

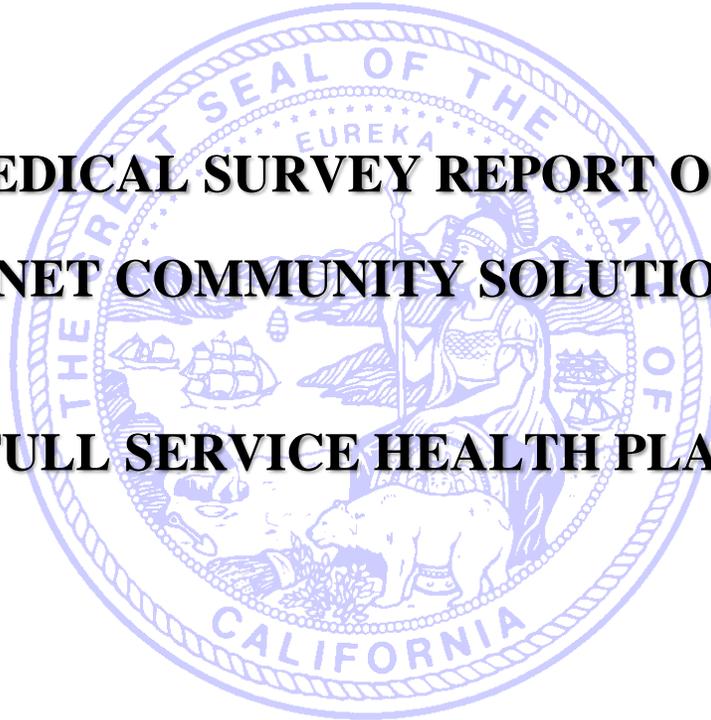
DEPARTMENT OF  
**Managed  
Health Care  
Help Center**

**DIVISION OF PLAN SURVEYS**

**CAL MEDICCONNECT**

**MEDICAL SURVEY REPORT OF  
HEALTH NET COMMUNITY SOLUTIONS, INC.**

**A FULL SERVICE HEALTH PLAN**



**DATE ISSUED TO DHCS: DECEMBER 30, 2015**

**Cal MediConnect Medical Survey Report  
Health Net Community Solutions, Inc.  
A Full Service Health Plan  
December 30, 2015**

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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 Inter-agency Agreement<sup>1</sup> 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 February 27, 2015, the Department notified Health Net Community Solutions, Inc. (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 May 4, 2015 through May 8, 2015<sup>2</sup>.

### SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreement, the Department provides the Cal MediConnect Medical Survey Report to the DHCS. The Report identifies potential deficiencies in Plan operations supporting the provision of Medicaid-based services for the Cal MediConnect population. This medical survey evaluated the following elements specifically related to the Plan’s delivery of care to the Cal MediConnect population as delineated by the Plan’s applicable three-way contract with DHCS and CMS (the Cal Medi Connect Three-Way Contract) , the Knox-Keene Health Care Service Plan Act of 1975 (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, policies, and 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.

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

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

## **II. Continuity of Care**

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

## **III. Availability and Accessibility**

The Department evaluated Plan operations to ensure that its Medicaid-based services are accessible and available to enrollees throughout its service areas within reasonable timeframes, and that the Plan addresses reasonable patient requests for disability accommodations or grievances made by individuals who experience difficulty accessing services due to a disability.

## **IV. Member Rights**

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

## **V. Quality Management**

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, and implements corrective action to improve quality of care with respect to the provision of Medicaid-based services. The Department also evaluated the Plan's system and processes related to quality improvement and quality management, including its oversight of any delegated quality management responsibilities or processes.

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

## **SUMMARY OF FINDINGS**

The Department identified five (5) potential deficiencies during the current medical survey.

## 2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES

<b>CONTINUITY OF CARE</b>	
<b>#1</b>	<p><b>The Plan does not conduct adequate oversight to ensure that its contracted vendor utilizes the Plan’s Health Risk Stratification data to schedule and administer Health Risk Assessments within required timeframes.</b></p> <p>Cal MediConnect Three-Way Contract § 2.8.1; Cal MediConnect Three-Way Contract § 2.8.2; Cal MediConnect Three-Way Contract § 2.8.2.3-4; Cal MediConnect Three-Way Contract § 2.9.9.2; DHCS Duals Plan Letter 13-002.</p>
<b>#2</b>	<p><b>The Plan does not consistently utilize a process to identify an enrollee’s need for an Individualized Care Plan (ICP), or develop the ICP within 30 working days of HRA completion.</b></p> <p>Cal MediConnect Three-Way Contract § 2.8.3; Cal MediConnect Three-Way Contract § 2.8.3.1; Duals Plan Letter 13-004.</p>
<b>MEMBER RIGHTS</b>	
<b>#3</b>	<p><b>The Plan does not consistently identify clinical concerns in Plan grievance files and refer them to qualified clinical staff for review.</b></p> <p>Cal MediConnect Three-Way Contract § 2.14.2; Cal MediConnect Three-Way Contract § 2.14.2.1.1; Cal MediConnect Three-Way Contract § 2.16.2.5-6; Cal MediConnect Three-Way Contract § 2.16.3.1; Cal MediConnect Three-Way Contract § 2.16.3.2.6.3; Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A)(B).</p>
<b>QUALITY MANAGEMENT</b>	
<b>#4</b>	<p><b>The Plan does not consistently document that it identifies and appropriately categorizes quality of care problems, and takes effective action to improve care.</b></p> <p>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).</p>
<b>UTILIZATION MANAGEMENT</b>	
<b>#5</b>	<p><b>The Plan’s written communications to a requesting physician or other health care provider of a denial, delay, or modification of a request do not include the name of the health care professional responsible for the denial, delay, or modification.</b></p> <p>Cal MediConnect Three-Way Contract § 2.11.4.5; Cal MediConnect Three-Way Contract § 2.11.6.5; Section 1367.01(h)(4).</p>

