DEPARTMENT OF
Managed
Health Care
Help Center

DIVISION OF PLAN SURVEYS

1115 WAIVER SENIORS AND PERSONS WITH DISABILITIES (SPD) ENROLLMENT SURVEY

SURVEY REPORT
FOR THE
DEPARTMENT OF HEALTH CARE SERVICES

1115 WAIVER SURVEY
OF
CONTRA COSTA MEDICAL SERVICES
dba CONTRA COSTA HEALTH PLAN

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: AUGUST 6, 2013

1115 Waiver Survey Report of the SPD Enrollment
Contra Costa Health Plan
A Full Service Health Plan
August 6, 2013

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EXECUTIVE SUMMARY

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

On October 29, 2012, Contra Costa Medical Services dba Contra Costa Health Plan (the "Plan") was notified that its Medical Survey had commenced and was requested to provide the Department with the necessary pre-onsite data and documentation. This is the first survey for the Plan relative to its SPD program. The Department's survey team conducted the onsite portion of the Medical Survey from March 4, 2013, through March 6, 2013.[2]

SCOPE OF SURVEY

The Department is providing DHCS this Summary Report of Medical Survey findings pursuant to the Inter-Agency Agreement and has identified potential deficiencies in Plan operations supporting SPD membership.

This Medical Survey evaluated the following elements specifically related to the Plan's delivery of care to the SPD population pursuant to the DHCS contract requirements and compliance with the Act:

I. Utilization Management

The Department evaluated Plan operations related to utilization management (UM), including implementation of the Plan's utilization management program and its policies and processes for effectively handling prior authorization of services, mechanisms for detecting over- and under-utilization of services, and methods for evaluating utilization management activities of delegated entities.

II. Continuity of Care

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

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

[2] Pursuant to the Knox-Keene Health Care Service Plan Act of 1975, codified at Health and Safety Code section 1340, *et seq*., Title 28 of the California Code of Regulations section 1000, *et seq.* and the Department of Health Care Services Two-Plan and GMC Boilerplate Contracts. All references to "Section" are to the Health and Safety Code unless otherwise indicated. All references to the "Act" are to the Knox-Keene Act. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated. All references to "Contract" are to the Two-Plan or GMC Boilerplate contract issued by the Department of Health Care Services.

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

IV. Member Rights
The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for primary care physician (PCP) selection and assignment, and to evaluate the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

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

The scope of the survey incorporated review of health plan documentation and files from the period Dec. 1, 2011 through Nov. 30, 2012.

SUMMARY OF FINDINGS

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

2013 SURVEY POTENTIAL DEFICIENCIES[3]

UTILIZATION MANAGEMENT	
#1	**The Plan does not ensure that clinical decisions based on medical necessity are consistent with Plan criteria and guidelines.** Section 1367.01(b); DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 2. Pre-Authorizations and Review Procedures.
#2	**The Plan's website and provider directory do not indicate levels of access or Medical Equipment access.** DHCS MMCD Policy Letter 12-006; DHCS Two-Plan Contract, Exhibit A, Attachment 13, Member Services, Provision 4. Member Information.
#3	**The Plan's *Member Handbook and Evidence of Coverage* incorrectly implies that members can only file an appeal to a grievance decision in writing.** Rule 1300.68(a)(1); DHCS Two-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1. Member Grievance System.

[3] The *Discussion of Potential Deficiencies* section of this report contains a discussion of these deficiencies.

#4	**The Plan does not ensure that grievance forms distributed by Contra Costa Regional Medical Center (CCRMC) to Plan members contain the statement described in Section 1368.02(b).** Section 1368.02(b).
#5	**The Plan's current reporting system does not produce adequate or accurate data that would allow the Plan to continuously review the quality of care provided to members and/or ensure that quality of care problems are identified and corrected.** Rules 1300.70(b)(1)(A) and (B); Rule 1300.70(b)(2)(C); Rule 1300.70(b)(2)(H)(2); Rule 1300.70(c); DHCS Two-Plan Contract, Exhibit A, Attachment 3, Management Information System, Provision 1. Management Information System Capability; Attachment 4, Quality Improvement System, Provision 1. General Requirement and Provision 6. Delegation of Quality Improvement Activities; DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 1. Utilization Management Program.
#6	**The Plan is not ensuring that its largest delegate implements corrective action plans when deficiencies in care are revealed.** Rule 1300.70(a)(1); Rule 1300.70(b)(2)(G); DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1. General Requirement and Provision 6. Delegation of Quality Improvement Activities.

