

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

CalViva Health

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: JULY 12, 2013

**1115 Waiver Survey Report of the SPD Enrollment
CalViva Health
A Full Service Health Plan
July 12, 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, better manage chronic conditions, and improve health outcomes. The Department of Managed Health Care (the “Department”) entered into an Inter-Agency Agreement with the DHCS¹ 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 February 6, 2013, Fresno-Kings-Madera Regional Health Authority dba CalViva Health (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. The Department’s survey team conducted the onsite portion of the Medical Survey from March 11, 2013, through March 13, 2013.²

SCOPE OF SURVEY

The Department is providing DHCS this Summary Report 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, including implementation of the Utilization Management Program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting over- and under-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

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 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. 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 (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 of January 1, 2011, through December 31, 2012.

SUMMARY OF FINDINGS

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

2013 SURVEY POTENTIAL DEFICIENCIES

MEMBER RIGHTS	
#1	<p>The Plan is not conducting sufficient monitoring of its delegated exempt grievance process.</p> <p>Section 1368(a)(4)(A); Section 1368(a)(5); Section 1368(a)(4)(B); Rule 1300.68(d)(8); and Rule 1300.68(b)(1); Two-Plan Contract, Exhibit A - Attachment 14 – Member Grievance System.</p>
QUALITY MANAGEMENT	
#2	<p>The Plan’s Quality Improvement/ Utilization Management Committee lacks an appropriate range of specialist providers and is not representative of the composition of the Plan’s contracted provider network.</p> <p>Rule 1300.70(b)(2)(E); DHCS Two-Plan Contract, Exhibit A, Attachment 4 – Quality Improvement System.</p>

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

In preparation for the enrollment of approximately 16,000 SPD members, the plan implemented the following activities in order to accommodate for the SPD transition into managed care:

Utilization Management:

- The Plan heightened its case management program and hired additional utilization management staff.
- The Plan's quality improvement program provides for separate review and analysis of SPD hospital readmissions and out-of-network use broken down by service category to detect and address patterns of over-utilization.
- The Plan has implemented an onsite concurrent review program to facilitate smooth transition from acute care to discharge and to facilitate continuity of care thereafter.
- The Plan has convened a workgroup to review utilization of services. The workgroup reviews utilization management reports from its delegated contractor, Health Net, and formulates corrective action plans, as appropriate and necessary.
- The Plan conducts an audit of Health Net's pre-authorization files semi-annually by randomly selecting a number of SPD files and measuring compliance with Plan policies and procedures and applicable rules, regulations and timeliness standards.
- The Plan's medical director is actively involved and exercises his oversight responsibilities through daily/regular communications with Health Net.
- The Plan employs the services of medical consultants, whose practices involve treating large numbers of SPD members, to assist in the development of pre-authorization guidelines, pharmacy policies and procedures, and the drug formulary.

Continuity of Care:

- The Plan reviewed its policies and procedures to ensure that provisions for continuity of care for new SPD members were in place.
- The Plan established an array of case management services at varying levels, including ambulatory case management, complex case management, and targeted disease management to ensure optimum coordination of care among various providers.
- The Plan's review nurses, who are stationed at several hospital sites, facilitate successful transition to appropriate levels of care, post-discharge.
- The Plan tracks the volume of case management services on the monthly Key Indicator Report.
- The Plan coordinates its efforts and care plans with various community agencies and programs, including those that provide social and educational services to SPDs. For example, Plan staff meet at least quarterly with CCS administration to ensure ongoing coordination of efforts, and the Plan has designated liaisons for specific programs, such as the Regional Centers, to facilitate exchange of information.
- The Plan has expanded its disease management program offerings to include chronic conditions, for example, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF).

Member Rights:

- To address SPD quality of care concerns and detect systemic issues swiftly, the Plan's contractor, Health Net, directs all incoming members clinical/quality of care grievances to the Nurse Care Manager for investigation and then to the Medical Director for recommendation. The final recommended action is forwarded to the Plan's Chief Medical Officer for review and decision.

Quality Management:

- The Plan includes, on its medical committees, providers with significant caseloads of SPDs. In addition, the Plan places an SPD member on its Public Policy Committee.
- The Plan has broken out services and activities for SPDs (e.g., average length of stay, inpatient days, readmissions, out of network referrals) separately from other subgroups of its membership in a number of its quality management reports and in its Group Needs Assessment. The Executive Management Oversight Group, the Quality Improvement/Utilization Management Workgroup, and the Quality Improvement/Utilization Management Committee review these measures regularly in order to effectively assess the service needs of this population.
- The Plan has devised two quality improvement projects—one on diabetic retinal exams, which the Plan identified based on preliminary HEDIS data, and another multi-plan project on "all-cause readmissions" that are particularly relevant to the SPD population.
- The Plan monitors HEDIS measure data at the PCP clinics, Plan-wide levels, and sends reports to providers identifying members who need services to help ensure that SPD members receive all needed preventive services.

