DEPARTMENT OF
Managed
Health Care
Help Center

DIVISION OF PLAN SURVEYS

CAL MEDICONNECT

MEDICAL SURVEY REPORT OF

L.A. CARE HEALTH PLAN

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: MAY 10, 2016

Cal MediConnect Medical Survey Report
L.A. Care Health Plan
A Full Service Health Plan
May 10, 2016

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EXECUTIVE SUMMARY

The Department of Health Care Services (DHCS) received authorization ("CMS APPROVAL") from the federal government to conduct a Duals Demonstration Project ("Cal MediConnect") to coordinate the delivery of health and long term care services to beneficiaries within California who are eligible for benefits under both Medicare and Medicaid. Starting in April 2014, DHCS began phase in enrollment of Cal MediConnect beneficiaries in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. The Department of Managed Health Care (DMHC) and the DHCS then entered into an interagency agreement[1] whereby the DMHC will be responsible for conducting medical survey audits related to the provision of Medicaid-based services provided to Cal MediConnect enrollees. Medical Surveys pursuant to this Agreement are conducted once every three years.

On May 12, 2015, the Department notified L.A. Care Health Plan (the "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 July 20, 2015, through July 24, 2015.[2]

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreement, the Department provides the Cal MediConnect Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the provision of Medicaid-based services for the Cal MediConnect population. This medical survey evaluated the following elements specifically related to the Plan's delivery of care to the Cal MediConnect populations delineated by the contract between the United States Department of Health and Human Services, centers for Medicare & Medicaid Services in Partnership with California Department of Health Care Services and LA Care Health Plan (Three-Way Contract):

I. Utilization Management

The Department evaluated Plan operations related to utilization management as it relates to the provision of Medicaid-based services, 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.

[1] The Inter-Agency Agreement (Agreement Number 13-90167) was approved on October 21, 2013.

[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 (DHCS) and Centers for Medicare and Medicaid Services (CMS) Cal MediConnect Three-Way Contract and amendments. All references to "Cal MediConnect Three-Way Contract" or "Three-Way Contract" are to the Cal MediConnect Three-Way Contract between CMS, DHCS, and the Plan, and amendments thereto. 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.

II. Continuity of Care

The Department evaluated Plan operations to determine whether Medicaid-based services are effectively coordinated both inside and outside the network. The Department also verified that the Plan takes steps to facilitate coordination of Medicaid-based services with other services delivered under the Cal MediConnect, through the enrollees' primary care physician and/or interdisciplinary team.

III. Availability and Accessibility

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

IV. Member Rights

The Department evaluated Plan operations to assess compliance with internal and external complaint and grievance system requirements related to the provision of Medicaid-based services. The Department also evaluated 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 as it relates to the provision of Medicaid-based services.

The scope of the medical survey incorporated review of health plan documentation and files from the period of July 1, 2014 through June 30, 2015.

SUMMARY OF FINDINGS

The Department identified **eleven** potential deficiencies during the current medical survey.

2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT	
#1	**The Plan does not consistently issue routine pre-authorization decisions within required timeframes.** Cal MediConnect Three-Way Contract § 2.11.4.5.; Cal MediConnect Three-Way Contract § 2.11.6; Section 1367.01(h)(1).
#2	**The Plan does not consistently notify the provider and enrollee in writing when it cannot make a decision within the required timeframe.** Cal MediConnect Three-Way Contract § 2.11.6.5.; Section 1367.01(h)(5).
CONTINUITY OF CARE	
#3	**The Plan does not notify PCPs of enrollment of new enrollees who have not completed a Health Risk Assessment.** Cal MediConnect Three-Way Contract § 2.5.1.10.; Cal MediConnect Three-Way Contract § 2.8.2.5.
#4	**The Plan does not consistently complete Health Risk Assessments within required timeframes.** Cal MediConnect Three-Way Contract § 2.8.2.; Cal MediConnect Three-Way Contract § 2.8.2.3-4.; Duals Plan Letter 13-002.
#5	**Individualized Care Plans (ICPs) are not developed in a timely manner and do not consistently integrate information from the HRA and fail to include enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs.** Cal MediConnect Three-Way Contract § 2.8.2.1.; Cal MediConnect Three-Way Contract § 2.8.3.1.; Duals Plan Letter 15-001.
MEMBER RIGHTS	
#6	**The Plan consistently fails to consider enrollee expressions of dissatisfaction as grievances.** Cal MediConnect Three-Way Contract § 2.14.2.; Cal MediConnect Three-Way Contract §2.14.2.1.1.; Section 1368(a)(4)(B).
#7	**The Plan does not consistently include the required Department contact information in grievance acknowledgment and resolution letters.** Cal MediConnect Three-Way Contract § 2.14.3.1.; Section 1368.02(b).
#8	**The Plan does not adequately ensure that members with limited English proficiency have access to, and can fully participate in, the grievance system.** Cal MediConnect Three-Way Contract § 2.14.2.1.1.; Cal MediConnect Three-Way Contract § 2.15.1.3.; Section 1368.03.

#9	**The Plan did not acknowledge receipt of each grievance in a timely manner and did not include the date of the receipt and the name, telephone number, and address of the Plan representative who may be contacted about the grievance.** Cal MediConnect Three-Way Contract § 2.14.2.1.1.; Cal MediConnect Three-Way Contract 2.14.2.1.2.1; Section 1368(a)(4)(A).
#10	**The Plan does not consistently provide a clear and concise explanation or address all issues included in member grievances.** Cal MediConnect Three-Way Contract § 2.14.2.1.1.; Cal MediConnect Three-Way Contract § 2.14.2.1.2.; Section 1368(a)(5).
QUALITY MANAGEMENT	
#11	**The Plan does not include monitoring and improvement of Long-Term Support Services (LTSS) in its Quality Improvement Program.** Cal MediConnect Three-Way Contract 2.16.3.2.6.; Cal MediConnect Three-Way Contract 2.16.3.3.4

DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

Potential Deficiency # 1: The Plan does not consistently issue routine pre-authorization decisions within required timeframes.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.11.4.5.; Cal MediConnect Three-Way Contract § 2.11.6.; Section 1367.01(h)(1).

Cal MediConnect Three-Way Contract
2.11.4.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261…

Cal MediConnect Three-Way Contract
2.11.6. Timeframes for Authorization

2.11.6.5. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the state for the need for additional information and how it is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be treated as such.

Section 1367.01(h)(1)
(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:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination.

Documents Reviewed:

- Plan Policy UM 112: Timeliness Standards for UM Decision Making and Notification and Attachment A (05/21/15)

- Three Utilization Management (UM) Denial Files (01/16/15 – 03/04/15)

Assessment: The Plan failed to consistently issue pre-authorization decisions within the required timelines. The Plan's Cal MediConnect Three-Way Contract states, "Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision … but, no longer than fourteen (14) calendar days from the receipt of the request." Similarly, Section 1367.01(h)(1) (2) and (5) states, "decisions… shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination."