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

- One of the identified strengths of the Plan is its implementation of strong educational outreach efforts to contracted providers, including regular video conferences.
- The Plan currently provides Cal MediConnect benefits within Los Angeles and San Diego counties to approximately 23,000 dual eligible enrollees. External vendors are used to conduct specific functions, such as completion of Health Risk Assessments (HRAs) for low risk enrollees, but the Plan completes HRAs and provides case management for enrollees with needs that are more complex. Medicaid Long Term Services and Supports such as County Based Behavioral Health Services, In Home Supportive Services, and the Multipurpose Senior Services Program are also provided by contracted entities.

## DISCUSSION OF POTENTIAL DEFICIENCIES

### CONTINUITY OF CARE

**Potential Deficiency #1: The Plan does not conduct adequate oversight to ensure that its contracted vendor utilizes the Plan's Health Risk Stratification data to schedule and administer Health Risk Assessments within required timeframes.**

**Contractual/Statutory/Regulatory Reference(s):** Cal MediConnect Three-Way Contract § 2.8.1; Cal MediConnect Three-Way Contract § 2.8.2; Cal MediConnect Three-Way Contract § 2.8.2.3-4; Cal MediConnect Three-Way Contract § 2.9.9.2; DHCS Duals Plan Letter 13-002.

#### Cal MediConnect Three-Way Contract

2.8.1. Risk Stratification. Contractor will use an approved health risk stratification mechanism or algorithm to identify new Enrollees with high risk and more complex health care needs. The health risk stratification shall be conducted in accordance with DHCS DPL 13-002.

#### 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.

#### Cal MediConnect Three-Way Contract

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

#### DHCS Duals Plan Letter 13-002<sup>3</sup>

##### A. Risk Stratification

No sooner than 60 days prior to new enrollee coverage, DHCS and/or CMS will electronically transmit historical Medicare and Medi-Cal FFS utilization and other data to the MCPs for use in their stratification process. These data may include, but are not limited to, Medicare Parts A, B, and D, Medi-Cal FFS, Medi-Cal In-Home Supportive Services (IHSS), Multipurpose Senior

<sup>3</sup> Duals Plan Letter 13-002 has been superseded by Duals Plan Letter 15-005. Duals Plan Letter 13-002 was in effect during the relevant time-period.

Services Program (MSSP), Skilled Nursing Facility (SNF), behavioral health pharmacy, and outpatient, inpatient, emergency department, pharmacy, and ancillary services, for up to the most recent 12 months.

MCPs are required to establish a risk stratification mechanism or algorithm designed for the purpose of identifying newly enrolled members who are considered higher or lower risk. Higher risk for risk stratification purposes means enrollees who are at increased risk of having an adverse health outcome or worsening of their health status if they do not receive their initial contact by the MCP within 45 calendar days of coverage date.

By analyzing the historical data provided, each MCP will identify higher risk as an enrollee who, at a minimum meets any one of the following criteria:

- Has been on oxygen within the past 90 days.
- Has been hospitalized within the last 90 days, or has had three or more voluntary and/or involuntary hospitalizations within the past year.
- Has had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases).
- Has IHSS greater than or equal to 195 hours/month.
- Is enrolled in MSSP.
- Is receiving Community Based Adult Services (CBAS).
- Has End Stage Renal Disease, Acquired Immunodeficiency Syndrome, and/or a recent organ transplant.
- Has cancer, currently being treated.
- Has been prescribed anti-psychotic medication within the past 90 days.
- Has been prescribed 15 or more prescriptions in the past 90 days.
- Has other conditions as determined by the MCP, based on local resources.

