

DEPARTMENT OF
**Managed
Health Care**
Help Center

DIVISION OF PLAN SURVEYS

**1115 WAIVER SENIORS AND PERSONS WITH
DISABILITIES**

MEDICAL SURVEY REPORT OF

**SANTA BARBARA SAN LUIS OBISPO HEALTH
AUTHORITY DBA CenCal Health**

A COUNTY ORGANIZED HEALTH SYSTEM PLAN

DATE ISSUED TO DHCS: JUNE 5, 2015

**1115 Waiver SPD Medical Survey Report
Santa Barbara San Luis Obispo Regional Health Authority
A County Organized Health System Plan
June 5, 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 August 14, 2014, the Department notified Santa Barbara San Luis Obispo Regional Health Authority dba CenCal Health (“CenCal” or the “Plan”) that its medical survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department’s medical survey team conducted the onsite portion of the medical survey from October 14, 2014 through October 17, 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-CenCal 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 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.

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.

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.

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 survey incorporated review of health plan documentation and files from the period of January 1, 2014 through July 31, 2014.³

SUMMARY OF FINDINGS

The Department identified **three** potential survey deficiencies during the current medical survey.

2014 SURVEY POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT	
#1	<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 reasons for the decision; • A description of the criteria or guidelines used; and • The clinical reasons for the decision. <p>DHCS-CenCal Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(C) – Pre-Authorizations and Review Procedures; DHCS-CenCal Contract, Exhibit A, Attachment 13 – Member Services, Provision 8(A) – Denial, Deferral, or Modification of Prior Authorization Requests; Section 1367.01(h)(4).</p>
#2	<p>For pharmaceuticals that require prior authorizations, the Plan does not consistently:</p> <ul style="list-style-type: none"> • Make a decision within 24 hours or one (1) business day; and • Notify the requesting provider of the decision. <p>DHCS-CenCal Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 6(A) – Delegation of Quality Improvement Activities; DHCS-CenCal Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(I) – Pre-Authorizations and Review Procedures and Provision 3(F) – Timeframes for Medical Authorization.</p>

³ SPD contract amendments were effective 1/1/2014.

AVAILABILITY & ACCESSIBILITY OF SERVICES

#3	<p>The Plan does not consistently display level of access results and accessibility symbols in the correct format.</p> <p>DHCS-CenCal Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 10(A) – Site Review; DHCS-CenCal Contract, Exhibit A, Attachment 13 – Member Services, Provision 4(D)(4) – Written Member Information; DHCS MMCD Policy Letter 12-006.</p>
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OVERVIEW OF THE PLAN’S EFFORTS TO SUPPORT SPD ENROLLEES

Since its inception in 1983, the Plan has managed enrollees described as “Aged, Blind and Disabled.” That population is now referred to as “Seniors and Persons with Disabilities” (SPD). Although the Plan has not developed programs specifically for its SPD population, SPDs have always been integrated into the Plan’s member population and operational processes throughout all of its business units:

- *Coordination of Care Portal:* In use since January 2011, this portal enables the Plan and its network providers to track and obtain emergency room utilization data. Information is sent directly from contracted hospital systems and additional information comes from claims data. Providers have access to information in the following areas:
 - Practice summary
 - Case management
 - Member addition (showing panel size and whether practice can accept more members)
 - Member reassignment
 - Health screening
 - Referral tracking
 - Medical authorization, emergency room utilization, inpatient utilization
- *Basic and Complex Case Management:* The Plan employs three case managers, including those with California Children’s Services experience, who proactively identify member candidates for various types of case management based on risk criteria. Other data used to identify members who would benefit from case management includes software that produces monthly SPD reports, tracks potentially preventable admissions, and records the activities of nurse case managers. Strong relationships/liaisons with network hospitals also facilitate early identification of case management candidates.
- *SPD Outreach:* The Plan contracts with two outside vendors that send out health risk assessment packets and telephone new SPD members for the purposes of outreach and reminders – including the importance and completion of health risk assessments and initial health assessments.
- *Nurse Advice Line:* Beginning July 1, 2014, the Plan contracted with a vendor to provide triage/nurse advice line services to ensure timely and consistent triage coverage for its members.

