

DEPARTMENT OF
Managed Health Care
Help Center

DIVISION OF PLAN SURVEYS

1115 WAIVER

SENIORS AND PERSONS WITH DISABILITIES

**MEDICAL SURVEY REPORT OF
ORANGE COUNTY HEALTH AUTHORITY**

dba CALOPTIMA

A COUNTY ORGANIZED HEALTH SYSTEM PLAN

DATE ISSUED TO DHCS: JULY 29, 2015

**1115 Waiver SPD Medical Survey Report
Orange County Health Authority
A County Organized Health System Plan
July 29, 2015**

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EXECUTIVE SUMMARY

The California Department of Health Care Services (“DHCS”) received authorization (“1115 Waiver”) from the federal government to conduct mandatory enrollment of seniors and persons with disabilities (“SPD”) into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The DHCS then entered into an Inter-Agency Agreement¹ with the Department of Managed Health Care (the “Department”) to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California’s strong patient-rights laws. Mandatory enrollment of SPDs into managed care began in June 2011.

On June 4, 2014, the Department notified Orange County Health Authority (“CalOptima” or the “Plan”) that its medical survey had commenced and requested the Plan to provide all necessary pre-on-site data and documentation. The Department’s medical survey team conducted the on-site portion of the medical survey from September 29, 2014 through October 3, 2014.

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreement, the Department provides the 1115 Waiver SPD Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the SPD population. This medical survey evaluated the following elements specifically related to the Plan’s delivery of care to the SPD population as delineated by the DHCS-CalOptima Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations:²

I. Utilization Management

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

II. Continuity of Care

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

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

² All references to “Contract” are to the County Organized Health System, Geographic Managed Care, and Two-Plan contracts issued by the DHCS. All references to “Section” are to the Knox-Keene Act of the Health and Safety Code. All references to “Rule” are to Title 28 of the California Code of Regulations.

III. Availability and Accessibility

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

IV. Member Rights

The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for Primary Care Physician selection and assignment, and to evaluate the Plan’s ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

V. Quality Management

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

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

SUMMARY OF FINDINGS

The Department identified nine potential deficiencies during the current medical survey.

2014 MEDICAL SURVEY POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT	
#1	<p>The Plan does not have effective mechanisms in place to detect and correct under- and over-utilization of health care services. DHCS-CalOptima Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 4 – Review of Utilization Data; Rule 1300.70(b)(2)(H)(2); Rule 1300.70(c).</p>
#2	<p>The Plan does not hold its delegated entities accountable for the submission of required reports. DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provisions 6(B)(2)-(3) – Delegation of Quality Improvement Activities; DHCS-CalOptima Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 5 – Delegating UM Activities.</p>

<p>#3</p>	<p>For decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response:</p> <ul style="list-style-type: none"> • A clear and concise explanation of the reason for the decision; • A description of the criteria or guidelines used; • The clinical reasons for the decision; and • The name and telephone number of the health care professional responsible for the denial, delay, or modification. <p>DHCS-CalOptima Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(C) – Pre-Authorizations and Review Procedures; DHCS-CalOptima Contract, Exhibit A, Attachment 13 – Member Services, Provision 8(A) – Denial, Deferral, or Modification of Prior Authorization Requests; Section 1367.01(h)(4).</p>
<p>AVAILABILITY & ACCESSIBILITY</p>	
<p>#4</p>	<p>The Plan does not have an effective mechanism to continuously review, evaluate, and improve access to and availability of services.</p> <p>DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 7(G) – Written Description; DHCS-CalOptima Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3(A)(1)-(2) – Access Requirements and Provision 3(B) – First Prenatal Visit.</p>
<p>MEMBER RIGHTS</p>	
<p>#5</p>	<p>The Plan does not consistently ensure adequate consideration of member grievances.</p> <p>DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Section 1368(a)(1); Rule 1300.68.</p>
<p>#6</p>	<p>The Plan does not consistently forward urgent grievances to its Grievance and Appeals Resolution Services unit.</p> <p>DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68.01(a).</p>
<p>#7</p>	<p>The Plan does not consistently process all expressions of dissatisfaction by members as grievances.</p> <p>DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68(a)(1)-(2).</p>
<p>QUALITY MANAGEMENT</p>	
<p>#8</p>	<p>The Plan does not adequately monitor, evaluate, and take effective action when potential quality issues are identified.</p> <p>DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement.</p>
<p>#9</p>	<p>The Plan does not consistently report serious quality deficiencies that result in the termination of a practitioner to the appropriate authorities.</p> <p>DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and 12(E) – Credentialing and Recredentialing; Rule 1300.70(b)(2)(C).</p>

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

- The Plan established a Member Liaison Unit within the Customer Service Department to assist Customer Service Representatives with the handling of SPD cases and other Plan members with chronic conditions.
- The Plan participates in a statewide Quality Improvement Project that addresses readmissions.
- The Plan's delegates are required to provide case management services for their assigned members; the Plan provides similar services for those members it manages. The Plan receives monthly oversight reports from its delegates and administers a satisfaction survey to assess members' case management experiences.
- The Plan provided initial training to providers on the needs of the SPD population and has educational programs that it shares with primary care providers (PCPs).
- To assist in the management of hospitalized patients, the Plan partners with a network of all hospitals in the county so that notification of all emergency department and inpatient admissions are sent to the Plan daily and subsequently distributed to its provider networks.

DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

Potential Deficiency #1: The Plan does not have effective mechanisms in place to detect and correct under- and over-utilization of health care services.

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 4 – Review of Utilization Data; Rule 1300.70(b)(2)(H)(2); Rule 1300.70(c).

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

4. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor’s internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request.

Rule 1300.70(b)(2)(H)(2)

A plan that has capitation or risk-sharing contracts must:

Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible underutilization of specialist services and preventive health care services.

Rule 1300.70(c)

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.

Documents Reviewed:

- Utilization Management Program Description (2013 and 2014)
- Utilization Management Committee Meeting Minutes with attachments (01/14/14, 04/24/14)
- Plan Policy GG.1532: Over and Under Utilization Monitoring (06/01/14)

Assessment: The Plan’s UM Program Description describes the Plan’s efforts to review the appropriateness of care provided to members and under- and over-utilization patterns. Examples of elements reviewed include hospital admits, all-cause readmissions, pharmacy utilization, bed days, emergency room visits, encounters per enrollee per year, and referral patterns. Prior to May 31, 2014, the Plan did not have policies and procedures in place for monitoring under- and over-utilization of services.