2013 CALVIVA HEALTH: DISCUSSION OF POTENTIAL DEFICIENCIES

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 DEFICIENCIES:

Based on the Department’s review, there were no potential deficiencies identified in the area of utilization management.

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.

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. Examination of a sufficient number of SPD member grievance files to ensure an appropriate audit confidence level.
- b. PCP selection and assignment requirements.
- c. Evaluation of available interpreter services and member informing materials in identified threshold languages.
- d. The health plan’s ability to provide SPDs access to the member services and/or grievance department in alternative formats or through other methods that ensure communication.

Potential Deficiency # 1: The Plan is not conducting sufficient monitoring of its delegated exempt grievance process.

Statutory/Regulatory/Contract Reference: Section 1368(a)(4)(A); Section 1368(a)(5); Section 1368(a)(4)(B); Rule 1300.68(c); and Rule 1300.68(d)(8); Two-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System.

Section 1368(a)(4)(A) states, in pertinent part, “(a) every plan shall do the following: (4)(A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B).”

Section 1368(a)(5) states, in pertinent part, “(a) Every plan shall do all of the following: (5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan’s response.”

Section 1368(a)(4)(B) states, “Grievances received by telephone, by facsimile, by email, or online through the plan’s Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint: (i) the date of the call. (ii) The name of the complainant. (iii) The complainant’s member identification number. (iv) The nature of the grievance. (v) The nature of the resolution. (vi) The name of the Plan representative who took the call and resolved the grievance.”

Rule 1300.68(d)(8) states, “Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's

name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in Subsection (b).”

Rule 1300.68(b)(1) states, “An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.”

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).

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Policy# AG-001 - Enrollee/Subscriber (Medi-Cal Member) Grievance Process
- Policy# AG-003 – Appeals and Grievances Coordination with Health Net
- Quarterly Member Appeals and Grievances Report - Q1, Q2, Q3, and Q4 2012
- CalViva Health Quality Improvement/Utilization Management Committee meeting minutes - 3/15/2012, 4/19/2012, 5/17/2012, 7/19/2012, 9/20/2012, 10/18/2012, and 11/14/2012
- Public Policy Committee Meeting Minutes, March 7, 2012
- CalViva Appeals and Grievances Dashboard, 2012
- Appeals and Grievances Audit Tool, version 4/16/12
- Annual CalViva Health Audit Review Findings – Appeals & Grievances for Health Net Community Solutions, June & July 2012

Assessment: The DHCS Two-Plan Contract requires that the Plan adhere to the requirements in Rule 1300.68, which in turn, requires the Plan to also adhere to the requirements of Section 1368. Generally, plans are required to send grievance acknowledgement and resolution letters pursuant to Sections 1368(a)(4)(A) and (a)(5). However, Section 1368(a)(4)(B) and Rule 1300.68(d)(8) provide that grievances received by telephone, by fax, by email or online and are not coverage disputes, disputed health care services involving medical necessity or experimental or investigation treatment, and that are resolved by the next business day, are exempt from the requirement to send an acknowledgment and resolution letter to the enrollee. If the Plan resolves grievances under this exemption, the Plan must maintain a log of those grievances considered exempt and must periodically review the log.

Here, Cal Viva delegates its day-to-day operations of the grievance and appeals process to Health Net Community Solutions, Inc. Rule 1300.68(b)(1) requires the Plan to retain responsibility for delegated grievance systems, and to continuously review the system. Since the Plan delegates the grievance and appeals process to Health Net Community Solutions, Inc., the Department reviewed the adequacy of the Plan’s monitoring activities regarding exempt grievances.

The Plan's policy AG-001, *Enrollee/Subscriber (Medi-Cal Member) Grievance Process*, defines "First Contact Resolution" as complaints received by telephone that are not coverage disputes, disputed health care services involving medical necessity, experimental or investigational treatment that are resolved by the next business day following receipt are exempt from the standard grievance policy. The policy also states that the Health Net Call Center is responsible for maintaining a log of the exempt complaints/grievances. The log will be periodically reviewed by the Plan and will include the required elements outlined in Rule 1300.68(d)(8).

The Plan conducts two separate monitoring activities of Health Net Community Solutions, Inc., concerning exempt grievances: the Plan receives monthly updates on the number of exempt grievances that are then incorporated into a Dashboard Report and the Plan conducts an annual oversight audit of the Grievance and Appeals department utilizing its own Appeals and Grievances Audit Tool. A review of the Plan's Dashboard report showed that the report only tracks the number of exempt grievances received. A review of the Plan's oversight audit tool shows that the tool only reviews whether or not the required elements are present in the log. There is no evidence indicating that the Plan conducts a substantive review (e.g. indications that the grievance was received by telephone, that the grievance is a coverage dispute, that the grievance was resolved by next business day, etc.) to ensure that Health Net Community Solutions, Inc. is correctly categorizing grievances as exempt in accordance to Section 1368(a)(4)(B) and Rule 1300.68(d)(8) (e.g. indications that the grievance was received by telephone, that the grievance is a coverage dispute, that the grievance was resolved by next business day, etc.).

