DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

CAL MEDICONNECT

MEDICAL SURVEY REPORT OF

ORANGE COUNTY HEALTH AUTHORITY
DBA CALOPTIMA

A COUNTY ORGANIZED HEALTH SYSTEM PLAN

DATE ISSUED TO DHCS: JULY 5, 2017

Cal MediConnect Medical Survey Report
Orange County Health Authority
A County Organized Health System Plan
July 5, 2017

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EXECUTIVE SUMMARY

The Department of Health Care Services (DHCS) received authorization 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 September 22, 2016, the Department notified Orange County Health Authority (CalOptima or 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 February 6, 2017 through February 10, 2017.[2]

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreement, the Department provides the Cal MediConnect Medical Survey Report to the DHCS. The Report identifies potential deficiencies in Plan operations supporting the provision of Medicaid-based services for the Cal MediConnect population. This medical survey evaluated the following elements specifically related to the Plan's delivery of care to the Cal MediConnect population as delineated by the Plan's applicable three-way contract with DHCS and CMS (the Cal MediConnect Three-Way Contract), the Knox-Keene 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 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 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 July 1, 2015 through October 31, 2016.

SUMMARY OF FINDINGS

The Department identified **nine** (**9**) potential deficiencies during the current medical survey.

2017 MEDICAL SURVEY POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

The Plan does not adequately demonstrate that it systemically and routinely analyzes utilization management data to monitor for potential under- and over-utilization of Cal MediConnect services.
Orange County Health Authority Cal MediConnect Three-Way Contract §2.11.5.1.; §2.11.7.; §2.16.

CONTINUITY OF CARE

The Plan does not consistently develop an Individualized Care Plan for enrollees within 30 working days of Health Risk Assessment completion.
Orange County Health Authority Cal MediConnect Three-Way Contract §2.8.3.

AVAILABILITY & ACCESSIBILITY

The Plan's policies and procedures fail to require flexibility in scheduling to accommodate the needs of enrollees with disabilities.
Orange County Health Authority Cal MediConnect Three-Way Contract §2.11.1.2.-§2.11.1.2.1.

The Plan failed to demonstrate that it takes into consideration the anticipated number of CalMediConnect enrollees when evaluating adequate access to Medicaid-based services.
Orange County Health Authority Cal MediConnect Three-Way Contract §2.10-§2.10.1.1.1.

MEMBER RIGHTS

The Plan failed to include the date of receipt of standard grievances in its acknowledgment letters. In addition, the Plan's grievance acknowledgment and resolution letters do not display the required information in 12-point, bold-faced font.
Orange County Health Authority Cal MediConnect Three-Way Contract §2.14.2.1.1 and §2.14.2.1.2.1.; Sections 1368(a)(4)(A)(ii); Section 1368.02(b).

The Plan classified enrollee expressions of dissatisfaction as inquiries rather than grievances.
Orange County Health Authority Cal MediConnect Three-Way Contract §2.14.2.1.1.; Rule 1300.68(1).

The Plan misclassified standard grievances as exempt.
Orange County Health Authority Cal MediConnect Three-Way Contract §2.14.2.1.1.; Section 1368(a)(4)B)(1).; Rule 1300.68(d)(8).

The Plan does not maintain a cultural and linguistic services program that includes: (1) goals and objectives; (2) a timetable for implementation and accomplishment of the goals and objectives; and (3) a narrative explaining the Plan's organizational chart that describes the oversight and direction to the community advisory committee.
Orange County Health Authority Cal MediConnect Three-Way Contract §2.9.7.2., §2.9.7.2.2., §2.9.7.2.3., and §2.9.7.2.4.

The Plan does not measure the time from which the telephone is answered to the point at which an enrollee reaches a CSR capable of responding to the enrollee's question in a manner that is sensitive to the enrollee's language and cultural needs.
Orange County Health Authority Cal MediConnect Three-Way Contract §2.12.2.2.

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

The Plan reported that it has implemented the following policies, procedures, and activities to improve its managed health care systems.

