

S T A T E O F C A L I F O R N I A

D E P A R T M E N T O F M A N A G E D H E A L T H C A R E

OFFICE OF HEALTH PLAN OVERSIGHT
DIVISION OF PLAN SURVEYS

FINAL REPORT OF THE ROUTINE MEDICAL SURVEY

SCRIPPS CLINIC HEALTH PLAN SERVICES, INC.

Issued to Plan: February 28, 2002

Issued to Public File: March 11, 2002



TABLE OF CONTENTS

	Page Number
SECTION I. Introduction & Survey Process	3
SECTION II. Overview of Organization and Health Care Delivery System	5
SECTION III. Summary of Deficiencies	12
SECTION IV. Summary of Plan's Efforts to Correct Deficiencies	12
SECTION V. Discussion of Deficiencies and Corrective Actions	13
Quality Assurance Program	13
Utilization Management	14
Appendix A List of Surveyors	21
Appendix B Plan Interview List	22
Appendix C Provider Interview List	23

SECTION 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 subjects of the survey fall into the following categories:

- 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:

This Final Report summarizes the findings of the medical survey of Scripps Clinic Health Plan Services, Inc. (the "Plan"). The Plan submitted pre-survey documentary information to the Department on September 17, 2001. The on-site review of the Plan was conducted on October 15-18, 2001.

As part of the survey process, the Department's survey team conducted interviews and examined documents at the Plan's administrative offices in San Diego, California and at the offices of Scripps Clinics, Scripps Encinitas Clinic and Penn Elm Medical Group. The names of the survey team members are listed in Appendix A. The titles of persons who were interviewed at the Plan and at each medical group are listed in Appendix B and C respectively. Medical groups are selected based upon any or a combination of the following factors: the number of Plan enrollees served by the group, the incidence of complaints/grievances filed by Plan enrollees, and the number of overturned appeals by the Plan per 1,000 Plan enrollees. The groups visited include:

Scripps Clinics
Scripps Encinitas Clinic
Penn Elm Medical Group, Inc.

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")].

This Final Report summarizes the findings of the medical survey of the Plan. If the Plan wishes to append its response to the Final Report, please notify the Department before March 11, 2002

The Preliminary Report of the survey findings was sent to the Plan on December 10, 2001. All deficiencies cited in the Preliminary Report required follow-up action by the Plan. The Plan was required to submit a response to the Preliminary Report within 45 days of receipt of the Preliminary Report. The Plan submitted its response on January 24, 2002.

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.

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, California after March 11, 2002. 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: www.dmhc.ca.gov.

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 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.

SECTION II. Overview of Organization 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 Health Plan with a limited license
For profit / Non-profit Status:	For Profit
Service Area(s):	San Diego County
Number of Primary Care Physicians:	163
Number of Specialty Physicians:	1,187
Number of Enrollees as of Date of Survey:	173,865 (as of Aug. 2001)

Commercial	125,675
Commercial POS	24,838
Medicare HMO	20,693
Health Net Medicare Supp	286
Medi-Cal HMO	2,373
Total	173,865

History and Organization Structure

Scripps Clinic Health Plan Services, Inc. (the "Plan") was established as a privately held for-profit Delaware corporation in October 1997 and received its limited Knox-Keene license in April 1999.

In 1997, The Plan's parent company, Scripps Clinic Physician Organization (SCPO), had wanted to enter into a full risk global service agreement with full service health plans—the HMOs. In order to do this, SCPO had to form a separate entity that would qualify for a Knox Keene license with waiver (limited license). Hence, in preparation for a limited license, SCPO created the Plan as a separate for-profit Delaware corporation in October 1997.

In April 1999, the Plan was granted a limited Knox Keene license by the California Department of Corporations. By January 2000, all managed care contracts were converted to global capitation agreements. Global capitation means the entity is paid a fixed rate for professional

and institutional services per member per month based on the number of assigned health plan enrollees.

In July 2000, Scripps Health bought SCPO, the parent company of the Plan via a merger agreement. Scripps Health is a California non-profit public benefit corporation and operates other entities that include the Scripps hospitals, Scripps Medical Foundation and Scripps Clinic Foundation. A management service agreement (MSO) exists between the Scripps entities and the Plan. Under such agreement, the Plan provides management services for two Scripps medical groups: (1) Scripps Clinic Medical Group (SCMG), a multi-specialty group and (2) Scripps Mercy Medical Group (SMMG), a primary care group. The Plan also provides management services for Penn Elm Medical Group (PEMG), an independent primary care group contracted by the Plan to provide professional services to enrollees who reside in the northeastern part of San Diego County.

The Plan also contracts with independent specialty physicians that include the University of California San Diego Medical Group (UCSDMG) as well as individual specialty practitioners. Primary care physicians of the three primary care groups are encouraged to use the specialists from Scripps Clinic Medical Group. UCSD specialists are utilized for services that are not available under Scripps Clinic.

