

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

CARE 1ST HEALTH PLAN

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: JUNE 5, 2014

**1115 Waiver Survey Report of the SPD Enrollment
Care 1st Health Plan
A Full Service Health Plan
June 5, 2014**

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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 September 24, 2013, Care 1st Health Plan (the “Plan”) was notified that its Medical Survey had commenced and was requested to provide the Department with the necessary pre-onsite data and documentation. The Department’s survey team conducted the onsite portion of the Medical Survey from December 3, 2013 through December 6, 2013.²

SCOPE OF SURVEY

The Department provides DHCS with this written Summary Report of Medical Survey findings pursuant to the Inter-Agency Agreement and has identified potential deficiencies in Plan operations supporting SPD membership. This Medical Survey evaluated the following elements specifically related to the Plan’s delivery of care to the SPD population pursuant to the DHCS contract requirements and compliance with the Act:

I. Utilization Management

The Department evaluated Plan operations related to utilization management, 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 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.

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 October 1, 2012, through September 30, 2013.

SUMMARY OF FINDINGS

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

2013 SURVEY POTENTIAL DEFICIENCIES³

UTILIZATION MANAGEMENT

1. The Plan's Utilization Management program does not ensure appropriate processes are consistently used to review and approve the provision of medically necessary services. DHCS GMC Contract, Exhibit A, Attachment 5, Utilization Management, Provision 1 – Utilization Management Program.

AVAILABILITY & ACCESSIBILITY OF SERVICES

2. The Plan does not adequately ensure that Physical Accessibility Reviews are conducted on primary care provider sites and on all provider sites that serve a high volume of SPDs, and that the results are consistently made available to members through the Plan's website and provider directories. DHCS GMC Contract, Exhibit A, Attachment, Quality Improvement System, Provision 10(A) – Site Review; DHCS MMCD Policy Letter 12-006; and DHCS MMCD Policy Letter 11-009.
3. The Plan's policies to ensure timely access to care do not provide an updated description of the Plan's monitoring procedures, or clearly define its methodology for calculating an annual rate of compliance for appointment wait time standards. Section 1386(b)(1); Rule 1300.67.2.2.(c)(5)(A-F); Rule 1300.67.2.2(d)(2); Rule 1300.67.2.2(g)(2)(B); and DHCS GMC Contract, Exhibit A, Attachment, Access and Availability, Provision 4(B) – Access Standards.

MEMBER RIGHTS

4. For appeals that uphold an original delay, modification, or denial of services based on a determination in whole or in part that the service is not medically necessary, the Plan

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

does not consistently include, along with its written response, the required application for independent medical review (IMR) and instructions, including an envelope addressed to the Department of Managed Health Care.

Rule 1300.68(d)(4); and DHCS GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provisions 1 – Member Grievance System, and 4(B)(2) – Notice of Action.

5. The Plan does not immediately inform members of the right to contact the Department when filing grievances requiring expedited review.
Section 1368.01(b); Rule 1300.68.01(a)(1); and DHCS GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1 – Member Grievance System.

QUALITY MANAGEMENT

6. The Plan's governing body does not direct ongoing operational Quality Improvement System modifications or track findings for follow-up in response to reports reviewed.
Rule 1300.70(b)(2)(C); and DHCS GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provisions 1 – General Requirement, and 3(D) – Governing Body.
7. The Plan does not adhere to its policy and procedure for timely evaluation and resolution of potential quality issues and, as a result, does not take effective action to improve care when deficiencies are identified to ensure that a level of care, which meets professionally recognized standards of practice, is being delivered to all enrollees.
Section 1386(b)(1); Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A); and DHCS GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement.

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

1. The Plan had implemented its 2013 San Diego SPD Pilot Project by collaborating with local community organizations (Access to Independence and Senior Community centers). The project aims to improve community integration of its SPD population as well as increase access to complex case management, housing resources, and peer counseling. The project also incorporates use of SPD data to measure emergency room and hospital utilization. Although the Plan's initial data analysis has not yet been completed, Plan staff are optimistic about preliminary results demonstrating evidence of improvement.
2. The Plan had increased its internal infrastructure to meet the demands of its expanding SPD population. These efforts included increased member services staffing, expansion of its specialty provider network (as a result of contracting with the University of California San Diego for tertiary care services), and greater accessibility to pain management and podiatry services.
3. The Plan offers a Physician Bonus Program whereby providers receive incentives based on improvements in HEDIS scores for their patients. Providers can initially check HEDIS measurement status information for patients when accessing the provider portal to confirm member eligibility. Providers can then utilize the data to bring their patients up-to-date on the needed HEDIS preventive/diagnostic services.