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

#### Documents Reviewed:

- Plan Policy CC-1: HRA P&P\_CMC (03/19/15)
- Plan Policy CC-6: Stratification Methodology\_CMC (03/18/15)
- 40 Health Risk Assessment (HRA) files (04/01/2014 – 01/31/15)
- CMC\_Optum\_Critical\_issue\_focus

**Assessment:** The Plan was unable to demonstrate that it conducts oversight to ensure its vendor uses each enrollee's risk stratification data to schedule and complete the administration of the Health Risk Assessment (HRA) within required timeframes. The Cal MediConnect

Three-Way Contract requires that the Plan utilize historical data sources to categorize an enrollee's risk level, through "an approved health risk stratification mechanism or algorithm to identify new Enrollees with high risk and more complex health care needs." (Three-Way Contract § 2.8.1.) Based upon the results of that stratification, DHCS Duals Plan Letter 13-002 requires that an HRA be administered "within 45 calendar days of coverage for those identified ... as higher risk, and within 90 calendar days of coverage for those identified as lower risk for the purpose of developing individualized care management plans." Plan policy, CC-1 (Health Risk Assessment-Cal MediConnect) conforms to these requirements. Plan Policy CC-6 (Stratification Methodology CMC) further describes the Plan's protocol for pre-enrollment stratification of enrollees as either high- or low-risk based on historical utilization data. The Plan remains accountable if it delegates any of these responsibilities, and it must evaluate and oversee the delegated entity to ensure that it performs the required functions. (Cal MediConnect Three-Way Contract § 2.9.9.2.)

The Plan failed to evaluate and oversee its contracted vendor's HRA process. During the review period, the Plan contracted with a vendor to administer HRAs to new enrollees within 45 days of enrollment for those deemed high-risk during the initial risk stratification process and within 90 days for new enrollees deemed at low-risk (CMC\_Optum\_Critical\_issue\_focus). However, the Plan did not monitor or ensure that the vendor complied with the Plan's contractual requirement to use the results of pre-enrollment stratification to determine the timeline for completion of the Health Risk Assessment (HRA). During Plan interviews, staff stated that they did not complete any oversight activities to ensure that the contracted vendor completed HRAs in a timely manner, using the appropriate stratification data. (See § 2.9.9.2 of the Cal MediConnect Three-Way Contract.)

The Department's review of the Plan's HRA files also contained no information demonstrating that it implemented HRA completion deadlines based on the appropriate risk stratification analysis. The Department reviewed 40 files of enrollees identified for HRAs to determine whether the HRAs were timely, based on the appropriate risk stratification data. In three cases, no HRA was necessary because the enrollee termination date was listed as the same date as the enrollment. In the remaining 37 files, risk stratification data was not consistently present for use in establishing timeframes. Twelve of the 37 files (32%) included no documentation of risk level and six (16%) were listed as "moderate," a category that does not exist under the DHCS Duals Plan Letter 13-002.

The lack of oversight may have contributed to HRAs not being completed timely. Of the 37 files, one case was clearly labeled as high-risk and, because an HRA was not completed until 60 days after enrollment, the case was non-compliant. In five additional cases compliance could not be substantiated. All extended more than 45 days from enrollment to HRA completion. Three of the five cases contained no documentation of risk stratification; therefore, it was unclear whether the 45-day or the 90-day timeframe was applicable. Two of the five cases were categorized by the vendor as "moderate." Because this category does not exist, it was unclear whether the 45-day or the 90-day timeframe was applicable. These five files contained inadequate documentation to identify and assess whether the vendor used the initial risk stratification rankings to determine the timeline for HRA completion. Plan staff stated in interviews that initial stratification rankings are available to the vendor through an online daily

data upload. However, there was no evidence in the files that the vendor used these pre-enrollment stratification rankings to complete its HRAs. The 37 files reviewed contained no indication that these rankings, or any other risk stratification ranking information, factored in to the vendor’s HRA completion objectives.

**Conclusion:** The Plan’s Cal MediConnect Three-Way Contract requires that the Plan use an approved health risk stratification to classify members as high and low risk. Additionally, Three-Way Contract § 2.8.2.3-4 and the DHCS Duals Plan Letter 13-002 require that, based on this stratification, an HRA be administered within 45 calendar days for high risk enrollees and 90 calendar days for low risk enrollees. The Plan conducted no oversight activities to ensure that the vendor completed HRAs using the required stratification data, and within the timeframes required by the Three-Way Contract, in violation of its obligations under the Cal MediConnect Three-Way Contract, § 2.9.9.2. Therefore, the Department finds the Plan in violation of this requirement.

**TABLE 1**  
**HRA File Review Results**

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Health Risk Assessment (HRA)	37	The Plan’s oversight of vendor implementation of initial risk stratification rankings, used in determining the appropriate timeline for HRA completion	0 (0%)	37 (100%)

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**Potential Deficiency #2: The Plan does not consistently utilize a process to identify an enrollee’s need for an Individualized Care Plan (ICP), or develop the ICP within 30 working days of HRA completion.**

**Contractual/Statutory/Regulatory Reference(s):** Cal MediConnect Three-Way Contract § 2.8.3; Cal MediConnect Three-Way Contract § 2.8.3.1; Duals Plan Letter 13-004.