The Plan contracts with full service health plans on a global capitation basis for commercial and senior products. The contracting full service health plans are Aetna, Blue Cross, Blue Shield, Cigna, HealthNet and PacifiCare. The Plan also contracts with full service health plans on a shared-risk basis for Medi-Cal products. These plans are Community Health Group, Universal Care, and HealthNet. The Plan is delegated by the full service health plans for the following managed care functions: (1) utilization management and (2) credentialing. The Plan performs UM for SMMG and SCMG. The Plan sub-delegates utilization management to PEMG. The Plan sub-delegates credentialing functions to its contracted specialty group, UCSDMG. The Plan provides oversight of these delegated functions. The Plan is not delegated to perform quality management and appeals/grievance functions by its contracted full service health plans.

Delivery Model

Scripps Clinic Health Plan Services, Inc., enrollees first enroll in a full service health plan. Then, they may either select a primary care physician (PCP) in the Plan network or select the Scripps Clinics without choosing a specific PCP. The full service health plan pays a fixed amount (“capitated”) based upon the number of enrollees to the Plan to provide global (institutional and professional) services for those enrollees. The Plan contracts with hospitals to provide hospital services. The primary care services are provided through three medical groups: SCMG, SMMG and PEMG. Specialty care is primarily provided by either a Scripps Clinic employed specialist or by a contracted specialist. Enrollees access all non-emergency health care services through their selected PCPs.

Contracting Providers/ Enrollment

The Plan has three contracting provider groups: (1) SCMG, a multi-specialty medical group, (2) SMMG, and (3) PEMG. SMMG and PEMG are primary care medical groups. The Plan contracts with 14 acute care hospitals for inpatient services, and 50 ancillary service providers located at over 70 locations.

Participating Medical Groups

Medical Group	Shared Risk	Full Risk	ENROLLMENT (as of Aug. 2001)
Scripps Clinic Medical Group	X		135,826
Scripps Mercy Medical Group	X		17,597
Penn Elm Medical Group	X		20,442
TOTAL			173,865 (100%)

Number Of Primary Care Practitioners

Type Of Practitioners	Number Of Practitioners	Estimated Percentage Of Enrollment
Scripps Clinic Medical Group	124	80%
Scripps Mercy Medical Group	19	8%
Penn Elm Medical Group	20	12%
TOTAL	163	100%

Number Of Specialty Care Practitioners

Type Of Practitioners	Number Of Practitioners	Estimated Percentage Of Enrollment
Scripps Clinic Specialty Care Physicians	357	N/A
Direct Contract Specialty Care Physicians	830	N/A
TOTAL	1,187	

Number Of Institutional And Ancillary Providers

Type Of Providers	Number In Network	Reimbursement Method
Acute Care Facilities/Hospitals	14	Per Diem
Sub-Acute Care Facilities	1	Per Diem
Skilled Nursing Facilities	20	Per Diem
Home Health Agencies	5	Per Diem
Free-Standing Ambulatory SurgiCenter	5	Per Diem
Other: ancillary (lab, DMEs, etc.)		

Arrangements for Specialty Care

Scripps Clinic has its own in-house specialty providers to provide specialty health care services to the Scripps Clinic enrollees. Enrollees in the other medical groups must obtain access to contracted specialists. Prior authorization for specialty referrals is required.

The Plan only manages behavioral health benefits for PacifiCare commercial and senior products and Health Net Senior products. The other contracted full service plan designated behavioral health providers manage the benefit for the enrollees. The behavioral health department at Scripps Clinic contracts with many of these designated behavior health providers.

Arrangements for In-patient Care

The Plan has per diem contracts with 14 acute care providers. Enrollees are directed to these hospitals by their PCPs or specialists. There is a hospitalist system where designated hospital physicians provide care for all adult enrollees admitted to the hospital.

Arrangement for Emergency Services

Enrollees may seek emergency care from any emergency provider without prior authorization. The Plan assumes risk for ER services within its service area (*in-area*) and, for certain full service plans, outside its service area (*out-of-area*). The remaining contracting health plans assume risk for out-of-area ER services.

Risk Assumption for Health Care Services (Who Pays?)

Generally, the Plan's risk arrangements with full service health plans and medical groups are described in the table below:

Risk Arrangements

Services	Full Service Health Plan	Plan	Medical Group
Primary Care			X
Specialty Care			X
In-Patient Hospital (Includes In-Patient Pharmacy, Diagnostics And Ancillary Services)		Shared	Shared
Out-Patient Pharmacy	X		
Mental Health	X		
Emergency Services (in-area and out-of-area)	X Varies by contract	X Varies by contract	X Varies by contract
Laboratory Services			X
Diagnostic Services			X
Allied Health Services			X
Nursing Home		Shared	Shared
Home Health		Shared	Shared
Hospice		Shared	Shared
Other (Describe)			
Chiropractic			X
Vision	X		
Mental Health	X		

