



**DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS**

**1115 WAIVER
SENIORS AND PERSONS WITH DISABILITIES**

**MEDICAL SURVEY REPORT OF
ORANGE COUNTY HEALTH AUTHORITY
DBA CALOPTIMA**

A COUNTY ORGANIZED HEALTH SYSTEM PLAN

DATE ISSUED TO PLAN: JULY 27, 2017

**1115 Waiver SPD Medical Survey Report
Orange County Health Authority
A County Organized Health System Plan
July 27, 2017**

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EXECUTIVE SUMMARY

The California Department of Health Care Services (DHCS) received authorization (1115 Waiver) from the federal government to conduct mandatory enrollment of seniors and persons with disabilities (SPD) into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The DHCS then entered into an Inter-Agency Agreement¹ with the Department of Managed Health Care (Department) to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patient-rights laws. Mandatory enrollment of SPDs into managed care began in June 2011.

On September 22, 2016, the Department notified Orange County Health Authority (CalOptima or Plan) that its medical survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department's medical survey team conducted the onsite portion of the medical survey from February 6, 2017 through February 10, 2017.

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreement, the Department provides the 1115 Waiver SPD Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the SPD population. This medical survey evaluated the following elements specifically related to the Plan's delivery of care to the SPD population as delineated by the DHCS-CalOptima Contract and Title 28 of the California Code of Regulations.²

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 under- and over-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

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 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 All references to "Contract" are to the County Organized Health System, Geographic Managed Care, and Two-Plan contracts issued by the DHCS. All references to "Section" are to the Knox-Keene Act of the Health and Safety Code. All references to "Rule" are to Title 28 of the California Code of Regulations.

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.

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.

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 medical survey incorporated review of health plan documentation and files from the period of November 1, 2014 through October 31, 2016.

SUMMARY OF FINDINGS

The Department identified **ten (10)** deficiencies during the current medical survey.

2017 MEDICAL SURVEY DEFICIENCIES

UTILIZATION MANAGEMENT

#1

The Plan's Notice of Action (NOA) communications to providers of denials, delays, or modifications of service authorization requests do not consistently include the direct telephone number of the health care professional responsible for the decision.

DHCS-CalOptima Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(l) – Pre-Authorizations and Review Procedures and Attachment 13 – Member Services, Provision 8(A) – Denial, Deferral, or Modification of Prior Authorization Requests; Section 1367.01(h)(4).

CONTINUITY OF CARE

#2

For newly enrolled members under 18 months of age, the Plan does not ensure the timely provision of an Initial Health Assessment.

DHCS-CalOptima Contract, Exhibit A, Attachment 10 – Scope of Services, Provision 5(A)(1) – Services for Members under Twenty-One (21) Years of Age.

AVAILABILITY & ACCESSIBILITY

#3

The Plan failed to establish hours of operation standards for provider facilities.

DHCS-CalOptima Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3 – Access Requirements; Rule 1300.67.2(b).

MEMBER RIGHTS

#4

The Plan failed to consistently identify all expressions of dissatisfaction as grievances.

DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 2 – Grievance System Oversight; Section 1368(a)(1); Rule 1300.68(a).

#5

The Plan’s practice of accepting declinations to file grievances from members after they have already expressed dissatisfaction does not ensure adequate consideration of enrollee grievances.

DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 2 – Grievance System Oversight; Section 1368(a)(1); Rule 1300.68(a).

#6

The Plan inappropriately documents grievances as resolved.

DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 2 – Grievance System Oversight; Section 1368(a)(1), (4)(B)(i); Rule 1300.68(a), (d).

#7

The Plan does not describe the issues raised in grievances as required by Rule 1300.68(e)(2).

DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 2 – Grievance System Oversight; Section 1368(a)(1), (4)(B)(i); Rule 1300.68(a), (d), (e)(2).

QUALITY MANAGEMENT

#8

The Plan has not established and implemented a systematic process to assess and evaluate utilization management data to monitor, identify, and correct under- and over-utilization of services.

The DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and Attachment 5 – Utilization Management Program, Provision 4 – Review of Utilization Data; Rule 1300.70(b)(2)(H)(2).

#9

The Plan does not consistently ensure that potential quality issues are being reviewed, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

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

#10

The Plan does not consistently ensure that potential quality of care issues are investigated in a timely manner.

DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; Rule 1300.70(a).

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

The Plan reported that it has implemented the following policies, procedures, and activities to improve its managed care systems.

- The Plan performs a random medical record review every month for members under highly complex case management.
- The Plan provides case management to 100% of SPD members with a ratio of one personal care coordinator per 600 SPD members.
- The Plan ensures person-centered planning through meetings of the Interdisciplinary Care Team (ICT), which meets monthly and includes input from members or members' authorized representatives.
- The Plan creates and distributes a monthly score card for each contracted health network (delegated group) with information about the number of SPD members, number of members in basic and long-term case management, number of Initial Health Assessments (IHA) received, etc.
- Contracting providers are represented on the Quality Improvement (QI) Committee, the Credentialing and Peer Review Committee, and the Provider Advisory Committee. SPDs are represented on the Member Advisory Committee. The Provider Advisory Committee and the Member Advisory Committee report directly to the Board of Directors (BOD).
- The Plan has six cross-function teams focused on improving HEDIS quality measures. Each team has a physician champion, a data analyst, and representation from various clinical areas, such as disease management, case management, and pharmacy.
- The Plan generates monthly HEDIS reports and calculates prospective rates, which it sends to the health networks. The Plan holds joint operations meetings quarterly with the health networks to discuss improvement opportunities.
- The Plan implemented a new tracking system for potential quality issue (PQI) files called the Guiding Care System to better integrate with the grievances and appeals process, and generate reports for tracking and trending.
- The Plan has developed several audit tools, which it utilizes to perform oversight and evaluation of its utilization management (UM) delegates.
- The Plan implemented a new medical management system to improve efficiency and effectiveness of the UM program and processes.
- The Plan utilizes an inter-rater reliability audit process to ensure physicians and UM staff apply criteria correctly. The Plan requires its UM delegates to conduct inter-rater reliability audits at least annually and verifies that the audits are performed during the annual UM delegation oversight process.
- The Plan has developed subcategories for delineating grievances, which it uses for tracking and trending.

