DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

ROUTINE MEDICAL SURVEY

FINAL REPORT

SCRIPPS CLINIC HEALTH PLAN SERVICES, INC.

ISSUED TO PLAN: FEBRUARY 28, 2005
ISSUED TO PUBLIC: MARCH 10, 2005

Scripps Clinic Health Plan Services, Inc.
Final Report of Routine Medical Survey
February 28, 2005

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducts a medical survey of each licensed health care service plan at least once every three years in order to evaluate the Plan's compliance with the Knox-Keene Act in the areas of Grievances and Appeals, Access and Availability, Utilization Management, and Quality Management. The survey includes an on-site visit, review of documents, and interviews with Plan staff.

This report provides the final results of the Department's medical survey of Scripps Clinic Health Plan Services, Inc (the "Plan"), a full-service health plan that provides medical care services to commercial and Medicare enrollees. Because the Plan holds a limited license, the Access and Availability section was not reviewed. Headquartered in San Diego, the Plan services approximately 39, 769 enrollees. As a limited licensee, the Plan holds contracts with five full service health plans to provide medical services to enrollees. The Plan provides services through a contracted network of three provider groups that include 137 primary care physicians and 700 specialty physicians.

The Department found five (5) deficiencies in the *Grievances and Appeals* section. The Plan has implemented corrective action plans for three (3) deficiencies; however, two (2) deficiencies remain uncorrected at the time of the Final Report. The Plan requires additional time to implement revised policies and procedures. The following two deficiencies will be re-evaluated at the Follow-up Review:

- The Plan does not demonstrate compliance with handling and resolving enrollee grievances. [Section 1368(a)(1), Section 1368(a)(4)(A), Rule 1300.68(a), and Rule 1300.68(d)(1)]

- The Plan's grievance system does not track and monitor grievances received by the Plan and those entities with delegated authority to receive or respond to grievances. [Rule 1300.68(e)(1) and (2)]

The Department found three deficiencies in the area of *Utilization Management*, and all three deficiencies were fully corrected at the time of the Final Report.

The Department found two deficiencies in the *Quality Management* area and one deficiency was corrected at the time of the Final Report. The following deficiency will be re-evaluated at the time of the Follow-up Review:

- The Plan does not adequately 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. <u>This is a repeat deficiency</u>. [Rule 1300.70(a)(1)]

I. INTRODUCTION

The Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), Section 1380, requires the Department of Managed Health Care (the "Department") to conduct a medical survey of each licensed health care service plan at least once every three years. The medical survey is a comprehensive evaluation of the Plan's compliance with the Knox-Keene Act. The subjects covered in the medical survey are listed in Health and Safety Code Section 1380 and in Title 28 of the California Code of Regulations, Section 1300.80.[1]

Generally, the survey reviews the major areas of Grievances and Appeals, Utilization Management, Access and Availability, and Quality Management; however, the Plan holds a limited license and is exempt from access and availability requirements. The following specific categories were reviewed:

- Procedures for obtaining health care services;
- Procedures for reviewing and regulating utilization of services and facilities;
- Procedures to review and control costs;
- Peer review mechanisms;
- Design, implementation and effectiveness of the internal quality of care review systems;
- Overall performance of the Plan in providing health care benefits; and
- Overall performance of the Plan in meeting the health needs of enrollees.

The Department regards a Plan's Grievance and Appeals process as a core mechanism that enrollees can utilize to exercise their rights should there be a need to resolve problems with their health maintenance organization (HMO). The Department requires Plans to resolve all Grievances and Appeals received in a professional and expeditious manner. This requirement is pursuant to the Knox-Keene Health Care Service Plan Act of 1975, beginning at Section 1368, and the corresponding regulations promulgated pursuant to the Act under Title 28 of the California Code of Regulations, beginning at Rule 1300.68.

The Department's continued efforts in ensuring that enrollees have the ability to exercise their rights was demonstrated with the further additions to the Grievance and Appeals regulations which were enacted as of February 2003. The Department is vigorously enforcing these regulations in order to ensure that enrollees are able to obtain the services to which they are legally entitled.

The Final Report summarizes the findings of the medical survey of Scripps Clinic Health Plan Services, Inc. (the "Plan"). The on-site review of the Plan was conducted on October 25, 26, and 27, 2004 at the Plan's administrative office in San Diego. The Exit Conference with the Plan was conducted on October 27, 2004.

[1] References throughout this report to "Section ____" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as amended [California Health and Safety Code Section 1340 *et seq*. ("the Act"). References to "Rule ____" are to the regulations promulgated pursuant to the Act [Title 28 of the California Code of Regulations, beginning at Section 1300.43. ("the Rules")].

As part of the survey process, the survey team conducted interviews and examined documents at the Plan 's administrative office in San Diego. The names of the survey team members are listed in Appendix A. The names and titles of persons who were interviewed at the Plan are listed in Appendix B. Appendix C contains a list of acronyms along with its definitions used throughout the report. Appendix D includes all applicable statutes and regulations used as the basis for each deficiency.

The Preliminary Report of the survey findings was sent to the Plan on December 20, 2004. All deficiencies cited in the Preliminary Report required follow-up action by the Plan. In addition to requiring follow-up actions, the Department may also take other actions in regards to violations, including enforcement actions. The Plan was required to submit a response to the Preliminary Report within forty-five (45) days of receipt of the Preliminary Report. The Plan submitted its response in a timely manner on February 3, 2005.

The Final Report contains the survey findings as they were reported in the Preliminary Report, a summary of the Plan's Response and the Department's determination concerning the adequacy of the Plan's Response. The Plan is required to file any modification to the Exhibits of the Plan's licensing application as a result of the Plan's corrective action plans as an Amendment with the Department. If the Plan wishes to append its response to the Final Report, please notify the Department before March 10, 2005.

Any member of the public wanting to read the Plan's entire response and view the Exhibits attached to it may do so by visiting the Department's office in Sacramento after March 10, 2005. The Department will also prepare a Summary Report of the Final Report that shall be available to the public at the same time as the Final Report.

One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's Response can be obtained from the Department at cost. The Final Report to the public will be placed on the Department's website: http://www.dmhc.ca.gov/library/reports/med_survey.

The Plan may file an addendum to its Response anytime after the Final Report is issued to the public. Copies of the addendum also are available from the Department at cost. Persons wanting copies of any addenda filed by the Plan should specifically request the addenda in addition to the Plan's Response.

Pursuant to Health and Safety Code Section 1380(i)(2), the Department will conduct a Follow-up Review of the Plan within eighteen (18) months of the date of the Final Report to determine whether deficiencies identified by the Department have been corrected. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1).

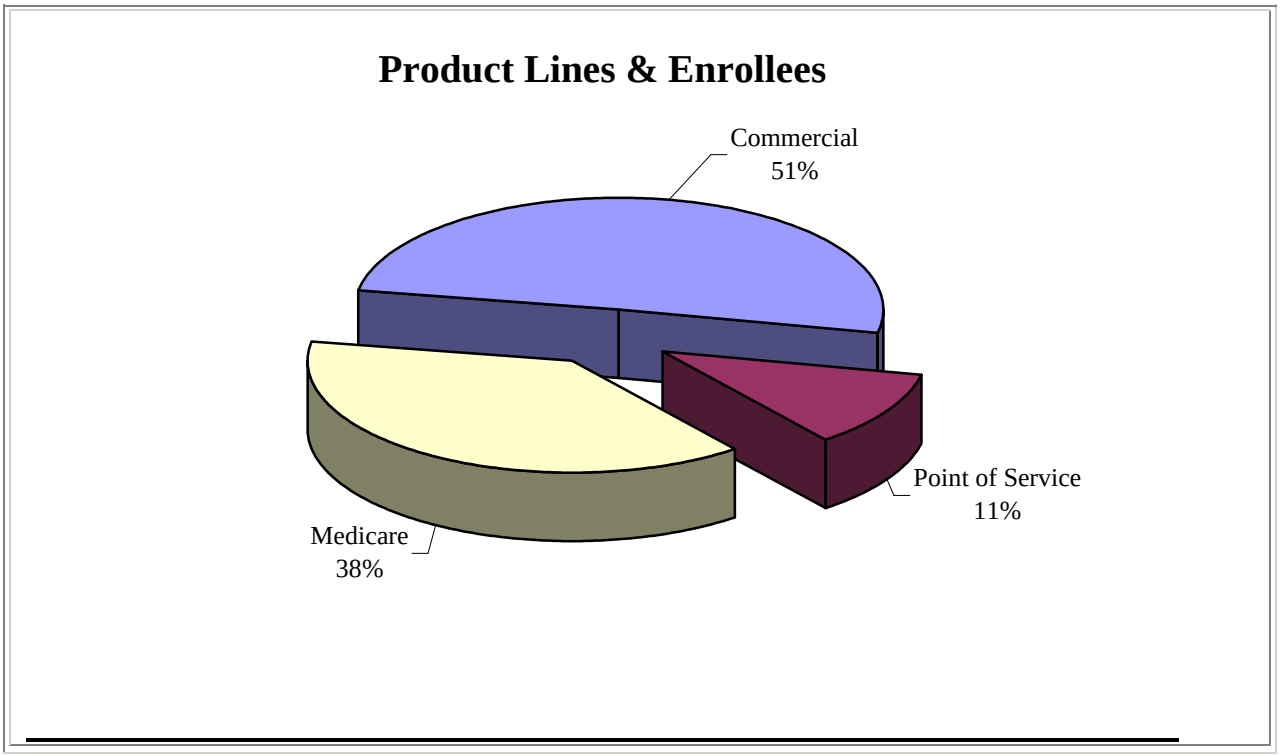
Preliminary and Final Reports are "deficiency" reports; that is, the reports focus on deficiencies found during the medical survey. Only specific activities found by the Department to be in need of improvement are included in the report. Omission from the report of other areas of the Plan's performance does not necessarily mean that the Plan is in compliance with the Knox-Keene Act.

The Department may not have surveyed these activities or may not have obtained sufficient information to form a conclusion about the Plan's performance.

