

DEPARTMENT OF  
**Managed**  
**Health Care**  
**Help Center**

**DIVISION OF PLAN SURVEYS**

**1115 WAIVER SENIORS AND PERSONS WITH  
DISABILITIES**

**SURVEY REPORT OF  
SANTA CLARA COUNTY HEALTH AUTHORITY  
dba SANTA CLARA FAMILY HEALTH PLAN  
A FULL SERVICE HEALTH PLAN**

**DATE ISSUED TO DHCS: MARCH 26, 2015**

**1115 Waiver SPD Survey Report  
Santa Clara County Health Authority  
A Full Service Health Plan  
March 26, 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 Department of Managed Health Care (the “Department”) entered into an Inter-Agency Agreement with the DHCS<sup>1</sup> 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 November 26, 2013, Santa Clara County Health Authority dba Santa Clara Family Health Plan (the “Plan” or “SCFHP”) was notified that its Medical Survey had commenced and was requested to provide the Department with the necessary pre-onsite data and documentation. The Department’s survey team conducted the onsite portion of the Medical Survey from March 3, 2014 through March 6, 2014.<sup>2</sup>

### SCOPE OF SURVEY

The Department is providing the DHCS this 1115 Waiver SPD Survey Report pursuant to the Inter-Agency Agreement and has identified potential deficiencies in Plan operations supporting SPD membership. This Medical Survey evaluated the following elements specifically related to the Plan’s delivery of care to the SPD population pursuant to the DHCS contract requirements and compliance with the Act:

#### **I. Utilization Management**

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

#### **II. Continuity of Care**

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

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

<sup>2</sup> 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 Boilerplate Contract. 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 Boilerplate Contract issued by the Department of Health Care Services.

**III. Availability and Accessibility**

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

**IV. Member Rights**

The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for Primary Care Physician 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, 2013 through December 31, 2013.

**SUMMARY OF FINDINGS**

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

**2014 SURVEY POTENTIAL DEFICIENCIES**

<b>UTILIZATION MANAGEMENT</b>	
<b>#1</b>	<p><b>The Plan does not have effective mechanisms in place to detect and correct under- and over-utilization of health care services.</b>            DHCS-SCFHP Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 4 – Review of Utilization Data; Rule 1300.70(b)(2)(H)(2); Rule 1300.70(c).</p>
<b>#2</b>	<p><b>The Plan does not consistently include in its written response a clear and concise explanation or clinical reasons for decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity.</b>            DHCS-SCFHP Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures; Section 1367.01(h)(4).</p>

<b>CONTINUITY OF CARE</b>	
<b>#3</b>	<p><b>The Plan does not adequately monitor the coordination of care provided to its SPD members by tracking, trending, and analyzing the provision and results of:</b></p> <ul style="list-style-type: none"> <li>• <b>Initial Health Assessments and Individual Health Education Behavioral Assessments; and</b></li> <li>• <b>Services for Developmental Disabilities and the Early Start Program.</b></li> </ul> <p>DHCS-SCFHP Contract, Exhibit A, Attachment 10 – Scope of Services, Provisions 3(A) and 3(B) – Initial Health Assessment (IHA); DHCS-SCFHP Contract, Exhibit A Attachment 11 – Case Management and Coordination of Care, Provision 1(C) – Comprehensive Case Management Including Coordination of Care Services; Rule 1300.70(b)(1)(A)-(B).</p>
<b>AVAILABILITY &amp; ACCESSIBILITY OF SERVICES</b>	
<b>#4</b>	<p><b>The Plan’s Quality Improvement Committee and its governing body do not review and evaluate on a quarterly basis, the information available to the Plan regarding accessibility, availability, and continuity of care.</b></p> <p>DHCS-SCFHP Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provisions 3(C) and 3(D) – Governing Body; DHCS-SCFHP Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3 – Access Requirements; Rule 1300.67.2(f); Rule 1300.67.2.2(d)(2)(D); Rule 1300.70(b)(2)(C).</p>
<b>#5</b>	<p><b>The Plan does not conduct an annual enrollee experience survey to ascertain the accessibility and availability of contracted providers.</b></p> <p>DHCS-SCFHP Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4 – Access Standards; Rule 1300.67.2.2(d)(2)(B).</p>
<b>#6</b>	<p><b>The Plan does not conduct adequate monitoring to ensure member access to specialists for medically necessary covered services.</b></p> <p>DHCS-SCFHP Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 1(F) – Utilization Management Program; DHCS-SCFHP Contract, Exhibit A, Attachment 6 – Provider Network, Provision 2 – Network Composition, Provision 6 – Specialists; DHCS-SCFHP Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 1 – General Requirement and Provision 3(A) – Access Requirements; Rule 1300.67.2(e).</p>
<b>MEMBER RIGHTS</b>	
<b>#7</b>	<p><b>The Plan does not have procedures to ensure that the person making the final decision for the proposed resolution of a grievance involving a denial based on lack of medical necessity, a denial of expedited resolution of an appeal, or any clinical issues, has not participated in any prior decisions related to the grievance.</b></p> <p>DHCS-SCFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(G) – Grievance System Oversight.</p>
<b>#8</b>	<p><b>The Plan does not have policies and procedures to enable members to make a standing request to receive all informing materials in a specified alternative format.</b></p> <p>DHCS-SCFHP Contract, Exhibit A, Attachment 13 – Member Services, Provision 4(C)(3) – Written Member Information.</p>

## QUALITY MANAGEMENT

#9

**The Plan does not consistently document that quality of care is being reviewed, problems are being identified, and effective action is taken to improve care where deficiencies are identified.**

DHCS-SCFHP Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-SCFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(E) – Grievance System Oversight; Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A)-(B).

## OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

To address the specific needs of the SPD population, the Plan took the following actions to implement new programs or expand upon existing ones:

- Developed a Health Risk Assessment Outreach Team;
- Hired an additional Registered Nurse Case Manager and three additional Licensed Clinical Social Workers;
- Provided training for its delegates' case managers on the SPD requirements for care coordination and case management;
- Contracted with the Indian Health Center to provide a comprehensive diabetes education program, including "open gym" memberships for the SPD population;
- Completed facility site reviews and posted the information on the Plan's website for members to reference;
- Calculated HEDIS measures for the SPD population; and
- Expected to begin reporting on multiple utilization measures broken out for SPD and non-SPD members in 2014.

## 2014 SANTA CLARA COUNTY HEALTH AUTHORITY: 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 under- and over-utilization of services.
- c. The methodologies and processes used to handle prior authorizations appropriately while complying with the requirements specified in the contract as well as in state and federal laws and regulations.
- d. The methodologies and processes used to evaluate utilization management activities of delegated entities.

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

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

#### DHCS-SCFHP Contract, Exhibit A, Attachment 5 – Utilization Management

##### 4. Review of Utilization Data

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

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

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

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

#### Rule 1300.70(c)

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

#### **Documents Reviewed:**

- Plan Policy UM050\_03: Utilization Management Over- and Under-Utilization of Medical Services (12/17/12)
- Plan Policy UM040\_50: Delegation of Utilization Management Activities (12/17/12)
- Utilization Management Committee meeting minutes (01/09/13, 04/10/13, 07/10/13, and 10/09/13)
- Santa Clara Family Health Plan Job Description – Medical Director (04/24/08)

- DHCS Pre-Onsite Document Request 1.5.4: Delegated Utilization Management Activities (undated)

**Assessment:** The Plan contracts with Valley Health Plan, Kaiser Permanente Health Plan, Physician’s Medical Group, and Premier Care. These four entities provide health care services to Plan members in exchange for either fully or partially capitated rates. In addition, the entities perform utilization management (UM) functions on the Plan’s behalf. The four UM delegates are audited by the Plan annually, and based on the individual delegation contracts, provide the Plan with either monthly or quarterly reports. Although the Plan delegates its UM activities, the Plan’s Delegation of Utilization Management Activities Policy states that the Plan is “accountable for all functions and responsibilities that are delegated to subcontractors.”

Plan Policy UM050\_03: Utilization Management Over- and Under-Utilization of Medical Services focuses on the UM Committee’s responsibility to assess utilization data. The policy enumerates various reports the Plan’s UM Committee reviews to detect the under- and over-utilization of health care services. Some examples of reports listed in the policy include: inpatient beds per day (includes number of admissions, readmissions, and average length of stays); outpatient specialty referrals; claims paid for specialty referrals; medical request denials; provider appeals of denied medical requests by category; member UM grievances by category; frequency of selected inpatient and ambulatory surgical procedures; emergency room visits; and other utilization data reports issued quarterly by delegated provider groups.

The Plan’s Chief Medical Officer works with the UM Committee to monitor the under- and over-utilization of services. Policy UM050\_03 states, “If problems in the utilization data are revealed, corrective action plans are discussed in the UM Committee; an implementation plan is developed by the UM Director based on input from the Committee and the Chief Medical Officer.” According to the Chief Medical Officer’s job description, one of the primary responsibilities of the position is to monitor and control the appropriate utilization of health care services in order to achieve high quality outcomes in the most cost effective manner. In addition, the Chief Medical Officer advises and oversees staffing for the UM Committee, and attends the quarterly UM Committee meetings.

Review of the four quarterly 2013 UM Committee meeting minutes revealed inadequate discussions regarding the detection and correction of the under- and over-utilization of health care services. The only reports presented to the UM Committee were: (1) Membership by Network & [Line of Business]; (2) Prior Authorization by Volume & Status; (3) Bed Days; and (4) Community Based Adult Service (CBAS) utilization. The Plan provided no documentation to substantiate that the other reports specified in Policy UM050\_03 were presented to and reviewed by the UM Committee. For example:

- *January 9, 2013:* The UM Committee meeting minutes noted that CBAS enrollment was down because the Plan had received different information from CBAS centers and the State. After the Plan received updated enrollment information from the State, it was determined that 450 members were receiving CBAS services, instead of 285 members as previously believed.

- *April 10, 2013:* The UM Committee meeting minutes noted that prior authorizations increased due to CBAS. In addition, enrollment has doubled since September, which brought membership numbers from 9,500 to 18,000.
- *July 10, 2013:* The UM Committee meeting minutes noted that SPD membership increased to 16,740 and remained steady. The number of prior authorizations also remained steady. Although bed days decreased for Healthy Kids and increased for SPDs in the third quarter, the Plan observed the highest number of bed days for all lines of business and implemented a Quality Improvement Project to reduce admission rates. Additional follow-up actions included obtaining discharge plans sooner so the Plan could intervene to prevent readmission, and hiring a social worker to decrease the rate of all-cause readmissions. In addition, as of July, there were 600 CBAS members, with 20 referrals and 20 face-to-face assessments received and completed per month.
- *October 9, 2013:* The UM Committee meeting minutes noted that the SPD membership remains steady. The UM Manager attributed the decline of bed days from the third quarter to the addition of UM staff conducting concurrent reviews. The Committee noted “great success over the last month” and planned to follow-up regarding this particular issue.

While the meeting minutes include discussions of utilization patterns pertaining to SPD membership, prior authorizations, bed days, and CBAS, the UM Committee did not review any other utilization reports as defined by Plan policy to detect and correct for the under- and over-utilization of health care services. For example, although the Prior Authorization by Volume & Status report was presented at each quarterly meeting, the only data reported was the total number of monthly approvals, denials, pending, and cancelled prior authorization requests for the previous quarter and the past year. There was no breakdown by prior authorization type to assist the Plan with identifying patterns or trends for specific types of requests. In addition, although the Plan implemented a Quality Improvement Project in the third quarter, there was no follow up during the fourth quarter to assess the effectiveness of the program.