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

In preparation for the enrollment approximately 13,000 SPD members, the Plan made several changes and enhancements to its operations to accommodate this influx of SPDs into managed care.

Utilization Management:

- The Plan increased staffing in this area in preparation for the increased volume membership resulting from the SPD enrollment.

Continuity of Care:

- The Plan conducted regular meetings with area providers in order to expand its network and executed letters of agreement with providers who were currently treating SPD patients.
- The Plan targeted recruitment of specialty providers who this group utilizes heavily, including pain management specialists.
- The Plan has enhanced case management capabilities and increased case management staffing.

Member Rights:

- The Plan recruited additional providers to expand its network to accommodate the SPDs.
- The Plan expects that its new electronic medical record system will enhance satisfaction not only among its providers but among its members, including the SPDs. Contra Costa Regional Medical Center (CCRMC), the Plan's major contracted facility in the area, is partially delegated to perform grievance functions to enhance member satisfaction by facilitating receipt, investigation and speedy resolution of grievances.

Quality Management:

- The Plan implemented a new data and electronic medical record system in mid-2012. Although the transition to this system has, to date, negatively impacted the Plan's ability to produce management reports and patient data. It is the Plan's expectation that in the future the system will provide enhanced reporting and facilitate exchange of information between and among the Plan and its providers.
- One Plan quality improvement project, which examines readmissions, has special relevance for SPDs. As part of the project, quality management staff intends to focus on SPD-specific concerns.

2013 CONTRA COSTA HEALTH PLAN: DISCUSSION OF POTENTIAL

UTILIZATION MANAGEMENT
In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's utilization management processes including: a. The development, implementation, and maintenance of a Utilization Management Program. b. The mechanism for managing and detecting over- and under-utilization of services. c. The methodologies and processes used to handle prior authorizations appropriately while complying with the requirements specified in the contract as well as in state and federal laws and regulations. d. The methodologies and processes used to evaluate utilization management activities of delegated entities.

Potential Deficiency #1: The Plan does not ensure that clinical decisions based on medical necessity are consistent with Plan criteria and guidelines.

Statutory/Regulatory/Contract Reference(s): Section 1367.01(b); DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management.

Section 1367.01(b) states, in pertinent part "policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes."

DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management. Provision 2, Pre-Authorizations and Review Procedures states, "Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:"

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

Supporting Documentation:
The Department requested and reviewed the following documentation:

- 1.1.1 UM Program Description 2011 and 2012
- Quality Council minutes for the audit period

Assessment: The Department reviewed the Plan's procedures for ensuring that utilization management review decisions are consistent with the Plan's Utilization Management criteria and guidelines. Section 1367.01(b) requires that a plan's policies and procedures ensure that utilization management decisions based on medical necessity are consistent with criteria or guidelines supported by clinical principles and processes. The DHCS contract also requires consistent application of criteria or guidelines for utilization review. The Plan's Utilization Management Policy # UM15.002 provides that its purpose is to

> "*ensure that medical necessity decisions for proposed health care services are consistent with criteria or guidelines that mimic standards established by the individuals product line or when not available or non specific, supported by sound clinical principles and processes.*"

The Plan's policy further provides, under *Application of Criteria or Guidelines*, that

> "*the consistency of applying approved criteria and guidelines are measured at all levels of delegation via periodic retrospective review by supervisory staff, utilization management rounds, or periodic audits of determinations made by using this criteria.*"

The Plan's policy states that it conducts three activities to ensure a consistent application by Plan personnel of medical criteria and guidelines. Those three activities are: periodic retrospective review by supervisory staff, utilization management rounds, or periodic audits of determinations made using the criteria and guidelines. During the onsite review, the Plan could not provide any evidence suggesting that it actually conducts the activities articulated in its policy or any other activity that would confirm the Plan is monitoring that utilization management decisions are consistent with clinical guidelines. Therefore, the Department could not verify that the Plan is actually ensuring consistency or adherence to its utilization management criteria or guidelines in the determination of utilization management decisions.