II. OVERVIEW OF PLAN OPERATIONS AND HEALTH CARE DELIVERY SYSTEM

The following summary is based on information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire:

Date Plan Licensed	April 7, 1999	
Type of Plan	Full service with a limited license	
For-Profit/Non-Profit Status	For Profit	
Service Area(s)	San Diego County	
Number of Physicians	**Primary Care Physicians**	**Specialty Physicians**
	137	700
Number of Affiliated Medical Groups	❑ Penn Elm Medical Group ❑ Scripps Clinic Medical Group ❑ Scripps Mercy Medical Group	
Number of Enrollees as of Date of Survey	**Product Line**	**Enrollees**
	Commercial	20,072
	Point of Service	4,441
	Medicare	15,256
	Total	39,769



A. Organizational Background and Structure

The Plan is a full service health plan with a limited license that provides medical services to enrollees. As a limited licensee, the Plan holds contracts with five (5) full service health plans to provide medical services to enrollees.

B. Delivery Model

Enrollees belonging to one of the five contracted full service health plans will select one of the three (3) provider groups for the provision of medical services. The Plan also contracts with two additional provider groups for specialty services. The contracted full service health plans pay the Plan a fixed, capitated amount based upon the number of enrollees assigned to each of the three provider groups. Except for primary care, emergency care, and obstetrical/gynecological (OB/GYN) services, enrollees are required to obtain valid treatment authorization prior to receiving specialty care services.

Arrangements for Obtaining Specialty Care

The Plan operates on a delegated group network model for delivery of specialty care services for Penn Elm Medical Group only. The Plan makes arrangements to provide specialty care services for the remaining two medical groups. The Plan contracts with independence practice associations/medical groups (IPA/MG), which establish reimbursement methodology with their contracted specialists. Enrollees access specialty care through the Plan, except for Penn Elm Medical Group.

Arrangements for Obtaining In-patient Care

The Plan contracts with fourteen (14) hospitals in San Diego County to provide inpatient care. Generally, the enrollee's primary care provider (PCP) obtains prior authorization for all planned inpatient hospital admissions and inpatient skilled nursing facility admissions from the contracted provider organization with which they are affiliated. The Plan's contracted full service health plans are responsible for out-of-area hospital services.

Arrangements for Obtaining Emergency Services

Members are also covered, without prior authorization, for emergency services in those cases where a prudent layperson acting reasonably, would have believed that an emergency medical or psychiatric condition existed. Enrollees may go to any hospital in the event of an emergency. If an enrollee has an urgent problem but is unsure if there is an emergency, the enrollee is encouraged to call their provider group for advice and direction.

Risk Assumption for Health Care Services

The Plan capitates its provider groups for all professional, diagnostic, outpatient therapies, and behavioral health. The following table presents the distributions of risk for the primary services for shared and full risk group.

SERVICES	Plan	Shared Risk	IPA/ MG	Contracted Plans
PRIMARY CARE			X	
SPECIALTY CARE			X	
IN-PATIENT HOSPITAL (includes in-patient pharmacy, diagnostics and ancillary services)		X Per Diem		
OUT-PATIENT PHARMACY				X
EMERGENCY SERVICES				X
LABORATORY SERVICES			X	
DIAGNOSTIC SERVICES			X	
ALLIED HEALTH SERVICES			X	
SKILLED NURSING		X		
HOME HEALTH		X		
HOSPICE		X Per Diem		
OTHER (DESCRIBE)				
Chiropractic				X
Vision				X
Mental Health		Per Diem		X

C. Delegated Functions and Plan Oversight Activities

The Plan delegates Utilization Management (UM) functions to Penn Elm Medical Group only. The Plan also delegates credentialing functions to UCSD and CSSD only. Prior to delegation, the Plan conducts an initial assessment of the provider group to ensure organizational structure and policies and procedures are in place to perform each delegated function. The Plan conducts delegation oversight audits annually to ensure delegated provider groups are in compliance with regulatory and Plan standards.

Additionally, the Plan conducts facility site reviews every three years at the time of recredentialing of all primary care and high-volume specialty providers. The Plan also conducts medical record audits annually for PCPs and at the time of recredentialing for high-volume specialists to oversee providers' record-keeping practices.

D. Plan Operational Functions

Grievance System:

The Plan's contracted full service health plans do not delegate grievance and appeals processing. All grievances and appeals are processed and resolved by the member's full service health plan, not the Plan. The Plan provides information to the full service health plan to help resolve the member grievance (i.e. patient records). The Plan retains policies and procedures to resolve grievances in the event the contracted full service health plans delegate that function to the Plan.

Utilization Management:

The Plan's Board of Directors has ultimate responsibility for the quality and cost effectiveness of the Utilization Management Program (UM Program). The Board delegates this responsibility to the Plan's Healthcare Operations Oversight Committee, which delegates the implementation of the UM Program to the Utilization Management/Quality Improvement Committee and the Green Hospital Utilization Management Committee. Various components of the UM Program include review of treatment authorization requests, discharge planning, case management, behavioral health, referral management, second opinions, emergent care, delegation, and technology assessment. The Plan delegates the review and determination of treatment authorization requests to Penn Elm Medical Group only. The Plan annually reviews the delegate's UM Program, policies and procedures, letter templates, and member files. The Plan also conducts an on-site review and approval of delegation status every three years.

Quality Management:

The Plan's Board of Directors has ultimate authority and responsibility of the Plan's Quality Improvement Program (QI Program). This responsibility is delegated to the Plan's Healthcare Operations Oversight Committee and the Utilization Management/Quality Improvement Committee. The Plan's Medical Director oversees the development and implementation of the QI Program and the Associate Medical Director participates in developing the QI Program, QI Work Plan, Credentialing Program and annual evaluation. The Plan's UM/QI Manager develops

and coordinates the operational components of the QI Program. The Plan's QI Program comprises of four (4) committees, including, but not limited to, the Board of Directors, Healthcare Operations Oversight Committee, Utilization Management/Quality Improvement Committee, and Credentialing Review Panel. Additional QI activities include risk management, member and provider satisfaction surveys, facility site reviews, medical record reviews, peer review, and delegation oversight.

III. SUMMARY OF DEFICIENCIES

The following section contains the status of the deficiencies based on the Department's review of the Plan's Response to the Preliminary Report. Unless otherwise noted for the deficiencies that are listed as Not Corrected, the Department found that although the Plan had initiated corrective actions in response to their deficiencies, the Plan has not had enough time during the forty-five day response period to provide sufficient evidence that it has effectively implemented the corrective actions. At the time of the Follow-up Review[2], the Department will review and report on the current status of the Plan's correction of those deficiencies.

For any deficiency where the Department finds that the Response to the Corrective Action Plan is insufficient to correct the deficiency, further Remedial Action may be required and will be noted by the Department below. In these cases, (which is noted by *REMEDIAL ACTION REQUIRED*), the Plan will be required to submit the requested information to the Department within thirty days from the date of the Final Report.

Please refer to Section IV of this the Final Report for specific discussion on the status of all deficiencies listed below:

GRIEVANCE SYSTEM

Deficiency 1: The Plan's grievance system does not allow (A) standard grievances to be resolved within thirty calendar days, (B) grievances to be filed at least 180 calendar days, and (C) multiple levels of grievance review to be completed within thirty calendar days. [Section 1368(a)(1), Section 1368.01(a), Rule 1300.68(a), Rule 1300.68(a)(4)(A), and Rule 1300.68(b)(9)] **– *CORRECTED***

Deficiency 2: The Plan's grievance system does not allow for (A) urgent grievances to be resolved within three calendar days and (B) the Department to contact the Plan regarding the urgent grievance twenty four hours per day, seven days per week. [Section 1368.01(b), Rule 1300.68.01(a)(2), and Rule 1300.68.01(b)(1)] – ***CORRECTED***

Deficiency 3: The Plan's grievance letters and complaint form fail to include the correct DMHC language. [Section 1368.02(b)] **– *CORRECTED***

Deficiency 4: The Plan does not demonstrate compliance with handling and resolving enrollee grievances. [Section 1368(a)(1), Section 1368(a)(4)(A), Rule 1300.68(a), and Rule 1300.68(d)(1)] **– *NOT CORRECTED***

[2] Section 1380(i)(2) (2) No later than 18 months following release of the final report required by subdivision (h), the department shall conduct a follow-up review to determine and report on the status of the plan's efforts to correct deficiencies. The department's follow-up report shall identify any deficiencies reported pursuant to subdivision (h) that have not been corrected to the satisfaction of the director.

Deficiency 5: The Plan's grievance system does not track and monitor grievances received by the Plan and those entities with delegated authority to receive or respond to grievances. [Rule 1300.68(e)(1) and (2)] **– *NOT CORRECTED***

UTILIZATION MANAGEMENT

Deficiency 6: The Plan does not include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or clinical guidelines used, and the clinical reasons for the decisions regarding clinical necessity on communications regarding denial, delay, or modification of a request for health care services. [Section 1367.01(h)(4)] **– *CORRECTED***

Deficiency 7: The Plan does not provide appropriate oversight for the delegation of utilization management functions. The Plan does not ensure its delegated provider group reimburses providers for emergency services provided to its enrollees. [Section 1367.01(a), Section 1371.4(b) and (c)] **– *CORRECTED***

Deficiency 8: The Plan does not ensure the criteria/guidelines used to make medical necessity determinations are developed with the involvement from actively participating health care providers with sound clinical processes and are evaluated and updated, if necessary, at least annually. [Section 1363.5(b)(1)(2)(3)] **– *CORRECTED***

QUALITY MANAGEMENT

Deficiency 9: The Plan's Board of Directors and QA committees have inadequate oversight of QA program responsibilities. [Rule 1300.70(b)(2)(C)] **– *CORRECTED***

Deficiency 10: The Plan does not adequately 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. <u>This is a repeat deficiency</u>. [Rule 1300.70(a)(1)] **– *NOT CORRECTED***

IV. DISCUSSION OF DEFICIENCIES, FINDINGS, AND CORRECTIVE ACTIONS

GRIEVANCE SYSTEM

Deficiency 1: The Plan's grievance system does not allow (A) standard grievances to be resolved within thirty calendar days, (B) grievances to be filed at least 180 calendar days, and (C) multiple levels of grievance review to be completed within thirty calendar days. [Section 1368(a)(1), Section 1368.01(a), Rule 1300.68(a), Rule 1300.68(a)(4)(A), and Rule 1300.68(b)(9)]

Discussion of Findings:

The Department reviewed the Plan's *#1211 Member Grievance Resolution* policy and procedure dated January 28, 2003. The following procedures outlined in this policy fail to meet regulatory requirements:

- *Standard grievance resolution timeframe*: The Plan's policy initially states on pages 1 and 2 that grievances are appropriately addressed within thirty calendar days as mandated by the Department. However, page 11 of the same policy states the total timeframe for grievance resolution is within twenty-five (25) working days from receipt of the grievance. The Department found twenty-five working days does not equal thirty calendar days and thus does not meet the requirements pursuant to Section 1368.01(a) and Rule 1300.68(a).