In an onsite interview, Plan staff conceded that the Plan had not been monitoring utilization of health care services as robustly as it should. The Chief Medical Officer acknowledged that the utilization reports currently generated by the Plan are insufficient to facilitate meaningful analysis and discussion. Plan staff indicated that improvements regarding the monitoring for under- and over-utilization of health care services were currently underway, but offered no projected timelines as to when improvements would take place or when results were expected to be seen.

DHCS-SCFHP Contract, Exhibit A, Attachment 5, Provision 4 and Rule 1300.70(b)(2)(H)(2) require that the Plan have mechanisms in place to detect and correct under- and over-utilization of health care services by at-risk providers. Rule 1300.70(c) further requires the Plan to implement reasonable procedures for continuously reviewing the utilization of services and facilities. Although the Plan’s policy describes various reports that the UM Committee must review to detect under- and over- utilization of services, the committee’s 2013 meeting minutes revealed only cursory discussions of a few reports specified in Plan Policy UM050\_03. Furthermore, when the Plan implemented actions to decrease over-utilization, it did not follow

up and analyze the success of its proposed actions during the following quarter. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

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**Potential Deficiency #2: The Plan does not consistently include in its written response a clear and concise explanation or clinical reasons for decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SCFHP Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures; Section 1367.01(h)(4).

DHCS-SCFHP 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:

D. Reasons for decisions are clearly documented.

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.*” [Emphasis added.]

**Documents Reviewed:**

- Plan Policy UM039\_02: Utilization Management Review Standards, Criteria and Guidelines (12/31/12)
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- Plan Policy UM002\_08: Prior Authorization Process for Non-Delegated SCFHP Members and Specialty Programs (12/17/12)
  
- DHCS Pre-Onsite Document Request 1.5.2: List of UM Delegates (2013)
- 8 Standard Appeal files (01/01/13-12/31/13)

**Assessment:** The Department reviewed eight standard appeals files to assess the initial denial processes by the Plan and its delegates when evaluating requests for medically necessary

services.<sup>3</sup> Of the eight initial denial letters reviewed, two letters (25%) did not include a clear and concise explanation of the reasons for the decisions, and one letter (13%) did not include the clinical reason for the denial.<sup>4</sup>

- *File #3:* The Plan denied the provider's Month Day, 2013 request for a Magnetic Resonance Imaging (MRI) test. The provider requested a MRI in order to establish the stage of the member's cancer. The Plan's letter stated the following reason for the denial:

Per Milliman, surveillance for recurrence of treated brain metastasis is every three months for one year. You had radiation treatment in Month 2010 and have had follow-up MRI on MM/DD/11 and MM/DD/12. Please follow up with your doctor for additional treatment options.

This explanation does not clearly indicate how the member does not meet the criteria cited. The Plan's letter failed to clearly express that the criteria's timeframe for an additional MRI scan expired before the date on which the additional MRI scan was requested. The mere mention of the dates of the two previous MRI scans in the denial was insufficient to inform the enrollee that the applicable timeframe had passed, given that the two post-treatment MRI scans were performed well after the cutoff date found in the criteria. The letter, while concise, does not provide a clear explanation of the denial. It is notable that the Plan later overturned the denial upon appeal.

- *File #5:* The Plan's delegate denied a neurological follow-up. The Plan's letter stated the following reason for the denial:

The service requested is being denied by Physician Medical Group of San Jose because the clinical information provided was reviewed for medical necessity by our physician reviewer and was determined to be within your PCP's scope of practice. Your medical condition and/or medical needs as described by the documentation above do not meet the definition of medical necessity as set forth in CA Code of Reg, Title 22, Section 51303(a).

The Plan's denial letter failed to meet the clear and concise requirement, as the reasoning behind the denial is unclear. The first sentence indicates that the service is medically necessary and would be approved if provided by the member's PCP. Then, the second sentence states that the service requested is not medically necessary, which contradicts the previous sentence. In addition, the denial letter lacks clinical reasons for the Plan's denial.

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<sup>3</sup> Out of the 40 standard appeals files randomly selected for review, eight files involved denial determinations based in whole or in part on medical necessity. The remaining 32 files were omitted from review against the requirements set forth by Section 1367.01(h).

<sup>4</sup> See Table 1: UM Medical Necessity Denials

**TABLE 1**  
**UM Medical Necessity Denials**

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
UM Denials	8	Clear and concise explanation	6 (75%)	2 (25%)
		Clinical reason for the denial	7 (87%)	1 (13%)

DHCS-SCFHP Contract, Exhibit A, Attachment 5, Provision 2(D) and Section 1367.01(h)(4) requires the Plan to provide a clear and concise explanation, a description of the criteria or guidelines used, and the clinical reasons for denial decisions regarding medical necessity. Review of the Plan’s denial letters revealed that the Plan did not consistently include clear and concise explanations or clinical reasons for its decisions. Therefore, the Department finds the Plan in violation of these contractual and statutory 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.

**Potential Deficiency #3: The Plan does not adequately monitor the coordination of care provided to its SPD members by tracking, trending, and analyzing the provision and results of:**

- **Initial Health Assessments and Individual Health Education Behavioral Assessments; and**
- **Services for Developmental Disabilities and the Early Start Program.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SCFHP Contract, Exhibit A, Attachment 10 – Scope of Services, Provisions 3(A) and 3(B) – Initial Health Assessment (IHA); DHCS-SCFHP Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care, Provision 1(C) – Comprehensive Case Management Including Coordination of Care Services; Rule 1300.70(b)(1)(A)-(B).

DHCS-SCFHP Contract, Exhibit A, Attachment 10 – Scope of Services

3. Initial Health Assessment (IHA)

An IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic, and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.

- A. Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.
- B. Contractor shall ensure that the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10) using an age appropriate DHCS approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.

DHCS-SCFHP Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care

1. Comprehensive Case Management Including Coordination of Care Services

Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.

- C. Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical data, and any other available data, as well as self and physician referrals.

Rule 1300.70(b)(1)

To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

- (A) A level of care which meets professionally recognized standards of practice is being delivered to all enrollees;
- (B) Quality of care problems are identified and corrected for all provider entities.