- Inquiry logs are reviewed in aggregate, and the Plan conducts a random audit of six calls per month per customer service representative (CSR) to ensure quality.
- The Plan has improved the “Facets” data system capture screens and enhanced the template forms for grievances and appeals, which the CSRs complete.

DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

Deficiency #1: The Plan’s Notice of Action (NOA) communications to providers of denials, delays, or modifications of service authorization requests do not consistently include the direct telephone number of the health care professional responsible for the decision.

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

DHCS-CalOptima 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 meet the following minimum requirements: ...

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

Attachment 13 – Member Services

8. Denial, Deferral, or Modification of Prior Authorization Requests

A. Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01....

Section 1367.01

(h) 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) ... Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations....

Documents Reviewed:

- 2015 Utilization Management Program Description
- 2016 Utilization Management Program Description
- 68 Standard UM denial files (11/1/14 – 10/31/16)

Assessment: In a file review, the Department found that the Plan does not consistently include in its Notice of Action (NOA) communications the direct telephone number of the health care professional who made the determination to deny, modify, or delay a health care service.

The Plan's *2015 Utilization Management Program Description* and *2016 Utilization Management Program Description* state:

All providers are encouraged to request information regarding the criteria used in making a determination. Contact can be made directly to the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director, or a copy of the specific criteria utilized.

The Department randomly selected and reviewed 68 standard UM denial files. Of the 68 files, 27 (40%) failed to include the telephone number of the health care professional responsible for the denial, delay, or modification discussed in the NOA.³

TABLE 1
UM Denial File Review

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard UM Denial Files	68	NOA includes the telephone number of the health care professional responsible for the	41 (60%)	27 (40%)

³ File # [the numbers were removed for confidentiality].

		denial, delay, or modification		
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Conclusion: The DHCS-CalOptima Contract Exhibit A, Attachment 5 – Utilization Management, Provision 2 – Pre-Authorizations and Review Procedures, requires the Plan to notify requesting providers or members of decisions to deny, modify, or delay service authorization requests. Section 1367.01(h)(4) requires written communications to providers regarding decisions to deny, delay, or modify requests to include the direct telephone number or extension of the health care professional responsible for the decisions. The Plan fails to consistently include in its NOA sent to providers the telephone number of the health care professional responsible for the denial, delay, or modification. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

CONTINUITY OF CARE

Deficiency #2: For newly enrolled members under 18 months of age, the Plan does not ensure the timely provision of an Initial Health Assessment.

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 10 – Scope of Services, Provision 5(A)(1) – Services for Members under Twenty-One (21) Years of Age.

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

5. Services for Members under Twenty-One (21) Years of Age

A. Provision of IHAs for Members under Age 21

1. For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 calendar days following the date of enrollment or within the most recent periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger, whichever is less....

Documents Reviewed:

- Plan Policy GG.1613: Initial Health Assessment (11/01/15)

Assessment: Based on a review of Plan policy and interviews with Plan staff, the Department determined that the Plan did not comply with the DHCS-CalOptima Contract, Exhibit A, Attachment 10 – Scope of Services, Provision 5(A)(1) – Services for Members under Twenty-One (21) Years of Age. This provision requires the Plan to provide IHAs “for Members under the age of 18 months ... within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger, whichever is less.”

Plan Policy GG.1613: Initial Health Assessment, refers to provision of an IHA for all members within 120 days of the date of enrollment. However, the policy contains no provision for enrollees under 18 months of age to receive the IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger, whichever is less.

During the onsite survey interviews, the Plan's Director of Health Education & Disease Management confirmed that the Plan does not have a policy with this special provision nor does it follow the periodicity timelines established by the AAP for the target IHA completion date.

Conclusion: The DHCS-CalOptima Contract, Exhibit A, Attachment 10 – Scope of Services, Provision 5(A)(1) – Services for Members under Twenty-One (21) Years of Age, requires that for members under the age of 18 months, the Plan must ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the AAP for ages two and younger, whichever is less. The Plan does not have a policy that reflects this requirement nor does it in practice follow the AAP timelines where these are less than 120 calendar days. Therefore, the Department finds the Plan in violation of this contractual requirement.

AVAILABILITY AND ACCESSIBILITY

Deficiency #3: The Plan failed to establish hours of operation standards for provider facilities.

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3 – Access Requirements; Rule 1300.67.2(b).

DHCS-CalOptima Contract, Exhibit A, Attachment 9 – Access and Availability 3. Access Requirements

Contractor shall establish acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2 and as specified below. DHCS will review and approve standards for reasonableness. Contractor shall ensure that Contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

Rule 1300.67.2

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees...
(b) Hours of operation and provision for after-hour services shall be reasonable.