Cal MediConnect Three-Way Contract

2.8.3. Individualized Care Plan (ICP). An ICP will be developed for each Enrollee that includes Enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs. It must include timeframes for reassessment. See Section 2.5.1.9.

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

### Duals Plan Letter 13-004<sup>4</sup>

#### A. Individual Care Plan

1. Should a need for a Care Plan be demonstrated by the member, the MMP will develop a plan and engage the member and/or his or her representative(s) in its design. This Care Plan is the responsibility of the MMP and is separate and distinct from the medical care plan which is created, established, and maintained by the member's primary care provider. a. A need for a Care Plan may be identified by the MMP through interactions with the member (e.g. when conducting the Health Risk Assessment [HRA]), stratifying members into lower and higher-risk categories (e.g. through the HRA risk-stratification process), and any other appropriate interactions.

#### **Documents Reviewed:**

- Plan Policy #CC-1: HRA P&P\_CMC (03/18/15)
- Plan Policy #CC-6: Development, Implementation and Monitoring of the Case Management Plan of Care - CMC
- Plan Policy FS1127-92015: Interdisciplinary Care Team Coordination of Care – Cal MediConnect (03/19/15)
- 40 Health Risk Assessment (HRA) files (04/01/14 – 01/31/15)
- 40 Individual Care Plan (ICP) files (04/01/2014 – 01/31/15)

**Assessment:** The Plan was unable to demonstrate that it timely develops an Individualized Care Plan (ICP) for each enrollee with an identified need for one, due to the enrollee's risk category, enrollee interactions, or other appropriate criteria. DHCS Duals Plan Letter 13-004 and Cal MediConnect Three-Way Contract Section 2.8.3, require the Plan to develop an ICP "for each enrollee that includes enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs. It must include timeframes for reassessment ... within thirty (30) working days of HRA completion." (Cal MediConnect Three-Way Contract § 2.8.3 and § 2.8.3.1.) DHCS Duals Plan Letter 13-004 instructs that the "need for a Care Plan may be identified . . . [by the Plan] through interactions with the member (e.g. when conducting the Health Risk Assessment [HRA]), stratifying members into lower and higher-risk categories (e.g. through the HRA risk-stratification process), and any other appropriate interactions."

Consistent with these requirements, Plan Policy CC-1 (HRA P&P\_CMC) states that each enrollee "has an individual care plan established based upon the [HRA] assessment and other information available." Plan Policy FS1127-92015 (Interdisciplinary Care Team Coordination of Care – Cal MediConnect) defines Individualized Care Plan/Care Plan as the "plan of care developed by an enrollee and an enrollee's Interdisciplinary Care Team or health plan." This policy further describes the Interdisciplinary Care Team as including participation from the Plan's Care Coordinator, the Primary Care Physician, the enrollee and other providers at the enrollee's discretion.

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<sup>4</sup> Duals Plan Letter 13-004 has been superseded by Duals Plan Letter 15-001. Duals Plan Letter 13-004 was in effect during the relevant time-period.

The Plan’s HRA and ICP files did not consistently demonstrate timely ICPs based on an established needs assessment process. The Department reviewed 40 enrollee files identified for HRAs and ICPs. In 12 files, the enrollee terminated enrollment prior to the 30 working day timeframe permitted to develop an ICP. (Cal MediConnect Three-Way Contract § 2.8.3.1.) These 12 files were eliminated from consideration. Of the remaining 28 files, 16 files (57%) were deemed timely as follows: 12 files showed evidence of ICP completion within 30 working days of the HRA. In one file, the enrollee declined care management. In three files, the Plan made multiple unsuccessful attempts to contact the enrollee in accordance with the appropriate processes and timeframes outlined in DPL 13-002.

The remaining 12 files contained untimely ICPs, or did not contain sufficient information to assess compliance with the Plan’s contractual obligations to evaluate the need for an ICP. These 12 files were deemed non-compliant. In two files, the Plan failed to provide sufficient information to assess ICP completion dates (one file showed an HRA completion date but, while ICP issues were identified, there was no completion date for the ICP; the other file showed a completed HRA but the only notation in the file for the ICP stated “no file received.”) In four files, the enrollee remained in the Plan for more than 30 working days but no ICP was completed. None of these four files contained documentation of an assessment of the need for a care plan, or that the enrollee declined care management or individual care team assistance. In six files, the need for an ICP was identified, and an ICP was completed, but not within the required 30 working days; completion dates ranged from 2 months to 6 months.

**Conclusion:** The Cal MediConnect Three-Way Contract § 2.8.3.1, requires that the Plan develop an ICP within 30 working days of completion of an enrollee’s HRA. DHCS Duals Plan Letters 13-004 and 15-001 outline the process that plans must use to assess the need for an ICP. In 12 of 40 files that the Department reviewed, ICPs were either not completed and the files did not contain appropriate documentation that an ICP was not needed, or the ICPs were completed outside the required timeframe. The Plan completed untimely ICPs, and also failed to utilize a valid process to identify the need for ICPs. This violated the Three-Way Contract, Duals Plan Letter 13-004, and the Plan’s own policy. Therefore, the Department finds the Plan in violation of its contractual requirements.

