

DEPARTMENT OF
**Managed
Health Care**
Help Center

DIVISION OF PLAN SURVEYS

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

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

**1115 WAIVER SURVEY
OF
HEALTH NET OF CALIFORNIA, INC.
A FULL SERVICE HEALTH PLAN**

DATE ISSUED TO DHCS: OCTOBER 31, 2013

**1115 Waiver Survey Report of the SPD Enrollment
Health Net of California, Inc.
A Full Service Health Plan
October 31, 2013**

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EXECUTIVE SUMMARY

The California Department of Health Care Services (“DHCS”) received authorization (“1115 Waiver”) from the federal government to conduct mandatory enrollment of seniors and persons with disabilities (“SPD”) into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The Department of Managed Health Care (the “Department”) entered into an Inter-Agency Agreement with the DHCS¹ to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California’s strong patient-rights laws. Mandatory enrollment began in June 2011.

On February 28, 2013, Health Net of California, Inc. (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 May 14, 2013 through May 17, 2013.²

SCOPE OF SURVEY

The Department is providing DHCS this 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.

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

² Pursuant to the Knox-Keene Health Care Service Plan Act of 1975, codified at Health and Safety Code section 1340, *et seq.*, Title 28 of the California Code of Regulations section 1000, *et seq.* and the Department of Health Care Services Two-Plan and GMC Boilerplate Contracts. All references to “Section” are to the Health and Safety Code unless otherwise indicated. All references to the “Act” are to the Knox-Keene Act. All references to “Rule” are to Title 28 of the California Code of Regulations unless otherwise indicated. All references to “Contract” are to the Two-Plan or GMC Boilerplate contract issued by the Department of Health Care Services.

III. Availability and Accessibility

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

IV. Member Rights

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

V. Quality Management

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

The scope of the survey incorporated review of health plan documentation and files from the period of March 1, 2012, through February 28, 2013.

SUMMARY OF FINDINGS

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

2013 SURVEY POTENTIAL DEFICIENCIES³

UTILIZATION MANAGEMENT	
#1	<p>The Plan does not track, trend or analyze utilization patterns for its SPD members.</p> <p>Rule 1300.70(a)(3); Rule 1300.70(b)(2)(H); DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 - Utilization Management, Provision 4.</p>
QUALITY MANAGEMENT	
#2	<p>The Plan is unable to demonstrate how it monitors quality of care problems identified, how effective action is taken where deficiencies are identified, and that follow up is planned for its SPD population.</p> <p>Rule 1300.70(a)(1); Rule 1300.70(b)(1); DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1.</p>

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

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

Utilization Management: Prior to and during the implementation of the 1115 Waiver in June 2011, the Plan undertook the following utilization management-related measures and initiatives to support the SPD members:

- Hired additional staff in the Utilization Management Department and Public Programs Department to accommodate and support the continuity-of-care process, including taking in requests, approving, and executing Letters of Agreements (LOAs) with providers, communicating to members, and moving members to more appropriate provider groups
- Instituted onsite concurrent review
- Improved identification of members with End Stage Renal Disease (ESRD) and their referral to case management
- Increased network participation of needed specialists and specialty types
- Enhanced the transportation benefit
- Contracted with a company that dispenses cell phones, text reminders, text-based disease coaching, and connectivity to PCP and Case Management
- Contracted with in-home physicians and nurse practitioners for assessment of home bound members
- Selected a vendor to provide in home assessments and medication management to prevent hospital re-admission
- Began consideration of pharmacy home model (not yet implemented)
- Began a contracting strategy for additional Skilled Nursing Facilities and Rehabilitation Facilities
- Currently developing (not yet implemented) online appointment scheduling for clinics and high volume providers, to allow Plan RN's or vendor RN's to book appointments with PCPs

In addition to the above initiatives, the Plan has undertaken the following supportive activities to benefit the SPD members:

- Providing providers with lists of members who frequent emergency rooms (ER) for non-emergent care
- Sending post cards to members after an ER visit for a non-emergent reason with alternative suggestions for care
- Educating providers and members about its 24 hour Nurse Advice Line
- Partnering with hospitals to identify and refer to Case Management the members who frequent the ER
- Identifying members with re-admissions
- Providing educational materials to providers about how to prevent hospital re-admission
- Assisting members with timely outpatient PCP follow-up after hospitalization
- Distributing disease-specific educational materials and monitoring information at the time of hospital discharge
- Placing members into Case Management who are frequently re-admitted