4. One of the Plan's contracted provider groups developed a dedicated coordinated care clinic in response to the multiple complex needs its SPD members. The clinic draws upon a variety of resources to meet the diverse needs of this population. It also serves as a resource for other non-SPD members with more complex health care needs.
5. The Plan's analysis of grievance and appeals data revealed a trend of complaints pertaining to enrollee delays in receiving authorizations/referrals. Based on this analysis, the Plan developed a quality improvement project to address issues with provider groups most frequently involved.
6. The Plan provided incentives for physicians' completion of satisfaction surveys, thereby effectively improving the overall provider response rate and providing the Plan with useful data on physicians' concerns.
7. The Plan has effective processes in place for Member Services agents to assist members who are being balance billed or sent to collections. The agents immediately contact the billing agency, and when necessary, provide the agency with a copy of the law prohibiting balance billing of Medi-Cal members.
8. The Plan has made extensive efforts to ensure the provision of translation and interpretation services to its members. Translated written materials in the members' preferred language are provided at every juncture. Turnaround times are excellent (within seconds for telephone interpretation, and 1-2 days for translation of grievance and appeals related documents). The Plan additionally conducts thorough reviews to confirm the accuracy of all translated materials.

2013 CARE 1ST HEALTH PLAN: 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 Deficiency #1:

The Plan's Utilization Management program does not ensure appropriate processes are consistently used to review and approve the provision of medically necessary services.

Statutory/Regulatory/Contract Reference: DHCS GMC Contract, Exhibit A, Attachment 5, Utilization Management, Provision 1 – Utilization Management Program.

DHCS GMC Contract, Exhibit A, Attachment 5 – Utilization Management

1. Utilization Management Program

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services.

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

- 10 Medical Necessity Appeals files (October 1, 2012 – September 30, 2013)
- 3 Expedited Appeals files (October 1, 2012 – September 30, 2013)
- 16 Potential Quality Issues (PQI)⁴ files (October 1, 2012 – September 30, 2013)
- TAR and Non-Benefit List: Codes 50000 – 59999 (January 2013)

Assessment: As part of its standard process for evaluating the Plan’s Grievances and Appeals (G&A) and Quality Management (QM) systems, the Department reviewed a random sample of standard grievances and appeals files, as well as all expedited appeals and PQIs filed during the survey review period. However, review of these files identified a potential concern regarding a delay in care, as it relates to the Plan’s Utilization Management (UM) program. Specifically, the UM program does not consistently ensure appropriate processes are used to review and approve the provision of medically necessary services.

The Department pulled a random sample of 44 grievance and appeals files of which 21 were appeals files. Ten standard appeals files and all three⁵ expedited appeals filed during the survey review period were reviewed to evaluate the Plan’s UM authorization process. The Department found the following expedited appeal case where medically necessary care was delayed due to an inappropriate Plan benefit denial:

- *File #2:* This case involved a member for whom the Plan’s initial denial of bladder irrigation treatment was overturned upon appeal after the external peer reviewer (urology) deemed the service medically necessary. The initial denial was based on use of the “Treatment Authorization Request (TAR) and Non-Benefit List” published by the Department of Health Care Services. The Plan misinterpreted the list as procedures and services that are not covered by Medi-Cal. However, the list should serve as a guideline only, as the Plan is still required to authorize and make available to the member medically necessary services. Although the denial was overturned upon appeal, the Plan’s erroneous interpretation of the list led to a delay in the member’s care. In an interview with the Plan’s Chief Medical Officer, it was mutually agreed that the initial denial was a Plan error. Also of concern, the case was not identified as a potential quality issue and therefore was not forwarded onto the Quality Improvement Department where it would have undergone appropriate investigation and implementation of corrective action to prevent future incidences from occurring.
- DHCS GMC Contract, Exhibit A, Attachment 5, Utilization Management, Provision 1 – Utilization Management Program, requires the Plan to ensure appropriate processes are

⁴ Cases, providers, processes or concerns identified through enrollee grievances, sentinel events (e.g., mortalities), data analysis and other sources as having *potential quality issues* that require investigation are often referred to as PQIs.

