLE 1
Standard Grievance and Appeal File Review Worksheet Results
Acknowledgement Letter Timeliness

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Grievances and Appeals	42	Plan is to provide for a written acknowledgment within five calendar days of receipt of a grievance.	35 (83%)	7 (17%)

Conclusion: The DHCS-HPSJ Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 - Member Grievance System requires the Plan to comply with Rule 1300.68(d)(1), which specifies that the Plan must provide written acknowledgment within five calendar days of the receipt of a grievance, except in limited circumstances. The Plan failed to provide timely acknowledgements in seven of 42 grievances. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Potential Deficiency #9: The Plan does not consistently ensure adequate consideration of standard enrollee grievances.

⁴ File #s 2, 5, 19, 21, 22, 37, and 42

⁵ File #s 5 and 19

Health Plan of San Joaquin
1115 Waiver SPD Medical Survey Report
March 30, 2016

Contractual/Statutory/Regulatory/Reference(s): DHCS-HPSJ Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 - General Requirement, Attachment 14 – Member Grievance System, Provision 1 - Member Grievance System; Rule 1300.68(a)(4); Rule 1300.70(a)(1).

DHCS-HPSJ Contract, Exhibit A Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. . . .

DHCS-HPSJ Contract, 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(a)(4)

(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:

(4) "Resolved" means that the grievance has reached a final conclusion

Rule 1300.70

(a) Intent and Regulatory Purpose.

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

Documents Reviewed:

- Plan Policy GRV02: Member Grievance/Complaint Procedures (07/14)
- Member Services Call Log
- 42 standard grievances and appeals (07/01/14 – 06/30/15)

Assessment: Plan Policy *GRV02: Member Grievance/Complaint Procedures* states:

The purpose of this policy is to ensure compliance with regulatory and contractual requirements in the receipt, processing, investigation, and resolution of Member Grievances/Complaints. HPSJ takes Grievances/Complaints seriously. Grievances/Complaints are an important mechanism for identifying issues of concern and areas of dissatisfaction to Members and Providers. A thorough investigation of the nature of each Complaint that considers all sides of the issue(s) is conducted. . . .

The Plan did not consistently ensure adequate consideration and rectification of enrollee grievances. A review of the Plan's standard grievance files, discussed below, revealed that in some instances the Plan did not fully investigate all aspects of a grievance prior to sending a resolution letter to the enrollee. As well, the Plan sent resolution letters that did not address all areas of the enrollees' grievances.

The Department reviewed a sample of 42⁶ standard enrollee grievances and appeals files, 20 of which were appeals, and determined that in eight⁷ cases, the Plan failed to document that the required investigation and rectification of enrollee grievances were completed. None of the non-compliant files were appeals. The following files exemplify these eight noncompliant cases:

- File #13: The enrollee reported "... when she calls PCP to make an appointment for RX she never can get an appointment for a refill and when she does it takes 2-3 weeks. Member states she is being told by her PCP they will replace her narcotics with alternatives and she is willing to do so but cant [sic] get seen." This grievance was categorized as a quality of care issue by the Plan. The Plan did not capture or categorize the access portion of the grievance. The Plan did not demonstrate that it had the ability to capture more than one category for a grievance. The Plan made several attempts to contact the enrollee but was unsuccessful. There was no evidence of the Plan addressing the access issue. A resolution letter sent to the enrollee did not include any information concerning her grievance. The letter stated:

The Quality Management Nurse has attempted to contact you to resolve your grievance and has been unsuccessful. Please contact Health Plan of San Joaquin if you have any further issues. The Quality Management Department will continue to address, monitor, report, and record this matter. The Quality Management Department will also use this as an opportunity to identify and improve any quality of care issue that may be present.

