DEPARTMENT OF
Managed
Health Care
Help Center

DIVISION OF PLAN SURVEYS

CAL MEDICONNECT

MEDICAL SURVEY REPORT OF

Health Plan of San Mateo

A CAL MEDICONNECT HEALTH PLAN

DATE ISSUED TO DHCS: APRIL 18, 2016

Cal MediConnect Medical Survey Report
Health Plan of San Mateo
A Cal MediConnect Health Plan
April 18, 2016

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EXECUTIVE SUMMARY

The Department of Health Care Services (DHCS) received authorization ("CMS APPROVAL") from the federal government to conduct a Duals Demonstration Project ("Cal MediConnect") to coordinate the delivery of health and long term care services to beneficiaries within California who are eligible for benefits under both Medicare and Medicaid. Starting in April 2014, DHCS began phase in enrollment of Cal MediConnect beneficiaries in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. The Department of Managed Health Care (DMHC) and the DHCS then entered into an interagency agreement [1]whereby the DMHC will be responsible for conducting medical survey audits related to the provision of Medicaid-based services provided to Cal MediConnect enrollees. Medical Surveys pursuant to this Agreement are conducted once every three years.

On August 24, 2015, the Department notified Health Plan of San Mateo (the "Plan") that its medical survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department's medical survey team conducted the onsite portion of the medical survey from November 2, 2015 through November 6, 2015.[2]

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreements, the Department provides the Cal MediConnect Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the provision of Medicaid-based services for the Cal MediConnect population. This medical survey evaluated the following elements specifically related to the Plan's delivery Cal MediConnect populations as delineated by the Cal MediConnect Three-Way Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations:

I. Utilization Management

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

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

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

II. Continuity of Care

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

III. Availability and Accessibility

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

IV. Member Rights

The Department evaluated Plan operations to assess compliance with internal and external complaint and grievance system requirements related to the provision of Medicaid-based services. The Department also evaluated the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats. .

V. Quality Management

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care as it relates to the provision of Medicaid-based services.

The scope of the medical survey incorporated review of health plan documentation and files from the period of November 1, 2014 through September 30, 2015.

SUMMARY OF FINDINGS

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

2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT	
#1	**The Plan does not have an effective mechanism to detect underutilization and overutilization of services to assess the quality and appropriateness of care provided to enrollees.** Cal MediConnect Three-Way Contract § 2.11.5.; Cal MediConnect Three-Way Contract § 2.11.5.2; Cal MediConnect Three-Way Contract § 2.16.3.2; Cal MediConnect Three-Way Contract § 2.16.3.2.4; Cal MediConnect Three-Way Contract § 2.16.3.3.5; Cal MediConnect Three-Way Contract § 2.19.2; Section 1363.5(b)(1)-(5); Rule 1300.70(b)(2)(H) and (G).
#2	**The Plan does not consistently complete enrollees' Health Risk Assessments (HRAs) within required timeframes.** Cal MediConnect Three-Way Contract § 2.8.2; DHCS Dual Plan Letter 13-002.
#3	**The Plan does not consistently document that the quality of care provided is being reviewed, that problems are being identified, and that effective action is taken to improve care where deficiencies are identified.** Cal MediConnect Three-Way Contract § 2.16.2; Cal MediConnect Three-Way Contract § 2.16.3.1; Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A-B).

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

Multiple process improvements have been implemented since early 2015 to address previously identified deficiencies in Plan operations, which were identified during the Department's review of other product lines, and to improve Plan effectiveness, for example:

- A Utilization Management Committee was initiated in August 2015 to provide review of utilization data and oversight of utilization management activities and improvement efforts.
- The Plan's policy for review of potential quality issues (PQIs) was revised.

DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

Deficiency #1: The Plan does not have an effective mechanism to detect underutilization and overutilization of services to assess the quality and appropriateness of care provided to enrollees.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract §2.11.5; Cal MediConnect Three-Way Contract§ 2.11.5.2; Cal MediConnect Three-Way Contract § 2.16.3.2; Cal MediConnect Three-Way Contract § 2.16.3.2.4; Cal MediConnect Three-Way Contract § 2.16.3.3.5; Cal MediConnect Three-Way Contract § 2.19.2; Section 1363.5(b)(1)-(5); Rule 1300.70(b)(2)(H) and (G).

Cal MediConnect Three-Way Contract
2.11.5 Utilization Management
2.11.5.2. These activities shall be done in accordance with Health and Safety Code Section 1363.5 and 28 CCR 1300.70(b)(2)(H) and (G) and 42 C.F.R. § 422.112, 422.152, 422.202, and 422.4.

Cal MediConnect Three-Way Contract
2.16.3.2. The Contractor shall:
2.16.3.2.1. Establish a mechanism to detect both underutilization and overutilization of services and assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Cal MediConnect Three-Way Contract
2.16.3.2.4. Establish internal processes to ensure that the quality management activities for primary, specialty, Behavioral Health services, and LTSS reflect utilization across the Provider Network and include all of the activities in this Section 2.16 of this Contract....

Cal MediConnect Three-Way Contract
2.16.3.3.5. Contractor shall develop an [sic] QI report for submission to DHCS and CMS on an annual basis. The annual report shall include:
2.16.3.3.5.1.1. The collection of aggregate data on utilization;

Section 1363.5(b)(1)-(5)
(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:
(1) Be developed with involvement from actively practicing health care providers.

(2) Be consistent with sound clinical principles and processes.

(3) Be evaluated, and updated if necessary, at least annually.

(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

Rule 1300.70 (b)(2)(H)
A plan that has capitation or risk-sharing contracts must:
2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible underutilization of specialist services and preventive health care services.

Rule 1300.70(b)(2)(G)(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.

Documents Reviewed:

- Plan Policy UM 31: Over-Under Utilization Policy and Procedure (effective 01/01/06; revised 06/10/15)
- Utilization Management Committee Meeting Minutes (08/06/15, 09/22/15, 10/27/15)
- Clinical Quality Committee Minutes (08/19/15, 10/30/15)
- Service Quality Improvement Agenda (09/24/15)
- 2015 Utilization Management Program Description
- 2015 Utilization Management Workplan
- 2015 Quarterly Reports-Inpatient Data/Observation Status Findings
- Inpatient UM Report (Q3 2014 – Q1-2015)
- 2015 Underutilization Intervention (undated)
- Monthly Trends Report (03/09/2015 – 08/9/2015
- Key Healthcare Expense and Budget Indicators (08/15)
- Health Plan of San Mateo Provider Manual

Assessment: While the Plan has had in place a policy and procedure for monitoring underutilization and overutilization since 2006, it has not demonstrated consistent ongoing monitoring of these measures.

Plan Policy UM 31, Over-Under Utilization Policy and Procedure (effective January 1, 2006, and revised June 10, 2015), outlines the process for monitoring and reviewing data, as follows:

1.0 Review

1.1 Utilization metrics are reviewed monthly by the Chief Medical Officer, Deputy Chief Medical Officer, Director of Health

Services, Associate Medical Director and/or the Utilization Management Committee to monitor appropriate utilization of care.

1.2 The Utilization Management Committee regularly reviews several utilization data sets. These data sets include but are not limited to:

- Acute bed days per thousand,
- Admits per thousand,
- ER visits,
- Average length of acute stay,
- Readmission rate, and
- Pharmaceutical utilization
- Members without a primary care provider appointment in the calendar year or the past 9 months

The Plan's 2015 Utilization Management Program Description confirms this Plan policy. The Plan's 2015 Utilization Management Workplan commits the Plan to develop a specific UM policy to track and trend underutilization and overutilization and develop associated indicators by December 31, 2015, but there was no evidence that these activities occurred during the survey review, nor by the time of the Department's onsite visit.