⁵ The Plan’s original *Expedited Appeals* log submitted to the Department contained two files. However, File #7, from the *Exempt* log was misclassified as “exempt” when it was in fact an “expedited” appeal. Therefore, it was moved from the *Exempt* log to the *Expedited Appeals* log, and a total of three expedited appeals files were reviewed.

used to review and approve the provision of medically necessary covered services. Review of the Plan's appeals files revealed an example of a delay in care due to an inappropriate process used to review preauthorization requests for medically necessary services. Therefore, the Department finds the Plan in violation of these regulatory and contractual requirements.

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.

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

AVAILABILITY AND ACCESSIBILITY

In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's processes to support access and availability including:

- a. The availability of services, including specialists, emergency, urgent care, and after-hours care.
- b. Health plan policies and procedures for addressing a patient's request for disability accommodations.

Potential Deficiency #2:

The Plan does not adequately ensure that Physical Accessibility Reviews are conducted on primary care provider sites and on all provider sites that serve a high volume of SPDs, and that the results are consistently made available to members through the Plan's website and provider directories.

Statutory/Regulatory/Contract Reference: DHCS GMC Contract, Exhibit A, Attachment, Quality Improvement System, Provision 10(A) – Site Review; DHCS MMCD Policy Letter 12-006; and DHCS MMCD Policy Letter 11-009.

DHCS GMC 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 the Site Review Policy Letter, MMCD Policy Letter 02-02 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 10-016 and W & I Code 14182(b)(9).

DHCS MMCD Policy Letter 12-006 states, in pertinent part, “Plans are to make the results of FSR Attachment C available to members through their websites and provider directories. The information provided must, at a minimum, display the level of access results met per provider site as either Basic Access or Limited Access. Additionally, Plans must indicate whether the site has Medical Equipment Access as defined in 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).”

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.

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

- Healthy San Diego Database – 2013 Site Review Assignment
- DMHC HiVol Spec List – PARS
- DMHC PCP PARS List (12/10/13)
- Attachment C – Physical Accessibility Review Survey
- Provider Directory – San Diego County
- Plan Policy 70.1.4.1: Facility Site Review, Physical Accessibility Review Survey / Medical Records Review Process (effective 4/2013)
- Plan Policy 80.1.4.8: Facility Site Review Survey Health Plans Collaborative Process (effective 2/2012)
- Plan Policy 70.1.1.38: Availability of Specialty Care Practitioners (effective 8/2013)
- Plan Policy 70.1.1.8: Access to Care Standards and Monitoring Process (effective 8/2013)

Assessment: The Plan is contractually required to conduct Facility Site Physical Accessibility reviews on primary care provider (PCP) sites, and all provider sites that serve a high volume of SPD beneficiaries. The Physical Accessibility portion (Attachment C) of the Facility Site Review (FSR) examines factors such parking, building (interior and exterior), exam room, restroom, and medical equipment access. In addition to conducting these reviews, the Plan is required to make the results of Attachment C available to members through its website and provider directory. To assess compliance with these contractual standards, the Department examined both the Plan’s completion of these reviews as well as posting of results on its online provider directory.

Completion of Physical Accessibility Reviews

Review of Plan policies indicates that the Plan initially conducts Physical Accessibility Reviews on primary care providers and high volume specialists upon entry into the network, and then every three years thereafter. The Plan collaborates with other Medi-Cal managed care plans in San Diego County to conduct the reviews and to share results, thereby avoiding the duplication of efforts.

The Department found that the Plan's Physical Accessibility Reviews for PCP sites were nearly complete, with only seven of 115 sites (two of which were relatively new sites) not having undergone review. As part of the San Diego multi-plan collaborative effort for 2013, the Plan was assigned to conduct reviews at 19 PCP sites. Reviews for all of these sites had been completed with the exception of three sites, which had closed, and therefore, no longer required review.

By contrast, the Plan had not completed reviews for more than half of its high volume specialist sites serving SPD beneficiaries. The Plan identified 65 high volume specialist sites requiring Physical Accessibility Reviews. The Plan's list of high volume specialists indicated that 38 of these specialists (58%) had not yet undergone the required review. When results were unduplicated to remove specialists working at identical office locations, 35 provider sites (54%) had not yet undergone review.

Availability of Results to Members on the Plan's Online Provider Directory

Review of the Plan's online Provider Directory indicates that it does not list the Physical Accessibility Review results for approximately two-thirds of providers, including those that the Department has verified as having undergone review. In interviews, Plan staff confirmed that most of the providers, whose results were not posted, have in fact undergone review. The Plan indicated that this oversight was due in part to the loss of the staff member responsible for updating the provider directory.