Documents Reviewed:

- Full Scope Site Reviews (12/01/14, 12/01/15, 05/31/16)

- 2015 Provider Manual
- Plan Policy GG.1600: Access and Availability Standards (05/01/16)
- Medi-Cal HMO Contract for Health Care Service Between CalOptima And [Provider]
- Plan Policy GG.1619: Delegation Oversight (09/01/15)
- Access and Availability Work Team Minutes (11/17/14 to 10/24/16)

Assessment: The Plan failed to establish accessibility standards to ensure that providers' hours of operation for after-hours services are reasonable. The Plan's Access and Availability Standards, Delegation Oversight Policy, Provider Contract Template, and Provider Manual do not address hours of operation. During an onsite survey interview, DHCS asked the Plan whether there is policy language regarding providers' hours of operation. Plan staff stated that there is not specific policy language that defines providers' hours of operation and that the Plan monitors the hours of operation by simply asking the providers.

Conclusion: DHCS-CalOptima Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3 – Access Requirements, requires that the Plan establish acceptable accessibility standards in accordance with Rule 1300.67.2, which requires plans to ensure that basic health care services are available during reasonable hours of operation. Plan staff acknowledged that the Plan has not established standards for hours of operation for provider facilities. Therefore, the Department finds the Plan is in violation of this contractual and regulatory requirement.

MEMBER RIGHTS

Deficiency #4: The Plan failed to consistently identify all expressions of dissatisfaction as grievances.

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 2 – Grievance System Oversight; Section 1368(a)(1), Rule 1300.68(a).

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

1. Member Grievance System

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

Section 1368(a)

Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Rule 1300.68

Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

(a) ...The following definitions shall apply with respect to the regulations relating to grievance systems:

(1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Documents Reviewed:

- Plan Policy HH.1102: CalOptima Member Complaint (06/01/16)
- Plan Policy HH.1103: CalOptima Health Network Member Complaint (06/01/16)
- QoC and/or Exempt Grievance Documentation (12/31/14)
- Medi-Cal CalOptima Direct Member Handbook (03/15/16)
- Call Inquiry Log (02/01/16 – 10/31/16)
- Exempt Grievance Log (02/01/16 – 10/31/16)
- 58 Exempt Grievance Files (11/1/14 – 10/31/16)

Assessment: The Department reviewed the Plan's call inquiry logs for the period February 1, 2016, through October 31, 2016, and reviewed other Plan documents to assess its grievance process.

Plan Policy HH.1102: CalOptima Member Complaint, and Plan Policy HH.1103: CalOptima Health Network Member Complaint define a grievance as an "oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member." The definition in this policy is generally consistent with the definition set forth in Rule 1300.68(a)(1).

Review of Inquiry Log

The Department reviewed the Plan's inquiry log. The information in the log included the Plan's unique case identification number, the designated line of business, the category of call, and a brief summary of the inquiry. The Department's review found that there were entries in the inquiry log that contained expressions of dissatisfaction. The following examples were identified in the inquiry log:

- File # [the number was removed for confidentiality]: The CSR documented, "Member's pain RX prescribed by his surgen (*sic*) are being denied and Member is in a lot of pain."

- File # [the number was removed for confidentiality]: The CSR documented, “Member unable to get medication for over 2 weeks already.”
- File # [the number was removed for confidentiality]: The CSR documented, “[M]ember saying that one of her spec (specialist) gave out her info to her employer w/ out her consent.”

Although these example case files suggest the members were calling to express dissatisfaction, the calls were included on the Plan’s inquiry log, and there was no evidence that any of the matters were subsequently processed as grievances. Expressions of dissatisfaction that are not processed as grievances preclude the member from the benefit of other rights that arise from the grievance process, such as receipt of a notice of acknowledgment, investigation of the complaint and receipt of a written resolution letter. Additionally, the Plan is unable to include the complaints in its grievance tracking process to identify trends.

Conclusion: DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System directs the Plan to implement and maintain a Member Grievance system in accordance with Rule 1300.68, which defines a grievance as an expression of dissatisfaction. Based on review of the Plan’s inquiry log, the Plan failed to consistently identify and process expressions of dissatisfaction received over the telephone as grievances. Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

Deficiency #5: The Plan’s practice of accepting declinations to file grievances from members after they have already expressed dissatisfaction does not ensure adequate consideration of enrollee grievances.

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 2 – Grievance System Oversight; Section 1368(a)(1); Rule 1300.68(a).

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

1. Member Grievance System

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

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.

Section 1368(a)

Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Rule 1300.68

Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

(a) ...The following definitions shall apply with respect to the regulations relating to grievance systems:

(1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

(4) "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

Documents Reviewed:

- Plan Policy HH.1102: CalOptima Member Complaint (06/01/16)
- Plan Policy HH.1103: CalOptima Health Network Member Complaint (06/01/16)
- QoC and/or Exempt Grievance Documentation (12/31/14)
- Medi-Cal CalOptima Direct Member Handbook (03/15/16)
- Call Inquiry Log (02/01/16 – 10/31/16)
- Exempt Grievance Log (02/01/16 – 10/31/16)
- 58 Exempt Grievance Files (11/1/14 – 10/31/16)

Assessment: As defined by Rule 1300.68(a)(1), a written or oral expression of dissatisfaction is a grievance and where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

The Plan's *QoC and/or Exempt Grievance Documentation* work aid leads the CSRs through the following steps:

1. Documenting the reason for the call.
2. Educating the member on his/her right to file a grievance/complaint.
3. Documenting the resolution.

The work aid states:

If a member/caller expresses dissatisfaction/discontent; you are to educate the member/caller on their right to file a grievance. If the member/caller chooses not to file a grievance, educate the member that we cannot

guarantee a resolution within 24 hours and will open a case to work towards immediate resolution. If the member/caller wishes to continue with the case, we do not check the complaint box and we document the call accordingly in Facets.

