



**1115 WAIVER SENIORS AND PERSONS WITH  
DISABILITIES (SPD) ENROLLMENT SURVEY**

**SURVEY REPORT  
FOR THE  
DEPARTMENT OF HEALTH CARE SERVICES**

**1115 WAIVER SURVEY  
OF  
ALAMEDA ALLIANCE FOR HEALTH  
A FULL SERVICE HEALTH PLAN**

**DATE ISSUED TO DHCS: March 28, 2013**

**1115 Waiver Survey Report of the SPD Enrollment  
Alameda Alliance for Health  
A Full Service Health Plan  
March 28, 2013**

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## **EXECUTIVE SUMMARY**

The California Department of Health Care Services (“DHCS”) received authorization (“1115 Waiver”) from the federal government to conduct mandatory enrollment of seniors and persons with disabilities (“SPD”) into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The Department of Managed Health Care (the “Department”) entered into an Inter-Agency Agreement with the 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 June 25, 2012, Alameda Alliance for Health (the “Plan”) was notified that its Medical Survey had commenced and was requested to provide the Department with the necessary pre-onsite data and documentation. The Department’s survey team conducted the onsite portion of the Medical Survey from October 16, 2012, through October 19, 2012.<sup>2</sup> The Department completed its information gathering and closed the survey on January 7, 2013.

### **SCOPE OF SURVEY**

The Department is providing DHCS 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.

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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 and GMC Boilerplate Contracts. All references to “Section” are to the Health and Safety Code unless otherwise indicated. All references to the “Act” are to the Knox-Keene Act. All references to “Rule” are to Title 28 of the California Code of Regulations unless otherwise indicated. All references to “Contract” are to the Two-Plan or GMC Boilerplate contract issued by the Department of Health Care Services.

**III. Availability and Accessibility**

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

**IV. Member Rights**

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

**V. Quality Management**

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

The scope of the survey incorporated review of health plan documentation and files from the period of July 1, 2011, through July 31, 2012.

**SUMMARY OF FINDINGS**

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

**2012 SURVEY POTENTIAL DEFICIENCIES<sup>3</sup>**

<b>ACCESS &amp; AVAILABILITY OF SERVICES</b>	
<b>#1</b>	<p><b>The Plan does not consistently display the level of access and the accessibility indicators for each provider site on its website and in provider directories.</b></p> <p>DHCS MMCD Policy Letter 12-006; DHCS Two-Plan Contract, Exhibit A, Attachment 13 Member Services, Item 4—Member Information</p>
<b>#2</b>	<p><b>The Plan does not ensure that appointments are available within the provider network at the required timeframes.</b></p> <p>DHCS Two-Plan Contract, Exhibit A, Attachment 9 - Access and Availability, Item 4 - Access Standards; Rule 1300.67.2.2(c)(1) and Rules 1300.67.2.2(c)(5)(D) and (F).</p>
<b>QUALITY MANAGEMENT</b>	
<b>#3</b>	<p><b>During the first half of the survey review period, the Plan’s governing body did not receive reports from the Plan’s Health Care Quality Committee.</b></p> <p>DHCS Two-Plan Contract, Exhibit A, Attachment 4 - Quality Improvement System, Item 3C - Governing Body; Rule 1300.70(a)(1); Rule 1300.70(a)(4)(D); and Rule 1300.70(b)(2)(C).</p>

**OVERVIEW OF THE PLAN’S EFFORTS TO SUPPORT SPD ENROLLEES**

The following is a summary of implementation efforts designed by the Plan to better serve the Plan’s SPD enrollment:

SPD members have access to a broad array of services offered by the Plan to all of its enrollees including non-emergency medical transportation and language assistance services. The Plan also conducts sensitivity training for staff that interacts with SPDs.