- The Plan has established a proactive approach for educating and assisting enrollees in accessing health plan benefits. The Plan's customer service representatives (CSR) deliver birthday greetings via telephone to enrollees as an opportunity to gather information about potential issues concerning health care services access that the enrollees might be experiencing. During this call, the CSRs will encourage its enrollees to visit their primary care providers for their annual examinations and will help enrollees schedule an appointment upon receiving an approval from the enrollees. The CSRs will remind enrollees that they could request for a transportation ride to their primary care provider's office if they need the service. Before ending the call, the CSRs will allow enrollees an opportunity to express any remaining concerns, which the CSRS will attempt to address and document.
- The Plan performs a random medical record review every month for members under highly complex case management.
- The Plan sends welcome packets to members that include instructions on selecting a PCP. Plan staff follows up with phone calls to remind members to schedule an appointment with a PCP. If a member does not select a PCP or network for 30 days, the Plan auto-assigns a PCP based on language, geography, and quality performance.
- The Plan has six cross-function teams focused on improving HEDIS quality measures. Each team has a physician champion, a data analyst, and

representation from various clinical areas, such as disease management, case management, and pharmacy.

- The Plan generates monthly HEDIS reports and calculates prospective rates, which it sends to the health networks. The Plan holds joint operations meetings quarterly with the health networks to discuss improvement opportunities.
- The Plan implemented a new tracking system for PQI files called the Guiding Care System to better integrate with the grievances and appeals process, and generate reports for tracking and trending.
- Practitioners from the delegated UM groups participate on the UM Committee.
- The CMO, Deputy Chief Medical Officer, and other medical directors are actively involved in the UM Program and processes as documented in the UM Committee minutes.
- The Plan has developed several audit tools, which it utilizes to perform oversight and evaluation of its UM delegates.
- The Plan implemented a new medical management system to improve efficiency and effectiveness of the UM program and processes.
- The Plan redesigned its Medical Management Department.

DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

Potential Deficiency #1: The Plan does not adequately demonstrate that it systemically and routinely analyzes utilization management data to monitor for potential under- and over-utilization of Cal MediConnect services.

Contractual/Statutory/Regulatory Reference(s): Orange County Health Authority Cal MediConnect Three-Way Contract §2.11.5.1.; §2.11.7.; §2.16.

Orange County Health Authority Cal MediConnect Three-Way Contract §2.11.5
2.11.5. Utilization Management
2.11.5.1. Utilization management program: Contractor shall develop, implement, and continuously update and improve, a utilization management program that ensures appropriate processes are used to review and approve the provision of medically necessary Covered Services, excluding Part D benefits. Contractor is responsible to ensure that the utilization management program includes:
2.11.5.1.6. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor shall ensure that all contracted Network Providers and noncontracting specialty providers are informed of the prior authorization and referral process at the time of referral.
2.11.5.1.8. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

Orange County Health Authority Cal MediConnect Three-Way Contract §2.11.7
2.11.7. Review of Utilization Data
2.11.7.1. Contractor shall include within the utilization management program mechanisms to detect both under- and overutilization of health care services. Contractor's internal reporting mechanisms used to detect Enrollee utilization patterns shall be reported to DHCS upon request.

Orange County Health Authority Cal MediConnect Three-Way Contract §2.16
2.16. Quality Improvement Program
2.16.1. Quality Improvement (QI) Program. The Contractor shall:
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.

Documents Reviewed:

- 2015 Utilization Management Program Description
- 2016 Utilization Management Program Description
- Plan Policy GG.1532: Over and Under Utilization Monitoring (effective 06/01/14)
- Over Under Utilization Matrix – One Care Connect (02/10/17)
- UMC Meeting Minutes (01/28-16, 05/12/16, 08/11/16, 11/10/16)
- CalOptima 2016 UM Workplan and Evaluation, OneCare Connect, OneCare and Medi-Cal, 3rd Quarter 2016 (11/10/16)

Assessment: The Department reviewed Plan documents specific to utilization management activities in order to evaluate the Plan's performance in monitoring under- and over-utilization of health care services during the survey review period. While the Plan's policy and procedure for under- and over-utilization has been in place since June 1, 2014, the Plan has not demonstrated that it consistently and effectively performs ongoing monitoring of under- and over-utilization of Cal MediConnect-based services for 2015 and 2016.

One of the goals the Plan stated in both its *2015 Utilization Management Program Description* and *2016 Utilization Management Program Description* was to identify and resolve problems and issues that result in over- or under-utilization and the inefficient or inappropriate delivery of health care services. *Plan Policy GG.1532, Over and Under Utilization Monitoring,* confirms this goal and describes the process for monitoring and reviewing data, along with the role of the Utilization Management Committee (UMC) in monitoring for under- and over- utilization of services.