The Plan's practice of instructing its CSRs to "educate the member/caller on their right to file a grievance" in response to an enrollee's expression of dissatisfaction demonstrates the Plan's failure to recognize that the expression of dissatisfaction is the submission of the grievance by the enrollee. Nothing in Rule 1300.68 contemplates the Plan's process of "educating" members on how to file a grievance after dissatisfaction has been expressed. Further, the Plan's practice may result in a chilling effect, as members may perceive there to be a required formal process, which can be intimidating. Finally, when a member declines to file a grievance when "educated," the Plan fails to process the grievance as required.

File Review

The Department reviewed files identified by the Plan as exempt grievance files. These files demonstrate a pattern in which the Plan failed to initiate its grievance system when members expressed dissatisfaction, but declined to file grievances.

- File # [number was removed for confidentiality]: Member authorized CalOptima to speak with his son during the call. Member's son called to express dissatisfaction with the quality of care received from neurosurgeon and asked to change providers. CSR advised member's son of his right to file a grievance. Member's son declined. CSR explained that member can be changed to another doctor and referred member's son to health network for assistance as authorizations are determined by the health network. The file showed no evidence that this case was referred for clinical review as a PQI
- File # [number was removed for confidentiality]: Member called in for assistance with obtaining pain medication. Member stated that pain management specialist only wants to give him shots and not a prescription for pain medication. CSR educated the member on his right to a grievance, but, member declined. CSR referred the member back to the provider for a prescription and advised the member that he can speak to his primary care provider about a referral to a different pain management specialist. If the PCP declines, the CSR will open an urgent Rx case and send to pharmacy department.
- File # [number was removed for confidentiality]: Member called in for assistance with locating an imaging facility for an MRI. Member was unhappy that the provider staff referred her to the wrong facility. CSR educated the member on her right to a grievance, but, member declined to proceed. CSR warm transferred the member to a Member Liaison specialist for further assistance.

Conclusion: The Plan's practice of responding to member expressions of dissatisfaction received by telephone by "educating" the member on how to file a grievance, rather than identifying and processing the expression of dissatisfaction as a grievance, does not comply with DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System or Rule 1300.68(a). Rule 1300.68(a)(1) defines the term "grievance" to include oral expressions of dissatisfaction. Therefore, the grievance is submitted at the time it is made, and Plan actions that impede the grievance process violate these contractual and regulatory provisions.

Deficiency #6: The Plan inappropriately documents grievances as resolved.

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 2 – Grievance System Oversight; Section 1368(a)(1), (4)(B)(i); Rule 1300.68(a), (d).

DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 2 – Grievance System Oversight;

DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System
1. Member Grievance System

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

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.

Section 1368(a)

Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

(4)(B)(i) Grievances received by telephone, by facsimile, by email, or online through the plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The

plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:

- (I) The date of the call.
- (II) The name of the complainant.
- (III) The complainant's member identification number.
- (IV) The nature of the grievance.
- (V) The nature of the resolution.
- (VI) The name of the plan representative who took the call and resolved the grievance.

Rule 1300.68

Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

(a) ...The following definitions shall apply with respect to the regulations relating to grievance systems:

(1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance....

(4) "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

(d) The plan shall respond to grievances as follows: ...

(8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of the resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in subsection (b).

Documents Reviewed:

- Plan Policy HH.1102: CalOptima Member Complaint (06/01/16)
- Plan Policy HH.1103: CalOptima Health Network Member Complaint (06/01/16)
- QoC and/or Exempt Grievance Documentation (12/31/14)
- Medi-Cal CalOptima Direct Member Handbook (03/15/16)
- Exempt Grievance Log (02/01/16 – 10/31/16)
- 58 Exempt Grievance Files (11/1/14 – 10/31/16)

Assessment: In a review of Plan documents, grievance logs and grievance files, the Department determined that the Plan inappropriately documents grievances as resolved and exempt.

Rule 1300.68(a)(4) defines "resolved" as meaning that "the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no

pending enrollee appeals within the plan's grievance system, including entities with delegated authority." The Department found that the Plan identifies some grievances as resolved before a final conclusion is reached with respect to the issues raised in the grievances.

The Plan's *QoC and/or Exempt Grievance Documentation* work aid instructs CSRs that, "[i]f a resolution cannot be provided and the member needs further assistance, please route the case using the appropriate template. Do not check the complaint box for a routed case." During interviews, the Associate Director of Customer service stated that the Plan considers exempt grievances "resolved" when the CSR transfers the case to the responsible department. However, under Rule 1300.68(a)(4), a grievance is not resolved until the issues raised in the grievance are concluded. Transferring a call to another department to handle does not conclude the issue raised by the member, in most cases.

File Review

The Department reviewed 58 files identified by the Plan as exempt grievance files during the survey review period. Of the 58 files, 18 (31%) contained grievances that were not adequately considered and rectified, but were marked as closed by the Plan upon transfer of the cases to another internal department.⁴ The following cases exemplify this procedure.

- File # (number was removed for confidentiality): The member's boyfriend called on behalf of the member to express dissatisfaction that her PCP was changed without notifying her. He also expressed dissatisfaction about the quality of surgical care received by the member because she was readmitted the day after discharge due to infection from a blockage that was not detected prior to surgery. The caller also told the CSR that the member needed to see the provider on the day of the call or go to the ER. The CSR transferred the call to Case Management for "Coordination of Care" and documented the potential quality of care issues for follow-up. The CSR closed the case in its CS system as a resolved exempt grievance.
- File # (number was removed for confidentiality): The member complained about having a bad day with the Plan, stating that the last representative he spoke to would not give his/her name, and he needed to talk to a supervisor. The member explained that he was referred to the Plan's vision service provider but needed an ophthalmologist. The Plan elevated the call to a member liaison supervisor and closed the exempt grievance as resolved.
- File # (number was removed for confidentiality): Member called in upset with emergency room staff because they asked her not to return for her chronic knee pain. The CSR advised the member how to file a grievance but the

⁴ File #(numbers were removed for confidentiality).

member declined at that moment, stating she would call back to file a grievance. The Plan closed the exempt case as resolved.