SPD members are served through the Plan’s complex case management and discharge planning. The Plan developed methods to identify members who would benefit from case management services. The Plan identified members by using utilization data, the member evaluation tool, clinical data, and referrals. The Plan also ensures that the necessary care, services and supports are in place in the community for SPDs before discharge. This includes scheduling outpatient appointments and conducting follow-ups with the patient or caregiver.

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

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In the Quality Management area, the Plan implemented various performance data and data-capturing mechanisms to assess services for SPD members. The Plan noted that one of the required DHCS HEDIS measures was modified to examine SPD and non-SPD rates for the item regarding the 'All Cause Readmissions' measure. The Alliance updated its reporting tools to flag SPDs to assist the Plan in monitoring utilization trends (e.g. admits, readmits, ER, pharmacy).

Additionally, the Plan includes the SPD population in its Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to gather member satisfaction data. The SPD population is also included in Quality Improvement Projects (QIPs) such as the current studies of readmissions and medication adherence in members with hypertension. Moving forward, the Plan intends to stratify data to examine SPDs and non-SPD rates.

As part of its oversight of the quality and availability of services offered by its providers, the Plan conducts Facility Site Reviews, Medical Record Reviews and Facility Site Physical Accessibility Reviews.

## **2012 ALAMEDA ALLIANCE FOR HEALTH: DISCUSSION OF POTENTIAL**

The Department identified potential deficiencies, by survey area.

### **UTILIZATION MANAGEMENT**

**In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s utilization management processes including:**

- a. The development, implementation, and maintenance of a Utilization Management Program.
- b. The mechanism for managing and detecting over- and under-utilization of services.
- c. The methodologies and processes used to handle prior authorizations appropriately while complying with the requirements specified in the contract as well as in state and federal laws and regulations.
- d. The methodologies and processes used to evaluate utilization management activities of delegated entities.

#### **POTENTIAL DEFICIENCIES:**

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

### **CONTINUITY OF CARE**

**In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s continuity of care processes including:**

- a. The methodologies and processes used to coordinate medically necessary services within the provider network.
- b. The coordination of medically necessary services outside the network (specialists).
- c. The coordination of special arrangement services including, but not limited to, California Children’s Services, Child Health and Disability Prevention, Early Start and Regional Centers.
- d. Compliance with continuity of care requirements in Section 1373.96 of the Health and Safety Code.

#### **POTENTIAL DEFICIENCIES:**

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

## ACCESS AND AVAILABILITY OF SERVICES

**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 # 1: The Plan does not consistently display the level of access and the accessibility indicators for each provider site on its website and in provider directories.**

### **Statutory/Regulatory/Contract Reference:**

DHCS MMCD Policy Letter 12-006 - August 9, 2012

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 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 Two-Plan Contract, Exhibit A, Attachment 13 Member Services, Item 4 – Member Information

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

### **Supporting Documentation:**

- Printed version of Medi-Cal Member Provider Directory, February 2012 and June 2012
- Plan’s online Provider Directory

**Assessment:** The Department’s review found that the Plan’s website and provider directory do not display the level of access information (Basic Access or Limited Access), as required by the DHCS MMCD Policy Letter 12-006. The Plan’s online provider directory displays the accessibility indicator categories but does not include the level of access results met per provider

site as either Basic Access or Limited Access. Moreover, review of the Plan's printed version (June 2012) of the provider directory revealed that the accessibility indicator information was missing for some provider sites. Plan staff informed the Department that an error occurred during the last update of the provider directory. As result, some of the accessibility code information was not carried over for each provider site in the Plan's June 2012 version.

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**Potential Deficiency #2: The Plan does not ensure that appointments are available within the provider network at the required timeframes.**

**Statutory/Regulatory Reference(s):** Rule 1300.67.2.2(c)(1) and Rules 1300.67.2.2(c)(5)(D) and (F)

Two-Plan Contract, Exhibit A, Attachment 9- Access and Availability, Item 4, Access Standards

4) 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.