The policy states:

> B. The Utilization Management Committee (UMC) establishes the process to identify under and over utilization through monitoring, tracking, and analyzing data including, but not limited to:

1. Acute and Behavioral Inpatient Bed Days, Admits, Lengths of Stay and Readmission Rates;
2. Specialty Care Access;
3. Grievances;
4. Healthcare Effectiveness Data & Information Set (HEDIS);
5. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Data;
6. Peri-Natal Support Program Utilization;
7. Emergency Room Utilization;
8. Annual Provider Satisfaction Survey of the Utilization Management process;
9. Inter-rater Reliability Scores;
10. Denial Rates;
11. Appeal Overturn Rates; and
12. Potential Provider Quality Issues (PQIs).

The policy further states on page 2:

E. The Utilization Management Department analyzes the data on at least a quarterly basis. The analysis includes, but is not limited to:
    1. Comparison against Utilization Management Committee (UMC) goals and work plan;
    2. Comparison against the mean and standard deviation from the group;
    3. Comparison against nationally recognized, evidence based, and external benchmarks, when available; and
    4. Qualitative analysis, including risk stratification, to determine cause and effect of data outside identified benchmarks.

G. The UMC reviews the analysis of the data and may require Corrective Action Plans (CAP) from a delegated Health Network or a specific Practitioner.

H. The Quality Improvement (QI) Department and the UMC measures the effectiveness of interventions in correcting under and over utilization.

I. The UMC works with the Quality Improvement Committee or Delegated Oversight Committee to identify, resolve, and monitor issues of concern related to utilization management and quality of care.

The Department conducted a comprehensive review of Plan documents to evaluate the Plan's adherence to contractual requirements and its own policy for monitoring under- and over-utilization of health care services. The Plan did not show evidence that it consistently analyzes and identifies significant trends and formulates actions to reach goals. The Plan reports aggregate denials, approvals, appeals, and overturns as well as unused authorizations but there is no evidence that the Plan consistently evaluates the types of referrals or service requests that are often denied, appealed and overturned. There is no evidence that the Plan systematically analyzes utilization data across networks to determine if corrective actions are needed, and no evidence of comparisons against benchmarks. These kinds of analyses would demonstrate that the Plan was effectively monitoring under- and over-utilization.

Meeting minutes of the Plan's UMC show intent to conduct under- and over-utilization monitoring and an awareness of the significance of this activity as it relates to both the Plan's network and shared risk group networks. The *UMC Meeting Minutes* of January 16, 2016, provide evidence that the Plan was moving toward monitoring utilization of various services. During this meeting, Plan officers stated that its behavioral health vendor (Beacon) intended to identify new targets for under- and over-utilization, and a Plan medical director pointed to the availability of data from the previous year (2015) for analysis in order to identify outliers and significant trends. However, there is no evidence that analysis of the 2015 data, as discussed in this meeting, was conducted during the survey review period, nor is there any evidence of other committee work to identify significant trends and outliers.

UMC Meeting Minutes throughout 2016 demonstrate continued discussions on the importance of analyzing and monitoring services for under- and over-utilization. The UMC Meeting Minutes of May 12, 2016, record that Plan officers recognized the need to monitor and work with its shared risk groups and define which aspects of utilization need to be reported. In the same meeting, the medical director (1) identified the areas that needed to be tracked — quality issues, utilization issues, and access issues; (2) stated, "there are more areas that are non HEDIS-based that would be worth tracking," and (3) acknowledged that the Plan has a lot of outliers, e.g., transplants, high cost members, pharmaceuticals, and high cost specialties and treatments. However, the UMC did not discuss any interventions at that meeting, nor in successive meetings in 2016. As of February 2017, the Plan has presented no evidence that it met with shared risk groups during the survey review period in order to identify aspects of utilization that needed reporting despite holding joint operations meetings with the groups on a quarterly basis.

UMC Meeting Minutes of August 11, 2016, and November 10, 2016, show that the medical director continued to verbalize the need to track provider under- and over-utilization across networks while acknowledging that Plan officers were still defining what to track. A blank *Over Under Utilization Matrix* was presented during these last two UMC meetings of 2016, listing data measures which the Plan intended to track and trend, and if issues were identified, address as necessary. The *Over Under Utilization Matrix* contains an "Action" column for documenting the Plan's corrective actions. When queried whether this matrix was used during the survey review period, the Director of Utilization Management stated that while data was collected during the survey period, the *Over Under Utilization Matrix* was not implemented until January 2017.

The Plan's UM *Workplan and Evaluation* for the first, second, and third quarter of 2016 (for product lines OneCare Connect, OneCare, and Medi-Cal), show that the Plan was still developing high cost reports; the "next steps" category was blank.

During interviews, Plan staff acknowledged the need to track and trend utilization data and affirmed that the Plan does not currently have a reliable system of tracking utilization data.