In June 2014, the Plan implemented Policy GG.1532: Over and Under Utilization Monitoring. The policy outlines processes to track and trend the appropriate utilization of medical care and services delivered to its members. It also describes processes the Utilization Management Committee (UMC) uses to identify under- and over-utilization through monitoring, tracking, and analyzing data. When potential under- or over-utilization is identified, the policy also includes

how the Plan identifies key variables in order to determine and assess the problem. Although the Plan's UM Program Description and Policy GG.1532 enumerate a variety of methods for monitoring under- and over-utilization of services, the Plan was unable to demonstrate that it collected, reviewed, and analyzed utilization data for patterns and trends.

Review of the Plan's 2014 UMC meeting minutes revealed that under- and over-utilization data was reviewed and analyzed during the January 14, 2014 and April 24, 2014 meetings. However, the only reports presented at these meetings included hospital admissions, readmissions, pharmacy utilization, bed days per thousand, and emergency room visits per thousand. There was no discussion of utilization patterns pertaining to SPD members. Also, the Plan was unable to provide documentation to demonstrate that all data elements outlined in the UM Program Description and Policy GG.1532 were collected, presented, and analyzed at the UMC meetings. Specifically:

- During the January 14, 2014 UMC meeting, an increase in bed days, admissions, readmissions, and average length of stays was reported for all but one of the Plan's provider networks. However, the minutes did not document discussions of causes, interventions, or the delegates' performance. The Plan's Chief Medical Officer requested that SPD data be reported separately at the next meeting.
- During the April 24, 2014 UMC meeting, attendees discussed the need to analyze utilization data and develop corrective action plans to improve performance. The Medical Director mentioned various indicators that should be analyzed to determine under- and over-utilization for all lines of business. Emergency room admissions and inpatient data from January 2013 to September 2013 was presented, but this data was not analyzed, and the committee's action plan indicated, "refer to PowerPoint." There was no evidence that the Plan had collected any data pertaining to the new service elements described in the 2014 UM Program – back surgery, bariatric surgery, lumpectomy, and mastectomy. No SPD data was presented despite the Chief Medical Officer's request from the previous meeting.

While meeting minutes revealed that various utilization reports were presented to the UMC, the Plan was unable to demonstrate that it collected and analyzed data regarding encounters per enrollee per year, referral patterns, denials, frequency of procedures, and cultural and linguistic reports reflecting barriers to access and delivery of care. In addition, the Plan did not take corrective actions when potential under- and over-utilization issues were identified. For example, reports indicated upward trends in areas such as inpatient hospitalization, bed days per thousand, emergency admissions, and average length of stays. However, the Plan did not provide any information about possible causes, facilitate follow-up discussions, or take actions to mitigate the over-utilization of these services.

In an onsite interview, Plan officers confirmed that the Plan needs to improve its collection and analysis of utilization data. Plan staff indicated that they were in the process of designing an UM dashboard that would allow the Plan to track and trend utilization data. The Plan will require their health networks to produce electronic authorization logs, request monthly reports from delegated health networks, and analyze the data for under- and over-utilization trends. Plan staff

also expressed their intention to analyze data for the SPD population separately. The Medical Director stated that the Plan has an UM Work Group that meets twice a month. During the May and June 2014 work group meetings, the Plan discussed developing a new under- and over-utilization assessment policy. However, specific under- and over-utilization issues encountered by the Plan were not discussed.

DHCS-CalOptima Contract, Exhibit A, Attachment 5, Provision 4 and Rule 1300.70(b)(2)(H)(2) require the Plan to have mechanisms in place to detect and correct under- and over-utilization of health care services. Rule 1300.70(c) further requires the Plan to implement reasonable procedures for continuously reviewing the utilization of services and facilities. The Plan did not regularly collect, review, and track aggregate utilization data as described in its UM program descriptions and policies. In addition, the Plan did not implement policies and procedures to monitor under- and over-utilization until June 2014, and the Plan was unable to provide utilization patterns for SPD members. Since the Plan does not consistently analyze available utilization data for patterns and trends to identify and correct problems, the Department finds the Plan in violation of these contractual and regulatory requirements.

Potential Deficiency #2: The Plan does not hold its delegated entities accountable for the submission of required reports.

Contractual/Statutory/Regulatory References: DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provisions 6(B)(2)-(3) – Delegation of Quality Improvement Activities; DHCS-CalOptima Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 5 – Delegating UM Activities.

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

6. Delegation of Quality Improvement Activities

B. Contractor shall maintain a system to ensure accountability for delegated Quality Improvement activities, that at a minimum:

2. Ensures subcontractor meets standards set forth by the Contractor and DHCS.
3. Includes the continuous monitoring, evaluation and approval of the delegated functions.

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

5. Delegating UM Activities

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.

Documents Reviewed:

- Plan Policy 1619: Delegation Oversight (04/01/13)
- Utilization Management Committee Meeting Minutes (01/14/14, 04/24/14)
- UM Work Group Meeting Minutes (05/02/14, 05/19/14, 05/30/14, 06/04/14)
- 2014 Audit & Oversight Program Description
- 2014 QM Program Description
- 2014 UM Program Plan and Description

- Delegation Agreements including CalOptima Health Network Delegated Responsibilities grids
- Audit reports for three health networks

Assessment: The Plan has 11 Health Network (HN) delegates that provide health care services to approximately 80 percent of the Plan's SPD population. The Plan contracts with the delegates to perform the following responsibilities: credentialing, UM, quality improvement, claims, and case management. Plan Policy 1619: Delegation Oversight states:

3. The QI Department shall:
 - a. On a quarterly basis, review report submissions from the HN and [Participating Medical Group (PMG)] and provide feedback utilizing the Industry Collaboration Effort (ICE) Quality Management (QM) and Utilization Management (UM) Assessment template.
 - b. Conduct comparative analysis of data submitted by each HN and PMG in relation to industry or CalOptima benchmarks; and
 - c. On a quarterly basis, or when data is available for reporting, report findings to the CalOptima Quality Improvement Committee (QIC), and a summary of HN and PMG annual delegation oversight audit results to the Compliance Committee as referenced in Section III.D.