The Department also reviewed information provided by the Plan's Grievances and Appeals Department to the Plan's Quality Improvement Committee in order to assess how the Plan's oversight committee is made aware of the results of exempt grievance monitoring. A review of the Plan's quarterly member Appeals and Grievances Reports for 2012, revealed that the reports did not contain any information regarding exempt grievances.

In addition, the Department reviewed meeting minutes for the Quality Improvement/Utilization Management Committee. The meeting minutes for meetings held in 2012 reflected minimal discussion of monitoring efforts for exempt grievances. For example, the July 19th, 2012 meeting minutes referenced the tracking of exempt grievances on the Plan's Appeal and Grievance Dashboard Report. The minutes contained the definition of exempt grievances and mentioned the number of exempt grievances but did not demonstrate that the committee has received and/or reviewed any reports regarding the type, disposition, timeliness or other pertinent information that would allow for analysis of trends and patterns.

The lack of meaningful information in both of the Plan's monitoring mechanisms and the Plan's lack of discussions in the Quality Improvement/Utilization Management Committee regarding exempt grievances indicate that the Plan's current monitoring mechanisms may not provide the Plan with enough information to ensure that exempt grievances are being categorized correctly by Health Net Community Solutions, Inc. The Plan should ensure that those grievances in the exempt grievance log meet the required elements of Rule 1300.68(d)(8), are evaluated for trends and patterns, and are subsequently discussed with the Plan's appropriate committees and governing body. Without adequate review of its delegated exempt grievance system, the Plan may also be non-compliant with the requirements of Rule 1300.68(b)(1).

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 #2: The Plan’s Quality Improvement/ Utilization Management Committee lacks an appropriate range of specialist providers and is not representative of the composition of the Plan’s contracted provider network.

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

Rule 1300.70(b)(2)(E) states, “In order to meet these obligations each plan’s QA program shall meet all of the following requirements: (E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.”

The DHCS Two-Plan Contract, Exhibit A, Attachment 4 –Quality Improvement System

A. Contractor shall implement and maintain a Quality Improvement Committee designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. Contractor must ensure that subcontractors, who are representative of the composition of the contracted provider network including but not limited to subcontractors who provide health care services to Seniors and Persons with Disabilities and chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to the QIC committee.”

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Quality Improvement/Utilization Management Committee Charter Description (last revision 11/17/2011)
- Quality Improvement/Utilization Management Committee Meeting Minutes, March-November 2012

Assessment: The Department’s review included an assessment of the Plan’s ability to monitor the full scope of clinical activities in accordance with Rule 1300.70(b)(2)(E) and the DHCS Two Plan Contract, Exhibit A, Attachment 4, Quality Improvement Committee. The Plan’s Quality Improvement/Utilization Management Committee Charter Description states, “The QI/UM Committee will be composed of participating health care providers, including physicians, as well

as other health care professionals representative of the CalViva direct contracting network and the Health Net provider network...Committee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population.”

The Department’s review revealed that although the Plan has approximately 800 specialists in its provider network and provides a wide scope of specialty services, the Plan’s standing committee does not include any specialist providers.

Rule 1300.70(b)(2)(E) requires that each plan’s quality management program have adequate physician participation to monitor the full scope of clinical services rendered. The Plan provides a wide scope of specialty services for which it must develop policies, conduct oversight and ensure quality. The Plan’s Committee is its primary means for network physician participation in key quality management activities such as policy-making, review of utilization and outcome data, and oversight of quality improvement studies and activities. Without standing members from the plan’s specialty network, it is unclear how the Plan’s Committee incorporates consistent and active input from its many contracted specialists.

The DHCS Two-Plan Contract requires the Plan to have a quality improvement committee that includes members who are representative of the composition of the contracted provider network. The Plan’s network includes a broad range of specialist physicians, but the committee does not include any specialists. The Plan cannot show that its Committee membership reflects an appropriate geographic and specialty mix of participating providers including those providers that provide specialty services to the Plan’s SPD membership.

A P P E N D I X A

APPENDIX A. SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS

Phillip Jenkins	Team Lead; Access & Availability Surveyor
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MANAGED HEALTHCARE UNLIMITED (MHU) TEAM MEMBERS

Bruce W. Carlin, MD	Utilization Management Surveyor
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Patricia Schano, MEd	Quality Management & Continuity of Care Surveyor
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Bernice Young	Member Rights Surveyor
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A P P E N D I X B

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED FROM: CalViva Health	
Patrick Marabella, M.D	Chief Medical Officer
Mary Beth Corrado	Chief Compliance Officer
Amy Schneider, RN	Director of Medical Management
Greg Hund	Chief Executive Officer

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	Sample Size (Number of Files Reviewed)	Explanation
Member Rights	29	The Department identified the sample size based upon its standard File Review Methodology and a file universe of 190.