- File #20: The enrollee contacted the Plan because she was unhappy with the care she received at her provider's office. The customer service representative stated the following:

Member states that when she arrived for her appointment she was taken to an exam room. The nurse put iodine on a square gauze pad [to] cleanse injection site on member's shoulder. Member states that the nurse placed the iodine soaked gauze pad on a place mat and then place[d] that in front of a window sill where the window sill, the blinds, the cord to the blinds and the window screen were dirty with black mold and dirt for at least 7-10 minutes before the attending physician came in with the intern. Member states that she voiced her concerns to the MD about the dirty window and her fear of gauze being possibly contaminated and the MD stated 'well this is County'. Member states that the comment is not acceptable. Member also states that the intern gave the member her injection in her shoulder and that intern injected member

⁶ The initial sample contained 43 cases; one case, an exempt grievance, was eliminated from the sample because it had incorrectly been included in the Plan's log of standard grievances and appeals.

⁷ File #s 10, 13, 18, 19, 20, 31, 33, 34

in the wrong place. Member states that she started to shake and told the MD that it was hurting. MD then told intern to remove needle from member's shoulder. Member states that the intern used the same contaminated square gauze pad soaked in iodine to wipe the needle. Member at this point believes that the needle [is] now contaminated. Member states that the intern asked MD if a new needle was needed and MD stated no and then used the same needle to finish member's injections.”

The resolution letter sent to the enrollee stated:

Resolution: The Quality Management Department has contacted you and assisted you with your grievance. We have followed up with Health Services Agency and they will be doing an additional investigation at the clinic site. We have discussed care coordination with the specialists as well as follow up care.

The Plan sent a summary of the enrollee’s complaints to the provider and requested a response. In response to an onsite request, the Plan could not produce the provider’s response to the complaints or documentation to demonstrate that it had re-contacted the provider for a response. The Plan also stated that no facility site review of this provider occurred. Moreover, this case was categorized inappropriately in the Plan’s Log, *PCP Selection & Assignment* as only a quality of service issue, when it should have been designated and addressed as a quality of care issue. As a result, the grievance was not forwarded for potential quality issue (PQI) review.

The DHCS-HPSJ Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 - General Requirement requires the Plan to “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” Similarly, Rule 1300.70(a)(1) requires that the quality assurance (QA) program document “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.” Plan Policy *GRV02: Member Grievance/Complaint Procedures* incorporates these requirements, stating that when a service representative (Rep) receives a grievance the representative “Forwards the Grievance/Complaint documentation to the Quality Management (QM) RN supervisor/designee who determines and assigns the appropriate individual to investigate the Complaint.” The policy further states: “Complaints involving clinical issues such as quality of care are evaluated by an appropriate clinician.” The Department found that the Plan failed to identify all issues in 12 enrollees’ standard grievances in the *Member Services Call Log*. Twelve⁸ cases were incorrectly categorized only as quality of service and access complaints; however, potential quality of care issues were not identified and, therefore, not referred for clinical review, investigation, and corrective action when indicated.

⁸ File #s 5, 6, 7, 10, 12, 13, 19, 20, 23, 25, 28, 29
Template Revision date: 3/30/2015

TABLE 2
Standard Grievance and Appeal File Review Worksheet Results
Fully Investigate All Areas of Grievance

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Grievances and Appeals	42	documentation that an investigation was completed	34 (81%)	8 (19%)
		identification of all issues	30 (71%)	12 (29%)

The file review of the Plan’s standard grievances demonstrated that the Plan did not routinely investigate quality of service issues expressed by enrollees. The Plan’s frequent response was to assign the enrollee to a new provider. There was no evidence that quality of service issues identified by enrollees were addressed by the Plan.

Conclusion: DHCS-HPSJ Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2 - Grievance System Oversight and Rule 1300.68(a)(4) require the Plan to adequately investigate grievances and identify problems. In eight⁹ of 42 cases the Plan did not identify all issues that merited investigation and failed to document a completed investigation. The DHCS-HPSJ Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 - General Requirement and Rule 1300.70(a)(1) require the Plan to implement corrective actions. Because issues were not consistently investigated, the Plan could not demonstrate that it (1) identified any deficiencies in the care and services enrollees received and (2) implemented corrective actions where appropriate. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Potential Deficiency #10: The Plan does not appropriately categorize exempt grievances.