**Documents Reviewed:**

- Plan Policy QM006\_06: Initial Comprehensive Health Assessment (IHA) (12/31/12)
- Plan Policy HE-04\_05: Initial Health Assessments (IHAs) and Behavioral Assessment (HEBA) (12/17/12)
- Plan Policy CM005\_03: Early Start Program (Early Intervention Services); Developmental Delay Identification, Referral and Care Coordination (12/17/12)
- Plan Policy CM038\_02: Developmental Disabilities – General Policy (12/31/12)
- DHCS Pre-Onsite Document Request 2.4.2: Monitoring of IHAs and IHEBAs (undated)
- SPD Potential Quality of Care Issues Track and Trend Annual Report (2013)

- DHCS Pre-Onsite Document Request 2.3.2: Reports for Developmental Disability and Early Start programs (undated)
- DHCS Pre-Onsite Document Request 1.5.4: Plan's System to Track Prior Authorizations at the IPA Level (undated)
- Memorandum of Understanding between Santa Clara County Early Start Program (ESP), Santa Clara County Office of Education (SCCOE), San Andreas Regional Center (SARC), and Santa Clara Family Health Plan (SCFHP) (08/15/12)
- Quality Improvement Committee meeting minutes (02/13/13, 05/08/13, 08/14/13, and 11/13/13)
- DMHC Onsite Request 55: SPD Members in Complex and Basic Care Management (03/06/14)

**Assessment:** The Department reviewed the Plan's policies, procedures, and monitoring reports pertaining to Initial Health Assessments (IHAs), Individual Health Education Behavioral Assessments (IHEBAs), services for Developmental Disabilities, and the Early Start Program in order to assess the Plan's coordination of care and provision of these services. The Department found that the Plan does not conduct adequate tracking, trending, and analysis to ensure the provision of these services.

#### **Initial Health Assessments and Individual Health Behavioral Assessments**

Plan Policy QM006\_06: Initial Comprehensive Health Assessment indicates that "the IS Department performs an annual calculation of IHA compliance rate by product line along with an analysis of rates for identification of patterns and trends for appropriate intervention activities." While the Plan identifies the need for compliance monitoring regarding the completion of IHAs, in the Plan's written response to the Department's pre-onsite request for monitoring reports on IHAs and IHEBAs, the Plan stated:

During the audit period, Santa Clara Family Health Plan did not have any monitoring reports for the IHA and/or the IHEBA. Monitoring was done during all recertification Facility Site Reviews for contracted Primary Care Providers. Individual scores are in the FSR folders of each Provider.

During onsite interviews, the Chief Medical Officer and staff agreed to provide the Department with tracking reports and corresponding analysis pertaining to IHAs and IHEBAs. The documents showed that the Plan tracks the total number of completed IHAs, basic case management cases, and complex case management cases. However, the Plan did not provide any tracking, trending, or analytic reports that could be used to identify service or outreach needs, or barriers to the completion of IHAs and IHEBAs. Therefore, although the Plan tracks compliance rates as required, it fails to comply with Policy QM006\_06 as it does not analyze rates to identify patterns and trends for appropriate intervention activities.

#### **Services for Developmental Disabilities and Early Start Program**

A Memorandum of Understanding (MOU) between the Early Start Program, the Santa Clara County Office of Education (SCCOE), the San Andreas Regional Center (SARC), and the Plan specifies a seven working day timeframe for the Plan's providers to refer potentially eligible members to the Early Start Program. In addition, the Plan's Director of Medical Management is

responsible for the development of a monitoring system to assess the effectiveness and timeliness of the identification and referral of potentially eligible Early Start Program members.

Plan policies CM005\_03: Early Start Program (Early Intervention Services) and CM038\_02: Developmental Disabilities – General Policy include procedures to identify and refer members who have developmental delays or disabilities and need early intervention services. While the policies emphasize coordination of care and collaboration between the Early Start Program, SCCOE, SARC, and the Plan, there are no monitoring procedures to ensure timely referral for services as required by the MOU.

In its written response to the Department’s pre-onsite request for monitoring reports on Developmental Disability Services and the Early Start Program, the Plan stated:

Santa Clara Family Health Plan does not currently have formal monitoring reports. The HP, SARC and Early Start do meet quarterly and discuss case management/care coordination of individual members at the MOU meetings in addition to the SARC monthly meetings, and via phone as needed.

During onsite interviews, Plan staff confirmed that there are no formal monitoring reports generated, but that individual cases are discussed during quarterly MOU meetings between the SARC and Early Start Program.

DHCS-SCFHP Contract, Exhibit A, Attachment 10, Provisions 3(A) and 3(B) require the timely provision of IHAs and IHEBAs to identify members whose health needs require coordination with appropriate community resources and other agencies. DHCS-SCFHP Contract, Exhibit A, Attachment 11, Provision 1(C) requires the Plan to monitor the coordination of care provided to members. Rule 1300.70(b)(1)(A)-(B) require the Plan to continuously review the quality of care provided to ensure that care meets professionally recognized standards of practice and quality of care problems are identified and corrected. Although the Plan tracks IHA, IHEBA, Developmental Disability Services, and Early Start Program data, the Plan has not used the data to identify patterns and trends. The Plan does not have monitoring procedures to ensure timely referrals for Developmental Disability Services and the Early Start Program. In addition, the Plan does not generate reports to monitor the coordination of care provided to its members or to identify and correct quality of care issues. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

<b>AVAILABILITY AND ACCESSIBILITY</b>
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<b>In accordance with the DHCS-DMHC Inter-Agency Agreement, the Department evaluated the Plan’s processes to support access and availability including:</b>
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- |  |
|--|
| <ul style="list-style-type: none"><li>a. The availability of services, including specialists, emergency, urgent care, and after-hours care.</li><li>b. Health plan policies and procedures for addressing a patient’s request for disability accommodations.</li></ul> |
|--|

**Potential Deficiency #4: The Plan's Quality Improvement Committee and its governing body do not review and evaluate on a quarterly basis, the information available to the Plan regarding accessibility, availability, and continuity of care.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SCFHP Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provisions 3(C) and 3(D) – Governing Body; DHCS-SCFHP Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3 – Access Requirements; Rule 1300.67.2(f); Rule 1300.67.2.2(d)(2)(D); Rule 1300.70(b)(2)(C).