CONTINUITY OF CARE
In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's continuity of care processes including: a. The methodologies and processes used to coordinate medically necessary services within the provider network b. The coordination of medically necessary services outside the network (specialists) c. The coordination of special arrangement services including, but not limited to, California Children's Services, Child Health and Disability Prevention, Early Start, and Regional Centers d. Compliance with continuity of care requirements in Section 1373.96 of the Health and Safety Code

POTENTIAL DEFICIENCIES:

Based on the Department's review, there were no potential deficiencies identified in the area of continuity of care.

ACCESS & AVAILABILITY
In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's processes to support access and availability including: a. The availability of services, including specialists, emergency, urgent care, and after-hours care. Health plan policies and procedures for addressing a patient's request for disability accommodations.

Potential Deficiency #2: The Plan's website and provider directory do not indicate levels of access or Medical Equipment access.

Statutory/Regulatory/Contract Reference: DHCS MMCD Policy Letter 12-006; DHCS Two-Plan Contract, Exhibit A, Attachment 13 Member Services, Provision 4. Member Information

DHCS MMCD Policy Letter 12-006 - August 9, 2012
Plans are to make the results of FSR Attachment C available to members through their websites and provider directories. The information provided must, at a minimum, display the level of access results met per provider site as either Basic Access or Limited Access. Additionally, Plans must indicate whether the site has Medical Equipment Access as defined in FSR Attachment C, and identify whether each provider site has or does not have access in the following categories: parking, building exterior, building interior, exam room, restroom, and medical equipment (height adjustable exam table and patient accessible weight scales).

DHCS Two-Plan Contract, Exhibit A, Attachment 13 Member Services, Item 4D – Member Information
4.D. Compliance with the following may be met through distribution of a provider directory: The name, provider number, address, and telephone number of each Service Location (e.g., locations of hospitals, Primary Care Physicians (PCP), specialists, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities, FQHCs, Indian Health Programs). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, provider number, address, and telephone number shall appear for each Physician provider: The hours and days when each of these facilities is open, the services and benefits available, including which, if any, non-English languages are spoken, the telephone number to call after normal business hours, accessibility symbols approved by DHCS, and identification of providers that are not accepting new patients.

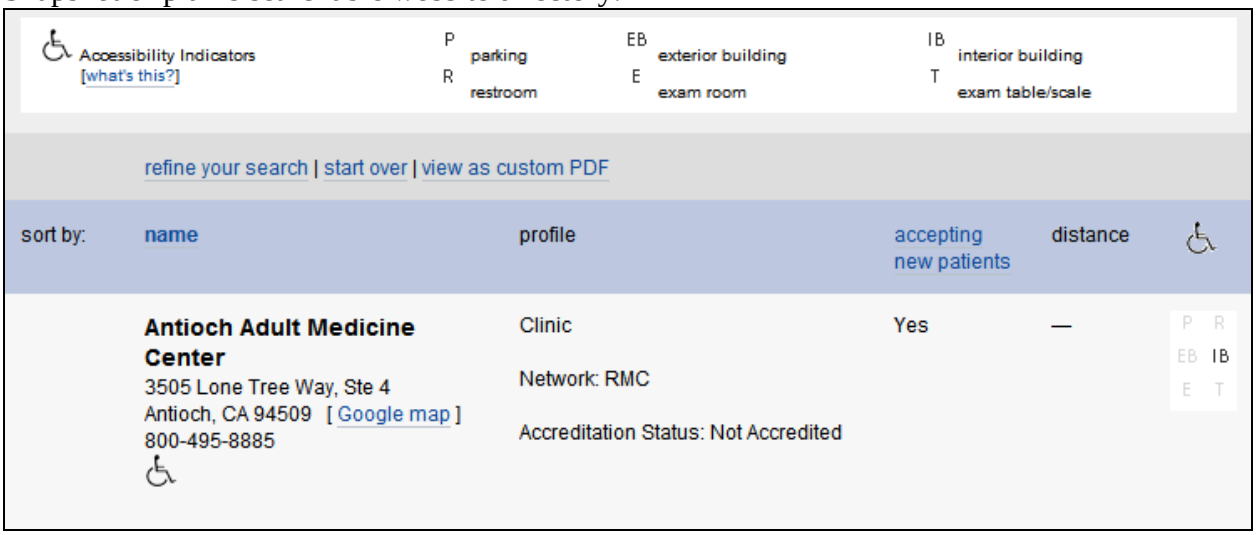
Supporting Documentation:
The Department requested and reviewed the following documentation:

- Plan's searchable online Provider Directory, http://cchealth.org/healthplan/provider-directory.php
- Your 2012 - 2013 Informational Materials for Medi-Cal Members – Section B: Provider Directory

Assessment:
The Department's review found that the Plan's website and provider directory partially meet the requirements outlined in the DHCS MMCD Policy Letter 12-006. The Plan's online provider

directory displays the accessibility indicator categories (i.e. parking, building exterior, building interior, exam room and restroom) but does not include the level of access results met per provider site as either Basic Access or Limited Access, and whether the site has Medical Equipment Access.

Snapshot of plan's searchable website directory:



MEMBER RIGHTS
In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's member rights processes, including: a. Compliance with requirements for a complaint/grievance system and examination of a sufficient number of SPD member grievance files to ensure an appropriate audit confidence level b. Primary Care Physician (PCP) selection and assignment requirements c. Evaluation of available interpreter services and member informing materials in identified threshold languages d. Ability to provide SPDs access to member services and/or grievance department in alternative formats or through other methods that ensure communication

POTENTIAL DEFICIENCIES:

Potential Deficiency #3: The Plan's *Member Handbook and Evidence of Coverage* incorrectly implies that members can only file an appeal to a grievance decision in writing.

Statutory/Regulatory/Contract Reference: Rule 1300.68(a)(1); DHCS Two-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System, 1: Member Grievance System and 4: Member Written Information.

Rule 1300.68(a)(1) states, in pertinent part, "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..."

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

1. Member Grievance System

A. Contractor shall implement and maintain a Member Grievance system in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

4. Written Member Information

D. Contractor shall develop and provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of the covered health care services. The Member Services Guide shall be submitted to DHCS for review prior to distribution to Members. The Member Services Guide shall include the following information:
Procedures for filing a grievance or appeal with Contractor, either orally or in writing, or over the phone, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization or other dissatisfaction with the Contractor and/or providers...

Supporting Documentation:
The Department requested and reviewed the following documentation:

- Notice of Action (NOA) – Denial About Your Treatment Request templates in English and Spanish
- *Member Appeal Process of Your Rights Under Medi-Cal Managed Care Enclosure*
- Your 2012 – 2013 Informational Materials for Medi-Cal Members: Section A. Member Handbook and Section B. Combined Evidence of Coverage and Disclosure Form (EOC)

Assessment: Rule 1300.68(a)(1) defines grievances as "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 consideration for reconsideration or appeal made by an enrollee or the enrollee's representative." Moreover, the DHCS 2-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 4 - Written Member Information requires the plan to provide members with procedures for filing a grievance or appeal with the Plan, either orally or in writing, or over the phone.

The Department found that the Plan does not consistently inform members that a grievance or appeal can be filed either orally or in writing in its member informing materials. The *Member Appeal Process of Your Rights Under Medi-Cal Managed Care* enclosure that accompanies the Plan's Notice of Action letters correctly instructs members that if they disagree with the Notice of Action, they may file an appeal by writing or by calling the member services toll free number. The enclosure states "If you disagree with the Notice of Action, you or your appointed representative can ask for an appeal by filing a written appeal, or calling Member Services..." However, the Plan's *Member Handbook and Evidence of Coverage* document distributed to

members incorrectly instructs members who wish to file an appeal to submit the appeal in writing.

For example:

- The Plan's Member Handbook states "… you may submit an appeal in writing to Member Services within 90 days …" (underline emphasis added)

- The Plan's Evidence of Coverage states: "You may send Member Services a written request for reconsideration within 90 days of the date of Plan denial." (underline emphasis added)

The Plan should ensure that correct and consistent information is provided to Plan members.

Potential Deficiency #4: The Plan does not ensure that grievance forms distributed by Contra Costa Regional Medical Center (CCRMC) to Plan members contain the statement described in Section 1368.02(b).