Contractual/Statutory/Regulatory/Reference(s): DHCS-HPSJ Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 - General Requirement;, Attachment 14 – Member Grievance System, Provision 2A;Rule 1300.68(d)(8); Rule 1300.70(a)(1).

DHCS-HPSJ Contract, Exhibit A Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor. . .

⁹ File #s 10, 13, 18, 19, 20, 31, 33, 34,
 Template Revision date: 3/30/2015

DHCS-HPSJ 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.

A. Procedure to ensure timely acknowledgement, resolution, feedback to complainant.

Rule 1300.68(d)(8)

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

(8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in Subsection (b).

Rule 1300.70

(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:

- Plan Policy GRV02: Member Grievance/Complaint Procedures (7/14)
- 15 exempt grievance files (07/01/14 – 06/30/15)

Assessment: Plan Policy *GRV02: Member Grievance/Complaint Procedures* states:

. . . Grievances received by 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 requirements to send a written acknowledgement and response, and will be logged as such in the Member Grievance Log. . . .

The Department's review of the Plan's exempt grievance files revealed that in some instances, as discussed below, the Plan did not appropriately categorize the grievance. In addition, for exempt grievances that included a quality of service and/or quality of care component, there was no evidence that the Plan took any action to "monitor, evaluate, and take effective action to address any needed improvements" as required.

The Department reviewed 15 cases identified by the Plan as exempt grievances.¹⁰ Of the 15 case files, 12 included documentation to demonstrate information collection and correct

¹⁰ The Department's initial sample contained 17 grievances. Two cases were eliminated as ineligible for the sample. In File #1, the enrollee withdrew the grievance, and File #2 was a standard grievance, incorrectly identified in the Plan's log as an exempt grievance.

categorization for each grievance. Three cases classified by the Plan as exempt grievances¹¹ should have been classified as inquiries. Nine¹² exempt grievances included a quality of service component, but there was no evidence that the Plan fully resolved the grievances – i.e., there was no evidence that the Plan investigated the concerns and, where problems were confirmed, took action to address the issues. In addition, file #9 included a quality of care component not addressed by the Plan. The following files exemplify these noncompliant cases:

- *File #7: Exempt Grievance Log* states: “Current PCP [primary care provider] did not want to see [member] when in the hospital and [member] is a seriously [ill with] cancer. [Member] states is wanting to [change] PCP [primary care provider] since [provider] did not want to see [member] in hospital. Sister believe[s] [provider] does not want [member] as a patient.”
- *File #17: Call log* states: “previous [provider] rude.”

In eight¹³ of the nine cases wherein no follow-up occurred to investigate the service issues, the enrollee’s calls involved a request for a change in PCP. In these cases, the Plan initiated a PCP change but there was no indication that investigation was conducted on the quality of service components of the grievances.

TABLE 3
Exempt Grievance File Review Worksheet Results
Correctly Classify and Fully Investigate All Areas of Grievance

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Exempt Grievances	15	accurate categorization of grievance issues	12 (80%)	3 (20%)
		documentation that an investigation was completed	6 (40%)	9 (60%)

Conclusion: DHCS-HPSJ Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2A requires the Plan to implement and maintain procedures to monitor resolution of enrollee grievances. Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and Rule 1300.70(a)(1) require the Plan to take effective action to address any needed improvements in care. Review of 15 exempt grievance files demonstrated that in three cases the Plan did not accurately categorize exempt grievances and in 9 cases the Plan did not investigate issues communicated to the Plan by enrollees. The DHCS-HPSJ Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 - General Requirement and Rule 1300.70(a)(1) require the Plan to implement corrective actions. Because issues were not consistently investigated, the Plan could not demonstrate that it (1) identified any deficiencies in the care and services enrollees received and (2) implemented corrective actions where

¹¹ File #s 3, 4, and 16

¹² File #s 6, 7, 8, 9, 10, 11, 12, 13, and 17

¹³ File #s 6, 7, 8, 9, 10, 12, 16, and 17

appropriate to rectify those deficiencies. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

QUALITY MANAGEMENT

Deficiency # 11: The Plan's Quality Assurance Program does not 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.