- *Grievances to be filed at least 180 calendar days*: The Plan's policy does not allow enrollees to file grievances for at least 180 calendar days following an incident or action that is the subject of the enrollee's dissatisfaction. The Plan's policy does not include this provision pursuant to Rule 1300.68(b)(9).

- *Multiple levels of grievance review*: Page 10 of the Plan's policy states that if the enrollee is not satisfied with the complaint resolution, they have the right to request reconsideration. The policy further states that all requests for reconsideration of a grievance resolution will be immediately forwarded to the member's full service health plan for consideration. The Department found this procedure fails to specify that all levels of grievance review shall be completed within thirty calendar days pursuant to Rule 1300.68(a)(4).

Finally, the Department found the Plan's *Member Grievance Resolution* policy dated January 28, 2003 has not been filed with the Department for review and approval pursuant to Section 1368(a)(1). The Plan's Compliance Officer confirmed that this policy and procedure has not been filed.

Corrective Action Plan 1:

The Plan shall submit a revised grievance system policy and procedure that allows standard grievances to be resolved within thirty calendar days, enrollees to file grievances for at least 180 calendar days following the incident or action that is subject of the complaint, and for multiple levels of grievance review to be completed within thirty calendar days.

The Plan shall file the revised grievance system policy and procedure with the Department's web portal as an amendment to its license pursuant to Section 1352(a).

Plan's Compliance Efforts 1:

The Plan's Response to the Preliminary Report dated February 3, 2005 states the Plan holds a limited Knox-Keene license and is not delegated for appeals and grievances by the contracted full service plans. The full service plans are responsible for resolving all appeals and grievances. In the past, the Plan has worked with the full service plans to ensure all records and other necessary information has been forwarded to the full service plans to ensure resolution within the timeframes mandated by the Department.

The Plan revised its *#1211 – Member Grievance Resolution* policy and procedure to reflect the following:

- Standard grievances are to be resolved within thirty calendar days.
- Enrollees are allowed to file grievances for at least 180 calendar days following the incident or action that is subject of the complaint.
- For multiple levels of grievance review, completion of the review is to be resolved within thirty calendar days.

The Plan's Utilization Management/Quality Improvement Committee (UM/QIC) approved the updated policy on January 6, 2005 and subsequently on January 18, 2005 due to additional changes to the policy. The Plan's Health Care Operations Oversight Committee (HCOOC) approved this policy on January 27, 2005. In addition, the Plan's UM and QI staff was educated on the revisions to the policy on January 28, 2005. The Plan's Response includes a copy of the *Staff Education Policies and Procedures* sign-in sheet to document Plan staff were educated on revised policies and procedures.

Finally, the Plan filed the redlined and clean versions of the revised policy as Exhibit W-1 through the Department's web portal on February 3, 2005.

Department's Finding Concerning Plan's Compliance Effort 1:

STATUS: CORRECTED

The Department found the Plan's compliance efforts adequately address this deficiency by the forty-five day response. No further information is required at this time.

Deficiency 2: The Plan's grievance system does not allow for (A) urgent grievances to be resolved within three calendar days and (B) the Department to contact the Plan regarding the urgent grievance twenty four hours per day, seven days per week. [Section 1368.01(b), Rule 1300.68.01(a)(2), and Rule 1300.68.01(b)(1)]

Discussion of Findings:

The Plan's *#1211 Member Grievance Resolution* policy and procedure dated January 28, 2003 states the following regarding the Plan's process to resolve urgent grievances:

> *"(b) The QI Coordinator prepares a case assessment and obtains all necessary medical records and other supporting documentation within two (2) working days of receipt. [Requests for records and/or provider or staff input will be noted as URGENT and must be returned to the QI Coordinator within 24 hours of receipt.]"*
>
> *"(d) Cases involving complex or questionable issues are referred to the Associate Medical Director of QI for consideration no later than the end of the second working day following grievance receipt."*
>
> *"(e) No later than the fourth working day following grievance receipt, the QI Coordinator, in conjunction with the Associate Medical Director of QI, will implement the appropriate corrective action, and the QI Peer Review Database will be updated accordingly."*
>
> *"(f) Within one (1) working day of resolution of the issue, the QI Coordinator will send a letter to the member outlining the results of investigation."*

The Department found the above process does not allow for urgent grievances to be resolved within three calendar days pursuant to Section 1368.01(b) and Rule 1300.68.01(a)(2). The Plan's use of "working days" fails to ensure urgent grievances will be resolved within three calendar days, especially if the urgent grievance is received before a weekend or holiday.

Additionally, the Plan's *Member Grievance Resolution* policy fails to include procedures for Plan staff to be available for the Department to contact regarding urgent grievances twenty-four hours per day, seven days per week pursuant to Rule 1300.68.01(b). The Plan's grievance policy fails to specify that during normal working hours, the Plan shall respond to the Department within thirty minutes and within one hour during non-work hours after initial contact from the Department. Also, the Plan's policy does not specify a Plan representative with authority to act on the Plan's behalf to resolve urgent grievances and to authorize the provision of health care services without first having to obtain approval from supervisors within the Plan pursuant to Rule 1300.68.01(b)(1).

Corrective Action 2:

The Plan shall submit revised grievance system policy and procedure that allows for urgent grievances to be resolved within three calendar days of receipt of the urgent grievance. The revised policy and procedure shall also allow for the Department to contact the Plan regarding urgent grievances twenty-four hours per day, seven days per week, including responding to the Department within thirty minutes during working hours and within one hour during non-working hours after initial contact from the Department. Finally, the Plan's revised policy and procedure shall specify the Plan representative(s) with authority to act on the Plan's behalf to resolve urgent grievances and to authorize the provision of health care services without first having to obtain approval from supervisors within the Plan.

The Plan shall file the revised grievance system policy and procedure with the Department's web portal as an amendment to its license pursuant to Section 1352(a).

Plan's Compliance Efforts 2:

The Plan's Response to the Preliminary Report dated February 3, 2005 states the Plan revised its *#1211 – Member Grievance Resolution* policy and procedure to reflect the following:

- The Plan shall ensure that urgent grievances are resolved within three calendar days of receipt of the urgent grievance.

- The Plan is available twenty-four hours a day, seven days per week for the resolution of urgent grievances should the Department need to contact the Plan. The Plan will respond to the Department within thirty minutes during working hours and within one hour during non-working hours after initial contact from the Department.

- The Plan's revised policy and procedure states that Plan representative(s) with authority to act on the Plan's behalf to resolve urgent grievances and to authorize the provision of health care services without first having to obtain approval from supervisors within the Plan are available twenty-hour hours per day, seven days per week.

The Department may contact the Plan 1-888-680-2273, which is listed with the Department's HMO Help Center. The Plan's business hours are 8:00 a.m. to 5:00 p.m. Calls made to this line during business hours are answered by one of the Plan's Member Relations Specialists. After business hours, a greeting is played which instructs the Department on how to obtain assistance with an urgent grievance. Plan staff to be contacted by the Department will be the Plan's Medical Director or UM/QI Manager. They will have the authority to act on the Plan's behalf to resolve urgent grievances and to authorize the provision of health care services.

The Plan's UM/QIC approved the revised policy and procedure on January 6, 2005 and subsequently on January 18, 2005 due to additional changes. The Plan's HCOOC approved the revised policy on January 27, 2005. Additionally, the Plan's UM and QI staff was educated on the revised policy for twenty-four hours per day, seven days per week coverage for urgent grievances. The Plan's Response includes a copy of the *Staff Education Policies and Procedures* sign-in sheet to document Plan staff were educated on revised policies and procedures.

Finally, the Plan filed the redlined and clean versions of the revised policy as Exhibit W-1 through the Department's web portal on February 3, 2005.

Department's Finding Concerning Plan's Compliance Effort 2:

STATUS: CORRECTED

The Department found the Plan's compliance efforts adequately address this deficiency by the forty-five day response. No further information is required at this time.

Deficiency 3: The Plan's grievance letters and complaint form fail to include the correct DMHC language. [Section 1368.02(b)]

Discussion of Findings:

The Plan's template grievance letters include the following information regarding the enrollee's right to file a grievance with the Department:

> *"If you feel your complaint has not been handled properly, you have the right to file a grievance with your health plan. The California Department of Managed Health Care is responsible for regulating health care service plans. The department's Health Plan Division has a toll-free telephone number **(1-800-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Services toll-free telephone numbers **1-800-735-2929 (TTY) or 1-888-877-5387 (TTY)** to contact the department. The department's Internet website (http://www.hmohelp.ca.gov**)** has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at **(**insert plan number**)** and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law."*

The Department found the above language fails to include the correct and updated information pursuant to Section 1368.02(b). The correct language is as follows:

> *"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."*

Corrective Action Plan 3:

The Plan shall submit a corrective action plan to ensure the Plan provides enrollees with correct and updated information on how to contact the Department. The Plan shall submit a revised grievance template letters and complaint form that includes the correct Department language pursuant to Section 1368.02(b).

The Plan shall file the revised grievance template letters and complaint form to the Department's web portal as an amendment to its license pursuant to Section 1352(a).