Statutory/Regulatory/Contract Reference: Section 1368.02(b); DHCS Two-Plan Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1. Member Grievance System.

DHCS Two-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System, 1. Member Grievance System
Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

DHCS Two-Plan Contract, Exhibit A, Attachment 4 Quality Improvement System
Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors.

Section 1368.02(b) states, in pertinent part, "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 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 address shall be displayed by the plan in each of these documents in 12-point boldface type using the statement described in Section 1368.02(b)."

Supporting Documentation:
The Department requested and reviewed the following documentation:

- Contra Costa Regional Medical Center & Contra Costa Health Centers, PATIENT COMPLAINT/GRIEVANCE – QUEJA DEL PACIENTE
- Plan Policy # MS 8.001, Handling of Complaints and Grievances, 12/2012

Assessment: The Plan delegates certain functions of the grievance process to Contra Costa Regional Medical Center (CCRMC), a major contracted facility. The Plan's Policy # MS 8.001, Handling of Complaints and Grievances, states that CCRMC… "may use their internal complaint and grievance forms as per agreement with CCHP for plan members…" In interviews, Plan officials confirmed that CCRMC uses its own grievance form to record member verbal grievances and then forwards the forms to the Plan. CCRMC also provides its own grievance forms to Plan members upon request. The Department reviewed the grievance form utilized by CCRMC and found that the grievance form does not include the statement as described in Section 1368.02(b).

QUALITY MANAGEMENT
In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's quality management processes including: a. Verifying that health plans monitor, evaluate, and take effective action to maintain quality of care and to address needed improvements in quality. b. Verifying that health plans maintain a system of accountability for quality within the organization. c. Verifying that health plans remain ultimately accountable even when Quality Improvement Plan activities have been delegated.

Potential Deficiency #5: The Plan's current reporting system does not produce adequate or accurate data that would allow the Plan to continuously review the quality of care provided to members and/or ensure that quality of care problems are identified and corrected.

Statutory/Regulatory/Contract Reference: Rules 1300.70(b)(1)(A) and (B); Rule 1300.70(b)(2)(C); Rule 1300.70(b)(2)(H)(2); Rule 1300.70(c); DHCS Two-Plan Contract, Exhibit A, Attachment 3, Management Information System; DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System; DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management.

Rules 1300.70(b)(1)(A) and (B) state in pertinent part, "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."

Rule 1300.70(b)(2)(C) states, "The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues."

Rule 1300.70(b)(2)(H)(2) states, "Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under- utilization of specialist services and preventive health care services.

Rule 1300.70(c) states, "In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department.'

<u>DHCS Two-Plan Contract, Exhibit A, Attachment 3, Management Information System Capability</u>
"Contractor's Management and Information System (MIS) shall have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's encounter data submission."

<u>DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System</u>
"Contractor shall implement an effective system Quality Improvement System (QIS) in order accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting."

<u>DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management</u>
"Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

F. 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. This specialty referral system should include non-contracting providers."

Supporting Documentation:
The Department requested and reviewed the following documentation:

- Quality Council meeting minutes December 2011 – February 2013
- UM15.008 Under-Over Utilization Policy (last revision date 06/05/09)
- Contra Costa Health Plan Committees' minutes - 2012

Assessment: The Plan's Utilization Management Policy #: UM 15.008, provides the following:

> *"Contra Costa Health Plan (CCHP) monitors healthcare services that are requested and/or rendered to members for under and over utilization activities by:*
>
> *1) Trending outpatient and inpatient days, including patters of readmission and similar diagnosis.*
>
> *2) Monitoring frequency of procedures, imaging studies, laboratory tests, or ancillary services.*
>
> *3) Reviewing level of care activities.*
>
> *4) Tracking access to care.*

The Plan currently utilizes EPIC, an electronic medical record and data system implemented in July of 2012, in order to produce reports for conducting the activities provided for in the Plan's Policy #: UM 15.0008. The activities include tracking, reviewing and monitoring quality of service and utilization of service including emergency services. Onsite interviews with Plan staff revealed that since the implementation of EPIC, the Plan has encountered significant issues with EPIC's ability to produce accurate and meaningful reports for tracking, trending and analysis of both quality and utilization of services for all members including SPDs.