The Department's review of meeting minutes from the Plan's recently established Utilization Management Committee showed intent on the part of the Plan to conduct underutilization monitoring, but there is no evidence that such monitoring took place during the survey review period. The minutes of the Utilization Management Committee's first meeting, on August 6, 2015, document discussion about reports the committee would be looking at, including the need to focus on underutilization, which the Chief Medical Officer stated was a significant problem. The September 22, 2015, meeting minutes do not demonstrate any follow-up discussion regarding underutilization[3]. No additional discussion of the Plan's efforts toward investigating, analyzing, or measuring underutilization was found in the minutes of other committees.

In staff interviews, the Department requested any additional documentation relating to the Plan's process for monitoring underutilization and overutilization; however, the Plan did not provide such information. The Plan's recently hired (April 2015) Chief Medical Officer is committed to increasing the use of data to manage Plan services. The Chief Medical Officer indicated that one area of focus was on underutilization and described the following plan of action, which was discussed in the September 2015 Utilization Committee meeting but not yet fully implemented:

[3] Though outside the review period, the October 27, 2015, meeting minutes (1) document a discussion of those enrollees who had not yet scheduled appointments with their PCPs (primary care providers) in 2015 and (2) indicate that reports were being developed and outreach planned for these enrollees in consultation with the county clinic where they are assigned. The Clinical Quality Committee minutes for October 30, 2015, showed discussion and some planned actions. Topics on the agenda included over and underutilization.

- Identify enrollees without a PCP visit
- Identify enrollees with emergency room visits and/or inpatient admissions
- Identify enrollees needing complex case management
- Initiate outreach calls to enrollees who have not seen their PCPs in 2015

Conclusion: The Plan's MediConnect Three-Way Contract § 2.16.3.2 requires the Plan to establish a mechanism to detect under- and over-utilization. The Contract further requires the Plan to ensure that its quality management activities for primary, specialty, behavioral health services, and LTSS reflect utilization of these services by enrollees. Section 1367.01(j) requires the Plan to develop provisions to assess trends and implement actions to correct identified problems. Rule 1300.70(b)(2)(G)(5) requires the Plan's quality assurance/utilization review mechanism to encompass provider referral and specialist care patterns of practice, including an assessment of timely access to ancillary support services. In a review of Plan documents and in staff interviews, the Department found no evidence that the Plan has adequately monitored over- and under-utilization of services during the survey review period. Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

CONTINUITY OF CARE

Deficiency #2: The Plan does not consistently complete enrollees' Health Risk Assessments (HRAs) within required timeframes.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.8.2; DHCS Dual Plan Letter 13-002.

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

- 2.8.2.3: For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as higher-risk, the Contractor will complete the HRA within forty-five (45) calendar days of enrollment in accordance with DHCS Dual Plan Letter 13-002.
- 2.8.2.4: For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as lower-risk, the Contractor will complete the HRA within ninety (90) calendar days of enrollment in accordance with DHCS Dual Plan Letter 13-002.

DHCS Duals Plan Letter 13-002[4]
B. Health Risk Assessment
MCPs are required to develop a health risk assessment survey tool that will be used to assess an enrollee's current health risk within 45 calendar days of coverage for those identified by the risk stratification mechanism or algorithm as higher risk, and within 90 calendar days of coverage for

[4] Duals Plan Letter 13-002 has been superseded by Duals Plan Letter 15-005. However, Duals Plan Letter 13-002 was in effect during the survey review period and the language is substantially similar.

those identified as lower risk for the purpose of developing individualized care management plans.

Documents Reviewed:

- Plan Policy CC-08: Health Risk Assessment (04/20/15)
- 69 Health Risk Assessment Files (04/01/14 – 07/01/15)

Assessment: The Plan failed to consistently complete HRAs for new enrollees within required timeframes, i.e., within 45 days of enrollment for higher-risk enrollees and within 90 days of enrollment for lower-risk enrollees. Plan Policy CC-08, Health Risk Assessment, sets forth these timeframe requirements and sets forth the procedures the Plan will take to contact newly enrolled members in order to complete the HRAs in a timely fashion.