Plan Policy UM 112: Timeliness Standards for UM Decision Making and Notification confirms this requirement, stating that a prior authorization must be made within five working days of the receipt of information, not to exceed 14 calendar days from date of receipt of request.

The Department reviewed the universe of three UM denial files from the survey review period. The Department's review revealed that the Plan failed to meet the contractual timeframes. In two cases, the Plan failed to make a determination within five business days from receipt of information, and failed to make a decision within 14 calendar days from the receipt of the request.

The following is a discussion of the two UM denial files:

- *File #2 (ID):* This request for Community Based Adult Services (CBAS) listed two receipt dates, 12 days apart. The date of request was [date], and the request was re-sent on [date]. Approval for a face-to-face assessment was made on [date]. Information was provided to the Plan on [date]. The decision to deny the request was made on [date], 6 business days after receipt of information necessary to render a decision. Using the first date, the Plan physician denied the request 38 business days (54 calendar days) from the receipt date.

- *File #3 (ID):* The request for CBAS was made on [date]. Approval for a face-to-face assessment was made within 5 business days. Information was provided to the Plan on [date]. The decision to deny the request was made on [date], 9 business days after receipt of information necessary to render a decision. The Plan physician denied this request for CBAS 40 business days (56 calendar days) from the receipt date.

The Plan's Long Term Supportive Services (LTSS) staff responsible for processing requests for CBAS were queried if any current Plan policies included a provision for an extension of time when additional information (e.g., CBAS eligibility evaluation) is necessary for the Plan to make a decision to deny, approve, or modify health care services. The Plan's staff stated that new policies were in process, but these policies were not available for review at the time of the Department's onsite visit.

Conclusion: The Cal MediConnect Three-Way Contract allows plans up to 14 calendar days to make preauthorization decisions from the receipt of the request. The Plan failed to demonstrate that it consistently makes preauthorization decisions within five business days of receipt of information necessary to render a decision and within 14 calendar days from receipt of the request. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

TABLE 1
Timeliness of Denial Decisions

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
UM Denials	3	Preauthorization decision made within five business days up to 14 calendar days	1 (33%)	2(67%)

Potential Deficiency #2: The Plan does not consistently notify the provider and enrollee in writing when it cannot make a decision within the required timeframe.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.11.6.5; Section 1367.01(h)(5).

Cal MediConnect Three-Way Contract
2.11.6. Timeframes for Authorization
2.11.6.5 Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the state for the need for additional information and how it is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be treated as such.

Section 1367.01(h)(5)
(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:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the

requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management (2)

…

(5) If the health care service Plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the Plan is not in receipt of all of the information reasonably necessary and requested, or because the Plan requires consultation by an expert reviewer, or because the Plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the Plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the Plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the Plan, the Plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

Documents Reviewed:

- Plan Policy UM 108: Delaying a Pre-Service Authorization Request (01/16/14 and 03/19/15)
- Three Utilization Management (UM) Denial Files (01/16/15 – 03/04/15)

Assessment: The Plan failed to consistently notify the provider and enrollee when it could not meet the required timeframe due to the need for additional information. The Cal MediConnect Three-Way Contract Section 2.11.6.5 permits plans to defer an authorization decision and allow an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the state for the need for additional information and how it is in the Enrollee's interest.

Section 1367.01(h)(5) requires that "upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the Plan cannot make a decision

.... The Plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered."

Plan Policy UM 108 supports these contractual and regulatory requirements. The policy provisions are as follows:

> When the Medical Director decides to Delay a UM Pre-Service decision beyond … 5 calendar days from receipt of the request:
> A formal Delay letter is prepared by the UM Nurse Specialist and sent to the Member and Requesting Provider requesting only the additional information needed as requested by the Medical Director to evaluate the request and the Delay letter must include:
> - the reason for the delay and
> - the specific information requested or not received(if applicable)
> - the expert reviewer to be consulted (if applicable)
> - the additional examinations or tests required (if applicable)
> - the date by which the requestor is to submit the additional information (this is always 14 Days for Medi-Cal (or 30 days for HF/HK) from the date of receipt of the request).

The Department reviewed the universe of three UM denial files from the survey review period. All three cases were delayed beyond the five-calendar day timeframe. The Department's review found that, in all the cases, the Plan issued an authorization for a face-to-face evaluation of the enrollee, the result of which would provide necessary for the Plan's reviewing physician to make a determination on eligibility for and necessity of CBAS. The authorization for face-to-face evaluation did not explain the need to delay the decision for the CBAS request until the Plan received and reviewed the results of the evaluation. Although the need for this additional information delayed the determinations (e.g., 14 to 56 calendar days), none of the files included a copy of a written notice to the requesting provider and the enrollee to advise them of the need for an extension to acquire the information in order to make a determination.

In all three cases, the Plan delayed its decision based on a need for additional information (e.g. a face-to-face assessment). The Plan did not notify the enrollee and provider in writing of the delay nor did it identify the anticipated date on which a decision would be rendered.

The Plan's LTSS staff was asked if there were any current Plan policies pertaining to the delay of decisions in cases in which a face-to face evaluation is authorized or pending. Plan staff stated that new policies were being developed, but these policies were not available for review at the time of the Department's onsite visit.

Conclusion: The Cal MediConnect Three-Way Contract Section 2.11.6.5, Section 1367.01(h)(5), and Plan policy permit an extension of the time required to make a decision to approve, modify, or deny a request for services if additional information, examinations, or tests are required. In such cases, the Plan shall notify the provider and enrollee of the delay, reason for the delay, the information needed, and the anticipated date on which a decision may be made. The three UM files reviewed failed to include evidence that the Plan notified the requesting provider and enrollee of this process. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

TABLE 2

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
UM Denials	3	Notify the provider and enrollee in writing when a decision will be delayed due to the need for additional information	0 (0%)	3 (100%)

CONTINUITY OF CARE

Potential Deficiency #3: The Plan does not notify PCPs of enrollment of new enrollees who have not completed a Health Risk Assessment.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.5.1.10; Cal MediConnect Three-Way Contract § 2.8.2.5.