Before the implementation of EPIC, the Plan used a dashboard report in order to monitor and track enrollee service usage and the use of case management services. Currently, EPIC cannot generate any reports that would show specialty referral appointments by specialty type, the frequency of key diagnoses, the use of urgent care by enrollees, and/or the use of services requiring pre-authorization. In addition, the Plan is unable to monitor, track, trend or analyze the current use of services, including prescription drug use, by SPD members. For example, Quality Council Minutes discussed a rise in prescription drug use from 2011-2012; however, the Plan could not produce reports that would allow the Plan to analyze whether the rise occurred because of the SPD transition or if there was another factor contributing to rise in pharmacy utilization. Moreover, Plan representatives stated that EPIC cannot produce electronic information necessary for the calculation of HEDIS measures.

Rule 1300.70(a)(3) requires the Plan to monitor whether the provision and utilization of services meets professionally recognized standards of practice. Rules 1300(b)(1)(A) and (B) provide that Plans are required to continuously review the quality of care provided to enrollees, ensure that a level of care meeting professionally recognized standards of practice be delivered to enrollees, and that quality of care problems be identified and corrected for all provider entities. Rule 1300.70(b)(2)(C) requires the plan to establish a program to monitor and evaluate the care provided by each contacting provider group to ensure that the care provided meets professionally

recognized standards of practice. Rule 1300.70(b)(2)(H)(2) requires that Plans having capitation contracts have a mechanism to detect and correct under-service by providers including possible under- utilization of specialist services and preventative health care. Rule 1300.70(c) requires the Plan to continuously review the utilization of services and facilities.

The DHCS Two-Plan Contract requires the Plan to establish a specialty referral system to track and monitor referrals requiring preauthorization and include in the UM program mechanisms to detect both under and over utilization of health care services. The DHCS Two-Plan contract also requires that the Plan have a management information system that has the ability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of the DHCS's encounter data submission. In addition, the DHCS Two-Plan contract requires that the Plan implement an effective Quality Improvement System in accordance with Rule 1300.70. The Plan shall monitor, evaluate, and take effective action to address any needed improvements.

The Plan's current inability to produce meaningful and useful reports that would allow for the tracking, trending and analyzing of services greatly impedes its ability to effectively monitor and evaluate the services it is providing to its members. Further, the Plan cannot meet its obligations under both the Rules and the DHCS Two-Plan Contract without being able to evaluate accurate data. The Plan cannot confirm issues operationally, identify root causes or implement corrective actions if it continues to rely on a faulty reporting system. Further, the Plan cannot ensure adherence to its own policy regarding the monitoring of utilization of services without a reliable data.

Potential Deficiency #6: The Plan is not ensuring that its largest delegate implements corrective action plans when deficiencies in care are revealed.

Statutory/Regulatory/Contract Reference: Rule 1300.70(a)(1); Rule 1300.70(b)(2)(G); DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System.

Rule 1300.70(a)(1) states, "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)(2)(G) states, "Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.
If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:
(1) Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the plan.

(2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise, and budgetary resources.
(3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities."

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 4, Quality Improvement System
"Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider."

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 4, Quality Improvement System
"Contractor is accountable for all quality improvement functions and responsibilities that are delegated to subcontractors."

Supporting Documentation:
The Department requested and reviewed the following documentation:

- Results of Plan's 2010 and 2011 – 2012 delegation audits of Contra Costa Regional Medical Center
- Quality Council meeting minutes December 2011 – February 2013
- Quality Management Policy Title: Delegation Oversight Process Policy #: QM14.301 (last revision date 6/25/12)
- Plan contracts with Contra Costa Regional Medical Center and Kaiser Foundation Health Plan

Assessment:
The Plan's largest delegate is Contra Costa Regional Medical Center (CCRMC). Approximately 60% of the Plan's members are assigned to CCRMC. The Plan's policy Quality Management, Delegation Oversight Process, Policy # QM14.301 provides that the Plan delegates the following activities to CCRMC: routine quality management-partial delegation, provider credentialing-full delegation, member satisfaction-partial delegation, access monitoring-partial delegation, service improvements-partial delegation, clinical practice guidelines-full delegation, routine utilization management-full delegation, utilization management criteria-full delegation, utilization management denials-partial delegation, cultural linguistics-full delegation, grievances-partial delegation and member health education-partial delegation.