**TABLE 2**  
**ICP File Review Results**

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Individualized Care Plan (ICP)	28	Completion of ICPs within 30 working days of completion of the Health Risk Assessment (HRA)	12 (43%) ICP completed within 30 working days	4 (14%) no evidence of ICP
			1 (4%) enrollee declined	2 (7%) insufficient information in file to evaluate
			3 (11%) Plan made	6 (21%) ICP

			multiple unsuccessful attempts to contact enrollee	completed but beyond the required timeframe
TOTAL			16 (57%)	12 (43%)

**MEMBER RIGHTS**

**Potential Deficiency #3: The Plan does not consistently identify clinical concerns in Plan grievance files and refer them to qualified clinical staff for review.**

**Contractual/Statutory/Regulatory Reference(s):** Cal MediConnect Three-Way Contract § 2.14.2; Cal MediConnect Three-Way Contract § 2.14.2.1.1; Cal MediConnect Three-Way Contract § 2.16.2.5-6; Cal MediConnect Three-Way Contract § 2.16.3.1; Cal MediConnect Three-Way Contract § 2.16.3.2.6.3; Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A)(B).

Cal MediConnect Three-Way Contract

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

- 2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, pursuant to the Knox-Keene Health Care Services Plan Act of 1975, WIC Section 14450 and CCR, Title 22, Section 53260.

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 ongoing analysis, evaluation and systematic enhancements based on:

- 2.16.2.5. Issues identified by the Contractor, DHCS and/or CMS; and
- 2.16.2.6. Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health services and LTSS.

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.

- 2.16.3.2.6.3. Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, appeals and grievances and utilization management.

#### Rule 1300.70(a)(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.

#### Rule 1300.70(b)(1)(A)(B)

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.

#### **Documents Reviewed:**

- Plan Policy MR-34: Member Appeal CMC (01/07/15)
- Plan Policy MR-26: A&G Timelines CMC (01/07/2015)
- Plan Policy MR-1: Medi-Cal Grievance P&P (12/18/14)
- 8 standard grievance files (04/01/14 – 01/31/15)
- 1 exempt grievance file (04/01/14 – 01/31/15)
- Plan Policy MR-25\_2014LA\_EOC Chap 9\_CMC, pages 19, 33, 35
- Plan Policy MR-25\_2014SD\_EOC Chap 9\_CMC, pages 19, 33, 35
- Plan Policy MR-25\_2015LA\_EOC Chap 9\_CMC, pages 17, 30, 32
- Plan Policy MR-25\_2015SD\_EOC Chap 9\_CMC, pages 17, 30, 32

**Assessment:** The Plan failed to consistently identify clinical quality concerns in its grievance files and refer them to qualified clinical staff for review and potential corrective actions.

Cal MediConnect Three-Way Contract, § 2.14.2 requires the Plan to “have a system in place for addressing Enrollee grievances, including grievances regarding reasonable accommodations and access to services under the ADA.” Section 2.16.3.2.6.3 of the Three-Way Contract, which addresses the Plan’s quality improvement activities, specifies that the Plan’s policies and procedures, “document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, appeals and grievances ....” Section 2.16.3.1 further specifies that the Plan’s Quality Improvement Program “shall meet the quality management and improvement criteria described in the most current NCQA health plan

accreditation requirements in 28 CCR Section 1300.70.” This criteria includes a requirement that the Plan “document that problems are being identified, that effective action is taken to improve care where deficiencies are identified” and that “quality of care problems are identified and corrected for all provider entities”.

The Plan’s grievance policy describes its process for handling grievances that include a potential clinical quality of care issue by stating:

Grievance processing varies based on whether the member’s grievance is an Administrative Grievance or Clinical Grievance. Health Net investigates the substance of all grievances, including any clinical aspects [RR3.A.2]. PQI issues are internally investigated using the plan’s grievance investigation protocols.

Plan Policy MR-1 (Medi-Cal Grievance) states, “The Intake Specialist shall immediately refer any Clinically Urgent quality of care grievance case to the A&G Clinical Specialist II (A&G Nurse)” and non-urgent quality of care grievances are “assigned to a Case Coordinator for handling.”

The Department reviewed nine grievance files: eight standard grievances and one exempt grievance. The exempt grievance file did not involve a quality of care concern. Of the eight standard grievance files, five contained potential quality issues (PQIs) that merited review by clinical professionals. One of these five files was removed from the Department’s consideration because it did not pertain to a Cal MediConnect Medicaid-based service. In two of the four remaining files, the Plan did not identify the clinical concerns and refer them to qualified clinical staff for review. In one instance, this was explained, because the enrollee did not provide the provider’s name, date of service, or other information relevant to the grievance. Plan staff attempted to contact the enrollee on three occasions but were unsuccessful in obtaining additional information and could not proceed with the case. Therefore, the Plan’s handling of one (25%) of the four files meriting clinical review was deficient.