The 2014 UM Program Description states:

Page 26: The UM Subcommittee receives quarterly health network and physician medical group reports of each delegate, which include, but are not limited to, information regarding utilization data, utilization issues, and ongoing reviews. The delegate's UM Committee functions and activities are monitored and reviewed by the Quality Improvement Department – Delegation Oversight unit on an on-going and annual basis.

Page 62: CalOptima will demonstrate accountability for delegated functions through summary documentation, descriptions of the delegates' activities, and the standards and requirements with which the delegated organization must comply.

Additionally, the CalOptima Health Network Delegated Responsibilities grid, attached to each delegation agreement, outlines each delegate's reporting responsibilities referenced in Policy 1619 and the UM Program Description. The delegates are required to submit utilization data and monitoring reports to the Plan on a monthly or quarterly basis. The Plan was unable to demonstrate that any of the health networks submitted reports as outlined in the policy and delegation agreements. Review of the Plan's UMC meeting minutes and staff interviews further confirmed that the Plan did not receive and review any utilization data or monitoring reports.

DHCS-CalOptima Contract, Exhibit A, Attachment 4, Provision 6(B)(2)-(3) and DHCS-CalOptima Contract, Exhibit A, Attachment 5, Provision 5 require the Plan to continuously monitor, evaluate, and approve delegated Quality Improvement and UM functions. Although the

delegated entities are required to submit utilization data and monitoring reports, the Plan was unable to produce these documents. As the Plan could not provide information on how it continuously monitors, evaluates, and approves delegated functions, the Department finds the Plan in violation of these contractual requirements.

Deficiency #3: For decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response:

- **A clear and concise explanation of the reason for the decision;**
- **A description of the criteria or guidelines used;**
- **The clinical reasons for the decision; and**
- **The name and telephone number of the health care professional responsible for the denial, delay, or modification.**

Contractual/Statutory/Regulatory References: DHCS-CalOptima Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(C) – Pre-Authorizations and Review Procedures; DHCS-CalOptima Contract, Exhibit A, Attachment 13 – Member Services, Provision 8(A) – Denial, Deferral, or Modification of Prior Authorization Requests; Section 1367.01(h)(4).

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

2. Pre-Authorizations and Review Procedures

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

C. Reasons for decisions are clearly documented.

DHCS-CalOptima Contract – Exhibit A, Attachment 13 – Member Services

8. Denial, Deferral, or Modification of Prior Authorization Requests

A. Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

Section 1367.01(h)(4)

Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall

include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification...

Documents Reviewed:

- 2014 UM Program Plan and Description
- 19 Appeals Files(01/01/14 to 06/30/14)

Assessment: The Plan’s 2014 UM Program Plan and Description states:

DENIAL NOTIFICATIONS:

All potential denial, and/or modification of service are discussed with the appropriate Medical Director, who makes the final determination. Services that are denied, modified, delayed, or terminated shall contain the following elements:

- Clear and concise explanation of the reason for denial
- Citation to the criteria used to support the decision
- Alternative treatment recommendation (which will, at the minimum, refer the member back to their physician for further discussion)
- Name and direct telephone number of the healthcare professional responsible for the denial, delay or modification
- Member Rights
- Appeal Rights and Process

The Department reviewed 17 files³ and discovered that the Notice of Action (NOA) denial and modification letters sent out by the Plan’s delegates did not consistently provide members with clear and concise explanations, descriptions of criteria or guidelines used, and the clinical reasons for the decisions. In three files (18%), the NOA letters did not provide a clear and concise explanation of the reasons for the denials.⁴ In three files (18%), the NOA letters did not include a description of the criteria or guidelines used to deny the request.⁵ In two files (12%), the NOA letters did not specify the clinical reason for the denials.⁶ In addition, the Department found that in two files (12%), the Plan’s delegates did not include the name and telephone number or extension of the health care professional who made the denial determination in the written communications to the requesting provider.⁷

- *File #22:* This file involved the modification of a request for a Positron Emission Tomography (PET) scan and Computerized Tomography (CT) scan, diagnostic tools used to detect cancer and stages of cancer. The delegate modified the PET scan request

³ The Department identified and reviewed 19 appeals files. Two appeals files involved denials based on benefit coverage and were excluded from the review.

⁴ File #22, 26, 28

⁵ File #22, 26, 28

⁶ File #22, 28

⁷ File #1, 44

to an oncologist specialist referral. The NOA letter stated the following reason for the modification:

The medical necessity for this referral is based on nationally accepted criteria. If the treating physician would like to discuss this case with the physician or health care professional reviewer or obtain copy of the criteria used to make this determination please call our medical director at ... This is initial notice that this referral request has been MODIFIED as reflected in the outcome above. A formal notification will be sent to the requesting provider and member in compliance with regulatory standards. For UM Service call [phone number].

The NOA letter does not indicate what services were requested, which service is being modified, and the reason for the modification. Although the Plan bases the modification on “nationally accepted criteria,” the Plan does not provide the criteria or guidelines it used to make that decision. The letter also does not mention which of the member’s specific conditions the Plan took into consideration when determining whether the member would meet the medical necessity criteria for a PET scan.

- *File #26:* This file involved a denial of a request for a laboratory test for Pediatric Acute-onset Neuropsychiatric Disorders Associated with Streptococcus/Pediatric Acute-onset Neuropsychiatric Syndrome (PANDAS/PANS). The denial letter states:

This requested service was reviewed by our Medical Director. This request is denied because, we cannot approve your request for a lab draw at [hospital]. Your child's medical records show that he has repeated ear infections. He also has history of ticks (spasms & twitches) that get worse when he has an infection. His doctor is requesting laboratory testing to be done at [hospital] to see if he has PANDAS/PANS (tics, compulsions and other symptoms associated with a specific type of infection). [Hospital] will send out the laboratory sample to [lab], the only laboratory facility in the country that does the requested tests. However, this test is not medically necessary for your son's condition. The records received do not show that he has active ticks at this time. The records do not also show that he has other symptoms that point to PANDAS/PANS. The identification of this disorder is based on defined features. The lab test serves as an aid to the doctor. At present, however, this test is not yet approved by the FDA (Food and Drug Administration; government agency). As a result, this request has been denied. We based this decision on the [lab] [w]ebsite.