Cal MediConnect Three-Way Contract
2.5.1.10. Basic Case Management. The PCP and/or Care Coordinator, in collaboration with the Contractor, will provide basic case management services.
2.5.1.10.1. Enrollees may choose to refuse any treatment, including case management.
2.5.1.10.2. Basic case management services include:
2.5.1.10.2.1. A review of clinical information from the provider;
2.5.1.10.2.2. Completion of the HRA. (see Section 2.8);
2.5.1.10.2.3. Creation of the ICP, in collaboration with the ICT (see Section 2.8.3);
2.5.1.10.2.4. Identification and referral to appropriate providers and facilities, such as medical, rehabilitation, support services, LTSS, Behavioral Health, Care Plan Option Services, and for covered and non-covered services;

2.5.1.10.2.5. Direct communication with Enrollee, Enrollee providers, and family; 2.5.1.10.2.6. Enrollee and family education, including health lifestyle changes when warranted (see Section 2.9.10.8); and
2.5.1.10.2.7. Coordination of services outside of the Cal MediConnect Plan, such as referral to appropriate community social services or specialty mental health or Drug Medi-Cal services.

Cal MediConnect Three-Way Contract
2.8.2.5. Contractor shall notify PCPs of enrollment of any new Enrollee who has not completed a HRA within the time period set forth above and whom Contractor has been unable to contact. Contractor shall encourage PCPs to conduct outreach to their Enrollees and to schedule visits.

Documents Reviewed:

- Plan Policy MM-CM-001: Care Management Process (Rev. 01/15)
- Policy MM-CM-008: Health Risk Assessment for Cal MediConnect Members (Rev. 01/15)
- Procedure MM-CM-008: Health Risk Assessment for Cal MediConnect Members (Rev. 01/15)

Assessment: The Cal MediConnect Three-Way Contract Section 2.5.1.10 defines specific roles in basic case management for the PCP and/or Care Coordinator in collaboration with the Plan. These include completion of the Health Risk Assessment (HRA), referrals for Long Term Support Services (LTSS), and coordination of care.

The Cal MediConnect Three-Way Contract Section 2.8.2.5 requires the Plan to "notify PCPs of enrollment of any new Enrollee who has not completed a HRA within the time period set forth ... [and] encourage PCPs to conduct outreach to their Enrollees and to schedule visits." Neither Plan Policy MM-CM-008 nor the corresponding Plan Procedure on Health Risk Assessment for Cal MediConnect Members specifies that this contact with PCPs will occur.

During interviews, Plan staff stated that the Plan does not directly involve the PCP in the creation of HRAs, nor does it inform the PCP of enrollees it has been unable to reach to conduct an HRA.

Conclusion: The Cal MediConnect Three-Way Contract Section 2.8.2.5 requires the Plan to notify PCPs of any new enrollee who has not completed a HRA within required timeframes and encourage PCPs to contact their enrollees and schedule the visits. The Plan does not inform PCPs about the lack of HRA completion, or encourage PCP outreach to enrollees and schedule a visit. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

Potential Deficiency #4: The Plan does not consistently complete Health Risk Assessments within required timeframes.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.8.2.; Cal MediConnect Three-Way Contract § 2.8.2.3-4.; Duals Plan Letter 13-002

Cal MediConnect Three-Way Contract
2.8.2. Health Risk Assessment (HRA). In accordance with all applicable federal and state laws WIC Section 14182.17(d)(2), the CMS Model of Care requirements, Dual Plan Letter 13-002, Contractor will complete HRAs for all Enrollees.
2.8.2.1. The HRA will serve as the starting point for the development of the ICP.
2.8.2.2. For all Enrollees, the assessment process will, at a minimum, identify:
2.8.2.2.1. Referrals to appropriate LTSS and home- and community-based services;
2.8.2.2.2. Caregivers, Enrollees, and authorized representatives' participation;
2.8.2.2.3. Facilitation of timely access to primary care, specialty care, DME, medications, and other health services needed by the Enrollee, including referrals to resolve physical or cognitive barriers to access;
2.8.2.2.4. Facilitation of communication among the Enrollee's providers, including Behavioral Health providers as appropriate;
2.8.2.2.5. Identification of the need for providing other activities or services needed to assist Enrollees in optimizing health or functional status, including assisting with self-management skills or techniques, health education, and other modalities improve health or functional status; and
2.8.2.2.5.1. Support for Enrollees who need more complex case management, as described in Sections 2.5.1.11 and 2.5.1.12.
2.8.2.2.5.2. Other elements as are specified in Dual Plan Letter 13-002.

Cal MediConnect Three-Way Contract
2.8.2.3. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as higher-risk, the Contractor will complete the HRA within forty-five (45) calendar days of enrollment in accordance with DHCS Dual Plan Letter 13-002.
2.8.2.4. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as lower-risk, the Contractor will complete the HRA within ninety (90) calendar days of enrollment in accordance with DHCS Dual Plan Letter 13-002

DHCS Duals Plan Letter 13-002[3]
B. Health Risk Assessment
MCPs are required to develop a health risk assessment survey tool that will be used to access an enrollee's current health risk within 45 calendar days of coverage for those identified by the risk stratification mechanism or algorithm as higher risk, and within 90 calendar days of coverage for

[3] Duals Plan Letter 13-002 has been superseded by Duals Plan Letter 15-005. Duals Plan Letter 13-002 was in effect during the relevant time-period.

those identified as lower risk for the purpose of developing individualized care management plans.

Documents Reviewed:

- Plan Policy MM-CM-008: Health Risk Stratification and Assessment for Cal MediConnect Members (Rev. 01/15)
- Procedure MM-CM-008: Health Risk Stratification and Assessment for Cal MediConnect Members (Rev. 1/15)
- Policy and Procedure UM-405: Health Risk Stratification and Assessment for Cal MediConnect Members (Rev. 11/14)
- 52 HRA/ICP Files of Newly Enrolled Cal MediConnect Enrollees (enrollment date 7/1/2014 to 3/1/2015).

Assessment: The Plan failed to consistently complete its HRAs in a timely fashion. The Cal MediConnect Three-Way Contract Section 2.8.2.3 requires plans to complete HRAs within 45 days for high-risk enrollees, and the Cal MediConnect Three-Way Contract § 2.8.2.4 sets a 90-day deadline for low-risk enrollees. The Plan's policies and procedures, MM-CM-008 and UM-405, confirm that the HRA's should be completed in the contractual timeframes.

The Department's review of 52 completed HRA files showed that the Plan completed 44, or 85%, of the HRAs within the required timeframes (45 days for high-risk enrollees and 90 days for low-risk enrollees). Eight, or 15%, of HRAs were deficient in terms of timeliness.

TABLE 3
HRA Timeliness

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
HRA	52	Timeliness (<45 days high risk, < 90 days low risk)	44 (85%)	8 (15%)

Conclusion: The Cal MediConnect Three-Way Contract § 2.8.2.3-4 and the DHCS Duals Plan Letter 13-002 require that an HRA be administered within 45 calendar days for high risk enrollees and 90 calendar days for low risk enrollees. The Plan did not consistently complete the Health risk Assessments within the timeframes required. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #5: Individualized Care Plans (ICPs) are not developed in a timely manner and do not consistently integrate information from the HRA and fail to include enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.8.2.1; Cal MediConnect Three-Way Contract § 2.8.3.1.; Duals Plan Letter 15-001

Cal MediConnect Three-Way Contract
2.8.2.1. The HRA will serve as the starting point for the development of the ICP.