These cases were recorded in the Plan’s exempt grievance log, but there is no indication that the issue(s) raised in the grievances were resolved to a final conclusion. The CSR simply transferred the call and marked the case as closed.

TABLE 2
Exempt Grievances

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt Grievance Files	58	Grievance resolved to a final conclusion	40 (69%)	18 (31%)

Conclusion: DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System directs the Plan to implement and maintain a Member Grievance system and maintain procedures to monitor the Member’s Grievance system in accordance with Rule 1300.68, which defines resolved as meaning “the grievance has reached a final conclusion with respect to the enrollee’s submitted grievance.” Based on the file review, the Plan inappropriately documents exempt grievances as resolved. Therefore, the Department finds the Plan in violation of the applicable contractual, statutory, and regulatory requirements.

Deficiency #7: The Plan does not describe the issues raised in grievances as required by Rule 1300.68(e)(2).

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 2 – Grievance System Oversight; Section 1368(a)(1), (4)(B)(i); Rule 1300.68(a), (d), (e)(2).

DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 2 – Grievance System Oversight;

DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System
 1. Member Grievance System

Contractor shall implement and maintain a Member Grievance system in accordance with Title 28 CCR Section 1300.68 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph D.13, and 42 CFR 438.420(a)(b) and 2. Grievance System Oversight

Section 1368(a)

Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Rule 1300.68

Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

(e) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances.

(2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.

Documents Reviewed:

- Plan Policy HH.1102: CalOptima Member Complaint (06/01/16)
- Plan Policy HH.1103: CalOptima Health Network Member Complaint (06/01/16)
- QoC and/or Exempt Grievance Documentation (12/31/14)
- Medi-Cal CalOptima Direct Member Handbook (03/15/16)
- Exempt Grievance Log (02/01/16 – 10/31/16)
- 58 Exempt Grievance Files (11/1/14 – 10/31/16)

Assessment: Rule 1300.68(e)(2) requires plan grievance systems to describe each issue raised in grievances as one of six specified categories so that grievances can be tracked and monitored within those categories. The Department found that the Plan categorizes grievances using a Facets Coding Guide, which contains five primary categories (Assistance and Education, Enrollment and Eligibility, Member Billing, MCAL, and Prior Authorization). These categories do not correlate to the categories listed in Rule 1300.68(e)(2). The five categories contain 62 subcategory codes (e.g., Share of Cost (SOC) Issues, Pharmacy Inquiry, and Benefits). Additionally, there are 46 reason codes to explain the sub-categories (e.g., Unsatisfied with Med Care, Language Barrier, and Transfer to Other Department). The Department found that the Plan's system of multiple categories, subcategories and numerous reason codes did not comply with the categorization as required by Rule 1300.68(e)(2). As such, the Plan is not able to track and trend its grievances according to those categories.

File Review

The following files demonstrate the categorization system of grievances used by the Plan:

- File # (number was removed for confidentiality): The member's daughter expressed dissatisfaction with the member's PCP and requested to change PCPs. She stated that the member was admitted to the hospital and nine days later had open heart surgery as a result of taking prescribed hydrochlorothiazide 25 mg (a diuretic). The Plan categorized this grievance as a "PHI Authorization Form Request" since the representative did not have an authorization on file to represent the member. There was no indication of this grievance being described as one of the six categories included in Rule 1300.68(e)(2).
- File # (number was removed for confidentiality): The member's mother called and expressed dissatisfaction with the provider office's front desk staff's behavior toward the member because the member did not have a Plan ID card at the time of the visit. The Plan categorized this grievance as "Eligibility Verification." There was no indication of this grievance being described as one of the six categories included in Rule 1300.68(e)(2).
- File # (number was removed for confidentiality): The member expressed dissatisfaction with the current PCP, requested a provider change, and reported facts indicating a possible quality of care issue. The Plan categorized this grievance as "Provider Information. There was no indication of this grievance being described as one of the six categories included in Rule 1300.68(e)(2).

Conclusion: While a plan is not prohibited from using category identifiers that provide the Plan with the degree of specificity as those used by the Plan, the DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System, requires the Plan to implement and maintain a grievance system in accordance with regulatory requirements. Rule 1300.68(e)(2) requires plans to describe grievances according to six specific categories. Therefore, the Plan is not exempt from the requirement of describing grievances as required by Rule 1300.68(e)(2) for purposes of tracking and trending grievances received by the Plan, or any delegated entity. Accordingly, the Department finds the Plan in violation of Rule 1300.68(e)(2).

QUALITY MANAGEMENT

Deficiency #8: **The Plan has not established and implemented a systematic process to assess and evaluate utilization management data to monitor, identify, and correct under- and over-utilization of services.**

Contractual/Statutory/Regulatory Reference(s): The DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and Attachment 5 – Utilization Management Program, Provision 4 – Review of Utilization Data; Rule 1300.70(b)(2)(H)(2).

DHCS-CalOptima Contract, Exhibit A

Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70....

Attachment 5 – Utilization Management

1. Utilization Management Program

Contractor shall develop, implement, and continuously update and improve, a 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: ...