**TABLE 3**  
**Grievances and Appeals Findings**

<b>FILE TYPE</b>	<b>NUMBER OF FILES REVIEWED</b>	<b>FILES CONTAINING QUALITY OF CARE CONCERNS MERITING CLINICAL REVIEW</b>	<b>REMAINING FILES CONTAINING QUALITY OF CARE CONCERNS AFTER EXCLUDED FILES</b>	<b>COMPLIANT</b>	<b>DEFICIENT</b>
Standard Grievances	8	5	4	3 (75%)	1 (25%)
Exempt Grievances	1	0	N/A	N/A	N/A

- *File #4:* This grievance pertained to an incident that occurred during an enrollee's transport by a Plan vendor. The enrollee stated that the driver pushed her foot under her wheelchair when transferring her to the vehicle. The enrollee sought medical treatment for the injuries sustained to her foot, including an x-ray to determine if her foot was broken, and antibiotics to treat the resultant infection. The vendor's incident report, which was submitted to the Plan, stated that the driver who transported the member was a non-credentialed driver. Because the grievance involved an incident that resulted in an injury requiring medical treatment, the grievance should have undergone clinical review. (See Three-Way Contract, § 2.14.2.1.2.6.2; Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A)(B).) Although the Plan sent timely acknowledgement and resolution letters to the enrollee, it did not refer the case for further review by clinical personnel; therefore, the Plan did not thoroughly investigate the clinical issue. There is no evidence that the Plan imposed corrective action on the vendor to address use of non-credentialed drivers. (Three-Way Contract, Appendix C.)

**Conclusion:** The Cal MediConnect Three-Way Contract section 2.16.3.2.6.3 requires that the Plan implement policies and procedures, including those pertaining to grievances, to ensure quality of clinical care. The Department found that one (1) of the four (4) relevant grievance files (25%) contained evidence of potential quality of care issues, and the Plan did not refer the case to its Quality Management Department for investigation and review by clinical personnel, as required by section 2.14.2.1.2.6 of the Three-Way Contract. In the absence of clinical review of all cases that involve potential quality issues, the Plan cannot ensure that it delivers to all enrollees a level of care which meets professionally recognized standards of practice. Additionally, because the Plan does not ensure that files undergo thorough clinical review to identify any quality of care problems, the Plan cannot ensure that effective action is taken to improve care for any existing deficiencies as required by Rule 1300.70(a)(1) and Rule 1300.70(b)(1)(B). Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

## QUALITY MANAGEMENT

**Potential Deficiency #4: The Plan does not consistently document that it identifies and appropriately categorizes quality of care problems, and takes effective action to improve care.**

**Contractual/Statutory/Regulatory Reference(s):** 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).

### 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 ongoing 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.

### Rule 1300.70(a)(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.

### Rule 1300.70(b)(1)(A)(B)

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.

### **Documents Reviewed:**

- Plan Policy #FB222-13540: Follow Up on Quality of Care Concerns (11/6/14)
- Two (2) files for cases identified by the Plan as potential quality issues (PQIs) (April 1, 2014 – January 31, 2015)

**Assessment:** The Plan did not adequately review and investigate the quality of care delivered by its providers. The Plan identified two PQI files during the survey period. One of the two files was removed from the Department's consideration because it did not pertain to a Cal MediConnect Medicaid-based service. In the remaining file, the Plan did not adequately investigate to ensure that it identified, appropriately leveled, and followed up on all existing problems to ensure correction.

The Plan is required by its Cal MediConnect Three-Way Contract § 2.16.3.1 to “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 ... 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.” The Cal MediConnect Three-Way Contract § 2.16.3.1 incorporates the quality management and improvement criteria from Rule 1300.70, which requires that “effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.” Similarly,

Rule 1300.70(b)(1)(A)(B) requires that “quality of care problems are identified and corrected for all provider entities.”

Plan Policy #FB222-13540, Follow Up on Quality of Care Concerns, acknowledges these requirements and establishes a process for addressing potential quality issues:

Potential Quality Issues (PQI): A reported potential or suspected deviation from expected performance, a clinical outcome which cannot be determined or be justified without additional evaluation and review. Health Net defines a PQI as an identified or discovered event by a Health Net Associate and/or the Plan’s providers and practitioners ... PQIs are initially reviewed by The RN, and referred to Health Net Medical Directors, as appropriate.

...Quality of Care Grievances are investigated through the Plan’s Member Grievance and Appeal processes and result in an issue determination. Member Quality of Care Grievances are received, reviewed, addressed and processed within the Plan’s Grievance and Appeal Department in a timely manner consistent with applicable State regulatory requirements...