Cal MediConnect Three-Way Contract
2.8.3. Individualized Care Plan (ICP). An ICP will be developed for each Enrollee that includes Enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs. It must include timeframes for reassessment.

2.8.3.1. ICPs will be developed within thirty (30) working days of HRA completion

Duals Plan Letter 15-001[4]

A. Individual Care Plan
1. Should a dual-eligible beneficiary demonstrate the need for a Care Plan, MMPs are required to develop a plan and engage the dual-eligible beneficiary and/or his or her representative(s) in its design. The Care Plan is the responsibility of the MMP and is separate and distinct from the medical care plan the primary care provider creates, establishes, and maintains.

a. The need for a Care Plan may be identified by the MMP through interactions with dual-eligible beneficiaries (e.g. when conducting the Health Risk Assessment [HRA]), stratifying beneficiaries into lower and higher-risk categories (e.g. through the HRA risk-stratification process), and any other appropriate interactions.

2. Dual-eligible beneficiaries or their authorized representative must have the opportunity to review and sign the Care Plan and any of its amendments. MMPs must provide dual-eligible beneficiaries with copies of the Care Plan and any of its amendments. The Care Plan must be made available in alternative formats and in a beneficiary's preferred written or spoken language.

3. A Care Plan must include:
a. The dual-eligible beneficiary's goals, preferences, choices, and abilities;
b. Measurable objectives and timetables to meet medical, behavioral health, and long term support needs as determined through the HRA, In-Home Supportive Services (IHSS) assessment results, Multipurpose Senior Services Program (MSSP), and Community-Based Adult Services (CBAS) records, behavioral health utilization, other data, self and provider referrals, and input from members of the ICT, as appropriate; and
c. Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies, when appropriate.

[4] Duals Plan Letter 13-004 was superseded by Duals Plan Letter 15-001 on March 9. 2015. Both Letters were in effect during the relevant time-period, and the language is substantially similar.

Documents Reviewed:

- Plan Policy MM-CM-004: Interdisciplinary Care Team (Rev. 01/15)
- Procedure MM-CM-004 Interdisciplinary Care Team (Rev. 01/15)
- Plan Policy MM-CM-005: Individualized Care Plan (Rev. 01/15)
- Procedure MM-CM-005 Individualized Care Plan (Rev. 01/15)
- Policy and Procedure UM-409: Individualized Care Plan (Rev. 10/14)
- 75 HRA/ICP Files of Newly Enrolled Cal MediConnect Enrollees (enrollment date 7/1/2014 to 3/1/2015).

Assessment: The Cal MediConnect Three-Way Contract Section 2.8.2.1 states, "the HRA will serve as the starting point for the development of the ICP." Pursuant to the Cal MediConnect Three-Way Contract Section 2.8.3 and Duals Plan Letter 15-001, the Plan must develop an ICP that "includes enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs." ICPs must be developed within 30 days of the completion of the Health Risk Assessment.

The Plan does not consistently complete ICPs within the required timeframe, nor does it use the HRA as a starting point for the ICP. The Plan's ICPs ignore personal needs communicated in the HRA and fail to mention personal or measurable goals and the need for LTSS and behavioral health services.

1. ICPs are not completed in a timely manner

The Cal MediConnect Three-Way Contract Section 2.8.2.1 sets a time limit of 30 working days for completion of the ICP. None of the Plan's pertinent policies and procedures (MM-CM-004 and MM-CM-005) or their predecessors (UM-405 and UM-409) contain this timeframe.

The Department's review of 75 HRA files revealed that ICPs were completed within 30 working days of the HRA in only 37 cases (49%). All 75 HRA files contained a draft template ICP that was automatically generated from enrollees' responses in their HRAs. These draft ICPs were not developed by qualified personnel, nor presented to an Interdisciplinary Care Team, per Plan policies. The Plan stated that if an enrollee refused to participate in the ICP process, or was unreachable (by telephone, email, etc.), these "default" ICPs are sent to the PCPs. However, while these default ICPs are generated immediately upon HRA completion, there is no evidence that the Plan took any further action (e.g., update, customize) on these default ICPs.

2) The ICPs do not demonstrate that they are based on the HRAs

The Cal MediConnect Three-Way Contract Section 2.8.2.1 states that the HRA is to be the starting point for the Plan's ICP. Plan Policy MM-CM-005 confirms this requirement:

> L.A. Care shall use the following to develop the ICP:
>
> 2.3.1 Information from the health risk assessments (HRAs) of the enrollee as the initial basis for developing the ICP

However, the Department's review of 75 completed ICPs show examples of ICPs that ignore information contained in the HRA (and in the automatically generated default ICP, which was to serve as a basis for actual ICP development). The following are examples:

- *File #26 :* The enrollee identified a behavioral health need, a past medical history of depression, and positive responses on depression screening questions embedded in the HRA. Although theenrollee was referred to the Plan's Managed Behavioral Health Organization, there is no mention of any behavioral health goals in the ICP.
- *File #36:* This file contained a non-specific ICP that ignored the enrollee's diagnosis of schizophrenia.

The Plan's ICP fail to include important information obtained in the HRA and therefore fail to use the HRA as the initial basis for developing the ICP.

3) The ICPs do not include enrollee goals and preferences, measurable objectives, and timetables to meet medical, behavioral health, and LTSS needs

The Cal MediConnect Three-Way Contract Section 2.8.2.3 and Duals Plan Letter 15-001 require ICPs to include enrollee goals and preferences, measurable objectives, and timetables to meet medical, behavioral health, and LTSS needs. Of the 75 ICP files reviewed, this requirement was not applicable for 34 files due to enrollees refusing participation, dis-enrolling, or being unreachable. Of the remaining 41 files, the Department determined that 22 files (54%) were not compliant with one or more of these elements. Some files contained problems in multiple areas.

As these files exemplify, the ICPs were not individualized:

- *File #39:* The ICP contained a single item, about visiting the PCP. It did not mention that the enrollee had serious congestive heart failure and was on hospice.
- *File #27:* The ICP did not mention that the enrollee lived in a board and care facility or was receiving CBAS services.

As these files exemplify, the ICPs ignored enrollees' expressed needs:

- *File #35:* This file contained a brief ICP that did not mention the enrollee's expressed need for a caregiver as identified in the HRA.
- *File #40:* This file contained only preventive health information. In the HRA, the enrollee expressed issues with pain control and managing activities of daily living which were not addressed.

As these files exemplify, the ICPs did not address behavioral health or LTSS needs:

- *File #57:* This file contained a single element related to medication compliance. The ICP did not include the enrollee's problems with activities of daily living and transportation problems.