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) Quality Assurance Program Structure and Requirements....

(2) Program Requirements....

(H) 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....

Documents Reviewed:

- 2015 Utilization Management Program Description
- 2016 Utilization Management Program Description
- Plan Policy GG.1532: Over and Under Utilization Monitoring (10/01/16)
- Utilization Reports
 - Inpatient UM Metric and Goals by Risk Groups January 2014 – September 2016 (11/09/16)
 - CalOptima Acute Inpatients Re-Admits 30 UM Metrics and Goals 2014-2016 Q3 (11/10/16)
 - Emergency Department (ED) Utilization (01/28/16)
 - Inpatient Utilization (01/28/16)
 - Emergency Department UM Metric and Goals by Risk Groups January 2014 – September 2016 (11/09/16)
 - Inpatient UM Metric and Goals by Health Networks January 2014 – September 2016 (11/09/16)
 - Over Under Utilization Matrix – Medi-Cal (02/10/17)
- UMC Meeting Minutes (01/28/16, 05/12/16, 08/11/16, 11/10/16)
- UM Workplan and Evaluation, 3rd Quarter, 2016 (11/10/16)
- Response from Director of UM Regarding Over Under Utilization Matrix – Medi-Cal (02/15/17)

Assessment: The Plan's 2015 and 2016 UM Program Descriptions include the scope of the Utilization Management Committee (UMC) related to mechanisms for detecting and correcting under- and over-utilization. Scope statements include the following:

- Reviews practitioner specific UM reports to identify trends and/or utilization patterns and makes recommendations to the QIC for further review;
- Reviews reports specific to facility and/or geographic areas for trends and/or patterns of under or over utilization;
- Examines appropriateness of care reports to identify trends and/or patterns of under or over utilization and refers identified practitioners to the QIC for performance improvement and/or corrective action; and,
- Examines results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM program and identify areas for performance improvement.

Policy GG.1532: Over and Under Utilization Monitoring, provides greater specificity of the Plan's mechanisms for detecting and correcting under- and over-utilization. The policy states:

B. The Utilization Management Committee (UMC) shall establish the process to identify Under and Over Utilization through monitoring, tracking, and analyzing data, including but not limited to:

1. Acute and behavioral inpatient bed days, admits, lengths of stay and readmission rates;
2. Specialty care access;
3. Grievances;
4. Healthcare Effectiveness Data & Information Set (HEDIS);
5. Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data;
6. Perinatal support program utilization;
7. Emergency room utilization;
8. Annual Provider satisfaction survey of the Utilization Management process;
9. Inter-rater Reliability scores;
10. Denial rates;
11. Appeal overturn rates; and
12. Potential Provider Quality Issues (PQIs).

Policy GG.1532: Over and Under Utilization Monitoring states the Utilization Management Department analyzes the data on at least a quarterly basis. Comparisons are made to UMC goals; the mean and standard deviation from the group; and nationally recognized, evidence-based, and external benchmarks, when available. The UMC reviews the analysis of the data. The UMC may require a corrective action plan from a delegated health network or a specific practitioner. In its review of documents, the Department saw no evidence of reports with the level of analysis specified by the Plan's policy reported to the UMC and no requests for corrective actions related to under- or over-utilization.

The Plan produced and submitted utilization reports that demonstrate monitoring of inpatient average length of stay, percent of re-admissions, bed days per thousand, ED visits, and inpatient length of stay for all its networks, including its shared risk group networks. The Plan monitors its HEDIS reports to detect underutilization of recommended preventive services. However, except for acute inpatient admissions, ED visits, and HEDIS data, the Plan did not show evidence that it consistently monitors and detects under- and over-utilization and acts to correct deficiencies to improve care. The Plan also generates reports of aggregate denials, approvals, appeals, and overturns as well as unused authorizations but there is no evidence that the Plan uses this information to monitor, detect, and correct patterns of under- and over-utilization.

Meeting minutes of the Plan's Utilization Management Committee (UMC) show intent to conduct under- and over-utilization monitoring and an awareness of the significance of this activity as it relates to both the Plan's network and shared risk group networks, but fail to demonstrate that the Plan has implemented an adequate system to do so.

The UMC Meeting Minutes of January 28, 2016, provide evidence that the Plan was moving toward monitoring utilization of various services. During this meeting, Plan staff discussed identifying targets for under- and over-utilization of behavioral health services and the availability of data from the previous year (2015) for analysis to identify outliers and significant trends. However, there is no evidence that analysis of the 2015 data, as discussed in this meeting, was conducted during the survey review period, nor is there any evidence of other committee work to identify under- and over-utilization patterns and outliers. The 2016 Utilization Management Work Plan was presented by a Plan medical director at the January 28, 2016 UMC meeting. The minutes include a statement that utilization outlier trending is a new reporting area introduced for this year.

UMC Meeting Minutes throughout 2016 demonstrate continued discussions on the importance of analyzing and monitoring services for under- and over-utilization. The UMC Meeting Minutes of May 12, 2016, record that Plan officers recognized the need to monitor and work with its shared risk groups and define which aspects of utilization need to be reported, including identification of specific areas to track and acknowledgment of outliers in specific areas. However, the UMC did not discuss any interventions at that meeting, nor in successive meetings in 2016.

UMC Meeting Minutes of August 11 and November 10, 2016, show that the medical director continued to verbalize the need to track provider under- and over-utilization across networks. However, Plan officers were still defining what to track. A blank *Over Under Utilization Matrix* was presented during these last two UMC meetings of 2016, listing data measures which the Plan intended to track and trend, and if issues were identified, address as necessary. The *Over Under Utilization Matrix* contains an "Actions" column for documenting the Plan's corrective actions. When queried whether this matrix was used during the survey review period, the Director of Utilization Management provided a written response, dated February 15, 2017, which states that while data was collected during the survey review period, the *Over Under Utilization Matrix* was not implemented until January 2017.