Plan's Compliance Efforts 3:

The Plan's Response to the Preliminary Report dated February 3, 2005 states the Plan updated its *#1211 – Member Grievance Resolution* policy to include a monthly audit of grievance cases to ensure members receive proper correspondence that includes the appropriate Department language. Any file deficiencies will be discussed with the QI Coordinator and the audit results will be taken to the UM/QIC on a quarterly basis.

The Plan's UM/QIC approved the revised policy and procedure on January 6, 2005 and subsequently on January 18, 2005 due to additional changes. The Plan's HCOOC approved the revised policy on January 27, 2005. Additionally, the Plan's UM and QI staff was educated on the revised policy on January 28, 2005. The Plan's Response includes a copy of the *Staff Education Policies and Procedures* sign-in sheet to document Plan staff were educated on revised policies and procedures.

In addition, the Plan updated its grievance template letters and complaint form with the appropriate language as mandated by the Department. Since the Plan is a limited licensee, it does not have a website to provide grievance forms. The Plan filed on June 18, 2003 an exemption from the Department in relation to having a website. On June 19, 2003, the Plan received a fax from the Department stating that the filing was approved. The current complaint form used by the Plan is available to Plan members in the lobby of the Plan's administrative offices, via fax, by email, or by mail upon request.

Finally, the Plan filed the redlined and clean versions of the revised policy as Exhibit W-1 through the Department's web portal on February 3, 2005. The Plan also filed redlined and clean versions of the grievance template letters and complaint form as Exhibit W-2 through the Departments web portal.

Department's Finding Concerning Plan's Compliance Effort 3:

STATUS: CORRECTED

The Department found the Plan's compliance efforts adequately address this deficiency by the forty-five day response. In addition, the Department's review of the Plan's revised template letters found it is not clear if the revised Department language is in twelve-point font pursuant to Section 1368.02(b). Please ensure the required Department language is in twelve-point font. No further information is required at this time.

Deficiency 4: The Plan does not demonstrate compliance with handling and resolving enrollee grievances. [Section 1368(a)(1), Section 1368(a)(4)(A), Rule 1300.68(a), and Rule 1300.68(d)(1)]

Discussion of Findings:

The Plan's pre-survey materials state that the Plan has a limited Knox-Keene license and is not delegated for appeals and grievances by the contracted full service plans. Plan staff indicated that the Plan's contracted full service plans process and resolve all member complaints. When the enrollee contacts the full service plan to file a complaint, the contracted health plan asks the Plan to submit information to assist in processing and resolving the grievance (i.e. copies of patient records).

The Department reviewed thirty (30) grievances. Of these files, twenty (20) grievances were received by the enrollee's full service plan. Upon request, the Plan provided the enrollee's full service health plan with the information needed to resolve the complaints. Of the remaining ten (10) grievances reviewed, the enrollees contacted the Plan regarding their grievance. Of these ten cases, the Plan issued resolution letters to five (5) enrollees. However, the Department did not find evidence that the Plan issued any acknowledgement letters within five calendar days pursuant to Rule 1300.68(d)(1). In addition, the Department is not clear on (A) why the Plan issued resolution letters when grievances are handled by the Plan's contracted full service plans, not the Plan and (B) why the Plan issued resolution letters to complainants, but not acknowledgement letters.

During Department interviews, the Plan's QI/UM Manager stated that the contracted full service health plans do not accept member grievances from the Plan. Rather, the enrollee must contact their full service health plan to file a grievance. In order for the contracted full service health plan to accept grievances from the Plan, the Plan must submit a consent form or release statement signed by the member stating the Plan may act on the member's behalf to file a grievance. Pursuant to Rule 1300.68(a)(3), a complainant is the person who files a grievance including the enrollee, a representative designated by the enrollee, or other individual with

authority to act on behalf of the enrollee. Therefore, the Department found this process of obtaining a signed consent form from the member presents a barrier to processing and resolving the grievance.

At the time of the medical survey, the Plan did not provide any documentation received from the contracted full service health plans that requires the Plan to obtain signed consent in order to file a grievance on behalf of the member (i.e. policy and procedure, letter, contract language, etc). In addition, the Plan was unable to clarify which of the five contracted full service health plans provided the Plan with these grievance instructions. Therefore, the Department found that the Plan's grievance process does not meet Department requirements pursuant to Section 1368(a)(1) and Rule 1300.68(a)(3).

Corrective Action 4:

The Plan shall submit a corrective action plan to ensure the Plan's process for handling and resolving member grievances meets Department requirements. The Plan's corrective action plan shall include the following:

- Acknowledgement letters are issued to complainants within five calendar days of receipt of the grievance.
- The Plan may act on the enrollee's behalf in submitting grievances to the contracted full service health plans without any barriers in accessing the grievance process.
- Revised policies and procedures to include the Plan's process to forward member grievances to contracted full service health plans for review and resolution.
- Documentation that each of the five contracted full service health plans instructed the Plan to obtain signed consent from the member to act on the member's behalf in filing a grievance.

Plan's Compliance Efforts 4:

The Plan's Response to the Preliminary Report dated February 3, 2005 states the Plan revised its *#1211 – Member Grievance Resolution* policy to ensure the following:

- An acknowledgement letter will be sent within five calendar days of receipt of the grievance. A copy of the grievance acknowledgement letter will be kept in the member's grievance file.
- An audit will be conducted on a monthly basis to ensure compliance with the above. The Plan's QI Supervisor will discuss any file deficiencies with the QI Coordinator.
- Results of the audit will be presented to the UM/QIC on a quarterly basis.

The Plan's UMQIC approved the revised policy and procedure on January 6, 2005 and subsequently on January 18, 2005 due to additional changes. The Plan's HCOOC approved the

revised policy on January 27, 2005. Additionally, the Plan's UM and QI staff was educated on the revised policy on January 28, 2005. The Plan's Response includes a copy of the *Staff Education Policies and Procedures* sign-in sheet to document Plan staff were educated on revised policies and procedures.

Additionally, the Plan filed the redlined and clean versions of the revised policy as Exhibit W-1 through the Department's web portal on February 3, 2005.

Furthermore, the Plan sent a letter to each of the contracted full service plan on January 19, 2005 asking that they instruct the Plan on how they want grievances to be handled since they do not delegate grievances to the Plan. The Plan's Response includes a copy of this letter. The Plan proposed the following to each full service plan:

- If the Plan receives a phone call, the Plan will do a three-way call with the full service plan to transfer the patient and allow the patient to present their issue. The Plan would participate in the call to determine any resolution necessary on the Plan's part.

- If the Plan receives a written request, the Plan would collect the pertinent information and forward the grievance to the full service plan. The Plan would need to follow-up with the full service plan to track that the grievance was resolved within the appropriate time frame.

The Plan's letter states that the full service plans acknowledge that they would like grievances handled this way or provide an alternate method to the Plan by January 31, 2005. To date, the Plan received responses from two full service plans. Should the Plan not receive responses from the remaining full service plans, the Plan will proceed with the above outlined process.

Finally, with respect to having a signed consent form from the member in order to resolve a grievance, the Plan feels the above process meets Department regulations and the need of helping the member resolve the grievance in a timely fashion.

Department's Finding Concerning Plan's Compliance Effort 4:

STATUS: NOT CORRECTED

The Department found the Plan's compliance efforts do not adequately address this deficiency by the forty-five day response. The Plan requires additional time to implement revised policies and procedures. At the time of the Follow-up Review, the Plan shall provide evidence of forwarding member grievances to the contracted full service plans for resolution. No further information is required at this time.

Deficiency 5: The Plan's grievance system does not track and monitor grievances received by the Plan and those entities with delegated authority to receive or respond to grievances. [Rule 1300.68(e)(1) and (2)]

Discussion of Findings:

Page 1 of the Plan's *#1211 Member Grievance Resolution* policy and procedure dated January 28, 2003 states the following regarding the monitoring of grievances:

> *"Quarterly summary reports will be submitted to the Quality Improvement Committee (QIC), the SCHPS Healthcare Operations Oversight Committee and the Board of Directors for evaluation of improvement opportunities."*

Page 30 of the Plan's *2004 Quality Improvement Program Description* (QI Program) states the following regarding grievances:

> *"SCHPS will maintain a process for resolving enrollee and provider grievances and complaints. The QI Department will have overall responsibility for maintaining and updating grievance policies and procedures; review and evaluation of the operations and results of the grievance process; review and assessment of trended data for identification and implementation of care, service, and/or process improvements; and for the utilization of any emergent patterns of grievances in the formulation of policy and procedure changes."*

The Plan submits the *QI/UM Performance Reports* to the Board of Directors on a quarterly basis, which include the volume of grievance cases the Plan worked on in conjunction with the contracted full service plans. The Department reviewed the *QI/UM Performance Reports* from first quarter 2003 through second quarter 2004. These reports include the volume of grievances for each of the following categories: access, internal invoices, care, external claims, physician network, service, and utilization management. The Department found the Plan's grievance reports include the ratio of grievances received for each category and not the total number of grievances received in each category pursuant to Rule 1300.68(e)(2).

Additionally, the Plan also reports the total number of appeals and the percentage of appeals upheld and overturned in the *HMO Coalition/UM Quarterly Reports*. The Department reviewed the *HMO Coalition/UM Quarterly Reports* from first quarter 2003 through second quarter 2004 that were reviewed by the Plan's UM/QIC and the HCOOC. The Plan's *QI/UM Performance Reports* also do not distinguish the number of medical necessity denials versus non-covered benefits pursuant to 1300.68(e)(2). The category "utilization management" represents UM appeals received at the contracted full service plans and forwarded to the Plan for assistance. It is not clear if this category represents those disputes regarding both medical necessity and non-covered benefit denials or only medical necessity denials.