Conclusion: The Orange County Health Authority Cal MediConnect Three-Way Contract §2.11.5.1.8 requires the Plan to have procedures for reviewing the utilization of services and facilities. §2.11.7.1 further requires that the Plan's utilization management program include mechanisms to detect both under- and over-utilization of health care services. The Plan presented no evidence of effective tracking, trending, and analysis of utilization data from 2015 and 2016 among its One Care Connect enrollees to monitor for, and address, under- and over-utilization. Therefore, the Department finds the Plan in violation of these contractual requirements.

CONTINUITY OF CARE

Potential Deficiency #2: The Plan does not consistently develop an Individualized Care Plan for enrollees within 30 working days of Health Risk Assessment completion.

Contractual/Statutory/Regulatory Reference(s): Orange County Health Authority Cal MediConnect Three-Way Contract §2.8.3.

Orange County Health Authority Cal MediConnect Three-Way Contract §2.8.3.
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.

Documents Reviewed:

- CalOptima 2015 Case Management Work Plan and Evaluation
- CalOptima 2016 Case Management Work Plan and Evaluation
- Cal MediConnect Continuity of Care Summary
- Quality Improvement Committee (QIC) Meeting Minutes with Attachments (01/13/16, 02/09/16, 05/10/16, 08/09/16, 09/13/16, 10/04/16)
- 70 ICP files (08/01/15 - 09/01/16)

Assessment: On January 1, 2016, all Cal MediConnect enrollees transitioned from the OneCare (OC) product line to the OneCare Connect (OCC - Cal MediConnect) duals-eligible product line. The Plan performed Health Risk Assessments (HRAs) effective with enrollment, but failed to consistently complete the corresponding Individual Care Plan (ICP) for each enrollee "within thirty (30) working days of HRA completion," as required by the Orange County Health Authority Three-Way Cal MediConnect Contract §2.8.3.1.

The Department reviewed a random sample of 70 ICP files from the universe files of 12,241 for the survey review period. Of the 70 files reviewed, 27 (39%) files did not

contain an ICP that was developed within thirty (30) working days of HRA completion.[3] Some delays extended over a period of months as the following files exemplify:

TABLE 1
Individualized Care Plan

File Number	File ID	Enrollment Date	HRA Completion Date	ICP Completion Date	Completed ICP Time (Working Days)
Removed	for privacy	01/01/2016	12/17/2015	05/26/2016	116
Removed	for privacy	04/01/2016	04/19/2016	09/08/2016	103
Removed	for privacy	06/01/2016	06/15/2016	10/20/2016	92
Removed	for privacy	03/01/2016	04/05/2016	08/25/2016	103

The Department found that in some cases the Case Manager or Primary Care Coordinator only completed the ICP after the member contacted the Plan about an unrelated matter, i.e., not as a result of any initiative from the Plan.

During the onsite survey interviews, Plan staff could not confirm that they had established a systematic monitoring effort to oversee the completion time of ICPs.

TABLE 2
ICP Completion Rate

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
ICP	70	Plan completed the ICP within 30 working days of HRA completion	43 (61%)	27 (39%)

Conclusion: The Orange County Health Authority Cal MediConnect Three-Way contract §2.8.3.1 requires that an ICP be completed for each enrollee within 30 working days of HRA completion. Department review of ICP files covering the survey review period indicated the Plan did not meet the required timeframe in 39% of the files reviewed. Therefore, the Department finds the Plan in violation of this contractual requirement.

AVAILABILITY AND ACCESSIBILITY

[3] File # (file numbers removed for privacy)

Potential Deficiency #3: The Plan's policies and procedures fail to require flexibility in scheduling to accommodate the needs of enrollees with disabilities.

Contractual/Statutory/Regulatory Reference(s): Orange County Health Authority Cal MediConnect Three-Way Contract §2.11.1.2 and §2.11.1.2.1.

Orange County Health Authority Cal MediConnect Three-Way Contract §2.11.1
2.11.1 General. The Contractor must provide services to Enrollees as follows:
2.11.1.2. Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services from the Contractor by:
2.11.1.2.1. Providing flexibility in scheduling to accommodate the needs of the Enrollees.