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

3. Governing Body

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

- C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.
- D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

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

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

Rule 1300.67.2(f)

Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

Rule 1300.67.2.2(d)(2)(D)

(2) Compliance monitoring ... shall include:

(D) Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services; and

Rule 1300.70(b)(2)(C)

The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. ... The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.

**Documents Reviewed:**

- Plan Policy PS023\_04: Quarterly Provider Network Analysis (03/01/11)
- Plan Policy QM001\_05: Access and Availability Standards (12/31/12)
- Plan Policy PS027: Timely Telephone Access to Contracted SCFHP Providers (04/05/11)
- Quality Improvement Committee meeting minutes (02/13/13, 05/08/13, 08/14/13, and 11/13/13)
- Board of Directors meeting minutes (02/21/13, 06/20/13, and 10/24/13)
- Quality Improvement Program (2013)

**Assessment:** The Plan's Quality Improvement Program (QIP) document includes an outline of the program's structure and organization, including a description of the primary duties and responsibilities of the Governing Board and Quality Improvement Committee (QIC). It states:

The Santa Clara County Health Authority Governing Board maintains ultimate authority and responsibility for the operation of SCFHP and for the quality of patient care for all its members ... The QIC oversees the development, implementation, and effectiveness of the QIP and is accountable to the Health Authority.

Plan Policy QM001\_05: Access and Availability Standards establishes access and availability standards to ensure that all members have timely access to care. In addition, it outlines monitoring, reporting, and follow-up actions to be taken by the QIC and Governing Board. It states:

I. Monitoring

Compliance with SCFHP's Access to Care Standards are monitored in coordination with other activities including, but not limited to credentialing, monitoring and resolution of member grievances and appeals, assessment of member satisfaction, Provider Services' visits, and Facility Site Reviews.

...

J. Reporting and Follow-Up

1. Provider Services reports access and medical advice/triage monitoring findings to the Quality Improvement Committee (QIC).
2. An annual Facility Site review analysis with findings regarding access to care standards is reported to the CMO/Medical Director, QIC, Chief Executive Officer (CEO), and Governing Board.
3. The CMO/Medical Director, QIC, and CEO make recommendations for further action and report their recommendations to the appropriate Department Directors. Provider Services will coordinate with the Quality

Improvement Department regarding activities to monitor and follow-up on compliance with the access to care standards.

The Department's review of quarterly meeting minutes for both the Governing Board and QIC revealed no discussion of key access related issues such as appointment wait times, geographic provider distribution, Plan provider network adequacy, or availability of after-hours services. Further, neither group reviewed provider appointment availability survey results, GeoAccess reports, enrollee satisfaction surveys, or other network adequacy monitoring reports.

In onsite interviews, Plan staff acknowledged that access and availability was not included as an agenda item for review in the 2013 quarterly meetings. Plan staff confirmed that they recognize this oversight and discussions regarding access and availability would be included in future meetings.

DHCS-SCFHP Contract, Exhibit A, Attachment 9, Provision 3 and Rule 1300.67.2(f) require the Plan to establish a system to monitor, evaluate, and address accessibility of care issues. Rule 1300.67.2.2(d)(2)(D) requires compliance monitoring to occur at least quarterly and contain information on accessibility, availability, and continuity of care. DHCS-SCFHP Contract, Exhibit A, Attachment 4, Provisions 3(C) and 3(D) requires the Governing Board to routinely receive written progress reports from the QIC describing actions taken, progress in meeting QIS objectives, and improvements made. The Governing Board must also modify the operational QIS on an ongoing basis and track all review findings for follow-up. Rule 1300.70(b)(2)(C) requires the Plan's Governing Board and QIC to meet quarterly, or more frequently if problems were identified. While the Plan's Governing Board and QIC are ultimately responsible for developing and directing the Plan's QIP, neither entity addressed the topics of accessibility, availability, or continuity of care at any point during the review period. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

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**Potential Deficiency #5: The Plan does not conduct an annual enrollee experience survey to ascertain the accessibility and availability of contracted providers.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SCFHP Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 4 – Access Standards; Rule 1300.67.2.2(d)(2)(B).

DHCS-SCFHP 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 ... Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

Rule 1300.67.2.2(d)(2)(B)

[A] plan's quality assurance program shall address ... [c]ompliance monitoring policies and procedures ... designed to accurately measure the accessibility and availability of contracted providers ... [by] conducting an annual enrollee experience survey, which shall be conducted in accordance with valid and reliable survey methodology...

**Documents Reviewed:**

- Plan Policy QM001\_05: Access and Availability Standards (12/31/12)

**Assessment:** Plan Policy QM001\_05: Access and Availability Standards establishes access and availability standards to ensure that all members have timely access to care. In addition, the policy requires the following monitoring activities to take place:

I. Monitoring

Compliance with SCFHP's Access to Care Standards are monitored in coordination with other activities including, but not limited to credentialing, monitoring and resolution of member grievances and appeals, *assessment of member satisfaction*, Provider Services' visits, and Facility Site Reviews. [Emphasis added.]

During an onsite interview, Plan staff confirmed that the member satisfaction survey designed to ascertain compliance with appointment wait time standards had not been conducted during the survey review period. Staff also reported that planning was underway and that a member satisfaction survey would soon be implemented.