Furthermore, the Plan's pre-survey materials state the Plan is not delegated by the contracted full service plans to process and resolve member grievances. While the Plan does not maintain grievance and appeals files, the Plan is still required to track and trend grievances and appeals received by the Plan or any entity with delegated authority to receive or respond to grievances. The Plan's UM/QI Manager stated that the Plan does not receive grievance reports from the full service plans. The Department found the Plan's grievance reports only include those grievance cases worked in conjunction with the contracted full service plans. The Department is not clear on the number and type of grievances the contracted full service plans received that were not

processed in conjunction with the Plan. Therefore, the Plan's grievance reports do not reflect the total number of all grievances received by the full service plans regarding the Plan and/or contracted provider groups for the identification and implementation of care, service, or process improvement activities.

Corrective Action 5:

The Plan shall submit a corrective action plan to ensure the grievance system tracks and monitors grievances received by the Plan, including those entities with delegated authority to receive or respond to grievances. The Plan shall submit revised grievance reports that (A) include the total number and type of grievances received as opposed to ratios and (B) separate appeals regarding medical necessity from non-covered benefit. The Plan's corrective action plan shall also include a mechanism to track and trend grievance and appeals data provided by the contracting full service plans on a routine basis.

Plan's Compliance Efforts 5:

The Plan's Response to the Preliminary Report dated February 3, 2005 states the following:

- The Plan's *#1211 – Member Grievance Resolution* policy clearly outlines the process that is followed to ensure grievances received by the Plan are tracked and monitored. The Plan will report to the UM/QIC on a quarterly basis the types of grievances received by the Plan and will implement appropriate corrective action to ensure problems revolving around access, care and service are corrected. A report on those grievances received by the Plan was presented to the UM/QIC on January 18, 2005. The Plan's UM/QIC approved the revised policy and procedure on January 6, 2005 and subsequently on January 18, 2005 due to additional changes. The Plan's HCOOC approved the revised policy on January 27, 2005. Additionally, the Plan's UM and QI staff was educated on the revised policy for twenty-four hours per day, seven days per week coverage for urgent grievances. The Plan's Response includes a copy of the *Staff Education Policies and Procedures* sign-in sheet to document Plan staff were educated on revised policies and procedures. The redlined and clean versions of the policy were filed as Exhibit W-1 through the Department's web portal on February 3, 2005.

- The Plan has written a new policy and procedure *#1219 – Quality Improvement Activities Related to Appeals and Grievance Data from Full Service Health Plans*. It describes the Plan's procedure for obtaining appeals and grievance information from the full service plans, tracking and trending the information, and determining implementation of appropriate improvement activities surrounding the Plan's performance and service levels. The Plan's UM/QIC approved the new policy on January 6, 2005 and the HCOOC on January 13, 2005. A clean version of the policy has been filed as Exhibit W-1 through the Department's web portal on February 3, 2005.

- In relation to the above policy, on December 7, 2004 a letter was sent to each full service plan requesting that at least on a quarterly basis the Plan receives reports that give detailed information regarding appeals and grievances for Plan members for all three medical groups. Thus far, the Plan has received reports from three full service plans. A

letter was received from a fourth full service plan, which did not offer any substantial information regarding the Plan's appeals and grievances. The Plan is following-up to obtain more meaningful information. A second letter is being sent to ensure the remaining full service plan responds. The reports that were received from the three full service plans were reviewed at the UM/QIC meeting on January 18, 2005. In addition, the Plan's QI Supervisor presented a report on the Plan's grievance data to the UM/QIC on January 18, 2005.

- The Plan revised its grievance report at the Department's request to reflect the total number and type of grievances received as opposed to ratios. The Plan's Response includes a copy of the revised grievance report.

- The Plan evaluated its customer service database and found it difficult to identify grievances by medical necessity versus non-covered benefit based on the current method of entering member concerns. The Plan's UM and QI staff were trained on January 28, 2005 on how to accurately identify the different types of member grievances for correct entry into the system. The Plan's Response includes instructions for Plan staff on how to accurately enter different types of member grievances into the computer system.

Department's Finding Concerning Plan's Compliance Effort 5:

STATUS: NOT CORRECTED

The Department found the Plan's compliance efforts do not adequately address this deficiency by the forty-five day response. The Plan requires additional time to implement revised policies and procedures. At the time of the Follow-up Review, the Plan shall provide evidence that (A) quarterly grievance reports are received by contracted full service plans, (B) quarterly grievance reports are reviewed by appropriate Plan committee(s), and (C) appeal reports separate the number of medical necessity appeals from non-covered benefit. No further information is required at this time.

UTILIZATION MANAGEMENT

Deficiency 6: The Plan does not include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or clinical guidelines used, and the clinical reasons for the decisions regarding clinical necessity on communications regarding denial, delay, or modification of a request for health care services. The Plan does not consistently provide to the requesting provider the name and direct telephone number of the health care professional responsible for the determination. [Section 1367.01(h)(4)]

Discussion of Findings:

The Department reviewed a sample of ten (10) emergency room denial files and found that seven (7) of the files failed to include a description of the criteria or guidelines used to deny, delay, or

modify a request for emergency health care services. For each of the enrollees listed above the Plan's denial letter stated:

> *"An emergency service is a service needed immediately due to acute symptoms (including pain) which a reasonable person feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health. Medical records do not support that the presenting symptoms meet the above definition of emergency. Use of non-Plan providers in a non-emergency situation is not payable by [XXXXX] health plan."*

The Department found the above language does not meet the requirements pursuant to Section 1367.01(h)(4). There was no description of the criteria used, no description as to how the criteria was applied to each individual case, and no indication as to how each denial failed to meet the criteria.

Additionally, the Department found seven (7) of the ten (10) emergency room denial letters to the member include the name and telephone number of the enrollee's full service health plan and information on the member's right to appeal the decision. The letters are copied to the providers and do not contain the name and direct telephone number of the health care professional responsible for the denial decision pursuant to Section 1367.01(h)(4).

Corrective Action 6:

The Plan shall submit a corrective action plan to provide evidence that it consistently:

- Uses clinical criteria or guidelines in the denial, delay, or modification of health care service requests;
- Includes in its communications a description of the criteria or guidelines used to deny, delay, or modify a request for emergency health care services;
- Communicates to the enrollee and requesting provider in writing, a description of the criteria used and the specific clinical reasons for the denial of emergency services; and
- Includes in its written communications to the requesting provider the name and direct telephone number of the health care professional that made the denial, delay, or modification decision.

Plan's Compliance Efforts 6:

The Plan's Response to the Preliminary Report dated February 3, 2005 states that following the on-site medical survey in October 2004, the Plan implemented a corrective action plan with the delegated provider group, which required secondary review by the Plan's Medical Director of all emergency related authorizations before final determination. The corrective action plan also de-delegated this provider group in relation to review of appeals related to emergency related services. At the UM/QIC on November 16, 2004, the decision was made by the Medical Directors of all three medical groups to start automatically approving all emergency related

authorizations and claims effective immediately. Therefore, the Plan will not issue any denial letters for emergency related services.

Additionally, the Plan's Response states that when the Plan generates a denial letter from the UM department to the provider, it does include the Medical Director's name and phone number that rendered the decision. The Plan's Response includes a sample denial letter that includes the Plan's Medical Director's name and direct telephone number.

Department's Finding Concerning Plan's Compliance Effort 6:

STATUS: CORRECTED

The Department found that the Plan's compliance efforts adequately address this deficiency by the forty-five day response. No further information is required at this time.

Deficiency 7: The Plan does not provide appropriate oversight for the delegation of utilization management functions. The Plan does not ensure its delegated provider group reimburses providers for emergency services provided to its enrollees. [Section 1367.01(a), Section 1371.4(b) and (c)]

Discussion of Findings:

The Department reviewed the Plan's 2003 and 2004 UM Program Descriptions and policy and procedure *#835 – Delegation of Utilization Management Activities,* which outline the Plan's requirements for a provider group or contractor to be granted delegation status for UM activities. The policy and procedure states that the UM activities delegated to contracted entities are assessed, monitored and evaluated annually by the Plan.

Page 1, third paragraph in policy and procedure #835 – *Delegation of Utilization Management Activities* states the following:

> "*The Contractor who has received a delegation determination for any SCHPS MCO UM or Credentialing activities is obligated to continuously adhere to the standards which are in accordance with SCHPS MCO's standards. SCHPS MCO will perform an initial, and ongoing annual, on-site audit of Contractor to assure compliance with standards, and to assure that the care provided by the Contractor is based on professionally recognized standards of practice. Failure t adhere to the standards may result in the recommendation to rescind the delegation determination for UM and/or credentialing activities."*

Page 2, Section 3-C of the same policy states:

> *"SCHPS MCO may take appropriate corrective action if oversight of the UM and/or Credentialing Programs indicates that such action is warranted. Corrective actions will be determined and pursued by the SCHPS MCO QI and UM Committees and their subcommittees. This action may include, but is not*

> *limited to, termination of the delegation agreement between SCHPS MCO and the Contractor, in which case providers associated with the Contractor will be subject to SCHPS MCO's internal UM and QI programs."*

Page 6, Section 10 of the Plan's *Scripps Clinic Health Plan Services Utilization Management Delegation Agreement* states the following:

> *"Provide written notification to the Contractor of serious problems concerning the provision of UM services. Review Contractor's action plan for appropriateness and increase audit frequency of Contractor's performance to ensure compliance with the action plan. If such serious problems cannot be corrected within thirty (30) days of notice by SCHPS MCO the Contractor, SCHPS MCO may terminate the agreement as described in Policy and Procedure #835 – Delegation of UM Activities."*

The Plan's policy *#812- Emergency Room Claims Review* states the following:

> *"The reviewer will apply the 'prudent layperson standard' for all Emergency Room record review. The NCQA definition of a 'prudent layperson' is: The prudent layperson is considered to be a person who without medical training and who draws on his/her practical experience when making a decision regarding whether emergency medical treatment is needed. A prudent layperson will be considered to have acted 'reasonably' if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary."*

The Plan delegates UM functions to one provider group only. The Department reviewed a sample of ten (10) emergency room claims denials for this provider group from October 2003 to July 2004 and found five (5) out of ten emergency room visits were denied inappropriately by the delegated provider group. The Department found these five emergency room visits met the Plan's "prudent layperson standard" and were medically necessary.