In addition, for those reviews whose results are posted, although the Plan displays the specific access indicators (P=Parking, EB=Exterior Building, IB=Interior Building, R=Restroom, E=Exam Room, T=Exam Table/Scale) that are met at each facility, the directory fails to specify, at minimum, whether this access is at the level of "Basic Access" or "Limited Access," as required.

DHCS GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 10(A) – Site Review, requires the Plan to conduct Facility Site Physical Accessibility Reviews on all primary care provider sites as well as other provider sites that serve a high volume of SPD beneficiaries. DHCS MMCD Policy Letter 12-006 further specifies that the Plan make the results available to members through its website and provider directory and identify the level of access met per provider site as either "Basic Access" or "Limited Access." The Plan has not completed reviews on over half of its high volume specialists (54% non-compliance rate). Further, for providers whose reviews have been completed, the Plan does not display the results for a large proportion of them in its provider directory, and results that are posted do not indicate each site as having "Basic Access" or "Limited Access." Therefore, the Department finds the Plan in violation of these contractual requirements.

Potential Deficiency #3:

The Plan's policies to ensure timely access to care do not provide an updated description of the Plan's monitoring procedures, or clearly define its methodology for calculating an annual rate of compliance for appointment wait time standards.

Statutory/Regulatory/Contract Reference: Section 1386(b)(1); Rule 1300.67.2.2.(c)(5)(A-F); Rule 1300.67.2.2(d)(2); Rule 1300.67.2.2(g)(2)(B); and DHCS GMC Contract, Exhibit A, Attachment, Access and Availability, Provision 4(B) – Access Standards.

Section 1386(b)(1) states, “The following acts or omissions constitute grounds for disciplinary action by the director: (1) The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.”

Rule 1300.67.2.2(c)(5) states, in pertinent part, “In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

- (A) Urgent care appointments for services that do not require prior authorization: within 48 hours...
- (B) Urgent care appointments for services that require prior authorization: within 96 hours ...
- (C) Non-urgent appointments for primary care: within ten business days...
- (D) Non-urgent appointments with specialist physicians: within fifteen business days...
- (E) Non-urgent appointments with a non-physician mental health care provider: within ten business days...
- (F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days...”

Rule 1300.67.2.2(d)(2) states, in pertinent part, “Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan’s provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan’s quality assurance program shall address: (2) Compliance monitoring policies and procedures, filed for the Department’s review and approval, designed to accurately measure the accessibility and availability of contracted providers...”

Rule 1300.67.2.2(g)(2)(B) states, in pertinent part, “By March 31, 2012, and by March 31 of each year thereafter, plans shall file with the Department a report, pursuant to subsection (f)(2) of Section 1367.03 of the Act, regarding compliance during the immediately preceding year. The first reporting period shall be the calendar year ending December 31, 2011. The reports shall document the following information: (B) The rate of compliance, during the reporting period, with the time elapsed standards set forth in subsection (c)(5), separately reported for each of the plan’s contracted provider groups located in each county of the plan’s service area. A plan may develop data regarding rates of compliance through statistically reliable sampling methodology, including but not limited to provider and enrollee survey processes, or through provider reporting required pursuant to subsection (f)(2) of Section 1367.03 of the Act.”

DHCS GMC Contract, Exhibit A, Attachment 9 – Access and Availability

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers' compliance with these standards."

B. Standards for Timely Appointments

Members must be offered appointments within the following timeframes:

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

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

- Plan Policy 70.1.1.29: Availability of Primary Care Practitioners (effective 8/2013)
- Plan Policy 70.1.1.38: Availability of Specialty Care Practitioners (effective 8/2013)
- Plan Policy 70.1.1.8: Access to Care Standards and Monitoring Process (effective 8/2013)
- 2012 Medi-Cal Provider Access Appointment Availability and After-Hours Audits
- Provider Directory – San Diego County

Assessment: The Plan has established and submitted to the Department policies for monitoring access to services, including timely access to primary/specialty care appointments, after hour services, and ancillary services. In evaluating the application of these policies, the Department discovered that the Plan is not consistently following its own procedures for compliance monitoring. The Plan's policies also do not clearly define its methodology for calculating an annual rate of compliance for appointment wait time standards.

No Updated Description of the Plan's Monitoring Procedures

The Plan does not consistently follow its own policies to ensure monitoring of timely access standards. For example, the Plan's policy, "Access to Care Standards and Monitoring Process," describes the following monitoring activity:

Primary Care Practitioners and High Volume Specialist Access to Care Study:

1. Care1st QI utilizes the access tally tool (Attachments 1 and 2) and conducts the study on all PCPs and high volume specialists annually.
2. Facility Site Review nurses complete the survey tally tool.
3. QI coordinators contact all practitioner offices, high volume specialist and completes the survey tool and appropriate tally sheet through a survey of the office staff asking them for appointment availability for each type of call. The QI staff performs a secret shopper survey on 10% of the access surveys completed and they utilize the tally sheet for documentation, which gives validity to the survey process.