- *File #38:* This file contained only preventative health information. The ICP did not include identified behavioral health issues or that the enrollee was receiving CBAS services.

TABLE 4
ICP Completion

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
ICP	75	ICP completed within 30 days of HRA	37 (49%)	38 (51%)
ICP	41[5]	ICPs are individualized, consider member needs and address behavioral health and LTSS needs	19 (46%)	22 (54%)

Conclusion: The Plan's Cal MediConnect Three-Way Contract Section 2.8.2.1 states that, the Plan will develop an ICP for each enrollee within 30 days of completion of the HRA. Using the HRAs as the starting point for development, the ICPs will address enrollees' goals and preferences as well as medical, behavioral health, and LTSS needs, and contain measurable objectives and timetables. The Plan's HRA and ICP files did not consistently demonstrate timely completion of ICPs. In addition, the resulting ICPs fail to address expressed enrollees' needs and preferences, and omit key information outlining enrollees' medical, behavioral health, and LTSS needs. Therefore, the Department finds the Plan in violation of this contractual requirement.

MEMBER RIGHTS

Potential Deficiency #6: The Plan consistently fails to consider enrollee expressions of dissatisfaction as grievances.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.14.2.; Cal MediConnect Three-Way Contract §2.14.2.1.1; Section 1368(a)(4)(B).

Cal MediConnect Three-Way Contract
2.14.2. Internal (plan level) Grievance: An Enrollee may file an Internal Enrollee grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Contractor

[5] 34 files were excluded either because the enrollee could not be contacted, or had refused participation in the program. (Files # 4, 5, 6, 15, 17,19, 20, 21, 22, 24, 25, 29, 33, 37, 44, 47, 48, 49, 50, 51, 52, 54, 55, 56, 58, 60, 63, 64, 65, 66, 70,71,74,75)

or its providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee grievances, including grievances regarding reasonable accommodations and access to services under the ADA.

Cal MediConnect Three-Way Contract
2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, pursuant to the Knox-Keene Health Care Services Plan Act of 1975, WIC Section 14450 and CCR, Title 22, Section 53260.

Section 1368(a)(4)(B)
Grievances received by telephone, by facsimile, by e-mail, 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.

Documents Reviewed:

- Plan Document: Inquiry Log – Cal MediConnect (July 2014)
- Plan Document: Inquiry Log – Cal MediConnect (February 2015)
- Plan Document: Inquiry Log – MediConnect (March 2015)
- LA Care Covered HMO Evidence of Coverage (January 1, 2015 – December 31, 2015)
- Plan Policy #AG-011: Cal MediConnect Member Grievance Process (03/31/14)

Assessment: The Plan fails to meet its legal and contractual obligations to appropriately identify grievances by misclassifying enrollee expressions of dissatisfaction as "inquiries." The Cal MediConnect Three-Way Contract Section 2.14.2 requires that the Plan provide enrollees with a means to file a grievance and that it "have a system in place for addressing Enrollee grievances, including grievances regarding reasonable accommodations and access to services under the ADA."

The Plan's Evidence of Coverage confirms this requirement, stating:

> You have many ways to file a grievance. You can do any of the following: Write, visit or call L.A. Care. You may also file a grievance online in English or in

Spanish through L.A. Care's website at www.lacarecovered.org. Please contact L.A. Care as listed below if you need a grievance form in a language other than Spanish or English, or in another format (large print or audio). L.A. Care Health Plan Member Services Department 1055 W. 7th Street, 10th Floor Los Angeles, CA 90017 1-855-270-2327 TTY/TDD: 1-855-576-1620 www.lacarecovered.org.

Plan Policy AG-011, Cal MediConnect Member Grievance Process, further confirms this requirement, stating, "Enrollees may file a grievance through either L.A.Care or Cal Medi-Connect Ombudsman Program for complaints relating to Medicare and Medi-Cal covered benefits and services." The Policy also defines inquiry as "any verbal or written request to L.A. Care, a provider or facility, without an expression of dissatisfaction…."

During interviews, the Plan's medical director acknowledged that until June 2015, the Plan had been misclassifying exempt grievances[6] as "inquiries." As a result, these inquiries were not tracked as grievances, i.e., "never logged and put into the grievance system." The Plan was unable to produce any exempt grievances or any record/log of exempt grievances from the survey review period for the Department to review. This information, offered by Plan staff, was verified by the Department upon review of inquiry logs that were received following the onsite visit.

The following examples demonstrate that the Plan has been classifying enrollee expressions of dissatisfaction (i.e., grievances) as inquiries and not processing grievances appropriately:

- Inquiry Log – Cal MediConnect
  Case # (removed for privacy): The enrollee called to inquire about the responsibilities of his IHSS worker. The enrollee expressed dissatisfaction with both his In Home Support Services (IHSS) worker and his PCP. Plan staff provided the enrollee with information about the role of IHSS workers and "offered to file a grievance against the IHSS worker and PCP." The enrollee declined, stating that he already filed a grievance against his PCP, and the "PCP became upset and took away 3 of his rx." Plan staff then offered the enrollee a "future retro" but the enrollee declined. Staff also referred the enrollee to PASC SEIU (Homecare Workers Health Care Plan) to find out more about what IHSS can offer. There was no documentation that the enrollee's complaints regarding his PCP and IHSS worker were forwarded and moved through the grievance process for further review and investigation.

- Inquiry Log – Cal MediConnect
  CIN # (removed for privacy): The enrollee stated that she was unable to contact Logisticare (transportation provider. Plan staff transferred the enrollee to a Logisticare

[6] One-day grievances (sometimes referred to as exempt grievances) are described by Section 1368(a)(4)(B) as "grievances received by telephone, by facsimile, by e-mail, 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 ...." Such grievances are exempt from the requirement to send acknowledgement and resolution letters; however, the Plan must maintain a log of these grievances.

representative. File documentation noted, "Can file grievance"; however, the documentation did not indicate what kind of grievance (exempt or standard).

- Inquiry Log – Cal MediConnect
  [*Case#*]: The enrollee request to change his PCP explaining that the provider wanted to charge him $75 for a flu shot. Further, he did not like going there because the provider did not seem to care about his health. The file documentation noted, "offered grievance mbr declined." It was also documented that staff was unable to process the PCP change through the electronic system and "will process once have access." The status noted on the log for this case indicates that it was closed/resolved, indicating that there was no documentation demonstrating if the Plan processed the PCP change request. The enrollee's complaint about his PCP's behavior was not correctly classified as a grievance.