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

DHCS-HPSJ Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

DHCS-HPSJ Contract, Exhibit A, Attachment 4 – Quality Improvement System

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor. 2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if subcontractor's obligations are not met.

B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum: 1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities. 2) Ensures subcontractor meets standards set forth by the Contractor and DHCS. 3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

Rules 1300.70(a)(1), (b)(1) and (b)(2)(G)(1)-(6)

(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:

(A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;

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

(2) Program Requirements.

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

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

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

(1) Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the plan.

(2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise and budgetary resources.

(3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.

(4) Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's QA program, and be assured of the entity's continued adherence to these standards.

(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

Documents Reviewed:

- Plan Policy QM07: Delegation of QI (Effective 07/12/12))
- PQI Severity Codes, (2014, 2015)
- Beacon CHIPA Final Executed Agreement (Effective 06/01/14)
- CHIPPA Beacon Health Delegation Approval Letter (Dated June 17, 2014)
- CHIPPA Beacon Health Pre-Delegation Audit Tool UM
- Beacon MD Appointment Spreadsheet (applicable period, 06/14 – 06/15 undated)
- Health Plan of San Joaquin/Beacon Joint Operations Meeting Minutes (10/30/14, 01/26/15, 04/30/15)

- Beacon Health Strategies HPSJ Quality Management and Improvement Program Evaluation (June – December 2014)
- Quality Operations Committee (QOC) Meeting Minutes (11/10/14, 11/14/14, 06/09/15)
- Quality Management and Improvement (QMI) Program Description Fiscal Year 2014 – 2015
- Quality Management Utilization Management Committee Meeting Minutes (08/14/14, 11/20/14, 01/29/15, 02/19/2015, 03/18/15)
- 30 PQI Files (07/01/14 – 04/30/15)
- 15 Exempt Grievances (07/01/14 – 06/30/15)
- 42 Standard Grievances and Appeals (07/01/14 – 06/30/15)

Assessment:

a. The Plan does not demonstrate that quality of care problems are identified and corrected for all provider entities.

1. The Plan does not consistently identify quality of care problems

The Department's review of 42 standard enrollee grievance files and 15 exempt grievance files revealed a failure by the Plan to document that it had identified potential quality of care issues (or ruled out a quality problem) in three cases as follows:

- *File #20:* The enrollee complained about the lack of sterile technique in an orthopedic clinic and was concerned with the quality of care provided. The grievance was not identified as a PQI and referred for clinical review/investigation.
- *File #5:* The enrollee reported that her PCP attempted to give her a steroid injection without explaining why it was necessary. She stated that she had a urinary tract infection (UTI) and did not understand the need for a steroid. She maintained that the doctor refused to tell her why she needed a steroid injection. The grievance was not identified as a PQI and referred for clinical review/investigation.
- *File #5:* The enrollee threatened to retain a lawyer regarding cancer treatment, stating: m[em]b[er] states that her current prov hasn't been taking care of her and mbr was recently diagnosed with cancer that she has apparently had since may [sic] and the prov just told her that she had cancer 10 days ago. This grievance was received on 1/26/15. The grievance was not identified as a PQI and referred for clinical review/investigation.

Plan staff stated during interviews about the grievance system that they are aware of missed PQIs and a need to improve the process.