The Department reviewed 69 HRA files randomly selected from the universe of 2,520 files. The Department found that the Plan took longer than the permitted timeframe (45 days for higher-risk and 90 days for lower-risk) to complete the HRA in 28 of the 69 files (41%). In 6 of the 28 files, the Plan made all required efforts to contact the enrollee, but the enrollee could not be reached; these files were deemed compliant. In 22[5] of the 28 late files (32% of the total 69 sample files), the delays in completing HRAs were attributable to the Plan's failure to conduct timely or adequate outreach (e.g. initial and follow-up phone calls to enrollees, mailing/re-mailing the paper HRA survey). (Eight of these 22 enrollees were initially stratified as higher-risk and 14 enrollees as lower-risk.) In 17[6] of the 22 cases, the Plan did not make its initial contact attempt until <u>after</u> the 45- or 90-day requirement had elapsed. In the remaining five cases, the Plan did not follow up on non-working phone numbers, and the Plan did not re-mail the HRA survey, or was late in doing so.

The Cal MediConnect Three-Way Contract § 2.8.2 and the DHCS Duals Plan Letter 13-002 require the Plan to administer a Health Risk Assessment (HRA) within 45 calendar days of enrollment for higher-risk enrollees and 90 calendar days of enrollment for lower-risk enrollees. The Department found that 22 HRAs (32% of the 69 randomly selected files) were delayed beyond the 45- and 90-day required periods as a result of the Plan's failure to conduct timely or adequate outreach. Therefore, the Department finds the Plan in violation of this contractual requirement.

[5]Files #4 (ID 2002), #7 (ID 1911), #12 (ID2520), #13 (ID 1965), #15 (ID 2493), #21 (ID 1750), #23 (ID 2406), #26 (ID 2272), #27 (ID 1373), #28 (ID 2218), #30 (ID 1733), #32 (ID 2413), #34 (ID 1992), #38 (ID 2379), #48 (ID 2110), #49 (ID 1858), #51 (ID 1524), #52 (ID 2433), #54 (ID 1821), #63 (ID 2127), #65 (ID 1427), #67 (ID 2019).
[6] All 17 files exceeded 120 days from enrollment to HRA completion; 11 exceeded a year.

TABLE 1

Timely Completion of the Health Risk Assessment

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	
Health Risk Assessment (HRA)	69	Timely completion of the HRA following enrollment	47 (68%)	22 (32%)

QUALITY MANAGEMENT

Deficiency #3: The Plan does not consistently document that the quality of care provided is being reviewed, that problems are being identified, and that effective action is taken to improve care where deficiencies are identified.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.16.2.; Cal MediConnect Three-Way Contract § 2.16.3.1.

Cal MediConnect Three-Way Contract
2.16.2 Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system through on-going analysis, evaluation and systematic enhancements …

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

Documents Reviewed:

- Plan Policy QI-03: Review and Handling of Quality of Care Complaints and Concerns, (revised 06/30/15)
- 32 Potential Quality Issue Files (04/01/14 – 07/01/15)

Assessment: The Plan could not demonstrate that it had a process in place for identifying and investigating Potential Quality Issues (PQIs) related to the provision of Medicaid-based services during the first five months (November 1, 2014, through March 31, 2015) of the 12-month survey review period. As a result, the Plan failed to consistently review care, identify problems,

take effective action and improve care upon identifying problems, and follow up as indicated during this timeframe.

The Department requested a list of all PQI cases identified and reviewed by the Plan during the survey review period (November 1, 2014, through September 30, 2015). The Department found that no PQIs (for Cal MediConnect nor for other lines of business) had been identified and reviewed by the Plan during the first five months of the review period (November 2014 through March 2015). The Plan's Chief Medical Officer confirmed this finding, stating in interviews, "the Plan had no process for PQI identification and review until April 2015."