The Department found no evidence that the Plan's Medical Director and/or UM/QI Manager took any action against the provider group to correct this problem pursuant to Section 1367.01(a). The Plan's Board of Directors, HCOOC, and UM/QIC meeting minutes fail to include any discussion, analysis, or corrective action plan regarding inappropriate ER denials.

Additionally, the Plan conducted an annual delegation oversight audit on the delegated provider group for year 2003 and made five recommendations for improvement; however, none of these recommendations were related to denial of emergency room claims. Therefore, the Department found the Plan has inadequate oversight of delegated UM activities. The Plan does not take corrective action to improve UM deficiencies identified from the Plan's delegation oversight activities.

Corrective Action 7:

The Plan shall submit a corrective action plan to ensure monitoring of delegated UM activities to comply with the Plan's standards. The Plan's procedure shall include, but not be limited to, timeframes for corrective action and follow-up, as well as levels of sanctions for continued non-compliance. The Plan's corrective action plan shall also include evidence that it consistently oversees the denials of emergency room services and denials always apply the "prudent layperson" definition for payment of emergency room claims.

Plan's Compliance Efforts 7:

The Plan's Response to the Preliminary Report dated February 3, 2005 states that immediately following the on-site medical survey in October 2004, the Plan's Medical Director contacted the delegated provider group's Medical Director regarding the situation surrounding the emergency room denials. The Plan's Medical Director informed the delegated provider group that a corrective action plan would be implemented which required secondary review by the Plan's Medical Director of all emergency related authorizations before final determination. The Plan's corrective action plan also de-delegated this provider group in relation to review of appeals related to emergency related services. At the UM/QIC on November 16, 2004, the decision was made by the Medical Directors of all three medical groups to start automatically approving all emergency related authorizations and claims effective immediately.

The Plan has taken the below steps to ensure all claims are approved automatically:

<u>Claims Department:</u>

- The Plan's Claims Manager was notified that effective immediately all emergency related claims should be paid automatically. A report was run to identify all emergency related claims that were in a pended status. Once the claims were identified they were paid.

- Certain policies and procedures were updated or deactivated due to the change in process.

- A memo was sent to all staff members and education was conducted on November 30, 2004 at a claims staff meeting.

<u>UM Department:</u>

- The Plan's UM/QI Manager notified the UM staff that all emergency related authorizations should be approved automatically effective immediately. Reports were run to identify any pending emergency authorizations. Once identified, the authorizations were approved.

- The following UM policies were updated or deactivated due to the change in process regarding auto approval of emergency related claims:

  # 804 – Retrospective Authorization Review – Updated
  # 812 – Emergency Room Claims Review – Deactivated

 # 813 – ER Claim Review Discrepancy Resolution – Deactivated
 # 846 – Call Slips for Emergency Room Visits – Deactivated

The UM policies were taken to the UM/QIC for review and approval on January 18, 2005. They were also taken to the HCOOC on January 27, 2005 for review and approval. Staff education was conducted on January 28, 2005 regarding changes to the above listed policies. The Plan's Response includes copies of meeting minutes and a copy of the *Staff Education Policies and Procedures* sign-in sheet to document Plan staff were educated on revised policies and procedures.

In addition, policy *#835 – Delegation of Utilization Management Activities* was updated to include language that clarifies timeframes for corrective action and follow-up, as well as levels of sanctions for continued non-compliance. The policy was distributed via email to the UM/QIC. Special approval was needed for the policy in order to file it in a timely manner with the Department. The Plan asked the committee members to respond via email in order to suggest changes to the policy or to approve it. The approval needed by committee members was received and is on file. The Plan filed redlined and clean versions of the policy as Exhibit J-9 through the Department's web portal on February 3, 2005.

Department's Finding Concerning Plan's Compliance Effort 7:

STATUS: CORRECTED

The Department found that the Plan's compliance efforts adequately address this deficiency by the forty-five day response. No further information is required at this time.

Deficiency 8: The Plan does not ensure the criteria/guidelines used to make medical necessity determinations are developed with the involvement from actively participating health care providers with sound clinical processes and are evaluated and updated, if necessary, at least annually. [Section 1363.5(b)(1)(2)(3)]

Discussion of Findings:

The Plan's 2004 UM Program Description states the Plan utilizes clinical guidelines and criteria based on professionally recognized standards of practice that are developed and/or adopted, approved by the UM/QIC, and are subject to annual review. The criteria and guidelines include, but are not limited to, Milliman and Robertson, Interqual Severity of Illness/Intensity of Service guidelines, clinical guidelines provided by the full service health plans, and clinical guidelines developed by Scripps Clinic Specialties.

The Plan's policy *#833 –Annual Review of Criteria for Utilization Review* outlines the process for the annual review of UM criteria as stated below:

"……..the SCHPS Medical Director and the Authorization Review Panel will review and update the criteria annually. Bi- annually the Utilization

> *Management Department will submit criteria developed by the Scripps Clinic Specialty division to the appropriate division for review and update. The use of nationally recognized and health plan criteria will be approved annually by the Utilization Management Committee as defined in the UM Program Description. In addition, the reviewed criteria will be presented to the UMC for approval."*

The Plan's *2004 Annual Utilization Work Plan* states the Plan uses criteria approved by the full-service health plans and is reviewed annually by the Plan. The Work Plan also states the Plan's UM/QIC reviewed and approved UM criteria in February 2004.

The Department reviewed the Plan's UM/QIC meeting minutes dated January 28, 2003; May 26, 2003; March 26, 2004; and June 17, 2004 and found there was no discussion regarding the criteria or guidelines used by the Plan to determine whether to authorize, modify, or deny requested health care services pursuant to Section 1363.5(b). The Plan's UM/QIC meeting minutes also do not document review and approval of the clinical guidelines utilized by the full service health plans. The Department did not find evidence that the UM/QIC met in February 2004 as stated in the 2004 Work Plan. In addition, there was no evidence that the Plan's participating providers are involved in the guideline development process.

Corrective Action 8:

The Plan shall develop a corrective action plan that ensures the clinical guidelines used by the Plan to determine whether to authorize, modify, or deny requested health care services are evaluated and updated at least annually. The Plan's corrective action plan shall ensure a process that includes the involvement of actively participating health care providers in the review and approval of the Plan's clinical criteria and guidelines. The Plan's corrective action plan shall also include a process or evidence of adopting clinical criteria and guidelines used by contracted full service health plans at least annually.

Plan's Compliance Efforts 8:

The Plan's Response to the Preliminary Report dated February 3, 2005 states the Plan developed a new policy and procedure *#879 – Use of FSHP Criteria for Utilization Review*. It states that the Plan will obtain and use the full service plan or Medicare criteria when determining whether to authorize, modify, or deny requested health care services. The Plan's Response includes copies of attestations dated January 31, 2005 to each contracted full service plan verifying annual review of their criteria and that they include the involvement of actively participating health care providers in the review and approval of clinical criteria and guidelines. In addition, the Plan deactivated several policies that would no longer apply since the Plan is using the full service plan or Medicare criteria.

Furthermore, the Plan's Response states the updated policy was taken to and approved by the UM/QIC on January 18, 2005 and the HCOOC on January 27, 2005. In addition, the Plan's UM and QI staff was educated on the revisions to the policy on January 28, 2005. The Plan's Response includes copies of meeting minutes and a copy of the *Staff Education Policies and Procedures* sign-in sheet to document Plan staff were educated on revised policies and procedures.

Finally, the clean version of the policy has been filed as Exhibit J-9 through the Department's web portal on February 3, 2005.

Department's Finding Concerning Plan's Compliance Effort 8:

STATUS: CORRECTED

The Department found that the Plan's compliance efforts adequately address this deficiency by the forty-five day response. No further information is required at this time.

QUALITY MANAGEMENT

Deficiency 9: The Plan's Board of Directors and QA committees have inadequate oversight of QA program responsibilities. [Rule 1300.70(b)(2)(C)]

Discussion of Findings:

Page 7, Section IV of the Plan's 2004 QI Program Description states the following regarding authority and accountability of the Plan's QI Program:

> *"The SCHPS Board of Directors has ultimate accountability for the oversight and effectiveness of the QI Program. The Board has delegated authority for QI Program implementation and planning to the Healthcare Operations Oversight Committee. The Healthcare Operations Oversight Committee has delegated responsibility for QI Program implementation to the Utilization Management/Quality Improvement Committee (UMQIC). The UMQIC is responsible for ongoing monitoring, evaluation, and improvement of the QI Program."*
>
> *"The Board of Directors reviews and approves the QI Program and QI work plan at least annually and at the time of any revision. The Board receives, at a minimum, a quarterly summary of all QI activities, including findings and actions taken by the UM/QI Committee. An annual QI Program evaluation is also prepared and submitted to the Board for review."*

Section V of the Plan's 2003 and 2004 QI Program Descriptions state the UM/QIC provides quarterly reports to the HCOOC, who, in turn, provides quarterly reports to the Board. Also, the QI Program Descriptions state the UM/QIC meets at least quarterly, schedules additional meetings as required, and provides quarterly reports to the HCOOC.

First, the Department reviewed the Plan's Board of Directors meeting minutes dated February 10, 2003; March 26, 2003; July 8, 2003; December 1, 2003; March 3, 2004, and June 3, 2004. The Board minutes for the September 2, 2004 meeting were not available for review at the time of the on-site survey. The Department found the Plan's Board did not review reports on QA activities on a quarterly basis pursuant to Rule 1300.70(b)(2)(C). In year 2003, the Department

did not find evidence that the Plan's Board reviewed any QA activity reports until the December 1, 2003 meeting, where at this meeting the Board reviewed the QI/UM Performance Reports for first, second, and third quarters 2003. The Department found this type of frequency in reporting does not allow the Board to oversee the QI Program, including any findings and actions taken on an ongoing basis. The Plan's Board minutes dated March 3, 2004 and June 3, 2004 document review of the fourth quarter 2003 and first quarter 2004 QI/UM Performance Reports, respectively. Nevertheless, the Department is citing this deficiency based on past performance.