- Inquiry Log – Cal MediConnect
  [*Case #*]: The enrollee was seeking a referral from her PCP, although the type of referral was not explained in the log entry. Plan staff contacted the PCP's office, and the subsequent file documentation noted that office staff stated, "she did not want to help this member due to her being a difficult member." This response was conveyed to the enrollee, who declined to file a grievance and said she would speak to her provider instead. The Plan categorized this information as an inquiry, and it was therefore not appropriately processed through the grievance system. Further, the status noted for the case indicated that it was "closed/resolved" although the enrollee's stated need for a referral from her provider was not addressed by Plan staff (e.g., by offering her the option of changing providers). Plan staff should have also inquired further about the type of referral being requested by the enrollee in order to determine if the case should be reviewed by clinical staff for determination of a potential quality issue (PQI) relating to access to a specialty provider.

During interviews, the Medical Director provided an additional example of the Plan's failure to correctly classify grievances. Specifically, she identified a situation in which a long-term care facility was being de-certified. The Plan wanted to move the enrollees out of the facility, but the state-assigned Ombuds provider advised the Plan that the enrollees did not want to move. The Medical Director stated that in the Plan did not consider the Ombuds call a grievance because they believed it was more of an administrative process. The Medical Director admitted that the Plan should have considered the call a grievance, but they did not do so due to preoccupation with moving the members.

Conclusion: The Plan's Cal MediConnect Three-Way Contract Section 2.14.2 requires the Plan to provide enrollees with a means to file a grievance and have a system in place for addressing those grievances. Review of Plan inquiry logs and interviews with Plan staff revealed that prior to June 2015, the Plan misclassified enrollee exempt grievances as "inquiries" and did not ensure that issues of dissatisfaction expressed by enrollees in those calls were resolved as grievances. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #7: The Plan does not consistently include the required Department contact information in grievance acknowledgment and resolution letters.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.14.3.1.; Section 1368.02(b).

Cal MediConnect Three-Way Contract
2.14.3.1. Pursuant to Health & Safety Code Section 1368(b), Contractor shall inform Enrollees that they may file an external grievance for Medi-Cal only covered benefits and services (not including IHSS) through the DMHC's consumer complaint process. Contractor shall inform Enrollees of the DMHC's toll-free telephone number, the DMHC's TDD line for the hearing and speech impaired, and the DMHC's website address pursuant to Health & Safety Code Section 1368.02.

Section 1368.02(b)
(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plans telephone number, and the department's Internet Web site address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement: "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(insert health plan's telephone number)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online." Each plan's obligation for notifying subscribers and enrollees about the plan's grievance system shall include information on the plan's procedures for filing and resolving grievances, and the telephone number and address for presenting a

grievance. The notice shall also include information regarding the Department's review process, the independent medical review system, and the Department's toll-free telephone number and website address.

Documents Reviewed:

- DMHC_GA_002-003.1 CMC_001_clin_ACKNOWLEDGEMENT_ENG_04232015 - jce.pdf (acknowledgement letter template)
- DMHC_GA_002-003.1 CMC_001_grv_ACKNOWLEDGEMENT_ENG_04232015 - jce.pdf (acknowledgement letter template)
- 16[7] Standard Grievance Files (July 1, 2014 – June 30, 2015)

Assessment: The Plan's Cal MediConnect Three-Way Contract Section 2.14.3.1 requires the Plan to inform its members of "the DMHC's toll-free telephone number, the DMHC's TDD line for the hearing and speech impaired, and the DMHC's website address pursuant to Health & Safety Code Section 1368.02." Section 1368.02(b), in turn, requires that plans' written acknowledgment of grievances present the Department's contact information in 12-point boldface type and include information on the procedures for filing and resolving grievances, as well as a statement about enrollees' rights to Independent Medical Review.

The Department reviewed 16 standard grievance files, which represent the universe of such files for the survey review period. The Department determined that in all 16 (100%) files, the Plan failed to provide the information as required by Section 1368.02(b) in its acknowledgment letters. In addition, the Department determined that 15 (89%) of the resolution letters did not include the aforementioned information. The Department found that the Plan inconsistently includes the information required by Section 1368.02(b) in the templates it uses to develop acknowledgment letters. The Department found that the Plan's acknowledgment letter templates fail to consistently include the information required by Section 1368.02

TABLE 5
Standard Grievance File Review Summary – DMHC statement

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Grievances	16	Statement as required by Section 1368.02(b) in acknowledgment letters	0 (0%)	16 (100%)
	15	Statement as required by Section 1368.02(b) in resolution letters	1 (7%)	14 (93%)

Conclusion: The Plan's Cal MediConnect Three-Way Contract Section 2.14.3.1 and Section 1368.02(b) require that written acknowledgment of grievances include the following

[7] 18 files were reviewed, however two files were duplicate files and therefore excluded. A third file was excluded as the file was still open and the grievance was not yet resolved.

information: DMHC's toll-free telephone number, DMHC's TDD line for the hearing and speech impaired, and DMHC's website address, all in 12-point boldface type; procedures for filing and resolving grievances; and a statement about enrollees' rights to Independent Medical Reviews. The standard grievance files reviewed by the Department did not consistently contain the required information in the acknowledgment and/or resolution letters. Therefore, the Department finds the Plan in violation of this contractual requirement.

Potential Deficiency #8: The Plan does not adequately ensure that members with limited English proficiency have access to, and can fully participate in, the grievance system.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract § 2.14.2.1.1.; Cal MediConnect Three-Way Contract § 2.15.1.3.; Section 1368.03.

Cal MediConnect Three-Way Contract
2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, pursuant to the Knox-Keene Health Care Services Plan Act of 1975, WIC Section 14450 and CCR, Title 22, Section 53260.

Cal MediConnect Three-Way Contract
2.15.1.3. Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. The Contractor must inform Enrollees that information is available in alternative formats and how to access those formats.

Section 1368.03
The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation.

Documents Reviewed:

- 18 standard grievance files (July 1, 2014 – June 30, 2015)

Assessment: The Plan's Cal MediConnect Three-Way Contract and Section 1368.03 require that the grievance system "address the linguistic and cultural needs of its enrollee population," requiring that "translations of grievance procedures, forms, and plan responses to grievances …" be provided to enrollees with limited English proficiency.

The Department reviewed 18 standard grievance files, which represents the universe of such files for the survey review period. The Department determined that in 8 (44%) of the 18 files, the Plan did not address the linguistic needs of its enrollees in its acknowledgment letters. Specifically, the Plan failed to attach a language insert along with the acknowledgment letters to inform enrollees that they are able to obtain the information in alternate formats. The Department further determined that in 6 (33%) of the 18 files, the Plan did not address the linguistic needs of its enrollees in its resolution letters.

TABLE 6
Standard Grievance File Review Summary – Language Requirements

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Grievances	18	Language insert (acknowledgment letters)	10 (56%)	8 (44%)
		Language insert (resolution letters)	12 (67%)	6 (33%)

During interviews, the Plan was unable to describe how the Plan ensures inclusion of the correct language insert in acknowledgment and resolution letters. Staff noted that a previous grievance and appeals director conducted internal monitoring; however, they were unable to provide details about this process when queried. The Plan did note that a new computer system initiated in early 2015 now attaches the proper language insert into the template letters.