**Supporting Documentation:**

- Timely Access Study - 2011
- 2011 Timely Access Regulation report submission
- 2012 Annual Network and Member Access Assessment Meeting
- Policy and procedure: PRO-GEN-0001 - Provider Availability and Access, revised on 1/11/12
- Draft update of PRO-GEN-0001 (not yet approved by committee/board dated 9/15/12)
- Policy and procedure: MED-DEL-0002 - DMHC Timely Access Standards for Delegated Providers, Effective Date: 1/1/10
- Access and Availability Audit Tool 2012
- Group Needs Assessment
- 2011 Consumer Assessment of Healthcare Providers and Systems(CAHPS) Survey

**Assessment:** Plans are required to monitor the availability of appointments within their provider network in accordance with Rules 1300.67.2.2(c)(1) and (5) and as required by the DHCS Two-Plan Contract, Exhibit A, Attachment 9 –Access and Availability, Item 4. During 2011, the Plan relied on a provider survey and an enrollee survey as a sole means of monitoring appointment availability within the Plan's contracted provider network. Survey questions were limited to broad categories related to the ease of obtaining primary care and specialty care appointments.

Rule 1300.67.2.2(c)(5) requires health plans to ensure appointments at the provider level are available within a certain number of hours/days of the request depending on appointment type. Although the Plan made an effort during 2011 to survey enrollees and providers regarding appointment wait times, the data gathered from the enrollee and provider surveys could not

provide the Plan with proper data to measure specific wait times for different appointment types considering the Plan only asked generalized questions regarding the ease of obtaining certain types of appointments

During staff interviews, Plan staff stated that for 2012, the Plan contracted with a vendor in order to assess the availability of appointments. The Plan also included a review of appointment wait times as part of their provider site audits. At the time of the onsite survey, data results from the vendor had not been analyzed.

#### **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 DEFICIENCIES:**

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

#### **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 #3: During the first half of the survey review period, the Plan’s governing body did not receive reports from the Plan’s Health Care Quality Committee.**

**Statutory/Regulatory Reference(s):** Rule 1300.70(a)(1); Rule 1300.70(a)(4); and Rule 1300.70(b)(2)(C)

DHCS Two-Plan Contract, Exhibit A, Attachment 4- Quality Improvement System, Item 3C – Governing Body

3) 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.

**Supporting Documentation:**

- Governing Body (Board of Directors) Quarterly Meeting Minutes for the period July 1, 2011 to July 31, 2012.

**Assessment:** The Department's review included an assessment of the Plan's Quality Assurance program in accordance with Rule 1300.70(a)(4). A review of the Plan's Board of Director meeting minutes reflecting July 1, 2011 through December 31, 2011, revealed that meeting minutes did not reflect any reporting from the Plan's Health Care Quality Committee for the Governing Board's review.

Interviews conducted during the onsite portion of the survey with the Plan's quality management staff revealed that prior to January 2012, there was no reporting of the activities conducted by the Plan's quality program to the Board of Directors nor was there any involvement by the Board of Directors with the quality management program.

Beginning in January of 2012, the Plan's Health Care Quality Committee minutes, which contained detailed information (e.g., delegate audit reports, quality issue reports), were presented to the Board. A Chief Medical Officer's report form has been developed for quarterly submission to the Board.

Rule 1300.70(a)(1) requires that the quality assurance program document that the quality of care provided is reviewed, that problems are 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)(2)(C) requires that reports to the plan's governing body be sufficiently detailed to include findings and actions taken as a result of the quality assurance program. The DHCS Two-Plan Contract requires that the contracted plan's governing body routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made. Although the Department noted improved reporting to the Board beginning in January 2012, there has not been sufficient time for the Plan to demonstrate full and consistent correction of this deficiency.

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

**APPENDIX C. FILE REVIEW**

*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.*

<b>Type of Case Files Reviewed</b>	<b>Sample Size (Number of Files Reviewed)</b>	<b>Explanation</b>
<b>Grievances and Appeals</b>	29 files reviewed	The Department identified the sample size based upon its standard File Review Methodology.