As of the February 2017 onsite survey, the Plan had presented no evidence that it met with shared risk groups during the survey review period to discuss identified patterns of under- and over-utilization, despite holding joint operation meetings with the groups on a quarterly basis. During interviews, Plan staff acknowledged the need to develop and implement a system to continuously monitor and detect under- and over-utilization. Staff confirmed that the Plan does not currently have a reliable system to monitor and detect utilization data.

Conclusion: The DHCS-CalOptima Contract, Exhibit A, Attachment 5 – Utilization Management, requires the Plan to have mechanisms in place to detect both under- and over-utilization of health care services and to continuously update and improve its UM program. Rule 1300.70(b)(2)(H)(2) requires the Plan to have a mechanism to detect and correct under-service by an at-risk provider, including possible under-utilization of specialist services and preventive health care services. The Plan presented insufficient evidence of effective tracking, trending, and analysis of utilization data from 2015 and 2016 of its Medi-Cal members to monitor for, and address, under- and over-utilization to improve the quality of care. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Deficiency #9: The Plan does not consistently ensure that potential quality issues are being reviewed, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

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

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

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. 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.

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....

C. Procedure for systematic aggregation and analysis of the grievance data and use for Quality Improvement.

D. Procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues. To this end, Contractor shall ensure that any grievance involving the appeal of a denial based on lack of Medical Necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues shall be resolved by a health care professional with appropriate clinical expertise in treating the Member's condition or disease.

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.

F. Procedure to ensure that requirements of Title 22 CCR Section 51014.2, and Title 42 CFR 438.420(a)-(c) are met regarding services to Members during the grievance process.

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[sic] with clinical expertise may be demonstrated by appropriate specialty training, experience or certification by the American Board of Medical specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions in treating a Member's condition or disease if any following apply:

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

Rule 1300.70

(a) Intent and Regulatory Purpose.

(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....

(b) Quality Assurance Program Structure and Requirements....

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements: ...

(E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved....

Documents Reviewed:

- 58 Exempt Grievance Files (11/1/14 – 10/31/16)

Assessment: In its review of 58 files identified by the Plan as exempt grievance files, the Department identified 10 files that contained quality components within the issues reported.⁵ Of these 10 files, eight (80%) files⁶ contained quality components that were

⁵ File # (numbers were removed for confidentiality). ⁶
File # (numbers were removed for confidentiality).

not elevated for potential quality issue (PQI) review. The following files exemplify this problem:

- File # (number was removed for confidentiality): The member’s son called to express dissatisfaction with care from a neurosurgeon and requested a different provider. He stated that the surgery was a success but there had been problems (e.g., the member was in the ER the previous day because of drainage from surgery). The Plan referred the enrollee to the health network for authorization to see a different specialist. There was no indication that the potential quality of care issue raised by the enrollee was investigated.
- File # (number was removed for confidentiality): The member’s mother presented a series of complaints about a hospital and requested that the member be seen at a different facility. She complained that the hospital had lost test results and wanted to repeat a painful test. She also stated that a therapist at the hospital said the she (the mother) was crazy. Upon filing a complaint at the hospital, she was given a different specialist. She then reported that she approached this specialist in public and spoke with her. The specialist complained and the provider group made her sign a letter agreeing that she would not threaten employees. The mother was referred to the state Ombudsman Office. There was no indication that the Plan investigated the potential quality of care issues raised.

TABLE 3
Exempt Grievance Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Exempt Grievance Files with Potential Quality Issues	10	PQIs are being reviewed, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated	2 (20%)	8 (80%)

Conclusion: The DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement requires that the Plan “implement an effective Quality Improvement System (QIS) in accordance with the standards” in Rule 1300.70 and “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.” Rule 1300.70(a)(1) requires that the Plan 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.” The DHCS-CalOptima Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2 – Grievance System Oversight, similarly requires the Plan to monitor its grievance system and have a procedure to use the system for quality improvement.

In a review of files identified by the Plan as exempt grievances, the Department found that grievances containing PQIs were not investigated. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Deficiency #10: The Plan does not consistently ensure that potential quality of care issues are investigated in a timely manner.

Contractual/Statutory/Regulatory Reference(s): DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; Rule 1300.70(a).

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

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. 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.

Rule 1300.70(a)

Intent and Regulatory Purpose.

(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.

Documents Reviewed:

- CalOptima Quality Improvement Program (10/06/16)
- 42 PQI⁷ Files (11/1/14 – 10/31/16)

Assessment: In a review of the Plan’s PQI files, the Department found that the Plan did not consistently complete its investigations of these cases in a timely manner. This failure impedes corrective actions where concerns are confirmed and enables ongoing unprofessional practices among providers, negatively impacting the quality of care delivered to members.

⁷ Cases, providers, processes or concerns identified through member grievances, sentinel events (e.g., mortalities), data analysis, provider site visits and other sources as having potential quality issues that require investigation are often referred to as PQIs.

The DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, requires the Plan to “implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70.” The contract further states the Plan must “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.” Rule 1300.70(a) requires that the Plan’s QA program 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.”

The Plan’s *Quality Improvement Program* confirms the contractual and regulatory requirements and assigns responsibilities for their completion. The document states on page 15:

The Quality Improvement department supports the specific focus of monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network Quality Improvement department activities include: Monitor, evaluate and act to improve clinical outcomes for members.