Continuity of Care: The Health Plan ensures 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 by assigning specific staff to be responsible for coordination of care to each of those areas requiring support for SPD enrollees. Several additional

Plan initiatives noted previously under Utilization Management (e.g., prevention of readmissions, referrals of ESRD patients, inappropriate use of the ER) also contribute to the Plan's efforts to ensure Continuity of Care. Additionally, the Plan:

- Created a Case Management Department at the Plan level (in addition to the case management provided at the provider group level) that is staffed by social workers
- Consolidated Case Management, Complex Case Management, Health Risk Assessment, Case Coordination and Nurse Advise within one platform under one company to enhance coordination and information sharing
- Placed Case Management on site in the hospitals to arrange after care for complex patients at risk of re-admission
- Expanded the Disease Management Program (from asthma and Diabetes to Asthma, Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure)

Quality Management: On-site review of quarterly Board of Director minutes demonstrated active participation of the Board of Directors in giving direction on quality endeavors and receiving updates on quality concerns. A Quality Indicator Calendar is used as a way to track and trend specific items as relating to the Medi-Cal population, including support of SPD enrollees.

Member Rights: The Plan addresses SPD enrollees' grievances using the same processes it uses for grievances submitted by Medi-Cal members. To address concerns requiring immediate action, the Customer Service Representative will forward the call to Medical Management unit for handling. To assist in detecting any patterns of concern, the Plan has also enhanced the tracking/trending of access-related appeals/grievances from SPD members.

Availability and Accessibility: The Plan has separate Customer Care Centers for State Programs and Commercial Programs and has separate screening and triage contracts for State Programs and Commercial Programs.

2013 HEALTH NET OF CALIFORNIA: DISCUSSION OF POTENTIAL

UTILIZATION MANAGEMENT

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

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

Potential Deficiency #1: The Plan does not track, trend or analyze utilization patterns for its SPD members.

Statutory/Regulatory/Contract References: Rule 1300.70(a)(3); Rule 1300.70(b)(2)(H); DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Provision 4.

Rule 1300.70(a)(3) states, in pertinent part, “(a) Intent and Regulatory Purpose. (3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

Rule 1300.70(b)(2)(H) states, in pertinent part, “(b) Quality Assurance Program Structure and Requirements. (2) Program Requirements. (H)2. A plan that has capitation or risk-sharing contracts must: 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.”

DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 1F. 1.G and 4

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.

G. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on reviews of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

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.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Policy #UM/CM-221ML, Potential Over- and Under-Utilization
- UM Work Plan 2011 and 2012
- Health Net's State Health Plan's Utilization Management/ Quality Improvement Committee meeting minutes 2012

Assessment: The Plan's policy *UM/CM-221ML, Potential Over- and Under-Utilization*, describes the Plan's mechanisms and metrics used to monitor utilization of services specific to the Plan's Medi-Cal line of business. However, the Plan was unable to demonstrate that it monitors service usage for the Plan's SPD membership. The Department's onsite review confirmed that although the Plan does track over and under -utilization for its Medi-Cal membership, the Plan does not conduct analyses on utilization data specific to the Plan's SPD membership.

Rule 1300.70(a)(3) requires that a plan monitor whether the provision and utilization of services meets professionally recognized standards of practice. Rule 1300.70(b)(2)(H) requires plans that have capitation contracts to 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. The DHCS contract requires each plan to include within its utilization management program mechanisms to detect both over- and under-utilization of health care services, track specialty referrals, and report UM activities to the appropriate Plan committees.

Without isolating the Plan's SPD membership utilization data from the Plan's general Medi-Cal product, it is unclear how the Plan is able to monitor utilization patterns for SPD members and ultimately comply with utilization management requirements as required under the Rules and the DHCS contract.

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.

QUALITY MANAGEMENT

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

- a. Verifying that health plans monitor, evaluate, and take effective action to maintain quality of care and to address needed improvements in quality.
- b. Verifying that health plans maintain a system of accountability for quality within the organization.
- c. Verifying that health plans remain ultimately accountable even when Quality Improvement Plan activities have been delegated.

Potential Deficiency #2: The Plan is unable to demonstrate how it monitors quality of care problems identified, how effective action is taken where deficiencies are identified, and that follow up is planned for its SPD population.

Statutory/Regulatory/Contract References: Rule 1300.70(a)(1); Rule 1300.70(b)(1); DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1.