Instead of the service requested we are recommending the following: Please return to your child's neurologist or Primary Care doctor for further evaluation and treatment options for his condition.

After reviewing the child’s medical records, the Plan concluded that the requested laboratory test was not medically necessary because the child did not exhibit defined features that are

specific to PANDAS/PANS. The Plan then stated that the request was denied because the test is not FDA approved. As two unrelated reasons were offered, the Plan did not provide a clear and concise explanation as to why the request was denied. In addition, the Plan indicated that the denial was based on the lab's website. However, the Plan did not specify where one can find the criteria or guidelines it relied upon as its basis for the denial.

- *File #28*: This file involved the denial of a request for a motorized wheelchair. The NOA denial letter states:

...This request is denied because, it does not meet Cal Optima Policy CG:1531 criteria. As a result, we cannot approve your request for a power operated wheelchair. Your request shows that this device will be used to help your back problems and joint swelling. This device is not medically necessary for your condition. Your records do not show that you are bed or chair bound. As a result, the requested service has been denied.

Instead of the service you requested, we are recommending the following: Please contact your Primary Care doctor for further evaluation and treatment options for your condition.

If you would like to obtain a copy of the actual benefit provision, guideline, protocol or other criteria on which the denial decision was based on please contact [delegate] at [phone number]...

The Plan asserted that the power wheelchair request was denied because it did not meet Policy CG:1531 criteria, but the denial letter did not provide any description of the policy on which the Plan relied. Moreover, the power-operated wheelchair was requested to alleviate the member's back problems and joint swelling. The Plan's clinical reason for the denial was that the medical records did not show the member to be bed or chair bound. However, just because one is not bed or chair bound does not mean that one does not suffer from back problems and joint swelling. The Plan did not directly address and provide reasons why the member's medical issues would not benefit from having a power wheelchair.

Furthermore, the NOA letter does not reflect the complete clinical reason for the denial. The April 28, 2014 assessment by the Plan's Durable Medical Equipment (DME) consultant states:

Although a powered wheelchair is medically necessary, powered mobility cannot be recommended until [member] has secured wheelchair accessible housing. Therefore, relocation assistance to wheelchair accessible housing is recommended before a powered wheelchair can be provided. Additionally, an assessment for In-Home Support Services is recommended for assistance for assistance with Activities of daily living.

In addition, the Case Summary in the member's file indicates:

Member meets [Milliman Care Guidelines] 18th edition Wheelchairs, Powered ACG: A-0353 due to medical necessity, however the DME consultant states that powered mobility cannot be recommended until member has a secured wheelchair (w/c) accessible housing. Case management will work with member for IHSS and housing for a secured w/c accessible location.

The Plan denied the request due to lack of medical necessity. However, based on information in the member’s file, the wheelchair was determined to be medically necessary for the member’s condition. The lack of wheelchair accessible housing, the actual reason for the Plan’s denial, was never presented to the member. As such, the letter does not present a clear explanation of the reason for the denial.

TABLE 1
UM Medical Necessity Denials

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
UM Denials	17	Clear and concise explanation	14 (82%)	3 (18%)
		Description of the criteria or guidelines used to make determination	14 (82%)	3 (18%)
		Clinical reason for the denial	15 (88%)	2 (12%)
		Name and telephone number or extension of physician	15 (88%)	2 (12%)

DHCS-CalOptima Contract, Exhibit A, Attachment 5, Provision 2(C) requires the Plan to clearly document its reasons for pre-authorization decisions. DHCS-CalOptima Contract, Exhibit A, Attachment 13, Provision 8(A) requires the Plan to provide written notification to members and/or their authorized representatives of decisions to deny, defer, or modify requests as specified in section 1367.01. Section 1367.01(h)(4) requires the Plan to provide a clear and concise explanation, a description of the criteria or guidelines used, and the clinical reasons for the denials, delays, and modifications regarding medical necessity. In addition, any written communication to the requesting provider shall include the name and telephone number of the health care professional responsible for the decision. Review of the Plan’s NOA letters revealed that the letters did not consistently include clear and concise explanations, criteria or guidelines, clinical reasons for its decisions, and the name of the telephone number of the decision making health care professional. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

AVAILABILITY AND ACCESSIBILITY

Potential Deficiency #4: The Plan does not have an effective mechanism to continuously review, evaluate, and improve access to and availability of services.

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 7(G) – Written Description; DHCS-CalOptima Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3(A)(1)-(2) – Access Requirements and Provision 3(B) – First Prenatal Visit.

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

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.

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

3. Access Requirements

Contractor shall establish acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2 and as specified below... Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

(1) Appropriate Clinical Timeframes:

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

(2) Standards for Timely Appointments:

Members must be offered appointments within the following timeframes:

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

B. First Prenatal Visit

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within 10 business days upon request.

Documents Reviewed:

- 2013 Accessibility Survey Tool
- 2013 Accessibility Report (September 2013)
- Plan Policy GG1600: Access and Availability Standards (01/01/14)

Assessment: The Plan conducts an annual provider survey to evaluate compliance with access and availability with a focus on appointment wait time standards. The survey tool displayed a listing of appointment types and asked providers to mark boxes labeled with ranges of days to indicate how soon a patient would be able to obtain an appointment.