DHCS-SCFHP Contract, Exhibit A, Attachment 9, Provision 4 requires the Plan to comply with the accessibility standards set forth in Title 28 CCR Section 1300.67.2.2 and to monitor compliance with these standards. Rule 1300.67.2.2(d)(2)(B) requires the Plan to conduct an annual enrollee experience survey to assess compliance with timely access to care standards. Since the Plan did not conduct a member satisfaction survey during the review period, the Department finds the Plan in violation of these contractual and regulatory requirements.

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**Potential Deficiency #6: The Plan does not conduct adequate monitoring to ensure member access to specialists for medically necessary covered services.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SCFHP Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 1(F) – Utilization Management Program; DHCS-SCFHP Contract, Exhibit A, Attachment 6 – Provider Network, Provision 2 – Network Composition and Provision 6 – Specialists; DHCS-SCFHP Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 1 – General Requirement and Provision 3(A) – Access Requirements; Rule 1300.67.2(e).

DHCS-SCFHP 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. Contractor is responsible to ensure that the UM program includes:

F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied,

deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers.

DHCS-SCFHP Contract, Exhibit A, Attachment 6 – Provider Network

2. Network Composition

Contractor shall ensure and monitor an appropriate provider network, including primary care physicians, specialists ... within each service area.

6. Specialists

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care...

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

1. General Requirement

Contractor shall ensure Members access to specialists for Medically Necessary Covered Services.

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

A. Appointments

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

Rule 1300.67.2(e)

A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral.

**Documents Reviewed:**

- Plan Policy QM001\_05: Access and Availability Standards (12/31/12)
- Plan Policy PS023\_04: Quarterly Provider Network Analysis (03/01/11)
- Plan Policy PS001\_09: Monitoring of Timely Access to Non-Emergency Health Care Services (December 2013)
- Provider Network Access Analysis (December 2013)
- Geographic Access Analysis – Specialists (March 2014)
- Contracted Specialists by Specialties and [Line of Business] (November 2013)
- Appointment Availability Premier Care of Northern California – Specialists (2013)
- Appointment Availability Physicians Medical Group of San Jose – Specialists (2013)
- Appointment Availability Palo Alto Medical Foundation – Primary Care Providers and Specialists (2013)

**Assessment:** The Plan's Contracted Specialists by Specialties and [Line of Business] document indicates that the Plan's network has multiple specialties with participating providers.<sup>5</sup> Therefore, monitoring specialist referrals, including the volume of requests and the Plan's ability to make timely appointments to meet those requests, is necessary to maintain adequate numbers of specialists, especially when members need medically necessary covered services in specialties with limited providers.

DHCS-SCFHP Contract, Attachment 6, Provision 6 requires the Plan to maintain adequate numbers and types of in-network specialists to accommodate specialty care needs. The Plan conducts an annual appointment availability survey, which asks providers to self-report on its ability to provide appointments with specialists within 15 business days of request. The Department's review of the 2013 appointment availability surveys for three of its delegated networks<sup>6</sup> yielded 96% to 100% compliance rates for surveyed specialists. However, as the survey does not differentiate between the types of specialists surveyed, the Plan does not collect or analyze data by individual specialties to identify potential patterns and trends specific to the various specialties.

Aside from its annual appointment availability survey, the Department requested that the Plan provide additional tracking, trending, or monitoring reports to demonstrate the Plan's ongoing analysis of specialty referral patterns. The Plan was unable to produce tracking reports for specialty referrals made in-network, out-of-network, or for its delegates.

DHCS-SCFHP Contract, Exhibit A, Attachment 6, Provision 6; DHCS-SCFHP Contract, Exhibit A, Attachment 9, Provision 1; and Rule 1300.67.2(e) require the Plan to ensure and monitor an appropriate network of specialists so that its members have access to medically necessary covered services. DHCS-SCFHP Contract, Exhibit A, Attachment 5, Provision 1(F) requires the Plan to establish a specialty referral system to track and monitor referrals requiring prior authorization. Aside from conducting an annual appointment availability survey to measure providers' self-reported compliance on meeting mandated timeframes for non-urgent specialty appointments, the Plan was unable to provide any other tracking or trending reports to demonstrate ongoing monitoring of specialty care utilization patterns. Therefore, the Department finds the Plan in violation of these contractual and regulatory 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.

<sup>5</sup> When necessary, the Plan utilizes services of non-participating providers through letters of agreement.

<sup>6</sup> Physician's Medical Group, Premier Care, and Palo Alto Medical Foundation

**Potential Deficiency #7: The Plan does not have procedures to ensure that the person making the final decision for the proposed resolution of a grievance involving a denial based on lack of medical necessity, a denial of expedited resolution of an appeal, or any clinical issues, has not participated in any prior decisions related to the grievance.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SCFHP Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 2(G) – Grievance System Oversight.

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

2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.

G. Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance and is a health care professional with clinical expertise in treating a Member's condition or disease if any of the following apply:

- 1) A denial based on lack of medical necessity;
- 2) A grievance regarding denial of expedited resolutions of an appeal; and
- 3) Any grievance or appeal involving clinical issues.

**Documents Reviewed:**

- Grievance Review Committee meeting minutes (February, March, May, July, September, and December 2013)
- Plan Policy GA001\_10: Member Grievance and Appeals Process (01/13/14)
- Pre-Onsite Survey Questionnaire
- 23 Standard Appeal files (01/01/13-12/31/13)

**Assessment:** Plan Policy GA001\_10: Member Grievance and Appeals Process outlines general policies and procedures regarding how the Plan handles grievances and appeals filed by its members. However, the Plan does not have any policies and procedures to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance. Although the Plan does not have a formal written policy in place, the Department's review of 23 standard appeals files involving clinical issues revealed that an appropriate reviewer made the final decision for all of the proposed resolutions. In an onsite interview, the Plan's Compliance Officer and Vice President of Member Operations confirmed that while this practice is in place, the Plan does not have a formal policy that details the procedure.