- *Network Development:* The Plan has worked closely with local medical groups and hospitals to recruit needed specialties, develop access procedures, implement telemedicine, and facilitate referrals.
- *Quality Monitoring:* The Plan's targeted quality improvement projects address topics relevant to the SPD population such as Avoidance of Antibiotic use for Acute Bronchitis and Readmissions. The Plan also tracks a variety of quality indicators including HEDIS measures, emergency department visits, member satisfaction measures, and timeliness of access to various health care services.

DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

Potential Deficiency #1: 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 reasons for the decision;
- A description of the criteria or guidelines used; and
- The clinical reasons for the decision.

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

DHCS-CenCal 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-CenCal 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)

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

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

Documents Reviewed:

- 13 Standard Appeal files (01/01/14 – 07/31/14)

Assessment: The Department reviewed nine standard appeal files⁴ to assess the Plan's initial denial process when evaluating requests for medically necessary services. Nine out of nine (100%) initial denial letters⁵ reviewed did not include a clear and concise explanation of the reasons for the Plan's decision. Three out of nine (33%) initial denial letters⁶ did not include a description of the criteria or guidelines used to make the decision. Nine out of nine (100%) initial denial letters⁷ did not include the clinical reason for the denial.⁸ For example:

- *File #10:* This file involved the denial of a request for a Danmar soft helmet. The Plan's denial letter to the requesting provider states:

CenCal has received a request to approve a Danmar soft helmet for this 2 year old child diagnosed with monosomy 21 and developmental delay, a rare genetic disorder. The clinical documentation submitted to CenCal Health has been reviewed. The documentation does not demonstrate the clinical need for this type of equipment. The requested protective helmet is therefore denied by CenCal Health. Please coordinate this care with the member and her family.

The Plan's denial letter to the member's parents states:

Your child's PCP has requested that CenCal Health approve a protective helmet for your child. The clinical records submitted to CenCal were reviewed. The documentation does not demonstrate the clinical need for this type of equipment. The request for protective helmet is therefore denied by CenCal. Please contact your PCP so that s/he can assist in coordinating these services for her. This service is not considered medically necessary based upon Interqual and/or Cal MediCal criteria rules. These are rules we use in deciding whether you need the requested treatment or not. You have a right to see these rules and our Member Services Department will be happy to get copies for you if you call us toll free at (1877) 814-1861 and ask for copies.

The Plan's letters to the provider and the member indicate that the request was denied because the clinical documentation reviewed failed to demonstrate that the helmet was medically necessary. The Plan's reason for the denial was vague and unclear as it was unknown what the Plan considered in denying the request. The Plan's denial letter to the provider lacks any mention of the criteria or guideline the Plan used to reach its determination. While the Plan's denial letter to the member provides that the Plan used "Interqual and/or Cal MediCal criteria rules" to make its determination, the criteria or specific provision that served as the basis of the denial was not identified. Although

⁴ Thirteen standard appeal files were reviewed. Four requests were denied based on lack of information and therefore were not assessed for compliance with section 1367.01(h)(4).

⁵ File #9, File #10, File #11, File #13, File #14, File #15, File #17, File #18, and File #20

⁶ File #10, File #11, and File #17

⁷ File #9, File #10, File #11, File #13, File #14, File #15, File #17, File #18, and File #20

⁸ See Table 1: UM Medical Necessity Denials

the Plan reviewed the member's medical records, neither denial letter included clinical reasons pertaining to the member's condition that justified the Plan's decision.

- *File #11:* This file involved the denial of a request for removal of loose skin (panniculectomy) post bariatric surgery. The member lost about 80 pounds, but the treating provider indicated in the medical record that the member had "not optimized weight loss," which meant the member was still expected to lose weight.

The Plan's denial letter to the member states:

The request is being denied because the medical necessity criteria has not been met. Please discuss this with your PCP. This service is not considered medically necessary based upon Interqual and/or CAL MediCal Criteria Rules. These are the rules we use in deciding whether you need the requested treatment or not. You have a right to see these rules and our Member Services Department will be happy to get copies for you if you call us toll free at (1877) 814-1861 and ask for copies.

The Plan's letter indicates that the provider's request was denied because the requested service was deemed to be not medically necessary. The Plan's reason for the denial was vague and unclear as it is unknown what the Plan considered in denying the request. The Plan used "Interqual and/or CAL MediCal Criteria Rules" to make its determination, but the criteria or specific provision that served as the basis of the denial was not identified. The Plan does not offer any clinical reasons for its decision, and it is unknown whether the Plan received or reviewed the member's medical records.