4. All practitioners that fall outside of the access to care requirements must submit a written corrective action plan that addresses the deficiencies...

However, the Plan was unable to provide the results of this study, and during interviews, Plan staff indicated that the use of this tool by Facility Site Review nurses had been discontinued in favor of an appointment availability and after-hours study conducted by a vendor.

In regards to the fourth provision of the study, which requires corrective action plans for non-compliant providers, Plan staff indicated that in follow-up to its 2012 access study, the Plan sent educational letters to non-compliant providers but did not require them to submit corrective action plans (CAPs) to address the deficiencies. This too, is in conflict with the Plan's own policy. Given the importance of ensuring quality patient care and satisfaction through timely access to appointments, the Department expects adherence to a more rigorous intervention such as CAP implementation. Plan staff confirmed that moving onward, based on the results of the 2013 access study, if a provider is identified as non-compliant, a formal CAP addressing the deficiency will be imposed, which is consistent with the Plan's current policy.

No Clearly Defined Methodology for Calculating an Annual Rate of Compliance

The Plan's policy, "Access to Care Standards and Monitoring Process," specifies a number of methods for monitoring compliance with timely access standards including an evaluation of member complaints and grievances, PQIs, member satisfaction surveys, medical record reviews, dis-enrollments, PCP transfers, and annual Access Surveys and Studies. However, the policy does not clearly distinguish which of these approaches will be used in calculating the Plan's rate of compliance for annual reporting to the Department, versus which methods will be used for the Plan's own internal monitoring. The Plan's policy further does not provide clearly defined methodologies for each method used, including descriptions of calculations, eligible sampling populations (e.g., all providers, only high volume providers), or survey administration methods (e.g., telephone, mail). Additionally, the policy does not indicate that the rate of compliance will be separately reported for each of the time elapsed standards for all contracted provider groups located in each county of the Plan's service area, as required.

It is noteworthy to mention that in interviews, Plan staff indicated that they are already in the process of updating the Plan's policies and submitting them to the Department as an amendment. These revisions are being made in follow-up to comment letters issued by the Department pertaining to the Plan's most recent Timely Access Regulation reporting submission. The revisions had not been completed at the time of the onsite survey; therefore, the finalized documents were not available for review. These updated policies (further revised as necessary to address the issues noted above) should be submitted as part of the Plan's response to this current report.

Rule 1300.67.2.2(c)(5)(A-F) and DHCS GMC Contract, Exhibit A, Attachment, Access and Availability, Provision 4(B) – Access Standards, establishes appropriate wait times standards that the Plan must abide by when offering appointments to its enrollees. Rule 1300.67.2.2(d)(2) requires the Plan to have compliance monitoring policies and procedures in place to accurately measure the accessibility and availability of contracted providers. Section 1386(b)(1) further provides penalties when the Plan operates at variance with basic organizational documents filed with the Department unless amendments allowing the variation have been submitted and

approved. Additionally, Rule 1300.67.2.2.(g)(2)(B) requires the Plan to submit an annual report to the Department that includes the rate of compliance with the appointment time standards reported separately for each of the Plan's contracted provider groups located in each county of the Plan's service area.

The Department finds the Plan is not consistently following its own access monitoring policies as submitted to the Department, nor, alternatively, amending policies for submission and approval to address changes in its operations. The Plan's failure to conduct its operations in compliance with its own established policies hinders the Department's ability to ensure that the Plan is in full compliance with the Act. Further, Plan policies do not clearly define methodology used to develop its rate of compliance, clearly distinguishing these methods from those used solely for internal monitoring. Finally, the Plan also does not indicate in its policy that it will separately report the rate of compliance by county and provider group in its service area. Therefore, the Department finds the Plan in violation of these statutory, regulatory, and contractual requirements.

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 #4:

For appeals that uphold an original delay, modification, or denial of services based on a determination in whole or in part that the service is not medically necessary, the Plan does not consistently include, along with its written response, the required application for independent medical review (IMR) and instructions, including an envelope addressed to the Department of Managed Health Care.

Statutory/Regulatory/Contract Reference: Rule 1300.68(d)(4); and DHCS GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provisions 1 – Member Grievance System, and 4(B)(2) – Notice of Action.