Second, the Department reviewed the Plan's HCOOC bi-weekly meeting minutes from January 16, 2003 through October 14, 2004. The Department found the Plan's UM/QIC did not provide quarterly reports to the HCOOC as specified in the Plan's 2004 QI Program Description. The Plan's HCOOC minutes document the following:

HCOOC Meeting Date	QI Reports Presented
January 16, 2003	No QI report presented
January 23, 2003	No QI report presented
February 13, 2003	No QI report presented
February 27, 2003	No QI report presented
March 6, 2003	No QI report presented
March 27, 2003	No QI report presented
April 3, 2003	No QI report presented
May 1, 2003	No QI report presented
May 15, 2003	No QI report presented
May 29, 2003	No QI report presented
June 12, 2003	No QI report presented
June 26, 2003	No QI report presented
July 10, 2003	No QI report presented
July 24, 2003	No QI report presented
August 21, 2003	***First and second quarter 2003 HMO Coalition Reports***
September 4, 2003	No QI report presented
September 18, 2003	No QI report presented
October 2, 2003	No QI report presented
October 16, 2003	No QI report presented
October 30, 2003	No QI report presented
November 20, 2003	***Third Quarter 2003 HMO Coalition Report and Year 2003 UM/QI Performance Report***
January 15, 2004	No QI report presented
January 22, 2004	Approved 2004 UM Program and Work Plan
February 5, 2004	No QI report presented

HCOOC Meeting Date	QI Reports Presented
March 4, 2004	***2003 Utilization Quarter Report Annual Evaluation***
April 22, 2004	No QI report presented
May 13, 2004	Approved the 2004 QI Program Description
May 27, 2004	No QI report presented
June 10, 2004	No QI report presented
June 24, 2004	No QI report presented
July 22, 2004	No QI report presented
August 19, 2004	***Reviewed denial letter audit and inter-rater reliability physician audit results for first quarter 2004***
September 2, 2004	No QI report presented
September 30, 2004	No QI report presented
October 14, 2004	No QI report presented

The Department found the Plan's HCOOC has inadequate oversight of QI activities. In year 2003, the Plan's HCOOC did not review any QI activity reports until August 21, 2003. At this meeting, the HCOOC reviewed the first and second quarter 2003 HMO Coalition Reports. Again, the frequency of reporting is not adequate to review and identify any quality issues on a quarterly basis as stated in the Plan's QI Program Description. In addition, the Plan's HCOOC only reviewed QI activity reports for year 2003 on August 21, 2003, November 20, 2003, and March 4, 2004. The HCOOC minutes do not document any review of quarterly QI activity reports for any activities occurred in year 2004, except for the denial letter and inter-rater reliability audit results. The Department did not find any documentation in the HCOOC minutes of any HMO Coalition Report (later renamed Utilization Quarter Report) or UM/QI Performance Report regarding first, second, and third quarter 2004 QI activities.

Third, the Department reviewed the Plan's UM/QIC meeting minutes dated January 28, 2003; May 26, 2003; March 26, 2004; and June 17, 2004. The Plan's UM/QIC minutes dated September 27, 2004 were not available for review at the time of the on-site survey. The Department found the Plan's UM/QIC did not meet on a quarterly basis to oversee their QI Program responsibilities pursuant to Rule 1300.70(b)(2)(C). The UM/QIC only met two times in year 2003. Also, at the January 28, 2003 meeting, the UMQIC decided to hold "virtual meetings" in which all materials would be mailed to committee members along with sign-off sheets where voting members can document requested revisions, sign for approval of voting items, and return the documentation to the Plan's UM/QI Manager. The virtual meeting concept was developed due to difficulty in obtaining adequate provider group representation at committee meetings. Beginning in June 2003, virtual meetings were held. The Department found the virtual meeting concept is not adequate and fails to meet the requirements pursuant to Rule 1300.70(b)(2)(C) because committee members, including participating providers, are not discussing, analyzing, and collaborating together as a body while reviewing various QI and UM reports, identifying any trends, and issuing any corrective action plans as needed.

The Department reviewed the UM/QIC meeting minutes dated March 26, 2004 and June 17, 2004, which were virtual meetings. The Department questions the accuracy and validity of the meeting minutes due to the following reasons:

- Minutes document the Plan's Medical Director, Associate Medical Director, UM/QI Manager, and five participating providers as being present at the meeting. However, because virtual meetings were held, these committee members were actually not present in person or via telephone to collaborate as a group to discuss various QI activities. Rather, participating providers signed and returned to the Plan various QI documentation that was reviewed individually, not in a group setting.

- Minutes document "*meeting called to order*" at the beginning and "*adjournment*" at the end. The Department questions why the Plan documents the meeting called to order and adjourned when actually no quorum was present and no meeting was actually held.

- Minutes fail to document any discussion, analysis, questions, or input from participating providers. The virtual meeting concept does not allow participating providers to provide feedback on various QI reports reviewed.

- The Department questions why the Plan's Medical Director signed the UM/QIC meeting minutes dated March 26, 2004 and June 17, 2004 when no actual meeting was held in March and June 2004.

Therefore, the Department found the Plan's UM/QIC did not meet on a quarterly basis in year 2003 and year-to-date 2004.

Corrective Action 9:

The Plan shall submit a corrective action plan to ensure adequate oversight of the QA program by appropriate Plan committees. The Plan's corrective action plan shall ensure the Plan's Board of Directors and other appropriate committees review QA activity reports on a quarterly basis. The Plan's corrective action plan shall also ensure the UM/QIC meets on a quarterly basis, including the removal of the "virtual meeting" concept.

Plan's Compliance Efforts 9:

The Plan's Response to the Preliminary Report dated February 3, 2005 states the UM/QIC began meeting monthly at the Plan's administrative office following the on-site medical survey in October 2004. Therefore, the Plan has removed the virtual meeting concept. The committee will continue to meet monthly, or more frequently if needed, until it feels it can transition to a quarterly schedule. The first meeting was held on November 16, 2004. The Plan's Medical Director asked the provider group Medical Directors to assign an alternate to attend the UM/QIC in their absence in order to ensure the Plan's UM/QIC has a consistent quorum. Results from the Department's medical survey have set forth action items for the UM/QIC. The action items have been documented in the Plan's 2005 QI Work Plan, which was approved by the UM/QIC on January 18, 2005 and by the HCOOC on January 27, 2005. The Plan's Response includes copies

of the UM/QIC meeting minutes dated November 16, 2004; January 6, 2005; and January 18, 2005.

The Plan's HCOOC continues to meet on a regular basis. The Plan's Response includes copies of HCOOC meeting minutes dated November 18, 2004; December 9, 2004; January 13, 2005; and January 27, 2005. The Plan's HCOOC minutes dated January 27, 2005 document review of the UM/QIC minutes dated November 16, 2004; January 6, 2005; and January 18, 2005. In the future, the HCOOC will review all UM/QIC meeting minutes to ensure adequate review of QI activities.

The Plan's Board continues to meet on a quarterly basis. The last Board meeting was held on November 30, 2004. The Plan's Medical Director presented the UM/QI Performance Report for third quarter 2004 along with other UM and QI information at this meeting. The Plan's Medical Director will continue to update the Board on activities that are being conducted to improve quality. The Plan's Response includes a copy of the November 30, 2004 Board minutes. In the future, the UM/QIC minutes will be taken to the Board for review on a quarterly basis. The Plan understands that although the Board had adequate oversight of UM and QI activities in year 2004, as noted by the Department, the Plan is being cited based on past performance.

Department's Finding Concerning Plan's Compliance Effort 9:

STATUS: CORRECTED

The Department found that the Plan's compliance efforts adequately address this deficiency by the forty-five day response. No further information is required at this time.

Deficiency 10: The Plan does not adequately 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. <u>This is a repeat deficiency</u>. [Rule 1300.70(a)(1)]

Discussion of Findings:

Pages 27 and 28 of the Plan's 2004 QI Program Description includes the following severity rating leveling system for potential quality issues:

Level	Description
Level 0	No quality of care issue.
Level I (A, B, C, and D)	Issues pertaining to medical record documentation (omission or non-completion), communication of patient perceptions of care and services.
Level II (A, B, and C)	Medical mismanagement with the potential for adverse effects on the patient.
Level III (A, B, and C)	Medical mismanagement with serious adverse effect on the patient

	(peer review required)
Level IV	The problem exists between the full service health plan and the patient, not a Plan issue.
Level V	Referred to peer review, acuity not finalized.

The Department reviewed the Plan's Primary Care Peer Review Committee minutes dated May 27, 2003; June 4, 2003; November 6, 2003; and July 9, 2004. This committee reviewed a total of four (4) peer review cases at these meetings, or one (1) case reviewed at each meeting. The Department found the Plan assigned inadequate severity levels in three (3) out of the four cases reviewed. The Plan's Primary Care Peer Review Committee minutes do not document any corrective action plan or future monitoring for the providers under review.

Additionally, the Department reviewed a total of thirty grievance files. Of the thirty grievance files reviewed, fifteen (15) cases were identified as quality of care issues. Of the fifteen quality of care grievances, the Department disagreed with the Plan's handling, resolution, and lack of follow-up for three (3) quality-related grievances.

The Department found this is a repeat deficiency from the Plan's Final Report dated March 11, 2002 and the Follow-up Report dated January 23, 2004. At the Final Report, the Plan's corrective action plan included revised work plan spreadsheets to clearly identify the quality issue or finding, the corrective action plan, the timeline to be completed, the results of the action taken, the parties to whom the findings were communicated, and the responsible party for monitoring the quality issue. At the Follow-up Review, the Plan's meeting minutes did not document review of various quality indicators on a periodic basis to identify any issues and develop corrective action plans as necessary, including results of member satisfaction surveys and access and availability monitoring activities. At this routine medical survey, the Department did not find any evidence of the Plan's committees or staff issuing corrective action plans and following-up on those corrective actions to ensure effective action is taken to improve care where deficiencies are identified and the follow-up is planned where indicated. Therefore, the Department found this as a repeat deficiency.