DHCS-SCFHP Contract, Exhibit A, Attachment 14, Provision 2(G) requires the Plan to ensure that the person making the final decision for the proposed resolution of a grievance involving a denial based on lack of medical necessity, a grievance regarding denial of expedited resolutions of an appeal, or any grievance or appeal involving clinical issues, has not participated in any prior decisions related to the grievance. Since the Plan's policies do not include this provision, the Department finds the Plan in violation of this contractual requirement.

**Potential Deficiency #8: The Plan does not have policies and procedures to enable members to make a standing request to receive all informing materials in a specified alternative format.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SCFHP Contract, Exhibit A, Attachment 13 – Member Services, Provision 4(C)(3) – Written Member Information.

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

4. Written Member Information

C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.

3) Contractor shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

**Documents Reviewed:**

- Plan Policy GA001\_10: Member Grievance and Appeals Process (01/13/14)
- Plan Policy CU001\_04: Member Language Access: Interpreter Services (02/18/13)
- Pre-Onsite Survey Questionnaire
- Medi-Cal Evidence of Coverage (2013-2014)

**Assessment:** Plan Policy CU001\_04: Member Language Access: Interpreter Services and the Medi-Cal Evidence of Coverage handbook includes provisions for members to receive written materials in alternative formats (e.g., threshold languages, Braille, large sized print, etc.). In interviews, Plan staff explained that member-informing materials in threshold languages are routinely sent to members when the Plan's data system has identified the member as speaking one of the threshold language based on information received from the DHCS. Other requests for member materials in alternative formats are handled manually on a case-by-case basis as the requests are received by the Plan.

Although the Plan provides its members with materials in alternative formats, the Department found that Plan policies lacked procedures to enable members to make standing requests to receive all informing material in specified alternative formats. Interviews with Plan staff confirmed that while the Plan would honor a standing request for materials in alternative formats, the Plan has no policies and procedures for members to make standing requests.

DHCS-SCFHP Contract, Exhibit A, Attachment 13, Provision 4(C) requires the Plan to establish policies and procedures that enable members to make standing requests to receive all informing materials in specified alternative formats. Since the Plan's policies do not include this provision, the Department finds the Plan in violation of this contractual requirement.

## 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 #9: The Plan does not consistently document that quality of care is being reviewed, problems are being identified, and effective action is taken to improve care where deficiencies are identified.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SCFHP Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-SCFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(E) – Grievance System Oversight; Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A)-(B).

### DHCS-SCFHP 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 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

### DHCS-SCFHP Contract, Exhibit A, Attachment 14 – Member Grievance System

#### 2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below to monitor the Member's grievance system...

- E. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Contractor's medical director.

### Rule 1300.70(a)(1)

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)-(B)

To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

- (A) A level of care which meets professionally recognized standards of practice is being delivered to all enrollees;
- (B) Quality of care problems are identified and corrected for all provider entities.

### **Documents Reviewed:**

- Plan Policy GA001\_10: Member Grievance and Appeals Process (01/13/14)
- Plan Policy QM002\_02: Potential Quality of Care Issues (12/31/12)
- Plan Member Services Department – Call Quality Monitoring Guide (January 2014)
- Identifying Issues on Member Calls – Compliance Department (February 2014)
- SCFHP Member Services Overview – DHCS/DMHC Joint Audit (03/03/14)
- Plan Response to DMHC Onsite Request #49 – PQI Training
- Plan Response to DMHC Onsite Request #50 – PQI Indicators
- Quality Improvement Committee Minutes (02/12/14)
- 41 Standard Grievance files (01/01/13-12/31/13)
- 6 Potential Quality Issue files (01/01/13-12/31/13)

**Assessment:** Plan Policy QM002\_02: Potential Quality of Care Issues identifies PQIs to be “a suspected deviation from expected provider performance, clinical care or outcome of care that cannot be confirmed without additional review. Such issues must be referred to the Quality Improvement Department for review. Not all PQIs are found to be quality of care problems.”

The policy further indicates that PQIs may be identified from a variety of sources including, but not limited to, referrals from staff conducting case management and utilization management activities, hospitalization data analysis, provider complaints, and member grievances. As described by staff in interviews, the Plan’s primary source for identifying PQIs is by member grievances, which may be received by telephone, in person, via mail, via email, or through the Plan’s website. Calls initially come into the Plan’s Member Services Department and are answered by member services representatives. If there is any indication that the call involves an expression of dissatisfaction or complaint, it is categorized as a grievance, and the case is forwarded onto the Grievances and Appeals Department for review.

The intake manager in the Grievances and Appeals Department reviews the case referred by the member services representative, looks for either quality of service or quality of care issues, and codes the grievance accordingly. If the intake manager believes that there may be a quality of care issue, then the case is forwarded to the QI Director for review because the intake manager does not have a clinical background. The QI Director, a registered nurse with a clinical background, determines whether a quality of care issues exists. All quality of care cases are then forwarded onto the Chief Medical Officer who retains ultimate responsibility for investigating the PQI, assigning a severity level, and imposing a corrective action plan if needed.

The Plan identified six PQI cases for its SPD members during the review period. The Department determined that all six cases were properly identified as PQIs and assessed within required timeframes. Upon review by the Chief Medical Officer, appropriate severity levels were assigned and, where indicated, suitable corrective action plans were implemented. Furthermore, follow-ups to ascertain the effectiveness of any imposed corrective action plans were conducted and all documentation indicated that cases were thoroughly investigated and properly handled.

The Department also reviewed a random sample of standard grievances to ensure that the Plan was consistently identifying all cases as PQIs that should have undergone review by a clinical professional either to confirm that care was appropriate, or to confirm that a quality of care

problem occurred. In its review, the Department determined that the Grievances and Appeals Department was not consistently identifying quality of care issues and forwarding standard grievance cases to clinical staff for further evaluations.