Documents Reviewed:

- Plan Policy MA.7007: Access and Availability (08/01/16)
- Cal MediConnect HMO Services Contract Between Orange County Health Authority DBA CalOptima And [Providers] Template
- 2015 Provider Manual
- Disability Awareness Training Slideshow (2016)

Assessment: The Plan does not have a written policy to ensure flexibility in scheduling for enrollees with disabilities. The Plan's *Policy MA.7007: Access and Availability*, its *2015 Provider Manual*, and the Plan's contract with its providers do not address flexibility in scheduling for enrollees with disabilities. In the *Disability Awareness Training Slideshow*, one of the slides states, "changes to provider office policies may include flexible appointment times" to accommodate patients with disabilities. While this slideshow suggests providers offer flexible appointment times for enrollees with disabilities, the Contract sections 2.11.1.2 and 2.11.1.2.1 require written policies and procedures to ensure that barriers do not inhibit enrollees with disabilities from obtaining services, including providing flexibility in scheduling.

Conclusion: The Department has determined that the Plan is not in compliance with §2.11.1.2.1 by failing to have written policies and procedures requiring its providers to provide flexibility in scheduling for enrollees with disabilities.

Potential Deficiency #4: The Plan failed to demonstrate that it takes into consideration the anticipated number of Cal MediConnect enrollees when evaluating adequate access to Medicaid-based services.

Contractual/Statutory/Regulatory Reference(s): Orange County Health Authority Cal MediConnect Three-Way Contract §2.10§2.10.1.1.1.

Orange County Health Authority Cal MediConnect Three-Way Contract §2.10.1.
2.10. Network Management
2.10.1. General requirements. The Contractor shall establish, maintain, and monitor a network that is sufficient to provide adequate access to all Covered Services in the Contract. Section 2.9.1 discusses the annual network review and approval requirement.
2.10.1.1. Taking into consideration:
2.10.1.1.1. The anticipated number of Enrollees

Documents Reviewed:

- OCC Timely Access and Availability Work Team Minutes (06/30/15, 07/28/15, 02/24/16, 01/26/16, 03/17/16, 04/26/16, 06/29/16, and 07/28/16)
- OCC Network Adequacy Access Minutes (12/15/15)
- OCC A & A Availability All Providers
- OCC A & A Network Adequacy (09/09/15)

Assessment: The Plan has not submitted documentation or other evidence to demonstrate that, in maintaining and monitoring its network for sufficiency, it takes into consideration the anticipated number of enrollees. The Department asked the Plan how it determines its projected enrollment numbers, and the Plan stated that its finance department is responsible for determining the projected enrollment numbers. The Plan briefly stated that the Plan looks at the ratios between enrollees and providers. However, the Plan's access and availability policies and procedures did not address Plan review of projected enrollment and meeting minutes included no discussions to demonstrate its ratio review process.

Conclusion: The Plan was not able to explain or provide evidence of how it determines its projected enrollment numbers. Therefore, the Department has determined that the Plan has not fulfilled its contractual agreements as set forth in §2.10.1 of the Plan's Cal MediConnect Three-Way Contract.

MEMBER RIGHTS

Potential Deficiency # 5: The Plan failed to include the date of receipt of standard grievances in its acknowledgment letters. In addition, the Plan's grievance acknowledgment and resolution letters do not display the required information in 12-point, bold-faced font.

Contractual/Statutory/Regulatory Reference(s): Orange County Health Authority Cal MediConnect Three-Way Contract §2.14.2.1.1 and §2.14.2.1.2.1.; Section 1368(a)(4)(A)(ii); Section1368.02(b).

Orange County Health Authority Cal MediConnect Three-Way Contract §2.14.2.1.1.

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.

Orange County Health Authority Cal MediConnect Three-Way Contract §2.14.2.1.2.1.
2.14.2.1.2. The contractor must maintain written records of all grievance activities, and notify CMS and DHCS of all internal grievances. The system must meet the following standards:
2.14.2.1.2.1. Timely acknowledgement of receipt of each Enrollee grievance.

Section 1368(a)(4)
(A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:
(ii) The date of receipt.

Section 1368.02(b)
(b)Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to Enrollees required under the grievance process of the plan, including any written communications to an Enrollee that offer the Enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

> "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(insert health plan's telephone number**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number

(**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site http://hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

Documents Reviewed:

- 30 CalOptima CMC Standard Grievance/Appeals Files (11/02/15 – 09/29/16)
- CalOptima Cal MediConnect Three-Way Contract
- Plan Policy CMC 9001: Member Complaint Process (8/1/16)
- Plan Policy CMC 9002: Member Grievance Process (8/1/16)

Assessment: The Plan fails to consistently include the date of receipt of the enrollee grievance in the acknowledgment letter. Moreover, the Plan fails to display the Department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site address in 12-point boldface type in acknowledgment and resolution letters. The Department reviewed 30 standard grievance files, which represents the universe for the review period. The Department determined that in 21 of 30 files, the grievance acknowledgment letter failed to include the date of receipt of the enrollee grievance.[4]