- *File #17:* This file involved the denial of a request for Oxycodone, a controlled substance used for pain management. The Plan's denial letter to the member states:

The quantity requested exceeds plan limit of 90 tablets a month (requested 180). Please consider use of long acting opioid analgesic such as generic MS Contin along with a short acting analgesics as needed for breakthrough pain. . . .

The Plan's reason for the denial was vague and unclear as it is unknown what the Plan considered in denying the request. The letter lacks any mention of the criteria or guideline the Plan used to reach its determination. The Plan also does not offer any clinical reasons for its decision, as the letter does not include any specific information pertaining to the member's condition that justifies the Plan's decision.

DHCS-CenCal Contract, Exhibit A, Attachment 5, Provision 2(C) requires the Plan's reasons for pre-authorization, concurrent review, and retrospective review decisions to be clearly documented. DHCS-CenCal Contract, Exhibit A, Attachment 13, Provision 8(A) requires the Plan to notify members of decisions to deny, defer, or modify prior authorization requests by providing written notification to members. Section 1367.01(h)(4) requires the Plan to provide members with clear and concise explanations, descriptions of the criteria or guidelines used, and the clinical reasons for the Plan's decisions to deny, delay, or modify provider requests based on medical necessity. Although the Plan notified its members of its denials of prior authorization

requests in writing, the three elements required in section 1367.01(h)(4) were not included in the Plan’s NOA letters. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

TABLE 1

UM Medical Necessity Denials

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
UM Denials	9	Clear and concise explanation	0 (0%)	9 (100%)
		Description of the criteria or guidelines	6 (67%)	3 (33%)
		Clinical reasons for the decision	0 (0%)	9 (100%)

Potential Deficiency #2: For pharmaceuticals that require prior authorizations, the Plan does not consistently:

- **Make a decision within 24 hours or one (1) business day; and**
- **Notify the requesting provider of the decision.**

Contractual/Statutory/Regulatory Reference(s): DHCS-CenCal Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 6(A) – Delegation of Quality Improvement Activities; DHCS-CenCal Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(I) – Pre-Authorizations and Review Procedures and Provision 3(F) – Timeframes for Medical Authorization.

DHCS-CenCal Contract, Exhibit A, Attachment 4, Quality Improvement System

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g., Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum:

- 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
- 2) Contractor’s oversight, monitoring, and evaluation processes and subcontractor’s agreement to such processes.
- 3) Contractor’s reporting requirements and approval processes. The agreement shall include subcontractor’s responsibility to report findings and actions taken as a result of the Quality Improvement activities at least quarterly.
- 4) Contractor’s actions/remedies if subcontractor’s obligations are not met.

DHCS-CenCal Contract, Exhibit A, Attachment 5, Utilization Management

2. Pre-Authorizations and Review Procedures

I. Contractor must notify the requesting provider or Member of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

3. Timeframes for Medical Authorization

F. Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).

Documents Reviewed:

- 13 Standard Appeal files (01/01/14 – 07/31/14)

Assessment: MedImpact is the Plan's pharmacy benefit management vendor, delegated to review, approve, and deny requests for pharmacy-related services. The Department reviewed nine standard appeal files⁹ to assess the initial denial process by the Plan when evaluating requests for medically necessary services. In three of the nine (33%) files reviewed,¹⁰ MedImpact did not make its decision within 24 hours or one business day as required under DHCS-CenCal Contract, Attachment 5, Provision 3(F). In those same three files, MedImpact also failed to notify the requesting provider of the denial. For example:

- *File #13:* MedImpact received the prior authorization request on Wednesday, April 16, 2014 and made the decision to deny the request on Friday, April 18, 2014, two business days after receiving the request. The requesting provider was not notified of the denial.
- *File #14:* MedImpact received the prior authorization request on Wednesday, April 16, 2014 and made the decision to deny the request on Friday, April 18, 2014, two business days after receiving the request. The requesting provider was not notified of the denial.
- *File #20:* MedImpact received the prior authorization request on Tuesday, May 13, 2014 and made the decision to deny the request on Thursday, May 15, 2014, two business days after receiving the request. The requesting provider was not notified of the denial.