3. Starting from today, please indicate how soon a patient could be seen for the following types of care ('day' refers to calendar days):

FOR PRIMARY CARE ONLY:

	Same day	Within 24 hrs	Within 48 hrs	3 days	4 days	5-7 days	8-14 days	15-21 days	22-30 days	31-90 days	91-120 days	120+ days	N/A
3a. Urgent care visit	<input type="checkbox"/>												
3b. Non-urgent acute care visit	<input type="checkbox"/>												
3c. Primary care visit	<input type="checkbox"/>												
3d. Routine physical exam and wellness visit	<input type="checkbox"/>												
3e. Initial Health Assessment (IHA) and Individual Health Education Behavioral Assessments (IHEBA)	<input type="checkbox"/>												
3f. Comprehensive health assessment	<input type="checkbox"/>												

FOR OB/GYN CARE ONLY:

	Same day	Within 24 hrs	Within 48 hrs	3 days	4 days	5-7 days	8-14 days	15-21 days	22-30 days	31-90 days	91-120 days	120+ days	N/A
3g. First prenatal visit	<input type="checkbox"/>												

FOR SPECIALTY CARE (NON OB/GYN) ONLY:

	Same day	Within 24 hrs	Within 48 hrs	3 days	4 days	5-7 days	8-14 days	15-21 days	22-30 days	31-90 days	91-120 days	120+ days	N/A
3h. Urgent specialty visit (once referral approved)	<input type="checkbox"/>												
3i. Routine specialty visit (once referral approved)	<input type="checkbox"/>												

DHCS-CalOptima Contract, Exhibit A, Attachment 9, Provisions 3(A) and 3(B) provide timeframes within which appointments must be offered. The Plan's survey tool indicates that "'day' refers to calendar days." Although the DHCS contract requires some appointments to be made available within a specified number of calendar days, some appointments must be provided within a certain number of business days after the appointment is requested. The Plan's survey tool is an inadequate mechanism for assessing whether members are able to obtain appointments within established wait time standards because the survey tool only collects data by calendar days and does not offer business days as an option. Furthermore, available answers on the survey tool are listed in ranges:

Same day	Within 24hrs.	Within 48 hrs.	3 days	4 days	5-7 days	8-14 days	15-21 days	22-30 days	31-90 days	91-120 days	120+ days	N/A
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The wide date ranges in the survey tool (e.g., 31-90 days, 91-120 days, and 120+ days) make it difficult to determine whether a non-compliant provider is deficient by days or weeks, which could potentially impact the Plan's assessment of the severity of the problem.

While contractual standards set maximum appointment wait times measured from the time of the member's request (which includes wait times for referrals to be approved), this requirement is not specified in the survey tool. In addition, for specialty care (non OB/GYN) appointments, the Plan's survey tool collects data on wait times for urgent and routine specialty visits after the referral is approved. By not measuring the wait time from the time of the member's request, providers may appear to be compliant while actually exceeding the appointment wait time standard.

DHCS-CalOptima Contract, Exhibit A, Attachment 4, Provision 7(G) requires the Plan to implement and maintain a written description of the mechanisms it uses to continuously review, evaluate, and improve access to and availability of services to ensure that members are able to obtain appointments within established standards. DHCS-CalOptima Contract, Exhibit A, Attachment 9, Provisions 3(A) and 3(B) require the Plan to communicate, enforce, and monitor providers' compliance with several identified clinical timeframes and timely appointment standards. Although the Plan created a survey tool to review and evaluate access and availability of services, the survey tool does not incorporate each of the aforementioned access requirements in the DHCS contract. Since the Plan cannot obtain an accurate assessment of appointment wait times, it is unable to properly evaluate and improve access to and availability of services. Therefore, the Department finds the Plan in violation of these contractual requirements.

MEMBER RIGHTS

Potential Deficiency #5: The Plan does not consistently ensure adequate consideration of member grievances.

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Section 1368(a)(1); Rule 1300.68.

DHCS-CalOptima 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 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph D.13, and 42 CFR 438.420(a)(b) and (c)...

Section 1368(a)(1)

Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Rule 1300.68

Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

Documents Reviewed:

- Plan Policy HH.1103: CalOptima Health Network Member Complaint (Revised 06/01/09)
- Plan Policy HH.1102: CalOptima Member Complaint (Revised 01/01/13)
- Customer Service Department – Appeals and Grievances (11/1/2011, Revised 06/03/14)
- Customer Service Department – Call Flow for Grievance, Appeals, and PCP/Health Network Changes (11/01/2011, Revised 09/25/2014)
- SPD Member Grievances (Quarter 1 and Quarter 2 2014)
- SPD Member Appeals (Quarter 1 and Quarter 2 2014)
- 46 Exempt Grievances⁸ (01/01/14 to 06/30/14)

Assessment: The Department reviewed 46 exempt grievances received over the telephone. In eight of the 46 cases (17%), records show that members expressed dissatisfaction with their providers. To address these grievances, the Plan offered the members the option of selecting a different provider or health network. The following are summaries of the eight cases:

- *File #1:* The member, unhappy with the current provider and nurse, requested to switch to [medical group]. Although the member did not meet the medical group’s enrollment criteria, the Customer Service Representative (CSR) mailed an enrollment packet to the member.
- *File #2:* The member was unhappy with her PCP’s staff. The CSR mailed an enrollment packet to the member.
- *File #11:* The member was unhappy due to difficulties getting through to the PCP’s office and long referral turnaround times. The CSR mailed an enrollment packet to the member.
- *File #20:* The member, unhappy with the current provider, requested to switch to [medical group]. The CSR advised that the [medical group] has a closed panel. Since the member did not have the name of another provider, the CSR was unable to take further action.
- *File# 30:* The member requested to be transferred to her previous PCP because her current PCP would not refer her to a [rheumatologist]. The CSR transferred the member to the health network to process the change.
- *File# 32:* The member called because the Plan did not receive her PCP selection form and she was auto assigned to another provider. The call was disconnected. The file does

⁸ One-day grievances, customarily referred to as “exempt grievances,” are described under rule 1300.68(d)(8) as grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment. If resolved by the close of the next business day, such grievances are exempt from the requirement of the plan to send written acknowledgment and response letters.

not contain notes that indicate whether the CSR called the member back to follow up on her issue.⁹

- *File #37*: The member is unhappy with his current pharmacy delivery service. The CSR provided the member with three pharmacy delivery service options.
- *File #43*: The member, unhappy with her current provider, requested to switch to [medical group]. The CSR assisted the member with her request.

In the above files, there was no documented evidence that the Plan asked members follow up questions to investigate the specifics of the grievances. Without investigation, the reasons for the members' dissatisfaction are unknown, and the Plan is unable to address and correct potential quality of care issues.