In addition, in all 30 standard grievance files reviewed, the Plan failed to include the DMHC's telephone number, TDD line, and Internet address in 12-pt boldface type in its acknowledgment and resolution letters as required by Section 1368.02

TABLE 3
Acknowledgment and Resolution Letters

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievance/Appeals	30	Acknowledgement letters failed to include date grievance was received	9 (30 %)	21 (70 %)
Standard Grievance/Appeals	30	Acknowledgement and resolution letters failed to include required language in appropriate format	0 (0%)	30 (100%)

Conclusion: The Plan fails to consistently include the date of receipt of the enrollee grievance in the acknowledgment letter. Moreover, the Plan fails to display the

[4] File # **(file numbers removed for privacy)**

Department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site address in 12-point boldface type in acknowledgment and resolution letters. Therefore, the Department has determined the Plan has failed to satisfy the requirements in the Plan's Cal MediConnect Three-Way Contract §2.14.2.1.1 and §2.14.2.1.2.1.and Section 1368.02(b).

Potential Deficiency #6: The Plan classified enrollee expressions of dissatisfaction as inquiries rather than grievances.

Contractual/Statutory/Regulatory Reference(s): Orange County Health Authority Cal MediConnect Three-Way Contract §2.14.2.1.1.; Rule 1300.68(1).

Orange County Health Authority Cal MediConnect Three-Way Contract §2.14.2.1.1.
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.

Rule 1300.68(1)
"Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Documents Reviewed:

- 13 CalOptima CMC Call Inquiry Files (1/25/16 – 10/25/16)
- CalOptima Cal MediConnect Three-Way Contract
- Plan Policy CMC 9001: Member Complaint Process (8/1/16)
- Plan Policy CMC 9002: Member Grievance Process (8/1/16)

Assessment: Plan policy *CMC 9002 Member Grievance Process* defines grievance as:

> "Any complaint or dispute, other than on organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken…."

The Department reviewed 13 Call Inquiry files out of the universe of 22 files for the review period. The Department found that in 11 of 13 calls (85%), the Plan's customer

service representatives failed to recognize oral expressions of dissatisfaction and classified the calls as inquiries [5]

- File #(file numbers removed for privacy) : Enrollee's son called in upset. The enrollee had not received her medical supplies for two months and that the supplier indicated that they did not send the supplies because when they called the enrollee's home, no one answered the phone. The son indicated that his mother does not speak English therefore, will not answer the phone. The call was classified as an inquiry.
- File #(file numbers removed for privacy) : The Member called the Plan to complain that authorization for medical transportation services had been denied. Despite the Member's expression of dissatisfaction, the Plan classified the call as an inquiry rather than processing it as a grievance.

TABLE 4
Call Inquiry File Review Results

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Call Inquiries	13	Calls with expressions of dissatisfaction classified as inquiries	2 (15 %)	11 (85 %)

Conclusion: The Orange County Health Authority Cal MediConnect Three-Way Contract §2.14.2.1.1 requires the Plan to maintain a grievance process under which enrollees may submit grievances pursuant to the Knox-Keene Act. Rule 1300.68(1) requires that the Plan process enrollee expressions of dissatisfaction as grievances. Plan inquiry files included calls that contained expressions of dissatisfaction that were not identified or handled as grievances. Therefore, the Department finds the Plan is in violation of these contractual requirements**.**

Potential Deficiency #7: The Plan misclassified standard grievances as exempt.

Contractual/Statutory/Regulatory Reference(s): Orange County Health Authority Cal MediConnect Three-Way Contract §2.14.2.1.1; Section 1368(a)(4)(B)(1); Rule 1300.68(d)(8).

Orange County Health Authority Cal MediConnect Three-Way Contract §2.14.2.1.1

[5] File #(file numbers removed for privacy)

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.

Section1368(a)(4)(B)(1)
Grievances received by telephone, by facsimile, by email, or online through the plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:

Rule 1300.68(d)(8)
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).