Conclusion: Cal MediConnect Three-Way Contract 2.15.1.3 and Section 1368.03 require that the Plan provide assistance to enrollees with limited English proficiency, including translations of grievance forms and plan responses to grievances. Upon review, the Department found that both grievance acknowledgement and resolution letters did not consistently address the linguistic needs of its enrollees. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

Potential Deficiency #9: The Plan did not acknowledge receipt of each grievance in a timely manner, and did not include the date of the receipt and the name, telephone number, and address of the Plan representative who may be contacted about the grievance.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract §

2.14.2.1.1.; Cal MediConnect Three-Way Contract 2.14.2.1.2.1; Section 1368(a)(4)(A).

Cal MediConnect Three-Way Contract
2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, pursuant to the Knox-Keene Health Care Services Plan Act of 1975, WIC Section 14450 and CCR, Title 22, Section 53260.

Cal MediConnect Three-Way Contract
2.14.2.1.2. The Contractor must maintain written records of all grievance activities, and notify CMS and DHCS of all internal grievances. The system must meet the following standards:
2.14.2.1.2.1. Timely acknowledgement of receipt of each Enrollee grievance;

Section 1368(a)(4)(A)
Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following: (i) That the grievance has been received. (ii) The date of receipt. (iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

Documents Reviewed:

- 16[8] standard grievance files (July 1, 2014 – June 30, 2015)

Assessment: The Plan's Cal MediConnect Contract 2.14.2.1.2.1 requires "timely acknowledgment of receipt of each Enrollee grievance." Section 1368(a)(4)(A) further specifies that each plan provide a "written acknowledgment within five calendar days of the receipt of a grievance." The acknowledgment must confirm that the "grievance has been received; the date of receipt; and the name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance."

The Department reviewed 16 standard grievance files, which represent the universe of such files for the survey review period. The Department determined that seven (44%) acknowledgment letters were not sent within the required timeframe; two (12 %) letters did not include the date of receipt of the grievance; and none of the 16 (100%) letters contained the Plan representative's name, telephone number, and address.

TABLE 7
Cal MediConnect Standard Grievance File Review Summary – Acknowledgment Letters

[8] 18 files were reviewed, however two files were duplicate files and therefore excluded.

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Grievances	16	Acknowledgment letter sent within five (5) calendar days	9 (56%)	7 (44%)
		Date of receipt of grievance	14 (88 %)	2 (12 %)
		Plan representative information (name, telephone number, address)	0 (0%)	16 (100%)

Conclusion: The Plan's Cal MediConnect Contract Section 2.14.2.1.2.1 requires timely acknowledgement of grievances. Section 1368(a)(4)(A) requires that plans provide an acknowledgment within five calendar days of receipt of a grievance and that the acknowledgement letter contain the date of receipt and the name, telephone number, and address of the Plan representative who may be contacted about the grievance. The Plan did not consistently acknowledge the grievances in a timely manner; did not consistently provide the date of receipt of the grievance in its acknowledgement letters; and did not include the name, telephone number, and address of the Plan representative in any of its acknowledgement letters. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

Potential Deficiency #10: The Plan does not consistently provide a clear and concise explanation or address all issues included in member grievances.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract 2.14.2.1.1; Cal MediConnect Three-Way Contract 2.14.2.1.2.; Section 1368(a)(5).

Cal MediConnect Three-Way Contract
2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which Enrollees may submit their grievances regarding all benefits and services, pursuant to the Knox-Keene Health Care Services Plan Act of 1975 and the regulations promulgated thereunder, WIC Section 14450 and CCR, Title 22, Section 53260.

Cal MediConnect Three-Way Contract
2.14.2.1.2 The Contractor must maintain written records of all grievance activities, and notify CMS and DHCS of all internal grievances. The system must meet the following standards:

2.14.2.1.2.3 Response, electronically, orally or in writing, to each Enrollee grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the grievance

Section 1368(a)(5)
Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response.

Documents Reviewed:

- 16[9] standard grievance files (July 1, 2014 – June 30, 2015)

Assessment: The Plan's Cal MediConnect Three-Way Contract 2.14.2.1.1 requires that the Plan "maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits ... pursuant to the Knox-Keene Health Care Services Plan Act of 1975 and the regulations promulgated thereunder." The Plan's Cal MediConnect Three-Way Contract 2.14.2.1.2 requires the Plan to "maintain written records of all grievance activities ..." and provide a response to the grievance within thirty days from receipt of the grievance Section 1368(a)(5) requires the Plan to respond to grievances "with a clear and concise explanation of the reasons for the plan's decision."

The Department reviewed 15 standard Cal MediConnect grievance files, which represents the universe of such files for the survey review period. The Department determined that the Plan's resolution letter did not include a clear and concise explanation for its decision in two (13 %) of the files, and that three (20 %) of the grievances were not adequately resolved by the Plan. In five (33%) of the files, the Department found that the Plan did not address all of the grievance issues.

The following case files exemplify these problems:

1) The resolution letter did not include a clear and concise explanation

- *File #14 (removed for privacy):* The enrollee called to check the status of a previously submitted grievance stemming from injury and damage related to transport by the Plan's vendor. The enrollee was not satisfied with the outcome and wanted compensation, stating that he continues to be in pain and had to go to two emergency rooms. Although the enrollee referenced a previously submitted grievance, no further documentation about that grievance was found in the file. The Plan sent a request for, and received, the enrollee's medical records. However, there was no documentation that described how the Plan used these records to render a decision. The only resolution documented was a referral to the vendor's legal department.

2) Grievances were not adequately resolved by the Plan

- *File #15 (removed for privacy):* The enrollee reported that the transportation driver arrived late and informed her that he had just been advised "last minute" to pick her up. The enrollee wanted the Plan to be aware of the issue and ensure that drivers are scheduled ahead of time. The resolution letter merely stated, "LogistiCare apologize [sic] for the inconvenience and we're sorry that your expectations were not met." However, the documentation included in the file did not demonstrate an effort by the Plan to

[9] 18 files were reviewed, however two files were duplicate files and therefore excluded. A third file was excluded as the file was still open and the grievance was not yet resolved.

investigate and address the enrollee's concerns that drivers are not scheduled ahead of time.

3) The Plan did not address all information related to the grievance

- *File #13 :* The enrollee complained that a supervisor with the Plan's transportation vendor was "very insensitive" and that the supervisor also provided the enrollee with incorrect information. The resolution letter did not contain any specific reference to a resolution of the complaint regarding the supervisor's "insensitive" behavior or misinformation. Instead, the Plan incorrectly invoked a confidentiality clause regarding the results of the investigation, stating, "we are required to keep any results or detail of any corrective actions ."