DHCS-CalOptima Contract, Exhibit A, Attachment 14, Provision 1 requires the Plan to implement and maintain a Member Grievance system in accordance with rule 1300.68. Rule 1300.68 requires the Plan to establish a grievance system pursuant to section 1368. Section 1368(a)(1) requires the Plan's grievance system to "provide reasonable procedures...that shall ensure adequate consideration of [member] grievances and rectification when appropriate." Instead of obtaining more information to determine the best way to resolve the members' expressions of dissatisfaction, the Plan's CSRs immediately arranged for members to switch to a different provider or health network. If member complaints are not adequately investigated and considered, then the Plan cannot appropriately resolve grievances and improve the quality of the health care services it provides to its members. Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

Potential Deficiency #6: The Plan does not consistently forward urgent grievances to its Grievance and Appeals Resolution Services unit.

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68.01(a).

DHCS-CalOptima 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 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph D.13, and 42 CFR 438.420(a)(b) and (c)...

Rule 1300.68.01(a)

⁹ Customer Service Department Call Flow for Grievance, Appeals, and PCP/Health Network Changes (revised 09/25/14) provides that if the member's call drops while he or she is expressing dissatisfaction to the CSR, then the CSR will attempt to contact the member. If the member does not answer the phone, then the CSR will leave a message for the member to call the Plan.

Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function (“urgent grievances”).

Documents Reviewed:

- Plan Policy HH.1103: CalOptima Health Network Member Complaint (Revised 06/01/09)
- Plan Policy HH.1102: CalOptima Member Complaint (Revised 01/01/13)
- 46 Exempt Grievances¹⁰ (01/01/14 to 06/30/2014)

Assessment: Plan Policy HH.1102: CalOptima Member Complaint, states that the Grievance and Appeals Resolution Services (GARS) unit will:

Review and immediately process all grievances involving an imminent and serious threat to the health of a Member, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis for effectuation of the decision within seventy-two (72) hours of receipt.

Of the 46 exempt grievances the Department reviewed, three files¹¹ were classified as “urgent” and one file¹² was classified as “super urgent.” According to Policy HH.1102, the Plan’s GARS unit should have reviewed these four grievances. Instead, according to the Plan’s GARS system notes, the files were processed by the Plan’s customer service department.

DHCS-CalOptima Contract, Exhibit A, Attachment 14, Provision 1 requires the Plan to implement and maintain a Member Grievance system. Rule 1300.68.01(a) requires the Plan’s grievance system to include procedures for the expedited review of urgent grievances. The Plan classified three files as “urgent” and one file as “super urgent.” According to the Plan’s policy, these four files must be forwarded to the Plan’s GARS unit for expedited review. However, since the files were handled by the customer service department instead of the GARS unit, the Department finds the Plan in violation of these contractual and regulatory requirements.

Potential Deficiency #7: The Plan does not consistently process all expressions of dissatisfaction by members as grievances.

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

DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System
1. Member Grievance System

¹⁰ The Department identified and reviewed 49 files. Three files were excluded because callers did not provide complete information.

¹¹ File #3, 4, 5

¹² File #47

Contractor shall implement and maintain a Member Grievance system in accordance with Title 28 CCR Section 1300.68 (except Subdivision 1300.68(c)(g) and (h))...

Rule 1300.68(a)(1)-(2)

Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:

(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.

(2) "Complaint" is the same as "grievance."

Documents Reviewed:

- Customer Service Department – Appeals and Grievances (Revised 06/03/14)
- Inquiry Log (06/13/14 to 06/30/14)

Assessment: "Customer Service Department – Appeals and Grievances" is the Plan's desktop training manual used by its customer service staff as a guide in assisting members with appeals and grievances. The manual provides definitions and outlines steps to guide processes. The manual instructs, "Complaint requested by member to be handled as inquiry – If member's issue cannot be resolved within 24 hours." The manner in which the instructions are worded predisposes CSRs to misclassify complaints as inquiries.

The Department reviewed five files¹³ where the Plan erroneously classified expressions of dissatisfaction as inquiries rather than grievances:

- *File #1:* The member's son stated that his mother received approval to see a specialist, but when he called to make an appointment, the specialist refused to see her. He indicated that the Plan always makes mistakes when approving services with this particular specialist and he was frustrated because his mother has not been able to see a specialist. When the CSR advised him to have his mother's PCP submit approval back to the Plan with a clinical note asking to modify the pre-authorization to another specialist, he refused and got upset. After some communications between the parties, the Plan provided the member's son with a specialist's phone number, and the son indicated that he would call the specialist for an appointment.
- *File #2:* The member called, upset that treatment for his injured hand was delayed. He was unable to get x-rays because the hospital and PCP were not communicating with

¹³ The Plan identified these five files as inquiries that should have been classified and processed as grievances. The members contacted the Plan between 06/13/14 and 06/30/14.

each other. Also, his PCP's office hung up on him several times. In the call log, the member indicated that "he cannot move his thumb and has a lot of pain and is worried it may be broken or fractured and treatment is being delayed." The CSR told the member that there is no guarantee that his issues could be resolved within 24 hours and that resolution could take up to 30 days. However, if an inquiry was opened, someone from the Plan would call him back within 24 to 48 hours. The member decided to open a case instead of filing a grievance. Ultimately, the member was approved to see an orthopedic and the case was closed.

- *File #3:* The member had difficulty getting a prescription filled while she was out of state for a family emergency. The CSR advised her that the Plan was unable to guarantee a resolution within 24 hours. She could either allow the Plan to work on the issue as an inquiry so she could get a resolution as soon as possible or she could file a grievance, which could take up to 30 days to resolve. The member chose to proceed with the inquiry instead of filing a grievance. Ultimately, the member received her medication and the case was closed.
- *File #4:* The member was unable to obtain his prescription even though his PCP submitted two prior authorizations. The member indicated that he was in a lot of pain. The Plan offered to open a grievance because the issue would not be resolved in 24 hours. The Plan also offered to open an inquiry, to which the member agreed. A few days later, the Plan contacted the member when the prescription was ready to be picked up.
- *File #5:* The member called because she had broken her leg and wanted to continue therapy with providers at a clinic she had been going to for two years. The CSR advised the member that she "has the right to file a Grievance if [she] is dissatisfied for resolution within letter within 30 days and acknowledgment letter in 5 days or [CSR] can continue to assist [her] with coordination." Upon hearing those options, the member opted for assistance from the CSR. Later during the call, she decided to file a grievance. A week later, she called back to withdraw the grievance.