Documents Reviewed:

- 14 CalOptima CMC Exempt Grievance Files (1/4/16 – 10/31/16)
- CalOptima Cal MediConnect Three-Way Contract
- Plan Policy CMC 9001: Member Complaint Process (8/1/16)
- Plan Policy CMC 9002: Member Grievance Process (8/1/16)

Assessment: 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 Department's review of 14 exempt grievance files demonstrated that the Plan misclassifies standard grievances as exempt. Five of the 14 files (36%) were non-compliant as they should have not been classified as exempt due to not meeting the requirements for exempt grievances.[6] For example:

- File #(removed for privacy) : An enrollee called the Plan to complain that she had tried on several occasions to contact the Plan's contracted non-emergency

[6] File #(file numbers removed for privacy) .

transport provider to make an appointment, but was unable to reach the provider. The Plan made multiple calls to the transport company over the following week and resolved the member's issue more than a week following the initial complaint. The Plan classified this grievance as exempt, although the grievance was not resolved by the close of the next business day.

- File #(number removed for privacy) : The enrollee called the Plan to complain that she had been told she would need to pay for her incontinence supplies. The Plan identified this grievance as exempt, although by definition under Section 1368(a)(4)(B)(i), coverage disputes cannot be exempt grievances.

TABLE 5
Exempt Grievance Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt grievances	14	Grievance meets the criteria for processing as an exempt grievance.	9 (64%)	5 (36%)

Conclusion: The Cal MediConnect Three-Way Contract and Section 1368(a)(4)(B)(1) allow certain grievances that are not coverage disputes and are resolved by the close of the next business day to be considered exempt grievances. The plan failed to consistently identify as exempt grievances those grievances that satisfied the statutory definition of exempt grievance. Therefore, the Department finds the plan in violation of this contractual requirement.

Potential Deficiency #8: The Plan does not maintain a cultural and linguistic services program that includes:(1) goals and objectives; (2) a timetable for implementation and accomplishment of the goals and objectives; and (3) a narrative explaining the Plan's organizational chart that describes the oversight and direction to the community advisory committee.

Contractual/Statutory/Regulatory Reference(s): Orange County Health Authority Cal MediConnect Three-Way Contract §2.9.7.2., §2.9.7.2.2., §2.9.7.2.3., and §2.9.7.2.4.

Orange County Health Authority Cal MediConnect Three-Way Contract §2.9.7.2.
2.9.7.2. Contractor shall implement and maintain a written description of its cultural and linguistic services program, which shall include at minimum the following:
2.9.7.2.2. Goals and objectives;
2.9.7.2.3. A timetable for implementation and accomplishment of the goals and objectives;

2.9.7.2.4. An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the community advisory committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described.

Documents Reviewed:

- Plan Policy CMC.4002: Cultural and Linguistic Services (Revised 8/01/16)
- OneCare Connect Member Advisory Committee Meeting Minutes (07/22/15 to 11/17/16)
- Provider Advisory Committee Meeting Minutes (07/16/15 to 11/10/16)
- Customer Service Member Liaison, Enrollment & Reconciliation And Cultural & Linguistics Organizational Chart
- Cultural & Linguistic Services Department Organizational Chart Explanations (Modified 02/09/17)

Assessment: The Plan's Cultural and Linguistic Services Program Policy states, in relevant part:

> OneCare Connect Member Advisory Committee (MAC) shall provide information and recommendations with respect to OneCare Connect's Cultural and Linguistic (C&L) Services and shall collaborate with the CalOptima Provider Advisory Committee (PAC) with regards to C&L Services on an ad hoc basis.

The Plan's C&L Services Program included an Organizational Chart that showed key staff persons with overall responsibility for cultural and linguistic services and activities, and the accompanying narrative had a description of the roles of their support staff, reporting relationships, and qualifications of staff. However, the Plan's Policy failed to include other information required by Contract section 2.9.7.2., such as goals and objectives or a timetable for implementation and accomplishment of the goals and objectives. Upon reviewing the MAC and PAC Committee Meeting Minutes, the Department found no evidence of oversight and direction concerning C&L services and activities reported to the community advisory committee.

Conclusion: The Plan's Cultural and Linguistic Services Program Policy does not include all the required information required by the Orange County health Authority Three-Way Contract §2.9.7.2., §2.9.7.2.2., §2.9.7.2.3., and §2.9.7.2.4. Additionally, there was no evidence that oversight and direction concerning C&L services and activities were provided to the relevant committee. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #9: The Plan does not measure the time from which the telephone is answered to the point at which an enrollee reaches a CSR capable of responding to the enrollee's

question in a manner that is sensitive to the enrollee's language and cultural needs.

Contractual/Statutory/Regulatory Reference(s): Orange County Health Authority Cal MediConnect Three-Way Contract §2.12.2.2.