DHCS-CenCal Contract Exhibit A, Attachment 4, Provision 6(A) holds the Plan accountable for all quality improvement functions and responsibilities delegated to subcontractors. For drugs that require prior authorizations, DHCS-CenCal Contract, Exhibit A, Attachment 5, Provision 3(F) requires the Plan to make a decision within 24 hours or one business day upon the Plan's receipt of the request. DHCS-CenCal Contract, Exhibit A, Attachment 5, Provision 2(I) requires the Plan to notify requesting providers when prior authorizations are denied.

As the Plan has delegated MedImpact to review and make decisions on pharmaceutical prior authorization requests, the Plan must ensure that MedImpact's actions comply with the applicable terms set forth in the Plan's contract with the DHCS. The files reviewed by the

⁹ Thirteen standard appeal files were reviewed. Four requests were denied based on lack of information and therefore were not assessed for compliance under section 1367.01(h)(4).

¹⁰ File #13, File #14, and File #20.

Department showed that the Plan’s delegate failed to make decisions on pharmaceutical prior authorization requests within the requisite timeframe. In addition, once decisions were made, the requesting providers were not notified. Therefore, the Department finds the Plan in violation of these contractual requirements.

TABLE 2

UM Medical Necessity Denials

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
UM Denials	9	Make a decision within 24 hours or one (1) business day	6 (67%)	3 (33%)
		Notify the requesting provider of the decision	6 (67%)	3 (33%)

AVAILABILITY & ACCESSIBILITY OF SERVICES

Potential Deficiency #3: The Plan does not consistently display level of access results and accessibility symbols in the correct format.

Contractual/Statutory/Regulatory Reference(s): DHCS-CenCal Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 10(A) – Site Review; DHCS-CenCal Contract, Exhibit A, Attachment 13 – Member Services, Provision 4(D)(4) – Written Member Information; DHCS MMCD Policy Letter 12-006.

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

10. Site Review

A. General Requirement

Contractor shall conduct Facility site and Medical Record reviews on all Primary Care Provider sites in accordance with to the Site Review Policy Letter, MMCD Policy Letter 02-02, 12-006, and Title 22, CCR, Section 53856. Contractor shall also conduct Facility Site Physical Accessibility reviews on Primary Care Provider sites, and all provider sites which serve a high volume of SPD beneficiaries, in accordance with the Site Review Policy Letter, MMCD Policy Letter 12-006 and W&I Code 14182(b)(9).

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

4. Written Member Information

D. The Member Services Guide shall be submitted to DHCS for review prior to distribution to Members. The Member Services Guide shall meet the requirements of an Evidence of Coverage and Disclosure Form (EOC/DF) as provided in Title 28 CCR Sections 1300.51(d) and its Exhibit T (EOC) or U (Combined EOC/DF), if applicable. In addition, the Member Services Guide shall meet the requirements contained in Health and Safety Code Section 1363, and Title 28 CCR

Section 1300.63(a), as to print size, readability, and understandability of text, and shall include the following information:

4. Compliance with the following may be met through distribution of a provider directory: The name, National Provider Identifier (NPI) number address and telephone number of each Service Location (e.g., locations of hospitals, Primary Care Physicians (PCP), specialists, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities, Federally Qualified Health Centers (FQHC), Indian Health Programs). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, NPI number, address and telephone number shall appear for each physician provider: The hours and days when each of these Facilities is open, the services and benefits available, including which, if any, non-English languages are spoken, the telephone number to call after normal business hours, accessibility symbols are approved by DHCS, and identification of providers that are not accepting new patients.

DHCS MMCD Policy Letter 12-006

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

Documents Reviewed:

- Physician Accessibility Analysis (01/01/14, 04/01/14)
- Contracted Provider List located at www.cencalhealth.org (04/01/14, 12/22/14)
- PCPs Requiring FSR (Facility Site Review) (10/17/2014)
- Facility Site Reviews Medical Record Reviews (2014)
- SPD High Volume Providers (undated)

Assessment: The Department reviewed the Plan's April 2014 provider directory and discovered that the Plan did not comply with the access level and accessibility symbol requirements set forth in the DHCS MMCD Policy Letter 12-006. Policy Letter 12-006 requires the Plan to display the level of access results met per provider site as either "Basic Access" or "Limited Access." Instead of listing "Basic Access" and "Limited Access" in the provider directory, the Plan sometimes used an icon of a wheelchair or an icon of a crutch to denote the two types of access, respectively.