In each of the above files, the caller contacted the Plan to complain about something – specifically, not being able to obtain appointments, prescriptions, and continuous treatments. Although the five files should have been processed as grievances, it appears that the Plan trained its CSRs to treat these calls as inquiries to dissuade members from filing grievances. This is especially obvious in File #2, 3, and 5, where the CSRs told members that resolving the case as an inquiry would be much quicker than waiting up to 30 days for a grievance resolution.

DHCS-CalOptima Contract, Exhibit A, Attachment 14, Provision 1 requires the Plan to implement and maintain a Member Grievance system in accordance with rule 1300.68. In rule 1300.68(a)(1), "grievance" is defined as an "expression of dissatisfaction regarding the plan and or provider... Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance." Rule 1300.68(a)(2) indicates that "complaint" is the same as "grievance." Even though the Plan is required to characterize and handle expressions of dissatisfaction as grievances, the Customer Service Department's training manual instructs CSRs

to treat complaints that cannot be resolved within 24 hours as inquiries. Furthermore, instead of giving members an objective explanation of what it means to file a grievance, it appears that some CSRs may describe the expeditiousness of the inquiry process to discourage the filing of grievances. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

QUALITY MANAGEMENT

Potential Deficiency # 8: The Plan does not adequately monitor, evaluate, and take effective action when potential quality issues are identified.

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement.

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

1. General Requirement

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

Documents Reviewed:

- Policy GG.1611: Potential Quality of Care Issue Review (March 2013)
- Policy GG.1612: Outcome scores for Potential Quality Issues (March 2013)
- Quality Improvement (QI) Program Description (2014)
- 53 PQI Files (01/01/14 to 06/30/14)

Assessment: Plan Policy GG.1612: Outcome Scores for Potential Quality Issues categorizes severity levels from a scale of zero to four.¹⁴ Severity scores are assigned to each PQI reviewed by the Quality Improvement Department and used to profile providers and health networks. The Department reviewed 52 PQI files.¹⁵ In 13 out of 52 PQI files (25%), the cases were assigned severity scores and closed before investigations were completed.¹⁶ For example:

- *File #4:* The member, an elderly Spanish speaker, complained that two men entered her room in a skilled nursing facility at midnight and attempted to change her diaper. She was not incontinent, did not know why she was in diapers, and checked out of the facility

¹⁴ According to Plan Policy GG:1611: Severity Outcome score 0=No quality of care or service issued identified; 1=Reflects a health care delivery system problem; 2=Clinical issue or judgement impacting Member care with potential for mild to moderate effect; 3=Clinical issue or judgement impacting Member care with potential for significant to serious effect; 4=Clinical issue with significant adverse outcome, including unnecessary prolonged treatment, complications, readmission, or Member management resulting in impairment disability, or death.

¹⁵ File #13 is still under review by the Plan's contracted independent review organization. It has not yet been determined if a quality of care issue exists in that file.

¹⁶ File #4, 5, 10, 14, 21, 23, 32, 35, 37, 41, 51, 52, 53.

the next day. No investigation took place, a severity level of zero was assigned, and the case was closed.

- *File #10:* The member went to her OB/GYN to determine if her intrauterine device (IUD) was intact. The provider's findings were inconclusive and a sonogram was ordered to ascertain the presence of the IUD. Due to a delay in obtaining the sonogram, the member became pregnant by the time she was informed that the IUD was no longer present. The Plan concluded there was no quality issue, a severity level of zero was assigned, and the case was closed.
- *File #32:* The member's child was turned away from an in-network urgent care facility without any attempt to treat the child (who had a high fever) because the mother did not have a CalOptima card to prove Medi-Cal coverage. The Plan did not seek input from the facility, a severity level of zero was assigned, and the case was closed.
- *File #37:* The member complained that the provider failed to provide necessary analgesia during an elective procedure, which resulted in extreme pain and distress. The physician responded to the Plan's inquiry and negated the member's allegations. Without further investigation or review of the procedure record to determine the veracity of the two opposing versions, a severity level of zero was assigned, and the case was closed.
- *File #51:* The provider passed the Plan's credentialing process despite having lost his medical license in Georgia due to substance abuse. A pharmacist reported that the provider was prescribing growth hormones and testosterone to the provider's son. Without determining if the provider has a valid California medical license, special qualifications to prescribe growth hormones, and whether the prescription was appropriate for the son's condition, a severity level of zero was assigned, and the case was closed.

Policy GG.1611: Potential Quality of Care Issue Review Process requires the Plan to implement corrective action plans (CAPs) on providers or health networks when quality of care issues are identified. Although CAPs are required when quality of care issues are confirmed, the policy does not specifically prescribe what type of CAP is appropriate for each severity level. In nine out of 52 cases (17%),¹⁷ the Plan assigned severity levels of one or greater and recommended tracking and trending, but CAPs were not implemented. While it is important for the Plan to track and trend issues, doing so neither ensures correction nor prevents the re-occurrence of an offense. Rather than waiting to see if issues continued or recurred, CAPs should have been implemented in order to address needed improvements.

DHCS-CalOptima Contract, Exhibit A, Attachment 4, Provision 1 requires the Plan to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers. Even though the Plan identified PQIs, many cases were closed without adequate investigation and member issues with providers were not addressed. When severity levels higher than zero were assigned, the Plan often opted to track and trend the issue

¹⁷ File #1, 18, 25, 26, 28, 29, 34, 50, 52

instead of implementing a CAP. Therefore, the Department finds the Plan in violation of this contractual provision.

Deficiency #9: The Plan does not consistently report serious quality deficiencies that result in the termination of a practitioner to the appropriate authorities.

Contractual/Statutory/Regulatory References: DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and 12(E) – Credentialing and Recredentialing; Rule 1300.70(b)(2)(C).

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

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider...

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

12. Credentialing and Recredentialing

E. Disciplinary Actions

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges...