2. The Plan does not take effective action to improve care when a deficiency is identified

Department review of 30 PQI case files revealed the Plan identified 13¹⁴ files as having confirmed quality issues. The Department determined that the Plan identified four¹⁵ cases, all assigned a Severity Level of 3, requiring a corrective action plan (CAP). While the Plan implemented a CAP in these four cases, three¹⁶ other cases assigned a Severity Level 3 received no CAP:

- File #3: This case involved a hospital readmission for small bowel obstruction. The case was assigned a Severity Level 3 (an avoidable quality issue identified that resulted in an admission to the hospital or increase in acuity), but there was no corresponding CAP.
- File #18: This case concerned care for an enrollee with multiple medical and behavioral health problems, who died upon hospital readmission. Despite assigning a Severity Level 3, the Plan documented no CAP.

The following PQI file mentions, but does not document a CAP:

- File #14: CAPs were requested but not documented as received from the providers. No documentation was submitted showing continued pursuit of the records by Plan staff.

The Plan demonstrated failure to implement CAPs where indicated. It failed to document CAPs it did find necessary. As a result, in seven cases the Plan failed to take effective actions to improve care when it identified deficiencies.

3. The Plan does not demonstrate follow-up of identified corrective actions

The Plan had two¹⁷ PQIs from a SNF that resulted in a single documented CAP. There was no follow-up of the extensive changes in policies and procedures as outlined by the SNF in their CAP.

Plan staff acknowledged that the past year had been one of process improvement in the handling of PQIs. Plan staff noted that previously no central PQI database was maintained; individual nurses kept unique sets of data. However, centralization of data now allows staff to better manage the PQI process.

4. The Plan does not document that quality of care is being reviewed

Two of the cases assigned a Severity Level of 3 lack documentation that appropriate clinical personnel reviewed the quality of care:

- File #3: A readmission of an enrollee for small bowel obstruction had no documented review of the provider's response to this PQI in the file. (Level 3.)

¹⁴ File #s

¹⁵ File #s

¹⁶ File #s

¹⁷ File #s (the ID# have been removed to secure PHI information)

- File #13: This enrollee was discharged home and became unable to care for herself. There was no response from the PCP and no resolution date in the file. (Level 3.)

The Plan does not consistently document its review of quality of care PQIs by the clinical personnel required to perform such review.

TABLE 4
PQI File Review Summary

FILE TYPE	NUMBER OF FILES*	ELEMENT	COMPLIANT	DEFICIENT
PQI	30	PQI reviewed by appropriate medical professional	23 (77%)	7 (23%)
	30	All quality issues related to the PQI identified and assessed	13 (50%)	13 (50%)
	7	CAP was implemented for PQI where Severity Level 3 problems were confirmed	4 (57%)	3 (43%)

b. The Plan fails to maintain a system to ensure accountability for its behavioral health delegate’s quality improvement activities.

The Plan delegates its behavioral health services as per the *Beacon CHIPA Final Executed Agreement* among the Plan, Beacon Health Strategies, its behavioral health delegate, and College Health IPA. The agreement outlines delegated activities encompassing the Quality Improvement Program structure, operations, access, availability, satisfaction, clinical practice guidelines, and continuity and coordination of care. However, the Department found that the Plan delegated quality improvement activities to these providers without an initial review and has conducted no continuous monitoring of the delegates’ activities.

As part of the Plan’s pre-onsite document submission, the Plan submitted a document file titled the *Beacon CHIPA Final Executed Agreement*. Examination of this document revealed it was actually a Utilization Management Pre-Delegation Audit Report of College Health IPA. A second document file, titled *Delegated UM Activities Beacon - CHIPA Final Executed Agreement Effective 6_1_14* was the actual signed agreement. Another document, the *CHIPPA Beacon Health Delegation Approval Letter*, dated June 17, 2014, informed the delegate, Beacon Health Strategies, of the results of the Beacon Health & College Health IPA On-Site Pre Delegation Evaluation, with “100% compliance with HPSJ’s Quality Improvement, Utilization Management, Credentialing and Member Rights and Responsibility, delegation requirements, standards and policies and procedures.”