The Department reviewed a random sample of 41 standard grievances. Of the 41 cases reviewed, five cases (12%) had been classified as quality of service issues when they involved potential quality of care issues. These five cases should have undergone review by a clinician to determine whether appropriate care had been provided:

- *File #7:* This case involved a member who requested a referral from her PCP for a total bone density scan, but received a referral for hip and femur studies. The member indicated that she needed a spine scan because she was unable to keep her balance as she was losing bone density, but that her PCP would not listen to her complaints. The member also wanted a referral for toxicology testing but the PCP refused.
- *File #12:* This case involved a member who had chest pain and waited over one hour in the Emergency Room without assistance.
- *File #36:* This case involved a medication issue where the member had gone <sup>7</sup> to the pharmacy but was only able to receive medicine for her asthma and not pain.
- *File #37:* This case involved a member whose PCP refused to see her even though she had not yet received proper notification regarding release from the PCP's care. The member was unable to receive medication refills to treat heart congestion and hypertension. She was admitted to the Emergency Room.
- *File #39:* This case involved a member who was referred to physical therapy without an examination to evaluate the complaint of shoulder pain.

As previously noted, if the QI Director confirms that a case has a potential quality of care concern, it is funneled through the PQI process and undergoes review by the Chief Medical Officer for investigation. However, if the QI Director does not identify the case as a potential quality of care, the Plan does not have a process to substantiate that the clinician had reviewed the case to make that determination since the rationale as to why the case did not have any potential quality of care concerns is not documented. This process hinders the Plan's ability to track the number of cases that underwent clinical review. In addition, the Plan is unable to monitor the accuracy of the determinations made by the QI Director.

In interviews, Plan staff reported that they recognize the existence of PQI identification issues and are in the process of addressing them. This is evidenced by discussions during the February 12, 2014 Quality Improvement Committee meeting. Meeting minutes state, "Interventions from

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<sup>7</sup> When the Plan was requested to provide a list of "PQI Indicators," the Plan's QI Director provided a written response to the Department indicating that one of the PQI indicators discussed in a September 2011 in-service included, "Medication Dispensing Issues – this can be identified in calls when member express they have a prescription and are not able to get the retail pharmacy to fill it, or if the member states provider gave them the wrong prescriptions or incorrect dose. Complete a PQI referral form with as much information as you have."

the Plan included continuing to track and trend referrals received. Also did some training with UM and [Case Management] nurses on how to identify a PQI, etc. Revised the PQI reporting form to be more user friendly.” Although discussion in the minutes document some efforts made by the Plan to improve PQI identification and tracking and trending of existing referrals received, the Plan’s interventions do not address the Department’s findings that potential quality concerns embedded within both inquiries and grievances are not consistently identified to undergo clinical review.

DHCS-SCFHP Contract Exhibit A, Attachment 4, Provision 1 and Rule 1300.71(b)(1) require the Plan to monitor, evaluate, and take effective action to address needed improvements in the quality of care. Rule 1300.70(a)(1) requires the Plan to document that quality of care 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. DHCS-SCFHP Contract, Exhibit A, Attachment 14, Provision 2(E) requires all grievances related to medical quality of care issues be referred to the Plan’s Chief Medical Officer.

As evidenced by the standard grievance files reviewed, cases containing quality of care concerns do not consistently undergo clinical review. For the clinically reviewed standard grievances determined not to contain potential quality of care issues, the QI Director does not document the rationale behind the determination. In addition, since the Plan does not ensure the identification of quality of care issues, not all grievances related to medical quality of care issues are referred to the Chief Medical Officer. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

**A P P E N D I X A**

**APPENDIX A. SURVEY TEAM MEMBERS**

<b>DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS</b>	
Jeanette Fong	Survey Team Lead, 916-255-3367
<b>MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS</b>	
Patricia Schano, MEd	Access and Availability Surveyor
Rose Leidl, RN	Utilization Management Surveyor
Bruce W. Carlin, MD	Quality Management & Continuity of Care Surveyor
Bruce Hoffman	Member Rights Surveyor

**A P P E N D I X B**

**APPENDIX B. PLAN STAFF INTERVIEWED**

<b>PLAN STAFF INTERVIEWED FROM: SANTA CLARA COUNTY HEALTH AUTHORITY</b>	
Elizabeth Darrow	Chief Executive Officer
Jeff Roberson, MD	Chief Medical Officer
Matt Woodruff	Chief Operating Officer
Rayne Johnson	Chief Information Officer
Dave Cameron	Chief Financial Officer
Pat McClelland	VP of Member Operations
Diane Brown	QI Director
Scott Bolin	UM Manager
Joan Yellen	Provider Services Director
Sarah Moline	Pharmacy Director
Tanya Nguyen	Member Services Director
Beth Paige	Compliance Officer
Victoria Phan	Compliance Auditor & Cultural Linguistic Manager

## A P P E N D I X C

*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
<b>Inquiries</b>	200	The Department reviewed a random sample of 200 Inquiry Case Notes from the Member Services Representative Call Quality Monitoring Reports. <sup>8</sup>
<b>Exempt Grievances</b>	6	The Department reviewed all six files identified by the Plan during the review period.
<b>Standard Grievances</b>	41	The Department reviewed a random sample of 41 files based upon its standard File Review Methodology.
<b>Standard Appeals</b>	23	The Department reviewed a random sample of 23 files based upon its standard File Review Methodology.
<b>Expedited Appeals</b>	8	The Department reviewed all eight files identified by the Plan during the review period.
<b>UM Denials</b>	8	The Department reviewed a random sample of eight files based upon its standard File Review Methodology. <sup>9</sup>
<b>Potential Quality Issues</b>	6	The Department reviewed all six of the files identified by the Plan during the review period. <sup>10</sup>

<sup>8</sup> Since the Plan's inquiry log does not categorize by member type, the Plan was unable to separate out SPD inquiries. Therefore, a random sample of 200 inquiries was reviewed, irrespective of member type.

<sup>9</sup> Forty standard appeals files were randomly selected for review. However, since only eight cases involved denial determinations based in whole or in part on medical necessity, the remaining 32 cases were omitted from review.

<sup>10</sup> Eight PQI files were initially identified by the Plan for the review period. However, since two files did not pertain to SPDs, six files were reviewed.