Corrective Action 10:

The Plan shall develop a corrective action plan to ensure quality of care 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 corrective action plan shall ensure that quality of care issues are assigned appropriate severity levels, that corrective action is taken against the provider or facility in question, and that follow-up is taken to ensure the quality problems are corrected.

Plan's Compliance Efforts 10:

The Plan's Response to the Preliminary Report dated February 3, 2005 states the Plan has finalized its 2005 QI Work Plan, which lists various QI activities for the year 2005. The 2005 QI Work Plan was reviewed and approved by the UM/QIC and HCOOC on January 18, 2005 and January 27, 2005, respectively.

The Plan's Response includes a copy of the revised policy and procedure *#1213 – Assignment of Acuity Level* to reflect that weekly audits will be conducted to ensure acuity levels are being assigned appropriately to all grievances. The policy also states that the Plan's QI Supervisor will run a monthly report of all Customer Service Requests identified as complaints for the purpose of identifying outliers and trends. The results will be presented to the UM/QIC on a quarterly basis. The Plan is in the process of developing the set of reports and database that will be used for the above process. The Plan expects to have its first set of results by the end of February 2005.

In addition, the Plan's UM and QI staff was educated on the revisions to the policy on January 28, 2005. The Plan's Response includes a copy of the *Staff Education Policies and Procedures* sign-in sheet to document Plan staff were educated on revised policies and procedures.

The Plan filed redlined and clean versions of the policy as Exhibit W-1 through the Department's web portal on February 3, 2005.

Furthermore, the Plan compiled a report that identifies the total amount of grievances received per provider. The report was compiled from the Plan's computer system and identifies grievance categories of access, care, and service for PCPs and specialists. The Plan's UM/QIC reviewed this report on January 18, 2005 and decided that the data was helpful in identifying areas for improvement, but could be improved. As a result, the data will be recaptured in a more meaningful format to be presented to the UM/QIC for further action.

Department's Finding Concerning Plan's Compliance Effort 10:

STATUS: NOT CORRECTED

The Department found that the Plan's compliance efforts do not adequately address this deficiency by the forty-five day response. The Plan requires additional time to implement revised procedures. At the time of the Follow-up Review, the Plan shall submit copies of audits results, complaint reports, and committee minutes to ensure acuity levels are being assigned appropriately for quality of care issues. No further information is required at this time.

V. OUTSTANDING DEFICIENCIES FROM FOLLOW-UP REPORT DATED JANUARY 23, 2004

QUALITY ASSURANCE PROGRAM

Deficiency 1: The Plan does not adequately document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. [Rule 1300.70(a)(1)] – *NOT CORRECTED*

As stated in Deficiency 10 above, the Department found this is a repeat deficiency from the Plan's Final Report dated March 11, 2002 and the Follow-up Report dated January 23, 2004. At the Final Report, the Plan's corrective action plan included revised work plan spreadsheets to clearly identify the quality issue or finding, the corrective action plan, the timeline to be completed, the results of the action taken, the parties to whom the findings were communicated, and the responsible party for monitoring the quality issue. At the Follow-up Review, the Plan's meeting minutes did not document review of various quality indicators on a periodic basis to identify any issues and develop corrective action plans as necessary, including results of member satisfaction surveys and access and availability monitoring activities. At this routine medical survey, the Department did not find any evidence of the Plan's committees or staff issuing corrective action plans and following-up on those corrective actions to ensure effective action is taken to improve care where deficiencies are identified and the follow-up is planned where indicated. **Therefore, the Department found this as a repeat deficiency**.

UTILIZATION MANAGEMENT

Deficiency 2: The Plan does not consistently communicate decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to providers within 24 hours of the decision. [Section 1367.01(h)(3)] – *CORRECTED*

Deficiency 5: The Plan has not established, as part of the quality assurance program for utilization review, a process that includes not only provisions for evaluation of complaints and assessment of trends, but also implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance. [Section 1367.01(j)] - *CORRECTED*

A P P E N D I X A

List of Surveyors

The Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Shelly Williams, M.H.A.	Associate Health Plan Analyst
Anne Potter, M.P.H.	Associate Health Plan Analyst
Lawrence Miller, M.D.	Medical Consultant

A P P E N D I X B

List of Staff Interviewed

The following are the key Plan officers and staff who were interviewed during the on-site survey at the Plan's administrative office on October 26 and 27, 2004.

SCRIPPS CLINIC HEALTH PLAN SERVICES, INC.	
Dan Dworsky, M.D.	Medical Director
Emily Awkerman, R.N.	UM/QI Manager
Maggie Moore, L.V.N.	UM/QI Supervisor
Denelle Bush	Manager of Customer Services
Colleen Luinenburg	Supervisor of Customer Services

A P P E N D I X C

List of Acronyms

ACRONYMS	DEFINITION
Board	Board of Directors or Governing Body
CAHPS	Consumer Assessment of Health Plans Survey
CAP	Corrective Action Plan
Department	Department of Managed Health Care
ER	Emergency Room
FSHP	Full Service Health Plan
GHUMC	Green Hospital Utilization Management Committee
HCOOC	Healthcare Operations Oversight Committee
HMO	Health Maintenance Organization
NCQA	National Committee on Quality Assurance
PCP	Primary Care Provider
Plan	Scripps Clinic Health Plan Services, Inc.
QI	Quality Improvement
QM	Quality Management
UM	Utilization Management
UM/QIC	Utilization Management/Quality Improvement Committee

A P P E N D I X D

Applicable Statutes and Regulations

The following are the specific citations used in this Final Report as the basis for the deficiencies identified by the Department.

GRIEVANCE SYSTEM

Deficiency 1: The Plan's grievance system does not allow (A) standard grievances to be resolved within thirty calendar days, (B) grievances to be filed at least 180 calendar days, and (C) multiple levels of grievance review to be completed within thirty calendar days. [Section 1368(a)(1), Section 1368.01(a), Rule 1300.68(a), Rule 1300.68(a)(4)(A), and Rule 1300.68(b)(9)]

Citations:

Section 1368(a)(1) states every plan shall 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.

Section 1368.01(a) states the grievance system shall require the plan to resolve grievances within 30 days.

Rule 1300.68(a) the grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system.

Rule 1300.68(a)(4)(A) states if the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.

Rule 1300.68(b)(9) states the grievance system shall allow enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the enrollee's satisfaction.

Deficiency 2: The Plan's grievance system does not allow for (A) urgent grievances to be resolved within three calendar days and (B) the Department to contact the Plan regarding the urgent grievance twenty four hours per day, seven days per week. [Section 1368.01(b), Rule 1300.68.01(a)(2), and Rule 1300.68.01(b)(1)]

Citations:

Section 1368.01(b) states the grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance.

Rule 1300.68.01(a)(2) states every plan shall include in its grievance system procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include a written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.

Rule 1300.68.01(b)(1) states each plan's grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department. The system established by the plan shall provide for the availability of a plan representative with authority on the plan's behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee's plan contract in a medically appropriate and timely manner. Such authority shall include making financial decision for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.

Deficiency 3: The Plan's grievance letters and complaint form fail to include the correct DMHC language. [Section 1368.02(b)]

Citation:

Section 1368.02(b) states 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 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 plan's telephone number, and the department's Internet 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."

Deficiency 4: The Plan does not demonstrate compliance with handling and resolving enrollee grievances. [Section 1368(a)(1), Section 1368(a)(4)(A), Rule 1300.68(a), and Rule 1300.68(d)(1)]

Citations:

Section 1368(a)(1) states every plan shall 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.

Section 1368(a)(4)(A) states every plan shall provide for a written acknowledgement within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgement 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.

Rule 1300.68(a) states the grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system.

(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.

(2) "Complaint" is the same as "grievance."

(3) "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

(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.

Rule 1300.68(d)(1) states a grievance system shall provide for a written acknowledgement within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgement will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance.

Deficiency 5: The Plan's grievance system does not track and monitor grievances received by the Plan and those entities with delegated authority to receive or respond to grievances. [Rule 1300.68(e)(1) and (2)]

Citations:

Rule 1300.68(e) states 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. The system shall:

(1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts. The system shall indicate whether an enrollee grievance is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) ac action filed or before a trial or appellate court; or (5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.

(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, (4) complaints about access to care (including complaints about the waiting time for appointments), (5) complaints about the quality of service, and (6) other issues.

UTILIZATION MANAGEMENT

Deficiency 6: The Plan does not include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or clinical guidelines used, and the clinical reasons for the decisions regarding clinical necessity on communications regarding denial, delay, or modification of a request for health care services. [Section 1367.01(h)(4)]

Citation:

Section 1367.01(h) states 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, every health care service plan subject to this section shall meet the following requirements:

(3) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services shall be communicated to the enrollee in writing, and to providers initially by telephone of facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. 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.

Deficiency 7: The Plan does not provide appropriate oversight for the delegation of utilization management functions. The Plan does not ensure its delegated provider group reimburses providers for emergency services provided to its enrollees. [Section 1367.01(a), Section 1371.4(b) and (c)]

Citations:

Section 1367.01(a) states every health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these

functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

Section 1371.4(b) states a health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

Section 1371.4(c) states payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

Deficiency 8: The Plan does not ensure the criteria/guidelines used to make medical necessity determinations are developed with the involvement from actively participating health care providers with sound clinical processes and are evaluated and updated, if necessary, at least annually. [Section 1363.5(b)(1)(2)(3)]

Citation:

Section 13653.5(b) states the criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

(1) Be developed with involvement from actively practicing health care providers.

(2) Be consistent with sound clinical principles and processes.

(3) Be evaluated, and updated if necessary, at least annually.

QUALITY MANAGEMENT

Deficiency 9: The Plan's Board of Directors and QA committees have inadequate oversight of QA program responsibilities. [Rule 1300.70(b)(2)(C)]

Citation:

Rule 1300.70(b)(2)(C) states the plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each

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

Deficiency 10: The Plan does not adequately 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. <u>This is a repeat deficiency</u>. [Rule 1300.70(a)(1)]

Citation:

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