The Department reviewed the Plan's monitoring of the delegated functions described above. Policy # QM14.301 provides that activities will be monitored by routine reporting throughout the year for certain activities. The Policy further provides that if opportunities for improvement have been identified, a Corrective Action Plan (CAP) will be written and sent.

The 2011/2012 Delegation Audit of CCRMC prepared by Contra Costa Health Plan's Quality Department and presented to the Plan's Quality Council February 28, 2013, revealed that

CCRMC failed the audit in the areas of Health Education, Quality Management and Access and Availability. The notes in the audit referred to CCRMC's continued failure to meet acceptable standards in the same areas over a period of three years and CCRMCs inability to meet the DHCS reporting contract requirements. The notes also mentioned the lack of interest by the facility in complying with the Plan's CAPs in the past and the facilities ongoing unresponsiveness to the Plan's concerns regarding the results of past audits.

Rule 1300.70(a)(1) requires that a Plan's Quality Assurance program be directed by providers, 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)(2)(G) allows plans to use the quality assurance programs of provider entities; however, the Plan must retain responsibility for reviewing the overall quality of care delivered to Plan enrollees. The DHCS contract requires that the Plan implement an effective Quality Improvement System in accordance with the standards in Title 28, CCR, Section 1300.70. The DHCS contract further provides that the Plan monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf and that the Plan be accountable for the quality of all covered services regardless of the number of contracting and subcontracting layers between the Plan and the provider.

Here, it appears the Plan is monitoring its delegate, CCRMC, as evidenced by its 2011/2012 audit and subsequent CAPs issued to the delegate. However, CCRMC continues to defy the Plan's CAPs where deficiencies in CCRMC's operations have been revealed. It is evident that the CAPs are not effective and CCRMC continues to provide substandard care to Plan enrollees. During interviews, Plan staff stated that an additional audit was scheduled to occur between the years of 2010 through 2013; however, CCRMC continuously impeded the Plan's ability to conduct the audit by not submitting requested documentation for Plan analysis. In addition, CCRMC would not answer questions related to the proposed audit. Although the Plan is attempting to conduct appropriate oversight, it should develop a method to ensure compliance from CCRMC despite CCRMC's continued indifference to audit findings.

A P P E N D I X A

APPENDIX A. SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Jennifer Childress	Team Lead; Access & Availability Surveyor
MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS	
Dawn Wood, MD	Utilization Management Surveyor
Patricia Schano, MEd	Quality Management & Continuity Of Care Surveyor
Bernice Young	Member Rights Surveyor
Rose Leidl, RN	Member Rights Surveyor, File Reviewer

A P P E N D I X B

APPENDIX B. PLAN STAFF INTERVIEWED

Contra Costa Health Plan	
Patricia Tanquary, MPH, PhD	Chief Executive Officer
Frank Lee, JD	Compliance Officer and General Counsel
Alycia Rubio	Claims Payments (Emergency Services) Manager
Florence Chan, RN, BSN, MBA	Utilization Management Manager
Kevin Drury	Quality Management Director, oversees delegation arrangements
Judi Louro	Plan officer with primary responsibility for the grievance system, day-to- day management of grievance and appeals staff, and oversight of member services
Terri Lieder, MPA, CPCS, CPMSM	PCP and Specialty Care Physician provider availability Manager
Belkys Teutle	Grievance Supervisor
Laurie Crider	Coordination of Care Manager
James Tysell, MD	Chief Medical Officer
Otilia Tiutin	Language Assistance Program Manager
Walter Boge	Project Manager for the “Tapestry” computer system (managed health care enrollees specific), this system is part of the recently implemented computer database software, “EPIC.”
Ates Temeltas	Contracted computer programmer for CCHS for 15 years
Luke Lim, R.Ph	Pharmacy Director
Mary Berkery, RN	Responsible for practitioners’ site visits and medical record view

A P P E N D I X C

APPENDIX C. LIST OF FILES REVIEWED

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

Type of Case Files Reviewed		
Member Rights	38	The Department identified the sample size based upon its standard File Review Methodology and a file universe of 99.