When a Quality of Care issue determination is decided, each concern is ranked based on the severity of the adverse outcome, enrollee damages sustained or the level of incompetence of the performance:

A/G Clinical Specialists II may only determine Outcome Severity Levels<sup>5</sup> of 0 and 1 ... the A/G Clinical Specialist II has questions, or is unable to determine the Outcome Severity Level at the 0 or Level 1, the RN will forward the prepared case file to the Health Net Medical Director for review, determination and Outcome Severity Leveling.

All other issues/cases must be referred to a Health Net Medical Director for Outcome Severity Leveling ...

Upon determination of the Outcome Severity Level, Health Net proceeds with improving the Quality of Care and service provided to its enrollees by following-up on the issue(s) identified. Follow-up actions are commensurate with the Outcome Severity Leveling.

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<sup>5</sup> The Plan classifies cases into five Outcome Severity Levels based upon its reviews.  
Level 0 (e.g., no quality of care issue, issue cannot be validated...from available records)  
Level 1 (e.g., known complication not due to negligence; error caught before significant problem)  
Level 2 (e.g., temporary injury or outcome; side effect from medications with no injury)  
Level 3 (e.g., clinical judgment impacting care with mild to moderate adverse outcome)  
Level 4 (e.g., major permanent injury/grave permanent injury; most serious injury; death)  
Follow-up actions are commensurate with the Outcome Severity Leveling (e.g., Levels of 0 or 1 tracked and trended). Levels of 2, 3, or 4 are initially addressed by Medical Director, who may issue an education letter or request a CAP. For Levels 3 or 4, the Medical Director will refer the case directly to the Plan’s Peer Review Committee.

In the one PQI file reviewed by the Department, the Plan did not adequately investigate to ensure that it identified, appropriately leveled, and followed up on all existing problems to ensure correction:

- *File #MCR*: This grievance was initiated by an enrollee’s daughter who expressed concern that her parent became “delirious” after receiving methadone and sedatives at a skilled nursing facility. The Plan rated the grievance at Level 0, reflecting no potential quality of care issue. Leveling was performed without any evidence that an investigation was conducted to determine the cause of the delirium, which could have been due to an overdose of medication, incorrect medication administered, or another reason. There is no evidence that the Plan attempted to gather information from the facility prior to rating the grievance.

Without further investigation, the Plan did not level the grievance appropriately according to Plan Policy #FB222-13540: Follow Up on Quality of Care Concerns (11/6/14).

**Conclusion:** In the one relevant case file that the Plan identified as a potential quality issue, the Plan did not identify or properly level potential problems, and did not effectively take action to improve care as required by its Cal Medi-Connect Contract sections 2.16.2 and 2.16.3.1, by Rule 1300.70(a)(1) and Rule 1300.70(b)(1)(A)(B), and by its own policy. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

**TABLE 4**  
**PQI File Review Results**

<b>FILE TYPE</b>	<b>NUMBER OF FILES</b>	<b>ELEMENT</b>	<b>COMPLIANT</b>	<b>DEFICIENT</b>
Potential Quality Issue	1	Identification of all existing quality of care problems	0 (0%)	1 (100%)

**UTILIZATION MANAGEMENT**

**Deficiency #5:** The Plan’s written communications to a requesting physician or other health care provider of a denial, delay, or modification of a request do not include the name of the health care professional responsible for the denial, delay, or modification.

**Contractual/Statutory/Regulatory Reference(s):** Cal MediConnect Three-Way Contract § 2.11.4.5; Cal MediConnect Three-Way Contract § 2.11.6.5; Section 1367.01(h)(4).

Cal MediConnect Three-Way Contract

2.11.4.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261...

Cal MediConnect Three-Way Contract

2.11.6.5. 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 fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee'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 Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

Section 1367.01(h)(4)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

**Documents Reviewed:**

- Plan Policy #UMCM-207: MediCal: Denial, Modification or Deferral of Services for Lack of Medical Necessity (12/19/14)

- Plan Policy #UMCM 209ML: MediCal: Precertification and Prior Authorization (12/19/14)
- Plan Policy LR48-15519: CBAS Providers: Coordination with Community Based Adult Services (10/03/14)
- 2 utilization management (UM) denial files (for the period 12/01/15 – 01/31/15)

**Assessment:** The Plan’s prior authorization request denial notices to providers failed to include the name and telephone number of the health care professional responsible for the denial, delay, or modification of an authorization request. This requirement is outlined in the Cal MediConnect Three-Way Contract § 2.11.4.5, and § 2.11.6.5, referencing Section 1367.01. The Plan further adopted this requirement in a policy, stating that notification will be provided “as specified in . . . Health and Safety Code 1367.01.” (Policy UMCM 209ML.)

The Three-Way Contract requires the Plan to provide requesting providers and enrollees with a “written notice of [a] any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.” (Three-Way Contract §2.11.4.5.) Section 1367.01(h)(4) further specifies that the denial letters sent to the requesting provider “include the name and telephone number of the health care professional responsible for the denial, delay, or modification.”