Rule 1300.68(d)(4) states, in pertinent part, "For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, ... The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814."

DHCS GMC 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).

4. Notice of Action

B. If a Member receives a NOA, the Member has three options:

- 2) Members may request an independent Medical Review (IMR) regarding the NOA from the Department of Managed Health Care (DMHC). An IMR may not be requested if a State Fair Hearing has already been requested for that NOA.

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

- Plan Policy 10.18.1: Member Appeal Processes (Pre-Service, Expedited, Post-Service) (effective 2/2012)
- 21 Medical Necessity Appeals files (October 1, 2012 – September 30, 2013)
- 3 Expedited Appeals files (October 1, 2012 – September 30, 2013)

Assessment: The Plan’s policy, “Member Appeal Processes (Pre-Service, Expedited, Post-Service)” states:

If the appeal is upheld, the information in the resolution letter shall include, but is not limited to the following:

- Information on how to contact Care 1st Health Plan or the Department of Managed Health Care to request an Independent Medical Review (IMR). As part of the appeal information, an IMR application form will be provided, *along with an envelope* addressed to Department of Managed Health Care, HMO Help Center, 980 Ninth St., 5th Floor, Sacramento, CA 95814. [Emphasis added].

To assess compliance with this standard, the Department isolated for review all 21 appeals files from the 44 randomly selected standard grievances and appeals files for the survey review period. In addition, all three⁶ expedited appeals identified by the Plan during the review period were also selected, to reflect 24 medical necessity appeals files that were reviewed. Ten of the 24 files were appeals that either were withdrawn by the member, or included a final determination that overturned the initial denial decision; therefore, these files did not require the necessary IMR notification. However, 14 of the 24 files included a final determination that upheld the initial denial, thereby requiring the IMR application and envelope addressed to the Department to be attached to the resolution response. Although all 14 files contained the IMR

⁶ The Plan’s original *Expedited Appeals* log submitted to the Department contained two files. However, File #7, from the *Exempt* log was misclassified as “exempt” when it was in fact an “expedited” appeal. Therefore, it was moved from the *Exempt* log to the *Expedited Appeals* log, and three expedited appeals files were reviewed.

application, six of the 14 files (43%) did not include documentation to substantiate that the required envelope had been attached.

It is noteworthy to mention that this deficiency was previously cited in the Routine Medical Survey conducted in December 2010 by the Department. The final report, issued to the Plan on May 2, 2011 indicated the status of the deficiency as “corrected” based upon the Plan’s commitment to implement training and incorporate use of a quarterly “appeal audit checklist.” However, file review conducted for this current survey demonstrates that this issue has yet to be consistently resolved. In an interview with the Plan’s Director of Appeals and Grievances, she indicated that she could not determine whether the envelope had not been provided to the member at all, or was simply not copied and placed in the file.

Rule 1300.68(d)(4) requires that for grievances involving delay, modification, or denial of services based on a determination in whole or in part that the service is not medically necessary, the Plan must include in its written response an application for independent medical review and instructions, including the Department’s toll-free telephone number and an envelope addressed to the Department of Managed Health Care. DHCS GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provisions 1 – Member Grievance System, and 4(B)(2) – Notice of Action requires compliance with this Rule. Review of the Plan’s appeals files do not include documentation that consistently substantiates the IMR envelope is being provided to members (43% non-compliance rate). Therefore, the Department finds the Plan in violation of these regulatory and contractual requirements.

Potential Deficiency #5:

The Plan does not immediately inform members of the right to contact the Department when filing grievances requiring expedited review.

Statutory/Regulatory/Contract References: Section 1368.01(b); Rule 1300.68.01(a)(1); and DHCS GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1 – Member Grievance System.

Section 1368.01(b) states, in pertinent part, “When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance.”

Rule 1300.68.01(a)(1) states, “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”). At a minimum, plan procedures for urgent grievances shall include: Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.”

DHCS GMC Contract, Exhibit A, Attachment 14 – Member Grievance System

1. Member Grievance System

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

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

- Plan Policy 10.18.1: Member Appeal Processes (Pre-Service, Expedited, Post-Service) (effective 2/2012)
- 3 Expedited Appeals (October 1, 2012 – September 30, 2013)

Assessment: Review of the Plan's policy, "Member Appeal Processes (Pre-Service, Expedited, Post-Service)" indicates that although processes are in place to ensure timely provider and member notification of decisions regarding expedited appeals (within 72 hours), there is no provision requiring the Plan to "immediately" notify the member of the right to contact the Department. Rather, information on how to contact the Department is included in the written resolution letter that is sent out to the member within three calendar days from receipt of the appeal.