Pre-Delegation Review

Plan Policy *QM07: Delegation of QI*, reinforces the contract, stating:

2. Prior to delegation, HPSJ evaluates the proposed Delegate's capacity to perform the proposed Delegated Activities in accordance with HPSJ's expectations and program requirements.
 - a. To determine the degree to which they are consistent with HPSJ's expectations and program requirements, as appropriate to the scope of the Delegation, HPSJ evaluates the proposed Delegate's:
 - i. Quality Improvement Program Documents, specifically including the QI Program Description, work plan, policies and procedures, and relevant committee minutes. . . .

Plan staff indicated a reliance on Beacon's status as an NCQA accredited managed behavioral healthcare organization (MBHO) as support for the delegate's quality improvement capabilities. Plan staff stated that they had performed a pre-delegation audit of the MBHO and submitted the *CHIPPA Beacon Health Pre-Delegation Audit Tool UM* as evidence. However, the Department's review of this report found that it focused on delegated utilization activities. There was no evaluation of the administrative capacity, technical expertise, and budgetary resources of the provider to conduct delegated quality improvement activities of operations, access, availability, satisfaction, clinical practice guidelines, and continuity and coordination of care. As a result, the Plan's documented pre-delegation audit failed to include a review of the provider's ability to conduct delegated quality improvement activities.

The Plan submitted the MBHO's Quality Improvement Program Evaluation document, *Beacon Health Strategies HPSJ Quality Management and Improvement Program Evaluation (June – December 2014)* covering the first six months of delegated activity. The MBHO reviewed only 19 records to assess coordination of care between behavioral health providers and PCPs. Compliance ranged from 10.5% to 47.4% across five measures. The MBHO refers to a very low utilization rate as the cause of these small samples and low performance. During onsite interviews with Plan staff, a utilization rate of 1.789% was quoted. Plan staff stated that their investigation of this low rate was limited to eliciting reassurances from the MBHO that the rate was higher than in other contracted Medi-Cal plans. However, public health statistics (e.g., Napili, A. and Bagalman E., "Prevalence of Mental Illness in the United States: Data Sources and Estimates," Congressional Research Service, March 9, 2015) show prevalence rates of mild to moderate mental health conditions to be far in excess of this percentage. The utilization rates experienced by the MBHO did not cause the Plan to initiate further monitoring or corrective action.

Ongoing Monitoring

Plan Policy *QM07, Delegation of QI*, states:

1. The Delegation Oversight Committee is responsible for overseeing all Delegation, including:
 - a. Reviewing the findings of Pre-Delegation evaluations.

- b. Annually approving the Delegate's documents describing how the Delegate intends to carry out the Delegated activities. As appropriate to the scope of the Delegation, these documents include:
 - i. Quality Improvement (QI) Program Description and/or relevant policies and procedures.
 - ii. Utilization Management (UM) Program Description and/or relevant policies and procedures.
 - iii. Credentialing and Recredentialing (CR) Program Description and/or relevant policies and procedures.
 - iv. Members' Rights and Responsibilities (RR) relevant policies and procedures.
 - v. Member Connections (MEM) relevant policies and procedures.
- c. Reviewing periodic reports submitted by Delegates. . . .

Plan staff stated that while its Delegation Oversight Committee did not exist during the survey review period, its Quality Operations Committee (QOC) performed quality improvement activities related to its delegate's responsibilities. The Plan submitted as part of the pre-on-site document submission, the *Beacon MD Appointment Spreadsheet* (applicable period, 06/14 – 06/15 undated) as documentation that monitoring of quality improvement activities was conducted by its QOC. This document appears to contain listings of enrollee issues with obtaining appointments with providers, but provides no evidence of any follow-up by the Plan to determine why these enrollees had difficulties obtaining appointments. Plan staff stated that since October of 2014, ongoing monitoring of delegated QI took place at joint operations meetings between the Plan and the MBHO. Department review of the *Health Plan of San Joaquin/Beacon Joint Operations Meeting Minutes* revealed discussions were held regarding utilization management, claims practices, and grievances among other topics, but no meaningful quality improvement activities were discussed.