The Department reviewed two Plan denial files, representing the total utilization management (UM) denials during the survey period. In both cases, the Plan failed to include the “name . . . and telephone number of the health care professional responsible for the denial, delay, or modification” based in whole or in part on medical necessity, in the notifications sent to the requesting providers as required by Sections 1367.01(h)(4) and Plan policy.

*File #1 and File #2:* In both cases, the enrollees’ physicians appealed the denials for referral of the enrollees to Community Based Adult Services (CBAS). The initial denial letters stated that the enrollees did not meet the criteria for CBAS. Inserts were included in both letters, providing a telephone number to call if any further discussion regarding the decision was required. However, neither the denial letters nor the inserts indicated the name(s) of the Plan’s reviewing health care professional(s) who issued the denials.

**Conclusion:** In order to facilitate communication, plans are required by Section 1367.01(h)(4) to include the name of the health care professional who made the decision in all written denials of authorization requests for medical services. Plan Policy UMCM 209ML also adopts this requirement. In two cases, which constitute the universe of standard denials by the Plan during the survey period, the Plan failed to include the name of the health care professional who made the denial decision in its denial letters to the providers. Therefore, the Department finds the Plan in violation of this requirement.

## **TABLE 5**

### Denial File Review

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Cal MediConnect UM denial files	2	Name of Plan's reviewing physician included in the denial letter	0 (0%)	2 (100%)

**APPENDIX A. MEDICAL SURVEY TEAM MEMBERS**

<b>DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS</b>	
Jennifer Luna-Friedrich	Medical Survey Team Lead
<b>MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS</b>	
Cliff Ridenour, LCSW	MHU Survey Team Lead
Marian Sama, RN	Utilization Management Surveyor
Dawn Wood, MD	Continuity of Care Surveyor
Annalisa Almendras, Psy.D.	Availability & Accessibility and Member Rights Surveyor
Dawn Wood, MD	Quality Management Surveyor

**APPENDIX B. PLAN STAFF INTERVIEWED**

<b>PLAN STAFF INTERVIEWED</b>	
Chris Hill	VP Clinical Services
Sharon Almany	VP Medical Operations
Steve Blake	VP Clinical Services
James Gerson	Medical Director, Sr.
Anil Chawla	Medical Director
Lynn Baker	Medical Director
Tony Rizzo	Director Clinical Services
Rita Lonzo	Director Delegation Oversight
Mari Baca	Director Health Care Services
Barbee Groshko	Manager Intake
Cynthia Kirkorian	Manager Health Care Services
Yvette Urbina	Manager Medical Operations
Larry Wong	VP Customer Contact Centers
Danielle Henderson	Director Appeals & Grievances
Mauricio Leal	Director Call Center
Jackie Duncan	Director Call Center
Carol Zaher	Medical Director
Earl Lynch	Medical Director
Letty Carrera	Manager Appeals
Tammy Pickering	Manager Customer Service
Annelie Ginn	Manager Clinical Appeals
Annie Haack	Manager Customer Service
Peggy Haines	VP Quality Management
Elaine Robinson-Frank	Director Quality Improvement
Amy Wittig	Manager Quality Improvement
Louba Aaronson	Manager Quality Improvement
Candace Ryan	Manager Quality Improvement
Linda Wade-Bickel	Director Care Management
Martha Santana-Chin	VP Dual Eligible Health Services Management
Lourdes Birba	Director Public Programs & LTSS
Meghan Speidel	Director Dual Eligible Delivery System Performance
Ama Neel	Director Clinical Accounts
Rita Lonzo	Director Delegation Oversight

Jessica Blake	Director Clinical Operations
Carol Spencer	Manager Quality Management
Daphne Chakurian	Manager Health & Wellness Vendor Management
Lorie Ballendine	VP Medical & Network Management
Liz Gallagher	Director Provider Network Management
Monica Nagle	Manager Customer Service

**APPENDIX C. LIST OF FILES REVIEWED**

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

<b>Type of Case Files Reviewed</b>	<b>Sample Size (Number of Files Reviewed)</b>	<b>Explanation</b>
<b>Standard Grievances</b>	8	The Plan identified a universe of 8 files during the review period. All 8 files were reviewed.
<b>Exempt Grievances</b>	1	The Plan identified a universe of 1 file during the review period. This file was reviewed.
<b>Potential Quality Issues</b>	2	The Plan identified a universe of 2 files during the review period. Both files were reviewed.
<b>UM Medical Necessity Denials</b>	2	The Plan identified a universe of 2 files during the review period. Both files were reviewed.
<b>Health Risk Assessments</b>	40	The Plan identified a universe of 8,870 files during the review period. A random sample of 40 files was reviewed.
<b>Individual Care Plans</b>	40	The Plan identified a universe of 8,870 files during the review period. A random sample of 40 files was reviewed.