Plan Policy QI-03, Review and Handling of Quality of Care Complaints and Concerns, describes the process for addressing PQIs, which the Plan defines as "suspected deviations from expected provider performance, clinical care, or outcome of care, which require further investigation to determine whether an actual quality issue or opportunity for improvement exists." The Plan describes a quality issue as "a confirmed deviation from expected provider performance, clinical care, or outcome of care, which has been determined through the PQI process to be inconsistent with professionally recognized standards of care." In June 2015, the Plan revised this policy to enhance and incorporate all required elements of PQI review. The Plan began identifying PQI cases in April 2015.

While the Plan did not identify or investigate PQIs during the first five months of the survey review period, it identified 90 PQIs for all of its lines of business combined[7], beginning in April 2015 through September 2015. Of these 90 PQIs, the Department randomly selected and reviewed 32 files and determined that the Plan's handling of PQIs for this timeframe was consistent with Policy QI-03. However, the Plan was unable to distinguish which of the 32 files were specifically Cal MediConnect cases.

The Cal MediConnect Three-Way Contract § 2.16.2 requires the Plan to apply the principles of CQI to all aspects of its service delivery system through ongoing analysis, evaluation, and systematic enhancement. Further, § 2.16.3.1 requires the Plan to maintain a quality improvement organizational and programmatic structure that supports the application of the principles of CQI throughout the service delivery system. The Department found that the Plan did not identify PQIs and did not have an effective policy and procedure for identification and review of these issues until April 2015. The Plan's failure to address potential quality issues prior to April may have enabled problems to continue or recur among its providers throughout this period, negatively affecting the quality of care delivered to its enrollees; therefore, the Department finds the Plan in violation of these requirements.

TABLE 2

Potential Quality Issues

[7] The Plan was unable to distinguish lines of business in its PQI listing.

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
PQI 11/14-3/15	NONE AVAILABLE	Identification, investigation and resolution of PQIs	0%	100%

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Porscha Brink	Medical Survey Team Lead
MANAGED HEALTH UNLIMITED TEAM MEMBERS	
Maureen Plumstead, RN	Utilization Management Surveyor
Roger Diemert, MD	Continuity of Care Surveyor
Madeline Hommel, MPH	Availability & Accessibility Surveyor
Cliff Ridenour, LCSW	Member Rights Surveyor
Roger Diemert, MD	Quality Management Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED	
Maya Altman	CEO
Ron Robinson	CFO
Khoa Nguyen	Director for Strategy & Business Support Services
Margaret Beed, M.D.	CMO
Chris Esguerra, M.D.	Deputy CMO
Ian Johansson	Compliance Officer
Carolyn Thon	Director of Member Services & Outreach
Ed Ortiz	Director of Provider Network Development & Services
Matt Javaheri	Claims Director
Barrie Cheung	Pharm.D, Pharmacy Services Manager
Gabrielle Ault-Riche	Grievance & Appeals Manager
Nicole Ford	Quality Manager
Jimmy Holman	Compliance Manager
Jose Santiago	Member Services/CareAdvantage Manager
Barbara Crawford	Claims Quality Assurance Manager
Anita Harris	Claims Resources Manager
Richard Cleofas	R.N., Utilization Review Nurse

APPENDIX C. LIST OF FILES REVIEWED

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

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Standard Grievances	2	The Plan identified a universe of 2 files during the review period. The Department reviewed 2 files.
Expedited Grievances	1	The Plan identified a universe of 1 file during the review period. The Department reviewed1 file.
Potential Quality Issues	32	The Plan identified a universe of 90 files during the review period. A random sample of 32 files were reviewed.
Health Risk Assessments	69	The Plan identified a universe of 2,520 files during the review period. Based on the Department's File Review Methodology, a random sample of 69 files were reviewed.
Individual Care Plans	69	The Plan identified a universe of 2,520 files during the review period. Based on the Department's File Review Methodology, a random sample of 69 files were reviewed.