Orange County Health Authority Cal MediConnect Three-Way Contract §2.12.2.2.
2.12.2.2. The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

Documents Reviewed:

- OneCare Connect Incoming Activity Monitoring Report

Assessment: The Plan's call center monitoring report does not show that the Plan has a process for measuring the amount of time it takes for an enrollee to reach a CSR who is capable of responding to the enrollee's question in a manner that is sensitive to the enrollee's language and cultural needs. During the onsite survey interview the Manager of Cultural and Linguistic Services Program stated, "There is no assessment specific to language" when asked if the Plan measured the amount of time it takes for an enrollee to reach a CSR who can assist the enrollee in his/her language.

Conclusion: The Department has determined that the Plan is out of compliance with §2.12.2.2 for failing to have a process for tracking and trending the amount of time it takes for an enrollee to be assisted in his or her language in a manner that is also sensitive to the enrollee's cultural background.

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS

Angalar Chi
Plan Surveys Analyst
Marie Broadnax
Plan Surveys Manager
Victoria Ciganda
Plan Surveys Counsel

MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS

Rose Leidl, RN
Utilization Management Surveyor
Hoa D. Tran, M.D.
Continuity of Care Surveyor
Kelly Gaspar & Angalar Chi
Availability & Accessibility Surveyor
Kelly Gaspar & Angalar Chi
Member Rights (Cultural and Linguistic Services Section) Surveyor
Nadine Peterson (Hintz)
Member Rights (Grievances and Appeals Section) Surveyor
Hoa D. Tran, M.D.
Quality Management Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED	JOB TITLE
Debra Armas	Director/UM
Tracy Hitzeman	Executive Director (interim) Clinical Operations
Judy Riley	Manager/UM
Edwin Poon	Director BH Integration
Marsha Peterson	Manager, Long Term Care Services & Support
Solange Marvin	Director/Audit & Oversight
Caryn Ireland	Executive Director/Quality Analytics
Esther Okajima	Director/Quality Improvement
Richard Bock, MD	Deputy Chief Medical Director
Laura Grigoruk	Director/Network Management
Michael German	Manager/Provider Relations
Lizeth Granados	Director/Network Management
Sloane Petrillo	Director (interim) Case Management
Richard Helmer, MD	Chief Medical Officer
Emily Fonda, MD	Medical Director, Medical Management
Julie Bomgren	Sr. Policy Advisor, Regulatory Affairs & Compliance
Silver Ho	Compliance Officer
Albert Cardenas	Associate Director, Customer Service
Belinda Abeyta	Director Customer Service
Carlos Soto	Manager, Cultural & Linguistic
Kelly Rex-Kimmet	Director, Quality Analytics
Marsha Choo	Manager, Quality Initiatives
Ladan Khamseh	Chief Operating Officer
Pshyra Jones	Director, Health Education & Disease Management
Kelly Klipfel	Director, Financial Compliance
Donald Sharps	Medical Director, Behavioral Health Integration
Frank Federico, MD	Medical Director
Himmet Dajee, MD	Medical Director, Medical Management
Ana Aranda	Manager, Grievance and Appeals
Hanh Bannister, Pharm D.	Manager, Clinical Pharmacist
Janine Kodama	Director, Grievances and Appeals
Kris Gericke, Pharm D.	Director Clinical Pharmacy
Le Nguyen	Associate Director, Customer Service

Miles Masatsugu, MD	Medical Director
Sandra Friend	Manager, Clinic Operations
Laura Guest	Supervisor, Quality Improvement

APPENDIX C. LIST OF FILES REVIEWED

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Standard Grievances/Appeals	30	The Plan identified a universe of 30 files during the review period. Based on the Department's File Review Methodology, a random sample of 30 files were reviewed.
Inquiries	13	The Plan identified a universe of 22 files during the review period. Based on the Department's File Review Methodology, a random sample of 13 files were reviewed.
Exempt Grievances	14	The Plan identified a universe of 70 files during the review period. Based on the Department's File Review Methodology, a random sample of 40 files were reviewed; however only 14 files are Medicaid-based services/benefits.
Expedited Appeals	0	The Plan identified a universe of 0 files during the review period.
Potential Quality Issues	2	The Plan identified a universe of 2 files during the review period. Based on the Department's File Review Methodology, both files were reviewed.
Health Risk Assessment	77	The Plan identified a universe of 12,241files during the review period. Based on the Department's File Review Methodology, a random sample of 77 files were reviewed.
Individualized Care Plan	70	The Plan identified a universe of 12,241 files during the review period. Based on the Department's File Review Methodology, a random sample of 70 files were reviewed.