The Department reviewed all three⁷ expedited appeals identified by the Plan during the survey review period and confirmed that none of the files contained documentation substantiating that the member had been immediately notified of his/her right (either verbally or in writing) to contact the Department regarding the expedited grievance. In an interview with the Plan's Director of Appeals and Grievances, she confirmed that the Plan's current process of handling expedited appeals does not include an immediate phone call or written notification to the member advising him/her of this right, but that the information is included in the resolution letter. However, this notification is sent out within three calendar days and is therefore not necessarily considered "immediate."

Section 1368.01(b) requires that, for cases requiring expedited review, the Plan must immediately inform members of the right to notify the Department of the grievance. Rule 1300.68.01(a)(1) requires the incorporation of this requirement into the Plan's policies and procedures. DHCS GMC Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 1 – Member Grievance System requires compliance with this rule. Review of expedited appeals files indicates that the Plan's current system does not include provisions for immediate member notification of the right to contact the Department, but rather within three calendar days. Therefore, the Department finds the Plan in violation of these statutory, regulatory, and contractual requirements.

⁷ The Plan's original *Expedited Appeals* log submitted to the Department contained two files. However, File #7, from the *Exempt* log was misclassified as "exempt" when it was in fact an "expedited" appeal. Therefore, it was moved from the *Exempt* log to the *Expedited Appeals* log, and three expedited appeals files were reviewed.

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 #6:

The Plan’s governing body does not direct ongoing operational Quality Improvement System modifications or track findings for follow-up in response to reports reviewed.

Statutory/Regulatory/Contract Reference: Rule 1300.70(b)(2)(C); and DHCS GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provisions 1 – General Requirement, and 3(D) – Governing Body.

Rule 1300.70(b)(2)(C) states, in pertinent part, “Reports to the plan’s governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.”

DHCS GMC 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...

3. Governing Body

Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following:

- D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

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

- Governing Body Meeting Minutes (October 1, 2012 – September 30, 2013)

Assessment: The Department reviewed all governing board meeting minutes for the survey review period. Each meeting documented the presentation of extensive reports regarding various quality improvement activities, and reflected review and approval of these reports by the governing body. However, the minutes did not document any active discussion, feedback, follow-up, or recommendations made by the governing board to quality improvement staff. Therefore, there was no evidence that the governing body directs ongoing modification or follow-up of quality improvement operations based on findings identified. In interviews, Plan

staff provided examples of the governing body's involvement in the quality improvement process, including the specific actions that were implemented in response to issues presented. However, there was no documented record of these activities in any the meeting minutes.

Rule 1300.70(b)(2)(C) requires reports submitted to the governing body to be sufficiently detailed to include findings and actions taken as a result of the QA program. DHCS GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 3(D) – Governing Body, requires specific involvement from the governing body in providing ongoing operational direction, modification, and follow-up to the quality improvement system in response to issues identified. Although reports submitted to the governing body were found to be extensive and detailed, meeting minutes did not document any direction, feedback, recommendations, or actions taken by the governing body in response to the reports reviewed. Therefore, the Department finds the Plan in violation of these regulatory and contractual requirements.

Potential Deficiency #7:

The Plan does not adhere to its policy and procedure for timely evaluation and resolution of potential quality issues and, as a result, does not take effective action to improve care when deficiencies are identified to ensure that a level of care, which meets professionally recognized standards of practice, is being delivered to all enrollees.

Statutory/Regulatory/Contract Reference: Section 1386(b)(1); Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A); and DHCS GMC Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement.

Section 1386(b)(1) states, “The following acts or omissions constitute grounds for disciplinary action by the director: (1) The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.”

Rule 1300.70(a)(1) states, “The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.”

Rule 1300.70(b)(1)(A) states, in pertinent part, “Each plan's quality assurance program shall be designed to ensure that a level of care which meets professionally recognized standards of practice is being delivered to all enrollees.”

DHCS GMC 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...”