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

Rule 1300.70(b)(1) states, in pertinent part, "...each plan's quality assurance program shall be designed to ensure that.. a level of care which meets professionally recognized standards of practice is being delivered to all enrollees (and) quality of care problems are identified and corrected for all provider entities."

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. 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. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Board of Directors minutes for February 2011 through November 2012
- Corporate-level Health Net Quality Improvement Committee and Peer-Review February 2011 through November 2012
- State Health Programs Utilization Management/ Quality Improvement Committee October 2011 through February 2013
- Policy FB-222-13540: Follow-up on Quality of Care Concerns

Assessment: The Department's review revealed that the Plan is unable to track Potential Quality Issues (PQIs)⁴ for its SPD members. Although the Plan does monitor PQIs for the Plan's general Medi-Cal enrollment, the Plan's current procedure does not involve separate identification, tracking and analysis of PQIs for the Plan's SPDs members. During the Department's review, the Plan could not provide the Department with a separate PQI file log for its SPD members. Therefore, the Department was unable to confirm, through file review, that the Plan is thoroughly monitoring the quality of care provided to SPDs.

Rule 1300.70(a)(1) requires each plan to demonstrate 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. Similarly, Rule 1300.70(b)(1) requires each plan to ensure that a level of care which meets professionally recognized standards of practice is being delivered to all enrollees and quality of care problems are identified and corrected for all provider entities. The DHCS contract requires that the Plan monitor quality of care provided to SPD members.

The Plan's inability to isolate PQIs that are specific to SPDs may impede the Plan's ability to assess potential medical care issues affecting the Plan's SPD members. The service needs and quality issues affecting SPDs may be different or more extensive than issues affecting the Plan's

⁴ Cases, providers, processes or concerns identified through enrollee grievances and other sources as having *potential quality issues* that require investigation are often referred to as PQIs.

general Medi-Cal membership. Therefore, the Plan should have a methodology that identifies, analyzes and follows up on issues presented by SPD members specifically.

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.

AVAILABILITY AND ACCESSIBILITY

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

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

POTENTIAL DEFICIENCIES:

Based on the Department’s review, there were no potential deficiencies identified in the area of availability and accessibility.

A P P E N D I X A

APPENDIX A. SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Jennifer Childress	DMHC Team Lead
Rose Leidl, RN	Utilization Management Surveyor
Ruth Martin, MPH, MBA	Availability and Accessibility Surveyor
Todd Cornett, MD, MBA	Quality Management & Continuity of Care Surveyor
Bernice Young	Member Rights Surveyor

A P P E N D I X B

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED FROM: Health Net	
Laurie Jurado	Director, Clinical Support Services for Grievances
Jennifer Nuovo, MD	State Health Plans Medical Director
Lakshmi Dhanvanthari, MD	Medical Director
Peggy Haines	VP Quality Management
Lesley Blumberg, MD	Medical Director
Steve Tough	President, Govt. Programs, Health Net Inc.
Jonathan Scheff, MD	Chief Medical Officer
Elizabeth Gallagher	Director Provider Services Operations, Provider Network Management
Rita Lonzo	Director Provider Oversight
Cary Uyemura	Director Clinical Pharmacy Operations
Neil Solomon, MD	VP, QI & Program Accreditation
Edward Reis, MD	Medical Director
Elaine Robinson-Frank	Director, Quality Improvement
Juanell Hefner	SVP Customer & Technology Services
Gary Neiman	VP Customer Contact Centers
Jackie Duncan	Director Call Center
Mauricio Leal	Director Call Center
Nancy Wongvipat-Kalev	Director Health Education & Cultural Linguistic Services
Diana Carr	Manager Cultural and Linguistic Services
Danielle Henderson	Business Compliance Consultant
Letty Carrera	Appeals & Grievances Manager
Marshall Bentley	VP Legal Affairs
Marsha Badillo	Director Appeals & Grievances
Carol Spencer	Manager Quality Management
Chris Hill	VP Clinical Services
Linda Wade-Bickel	Director Care Management
Lynn Baker, MD	Medical Director (MHN)
Tony Rizzo	Manager Clinical Services
Deborah Hudson	Manager Care Management

A P P E N D I X C

APPENDIX C. LIST OF FILES REVIEWED

Note: The statistical methodology utilized by the Department is based on an 80% Confidence Level with a margin of error of 7%. Each file review criterion is assessed at a 90% compliance rate.

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Standard Grievances	30	The Department identified the sample size based upon its standard File Review Methodology and a file universe of 1470.