TABLE 8
Cal MediConnect Standard Grievance File Review Summary – Resolution Letters

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Standard Grievances	15	Clear and concise explanation	13 (87 %)	2 (13 %)
		Adequately resolve	12 (80 %)	3(20 %)
		Address all grievance issues	10 (67%)	5 (33%)

Conclusion: LA Care Cal MediConnect Three-Way Contract Sections 2.14.2.1.1 and 2.14.2.1.2 require the Plan to establish and maintain a grievance system under which enrollees may submit grievances. Section 1368(a)(5) requires that the Plan respond to enrollee grievances within 30 days with a clear and concise explanation of the reasons for the Plan's decision. The Plan's resolution letters did not consistently include clear and concise explanations of its decisions, and the Plan did not adequately resolve grievances nor address all information related to the grievances. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

QUALITY MANAGEMENT

Potential Deficiency #11: The Plan does not include monitoring and improvement of Long-Term Support Services (LTSS) in its Quality Improvement Program.

Contractual/Statutory/Regulatory Reference(s): Cal MediConnect Three-Way Contract **§** 2.16.3.2.6.; Cal MediConnect Three-Way Contract § 2.16.3.3.4

Cal MediConnect Three-Way Contract
2.16.3.2.6. Address all aspects of health care, including specific reference to Behavioral Health services and to LTSS, with respect to monitoring and improvement efforts, and integration with

physical health care. Behavioral Health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description as follows:
2.16.3.2.6.1. Address the roles of the designated physician(s), Behavioral Health clinician(s), and LTSS providers with respect to QI program;
2.16.3.2.6.2. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and
2.16.3.2.6.3. Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and grievances and utilization management.

Cal MediConnect Three-Way Contract
2.16.3.3.4. Evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to the DHCS and CMT. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and Behavioral Health services rendered, the effectiveness of LTSS, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan

Documents Reviewed:

- 2014 QI Program description and work plan
- 2015 QI Program description and work plan
- 2014 Quality Improvement Program Annual Report and Evaluation

Assessment: The Plan failed to demonstrate that it includes monitoring and improvement of LTSS services in its Quality Improvement Program. The Plan's Cal MediConnect Three-Way Contract 2.16.3.2.6 requires the Plan to "address all aspects of health care, including specific reference to Behavioral Health services and to LTSS…" The Plan may include LTSS in the QI description, or in a separate QI Plan referenced in the QI description. The Plan's 2014 program description included language to this effect:

> Collect and analyze data related to the goals and objectives and establish performance goals to monitor improvement including Long-Term Support Services (LTSS) Community Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and In-Home Support Services (IHSS) and Long-Term Care (LTC)/Skilled Nursing Facility (SNF) and other facilities through an organized committee structure.

There is no mention of non-emergency medical transportation or non-medical transportation (LTSS services) in the 2014 QI program description

The 2014 QI program evaluation contains no mention of LTSS performance goals, or monitoring. In interviews, staff indicated that they did not perform these activities. The Plan's Medical Director for Medicare stated that establishing performance goals proved difficult, so the Plan did not develop them. Data collection and analysis to establish performance goals for LTSS

remain in the 2015 program description; however, there is no current development of these data. Plan staff could provide no separate report or evidence that the QI Program encompasses LTSS, non-medical and non-emergency medical transportation.

Conclusion: The Cal MediConnect Three-Way Contract 2.16.3.2.6 requires the Plan to address all aspects of health care and includes specific reference to LTSS. Plan staff conceded that monitoring and improvement of LTSS was not conducted during the survey review period and is therefore not part of its Quality Improvement Program. Based on a review of Plan documents and staff interviews, the Department determined that the Plan did not include monitoring and improvement of LTSS in its Quality Improvement Program. Therefore, the Department finds the Plan in violation of this contractual requirement.

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE	
Jennifer Friedrich	Medical Survey Team Lead
Cindy Liu	Attorney
MANAGED HEALTHCARE UNLIMITED, INC.	
Erick Davis, MD	Utilization Management Surveyor
Betty Furhmann, RN	Utilization Management Surveyor
Roger Diemert, MD	Quality Management/Continuity of Care Surveyor
Gene Beed, MD	Quality Management/Continuity of Care Surveyor
Madeline Hommel	Availability & Accessibility Surveyor
Annalisa Almendras, Psy D	Member Rights Surveyor
Teresa Kries, PHA	Grievance and Appeals Surveyor

APPENDIX B. PLAN STAFF AND PROVIDERS

PLAN STAFF ATTENDEES: L.A. CARE HEALTH PLAN	
Judy Cua-Razonable	Director, MLTSS
Laura Jaramillo	Director, Product Management
Lenna Monte	Manager, Health Education
Linda Lee	Director, Medicare Performance Management
Linda Robles	Quality Management Specialist
Lynnette Hutcherson	Senior Director, Clinical Assurance
Malayan Boyd	Compliance Program Manager, Delegated Provider Audits, Reviews, and Oversight
Maria Casias	Manager, QI Accreditation
Maribel Ferrer	Senior Director, Member & Medi-Cal Services
Marie Mercado	Manager, Cultural & Linguistic Services
Marita Nazarian	Clinical Pharmacist
Mary Schamus	Senior Director, Business Process Improvement
Mike Shook,	Director, Quality Improvement
Murleen Ryder	UM Oversight & Compliance Specialist
Nai Kasick	Director, Health Education, Cultural & Linguistics Services
Nanci Fulbright	Utilization Management Liaison
Nicole Lehman	Director, Behavioral Health Operations
Nicole Moussa	Senior Pharmacy Support Supervisor
Paul Van Duine	Senior Director, Provider Network
Penny Tunney	Director, Credentialing
Phinney Anh	Senior Project Manager to CEO
Rafael Amezcua	Medical Director, Medicare
Rebecca Cristerna	Director, Call Center
Sean Scott	Director, Medicare Part D Business Operations
Sharon Parker-Martin	Director, Membership Accounting
Sharon Vickers	Senior Compliance Advisor, Program Integrity
Steven Goby	Associate Counsel IV
Susan Williams	Manager, Credentialing
Veronica Richardson	Privacy Officer
Wendy Magnacca	Director, Claims
Yana Paulson	Senior Director, Enterprise Pharmacy

APPENDIX C. LIST OF FILES REVIEWED

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

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Standard Grievances	18	The Plan identified a universe of 18 files during the review period. Based on the Department's File Review Methodology, all 18 files were reviewed.
UM Medical Necessity Denials	3	The Plan identified a universe of 3 files during the review period. Based on the Department's File Review Methodology, all 3 files were reviewed.
Health Risk Assessments/Individual Care Plans	75	The Plan identified a universe of 1,464 files during the review period. Based on the Department's File Review Methodology, a random sample of 75 files were reviewed.