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

- Plan Policy 70.1.1.7: Clinical Grievance Process (effective 2/2013)
- Plan Policy 70.1.1.9: Potential Quality of Care and Quality of Care Issues (effective 2/2013)
- 16 Potential Quality Issues (PQI)⁸ files (October 1, 2012 – September 30, 2013)

Assessment: The Plan’s policy, “Clinical Grievance Process,” distinguishes administrative grievances from clinical grievances. All member grievances with a quality of care component are defined as “clinical grievances” and are forwarded onto the Quality Improvement Department for investigation, severity level coding, and corrective action implementation if warranted. Although clinical grievances are resolved with the member within 30 days of receipt of the grievances, the policy regarding the investigation of the actual potential quality issue (PQI) component states, “All clinical grievance cases will be closed within 180 days from time of initial date stamp.” The Plan’s policy, “Potential Quality of Care and Quality of Care Issues,” further emphasizes the Plan’s internal timeframe and similarly states, “PQI’s Cases will be completed within 180 days of receipt into the Quality Department unless there are extenuating circumstances.”

To assess the Plan’s handling of PQIs or clinical grievances, the Department reviewed the entire universe of 16 PQI files identified by the Plan during the survey review period. Three of 16 files (19%) were found to have taken greater than 180 days from identification of the PQI to resolution of the case. These cases required 304, 291 and 310 days for resolution, primarily due to delays in referring the case to the physician reviewer. In each case, following initial assessment by the registered nurse and the receipt of additional information by staff, there was significant delay (8-9 months) before referral to the physician reviewer. For example:

- *File #12:* This case involved the hospitalization of a member with the possibility of inappropriate follow-up care arranged upon discharge. The case was identified as a PQI on October 19, 2012 with all the necessary and additional information required to review the case received on November 15, 2012 (approximately one month later). However, the file was not reviewed by the physician reviewer until August 19, 2013 (approximately nine months from receipt of information). Although the Plan thoroughly investigated the case and no quality of care issues were identified, the case was not fully resolved with the appropriate severity level assigned until almost one year later (304 days).
- *File #13:* This case involved a member who experienced complications during a surgical procedure. The case was identified as a PQI on November 25, 2012 with all necessary and additional information required to review the case received on December 26, 2012 (approximately one month later). However, the physician reviewer did not review the

⁸ Cases, providers, processes or concerns identified through enrollee grievances, sentinel events (e.g., mortalities), data analysis and other sources as having *potential quality issues* that require investigation are often referred to as PQIs.

file until September 12, 2013 (approximately eight months from the receipt of additional information). At that time, the case was referred for expert review where it was opined that the member experienced expected complications that were recognized for this particular procedure. Although the Plan opened the investigation promptly and obtained all necessary records within a reasonable timeframe, the case was not fully resolved with the appropriate severity level assigned until almost nine months later (291 days).

- *File #16:* This case involved a member who experienced significant post-surgical complications. The case was identified as a PQI on October 10, 2012 with all necessary and additional information required to review the case received on January 17, 2013 (three months later). However, the physician reviewer did not review the file until August 16, 2013 (seven months from receipt of information). Upon investigation and further literature review, the case was assigned a Level 1 severity level by the Medical Director due to known complications and no CAP was required. However, should a CAP been warranted, it would not have been implemented until almost one year later when the case was fully resolved with the appropriate severity level assigned (310 days).

Section 1386(b)(1) indicates grounds for disciplinary action when the Plan is operating at variance with basic organizational documents or its published plan as submitted to the Department, unless amendments have been approved. In addition, Rules 1300.70(a)(1) and 1300.70(b)(1)(A), and DHCS GMC Boilerplate Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1, require the Plan to take effective action to improve care where deficiencies are identified and that such care be at a level that is consistent with professionally recognized standards. In its assessment of the Plan's handling of PQI files, the Department found significant delays in case closure and resolution (19% non-compliance rate) beyond the 180 turnaround time for processing of clinical grievances per the Plan's own internal policy. Excessive delays in resolution of PQIs and implementation of indicated corrective action may adversely impact the quality of care delivered to enrollees and, therefore, does not constitute effective action to improve care. Therefore, the Department finds the Plan in violation of these statutory, regulatory, and contractual requirements.

APPENDIX A. 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
Standard Grievances/Appeals	24	The Department randomly selected a sample of 44 of the 97 standard grievances and appeals files identified by the Plan during the survey review period.
Exempt (One-Day) Grievances	6*	The Department selected all 7 exempt grievances identified by the Plan during the survey review period.
Expedited Appeals	3 [#]	The Department selected all 2 expedited appeals identified by the Plan during the survey review period.
Medical Necessity Denials	21	The Department selected all 21 appeals from the 44 randomly selected standard grievances and appeals files from the Department's Standard Grievances/Appeals pull and reviewed the initial denial documentation.
Potential Quality Issues	16	The Department selected all 16 PQI files identified by the Plan during the survey review period.