Rule 1300.70(b)(2)(C)

...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...

Documents Reviewed:

- 53 PQI files (01/01/14 to 06/30/14)
- Policy GG.1607: Adverse Activity Process (February 2013)
- File 8: PQI Progress Notes (Opened 04/14/14)
- File 8: Case Review Summary (Received 05/07/14)
- File 8: Quality Improvement Department – Clinical Grievance (06/20/2014)
- Credentialing & Peer Review Committee Ad Hoc (03/26/14, 05/28/14, 06/11/14)

Assessment: Plan Policy GG.1607 Section II.B. requires the Plan to “take appropriate action against Practitioners or [Health Delivery Organizations] when the CalOptima Quality Improvement (QI) Department identifies occurrences of poor quality.” The Department’s review

of the PQI files revealed a case¹⁸ where the member reported to the Plan that the treating physician inappropriately touched her while her son was in the examination room.

According to the March 26, 2014 Credentialing and Peer Review Committee meeting minutes, the physician in that case was required to have a chaperone in the room when seeing female patients. In addition, the presence of a chaperone must be documented in the member's file. A review of 11 charts showed that chaperone presence was only recorded twice. During the meeting, one of the Plan's medical directors recommended that the physician's Plan membership be closed immediately, but no action was taken at that time.

On June 11, 2014, the Credentialing and Peer Review Committee terminated the physician from the Plan based on non-compliance with the chaperone requirement. Although the physician was no longer allowed to participate in the Plan, the June 20, 2014 Resolution letter indicated, "According to documentation received and reviewed the [Credentialing and Peer Review Committee] closed this case on June 13, 2014 and leveled at 0: No quality of care service issue identified." Furthermore, the Plan did not report the physician's termination to the appropriate authorities.

The DHCS-CalOptima Contract requires the Plan to report serious quality deficiencies that result in the termination of a practitioner to the appropriate authorities. While the Contract does not specify who the appropriate authorities are, to meet professional standards of practice, the Plan could have adhered to Business and Professions Code section 805. Section 805(e) requires plans to file a report with the Medical Board of California "within 15 days following the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days." During onsite interviews, the Plan's Chief Medical Officer conceded that the Plan should have reported the physician's termination to the Medical Board. Further, Plan staff added that Policy GG.1607 should be evaluated and updated.

DHCS-CalOptima Contract, Exhibit A, Attachment 4, Provision 1 requires the Plan's QIS to comply with rule 1300.70 so that the Plan can monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by its providers. DHCS-CalOptima Contract, Exhibit A, Attachment 4, Provision 12(E) requires the Plan to implement and maintain a system for the reporting of serious quality deficiencies that result in the termination of a physician to the appropriate authorities. Rule 1300.70(b)(2)(C) requires the Plan to monitor and evaluate the care provided by its physicians meets professionally recognized standards of practice. Even though inappropriate behavior with female patients caused serious quality deficiencies that ultimately led to the physician's termination with the Plan, the Plan did not report the termination to the appropriate authorities. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

¹⁸ File #8

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Jeanette Fong	Medical Survey Team Lead
Jennifer Friedrich	Health Care Service Plan Analyst
Cindy Liu	Attorney
MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS	
Rose Leidl, RN	Utilization Management Surveyor
Senia Vitale, PhD	Utilization Management Surveyor
Martin Glasser, MD	Quality Management / Continuity of Care Surveyor
Patricia Allen-Schano, MEd	Availability & Accessibility Surveyor
Bernice Young	Member Rights Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED	
Michael Schrader	Chief Executive Officer
Richard Helmer, MD	Chief Medical Officer
Bill Jones	Chief Operating Officer
Richard Bock, MD	Deputy Chief Medical Officer
Himmat Dajee, MD	Medical Director
Nguyen Luu-Trong, MD	Medical Director
Roberto Madrid, MD	Medical Director
Donald Sharps, MD	Medical Director – Behavioral Health
Emily Fonda, MD	Medical Director – Case Management
Terrie Stanley	Executive Director Clinical Operations
Ladan Khamseh	Executive Director of Operations
Jennifer McAleer	Interim Compliance Officer
Annabel Vaughn	Manager of Medi-Cal Compliance
Heidi Arndt	Compliance Support
Katie Mortensen	Compliance Analyst
Kyle Crump	Compliance Analyst
Marjan Siddiqui	Compliance Analyst
Marie Jeannis	Director of Case Management
Novella Quesada	Manager of Quality Improvement
Sheila Muller	Interim Director of Quality Improvement
Alberta Forester	Director of Claims Administration
Javier Sanchez	Chief Network Officer
Marsha Choo	Manager of Quality Improvement Initiatives
Laura Grigoruk	Director of Network Management
Julie Bomgren	Senior Manager of Government Affairs
Sun Janicek	Director of Audit & Oversight
Nancy Chen	Manager of Cultural & Linguistics
Pshyra Jones	Director of Health Education & Disease
Michelle Amador	Director of Customer Service
Reshma Thomas	Supervisor of Health Education
Belinda Abeyta	Director of GARS
Ginny Gamel	Manager of GARS

APPENDIX C. LIST OF FILES REVIEWED

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

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Inquiries	5	The Department reviewed a targeted sample of 5 inquiries during the review period of June 13, 2014 through June 30, 2014.
Exempt Grievances	49	The Plan identified a universe of 498 files during the review period. Based on the Department's File Review Methodology, a random sample of 49 files was reviewed.
Standard Grievances & Appeals	27	The Plan identified a universe of 198 files during the review period. Based on the Department's File Review Methodology, a random sample of 27 files was reviewed.
Standard Appeals	16	The Plan identified a universe of 198 standard grievances & appeals files during the review period. Based on the Department's File Review Methodology, a random sample of 57 files was pulled, 16 of which were appeals. All 16 appeals files were isolated and reviewed for both the initial utilization management and appeals determination processes.
Expedited Appeals	3	The Plan identified a universe of 3 files during the review period. Based on the Department's File Review Methodology, all 3 files were reviewed for both the initial utilization management and appeals determination processes.
Potential Quality Issues	53	The Plan identified a universe of 206 files during the review period. Based on the Department's File Review Methodology, a random sample of 53 files was reviewed.