File Review

The Department reviewed 42 PQI files. In 15 (36%) of the 42 files, the Plan did not ensure timely investigation of the PQIs.⁸ The delays ranged between 6 and 18 months. The following files exemplify this problem:

- File # (number was removed for confidentiality): The member complained of sleeping problems due to difficulty breathing and allergies and felt that the care received was not appropriate care because the PCP would not submit an authorization request for a specialist referral (ENT or allergist). The Plan received this PQI on April 13, 2015, but the case was not determined to represent an actual quality issue until January 20, 2016, a nine-month delay.
- File # (number was removed for confidentiality): The member's mother complained that the doctor failed to inform them of abnormal lab results, which suggested that the member might have a urinary tract infection. The file contained no documentation that the results were discussed with the member or the mother, and no treatment was prescribed. The Plan received this PQI on June 1, 2015, but the case was not determined to represent an actual quality issue until February 5, 2016, an eight-month delay.
- File # (number was removed for confidentiality): The member complained that her doctor prescribed tramadol (a narcotic pain medication) while she was

⁸ File # (numbers were removed for confidentiality).

on methadone, and she had a severe reaction (convulsions). The member reported that she was advised by a pharmacist that these medications should not be mixed. The Plan received this PQI on March 11, 2015, but the case was not determined to represent an actual quality issue until September 15, 2016, an 18-month delay.

During interviews, the Executive Director of Quality Analytics stated that the Plan does not have a written policy on the timeframe to investigate PQIs; however, the internal goal is a 90-day turnaround. She also admitted that the Plan is aware of the delay in investigation of some PQIs. She attributed the delays to a sudden influx of members in the last few years and inadequate staff to process PQIs. She asserted that the Plan is now caught up due to hiring of additional staff and stabilized membership.

TABLE 4
PQI File Review Summary

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
PQI Files	42	Timely investigation of PQI cases	27 (64%)	15 (36%)

Conclusion: The DHCS-CalOptima Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, requires the Plan to implement an effective quality improvement system in accordance with the standards in Rule 1300.70. Rule 1300.70(a) states that the Plan’s QA program 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. In a file review, the Department determined that the Plan’s investigation of PQIs during the review period was not timely. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS

Angalar Chi, Plan Surveys Analyst
Marie Broadnax, Plan Surveys Manager
Jared Laiti, Plan Surveys Counsel

MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS

Cindy Allen-Fedor, RN , Utilization Management Surveyor
Chrissy Hsieh, MD, JD , Continuity of Care Surveyor
Kelly Gaspar, Availability & Accessibility Surveyor
Bruce Hoffman, MBA, PhD, CHC , Member Rights Surveyor
Chrissy Hsieh, MD, JD , Quality Management Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

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Debra Armas, Director/UM
Tracy Hitzeman, Executive Director (interim) Clinical Operations
Judy Riley, Manager/UM
Edwin Poon, Director BH Integration
Marsha Peterson, Manager, Long Term Care Services & Support
Solange Marvin, Director/Audit & Oversight
Caryn Ireland, Executive Director/Quality Analytics
Esther Okajima, Director/Quality Improvement
Richard Bock, MD, Deputy Chief Medical Director
Laura Grigoruk, Director/Network Management
Michael German, Manager/Provider Relations
Lizeth Granados, Director/Network Management
Sloane Petrillo, Director (interim) Case Management
Richard Helmer, MD, Chief Medical Officer
Emily Fonda, MD, Medical Director, Medical Management
Julie Bomgren, Sr. Policy Advisor, Regulatory Affairs & Compliance
Silver Ho, Compliance Officer
Albert Cardenas, Associate Director, Customer Service
Belinda Abeyta, Director Customer Service
Carlos Soto, Manager, Cultural & Linguistic
Kelly Rex-Kimmet, Director, Quality Analytics
Marsha Choo, Manager, Quality Initiatives
Ladan Khamseh, Chief Operating Officer
Pshyra Jones, Director, Health Education & Disease Management
Kelly Klipfel, Director, Financial Compliance
Donald Sharps, Medical Director, Behavioral Health Integration
Frank Federico, MD, Medical Director
Himmat Dajee, MD, Medical Director, Medical Management
Ana Aranda, Manager, Grievance and Appeals
Hanh Bannister, Pharm D., Manager, Clinical Pharmacist
Janine Kodama, Director, Grievances and Appeals
Kris Gericke, Pharm D., Director Clinical Pharmacy
Le Nguyen, Associate Director, Customer Service
Miles Masatsugu, MD, Medical Director
Sandra Friend, Manager, Clinic Operations
Laura Guest, Supervisor, Quality Improvement

APPENDIX C. LIST OF FILES REVIEWED

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Standard Grievances/Appeals	67	The Plan identified a universe of 1,210 files during the review period. Based on the Department's File Review Methodology, a random sample of 67 files were reviewed.
Inquiries	69	The Plan identified a universe of 2,185 files during the review period. Based on the Department's File Review Methodology, a random sample of 69 files were reviewed.
Exempt Grievances	58	The Plan identified a universe of 355 files during the review period. Based on the Department's File Review Methodology, a random sample of 58 files were reviewed.
Expedited Appeals	12	The Plan identified a universe of 12 files during the review period. Based on the Department's File Review Methodology, a random sample of 12 files were reviewed.
Potential Quality Issues	42	The Plan identified a universe of 102 files during the review period. Based on the Department's File Review Methodology, a random sample of 42 files were reviewed.
UM Medical Necessity Denials	68	The Plan identified a universe of 3,607 files during the review period. Based on the Department's File Review Methodology, a random sample of 68 files were reviewed.