In addition, Policy Letter 12-006 also requires the Plan to identify whether each provider site has access to parking, building exterior, building interior, exam room, restroom, and certain types of medical equipment.¹¹ These accessibility symbols have been standardized and approved by the

¹¹ DHCS MMCD Policy Letter 11-009 establishes policy and guidelines for use of standardized physical accessibility indicators in all provider directories to assist SPDs in locating physically accessible provider sites.

DHCS.¹² The Department found that the Plan did not consistently display all of the symbols throughout the provider directory.

During interviews, Plan staff reported that a transition to the consistent usage and inclusion of the level of access results and accessibility symbols was in progress and that an updated version of the provider directory would be posted to the Plan's website in November 2014. On March 26, 2015, the Department reviewed the online PDF version of the Plan's December 2014 provider directory. Although the level of access results and accessibility symbols were consistently displayed for the PCPs listed in the directory, changes still needed to be made to the list of specialists who serve a high volume of SPD beneficiaries. The Plan continues to use the wheelchair and crutch icons instead of "Basic Access" and "Limited Access" and does not include accessibility symbols in the directory. In addition, the "Information for Seniors and Persons with Disabilities" section of the provider directory still refers to "Partial Access" rather than "Limited Access."

DHCS-CenCal Contract, Exhibit A, Attachment 4, Provision 10(A) requires the Plan to conduct Facility Site Physical Accessibility reviews on PCP sites and all provider sites which serve a high volume of SPD beneficiaries. DHCS-CenCal Contract, Exhibit A, Attachment 13, Provision 4(D)(4) requires the Plan to include accessibility symbols approved by the DHCS in the Plan's provider directory. DHCS MMCD Policy Letter 12-006 requires the Plan to display level of access results and accessibility symbols on the Plan's website and provider directory. Since the Plan does not consistently list the level of access results or standardized physical accessibility standards in all provider directories, the Department finds the Plan in violation of these contractual requirements.

APPENDIX A. SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS

¹² Per DHCS MMCD Policy Letter 11-009: P= Parking; EB = Building Exterior; IB = Building Interior; E = Exam Room; R = Restroom; T = Medical Equipment.

Jeanette Fong	Survey Team Lead
MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS	
Senia Vitale, PhD	Utilization Management Surveyor
Rose Leidl, RN	Continuity of Care & Utilization Management Surveyor
Patricia Allen-Schano, MEd	Access and Availability Surveyor
Bernice Young	Member Rights Surveyor
Peter Leidl, MD	Quality Management Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED FROM: CENCAL HEALTH	
Mark Maddox, MD	Chief Medical Officer
Julio Bordas, MD	Medical Director
Paul Jaconette	Chief Operations Officer
Caitlin Larsen	Director of Legal Affairs/Compliance Officer
Carlos Hernandez	Director of Health Services/Quality
Paula Curran, RN	Quality Improvement Manager
Elizabeth Smoot, RN	Senior Care Management Nurse
Anne Cody, RN	Senior Care Management Nurse
Johnathan Evans	Health Services Operations Manager
Suzanne Michaud	Senior Health Promotion Educator
Armando Rivera	Supervising Care Manager/Social Worker
Dave Seibel	Director of Information Technology/Security Officer
Donna Slimak	Director of Member Services/Privacy Officer
Eric Buben	Grievance & Quality Improvement Manager
Marina Owen	Director of Provider Services/Program Management
Sheila Thompson, RN	Provider Services Manager
Jeff Januska, PharmD	Director of Pharmacy Services
Allen Freymuth	Director of Claims
Lulu Von Alvensleben	Associate Director of Claims
Rebecca Hudson	Senior Compliance Coordinator
Rita Washington	Compliance Specialist

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
Standard Grievances	22	The Department reviewed 22 standard grievances identified during the survey review period.
Appeals	13	Department reviewed the initial denial files for 13 appeals identified during the survey review period.
Potential Quality Issues	4	The Department reviewed four grievances referred for PQI review identified during the survey review period.