At the end of the survey review period, the delegation agreement had been in place for 13 months. The Plan had not performed any site visit or audit activity during this time. Plan staff indicated planning for an annual oversight audit of the MBHO during fiscal year 2016. The Department's review of Plan documents and interviews with Plan staff failed to demonstrate that the Plan meets its own policy for ongoing monitoring of quality improvement.

c. The Plan does not monitor to ensure identification and correction of quality problems in laboratories and outpatient surgery centers.

The Plan does not delegate its quality improvement activities to laboratories or outpatient surgery centers, and the scope of its own Quality Improvement Program does not cover these providers. The Plan's *2014-2015 QMI Program Description* outlines a broad scope of responsibility:

The scope of the QMI Program is comprehensive and addresses both the quality and safety of medical and behavioral health care provided to our members and participants for all lines of businesses.

However, the *QMI Program Description* does not specify how the quality and safety of enrollees receiving services in a laboratory environment or an outpatient surgery center are performed. The description mentions no mechanisms for continuous review, problem identification, or

correction for these providers nor does it include the mechanism by which the Plan oversees the adequacy, utilization, and quality of the services.

Plan staff acknowledged in interviews that the QI Program did not extend to the areas of outpatient surgery and laboratories during the survey review period, with the exception of the use of laboratory data for Healthcare Effectiveness Data and Information Set (HEDIS) reporting or quality of care issues for which enrollees might file grievances.

The Plan's *Quality Management Utilization Management Committee Meeting Minutes* for the survey review period do not disclose any discussion of the review of laboratory services or outpatient surgery centers, and a review of 30 PQI files disclosed that the Plan had identified no PQIs related to laboratory or outpatient surgery services.

Conclusion: The DHCS-HPSJ Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement requires the Plan to monitor quality of care, evaluate problems, and take effective action to address any needed improvements. Rules 1300.70(a)(1) and (b)(1)(B) also require the Plan identify and correct quality of care problems for all providers, including laboratories and outpatient surgery centers. As discussed above, the Plan's QA Program failed to adequately document that quality of care was reviewed, that problems were identified, that effective action was taken when deficiencies were identified, and that follow-up was planned where indicated. The Plan also failed to adhere to the DHCS-HPSJ Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 6 – Delegation of Quality Improvement Activities, Rule 1300.70(b)(2)(G)(1)-(6) and its own internal policy regarding delegation oversight. The Plan did not conduct an initial review of its behavioral health services delegate to assure that the provider had the administrative capacity, task experience, and budgetary resources to fulfill its delegated responsibilities, and it did not provide evidence of adequate oversight of quality improvement activities during the survey review period. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Jeanette Fong	Medical Survey Team Lead
MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS	
Rose Leidl, RN	Utilization Management Surveyor
Gene Beed, MD	Continuity of Care Surveyor
Madeline Hommel, MPH	Availability & Accessibility Surveyor
Teresa D. Kries, DHA,CHC	Member Rights Surveyor
Gene Beed, MD	Quality Management Surveyor

APPENDIX B. 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
Standard Grievances and Appeals	42	The Plan identified a universe of 290 files during the review period. Based on the Department's File Review Methodology, a random sample of 43 files were reviewed.
Exempt Grievances	15	The Plan identified a universe of 17 files during the review period. The entire universe of files was reviewed.
Potential Quality Issues	30	The Plan identified a universe of 31 files during the review period. Based on the Department's File Review Methodology, a random sample of 30 files was reviewed.
UM Medical Necessity Denials	52	The Plan identified a universe of 611 files during the review period. Based on the Department's File Review Methodology, a random sample of 52 files was reviewed.