Delegated Functions to IPA/MG:

The Plan has delegated the following responsibilities to contracted Medical Groups:

IPA/MG	Utilization Management/ Treatment Authorizations	Credentialing	Quality Assurance	Grievances & Appeals
Penn Elm Family Practice	Yes	No	No	No
UCSD Medical Group	No	Yes	No	No

Plan Oversight Activities

The Plan delegates responsibility for referral management (in-area referrals), prospective, concurrent and retrospective review, and discharge planning to PEMG (delegate). The delegate maintains a utilization management program, which is reviewed at least annually and updated as needed. The delegate maintains and annually reviews and updates utilization management criteria/guidelines consistent with professionally recognized standards of practice. In addition, the delegate maintains written policies and procedures consistent with Plan Utilization Management requirements.

The Plan conducts annual oversight audits using the National Independent Physician Association Coalition (NIPAC) tool. The Plan reviews and approves the delegate's utilization management program/plan and policies and procedures. The Plan generates monthly reports on delegate utilization activities, including denials, utilization trends for key indicators, turn around times and complaints. The Plan conducts joint operating committee meetings quarterly and maintains representation on the delegate's utilization management committee. The delegate's medical director sits on the Plan's utilization management committee.

Plan Audit:

The Plan performs scheduled audits for delegated utilization management and credentialing functions. UM oversight review was performed for PEMG within the last 12 months. Medical records of participating PCPs are audited at the time of re-credentialing and are not a part of Plan delegation oversight.

	AUDIT SCHEDULE
Utilization Management	Annual
Quality Assurance	N/A
Grievances	N/A
Credentials	Annual
Other: Medical Records	N/A

Access & Availability of Health Services

The Plan has established standards for the following:

Type of Services	Standard
Emergency Care	Immediately
Urgent Care	Within 24 hours
Non-urgent Care	Within 7 calendar days
Specialty Referral	Within 14 calendar days
Preventive Care	Within 30 days
Waiting Room Time	Less than 30 minutes
After-hours Care	24 hours/day by telephone
Telephone Access	24 hours/day by live operator or answering service; return call after-hours in fewer than 30 minutes
Call Wait Times	Answer in fewer than 4 rings or within 45 seconds (applies to all appointment scheduling and operational areas with direct patient interface)

SECTION III. Summary of Deficiencies

The Department of Managed Health Care's routine medical survey of the Plan has found the following deficiencies that the Plan is required to correct:

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)]

UTILIZATION MANAGEMENT

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

Deficiency 3: The Plan does not clearly specify the provisions in the contract that exclude that coverage when denials are based in whole or in part on a finding that the requested health care service is not a covered benefit. [Section 1368(a)(4)]

Deficiency 4: Plan communications to physicians and other health care providers of a denial, delay, or modification of a request do not include the name and telephone number of the health care professional responsible for the denial, delay, or modification. [Section 1367(h)(4)]

Deficiency 5: The Plan has not established a quality assurance process for utilization management 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)]

SECTION IV. Summary of Plan's Efforts to Correct Deficiencies

Upon review of the Plan's response to the Preliminary Report, the Department found that the following deficiency has been corrected:

Utilization Management Deficiency 4

Upon review of the Plan's response to the Preliminary Report, the Department found that although the Plan had initiated corrective actions in their deficiencies, full implementation of those actions and assessment of their effectiveness would require more than forty-five (45) days. They are as follows:

Quality Assurance: Deficiency 1

Utilization Management: Deficiency 2, 3, and 5

SECTION V. Discussion of Deficiencies and Corrective Actions

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)]

Rule 1300.70(a)(1), states in relative part, that 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.

Department Findings: The Plan provides all required quality of care and quality of service activities. The activities have benchmarks, goals, measurements, and results that are presented to the QM committee. Corrective actions are formulated, implemented, and results re-measured. However, documentation of the critical analysis of activities, particularly in the QI committee minutes is often lacking. The QI committee minutes fail to discuss and address QM activities and issues in a concise and consistent manner. The committee minutes do not demonstrate adequate QM Program oversight is being consistently practiced. Quality Assurance (QA) related issues and deficiencies and appropriate follow-up activities are not being addressed by the QI committee.

Corrective Action 1: The Plan shall demonstrate that it documents the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The minutes of the QI and QM Committees, and other committees responsible for QA/QI review, require additional documentation and detail and attention directed towards the Plan's Quality Management activities and issues that pertain to the Quality Management Program.

Plan's Response and Compliance Efforts 1:

The Plan stated its intention to redesign the QI committee meeting agenda and minutes to include work plan spreadsheets. These spreadsheets will clearly identify the quality issue or finding, the standard it should be measured against (if one exists), the corrective action plan, the timeline in which it is 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.

Time Frame for Corrective Action: June 2002

Department's Response to Plan's Compliance Efforts 1:

Not Corrected.

The Plan's proposed Corrective Action Plan (CAP) is not adequate to remedy the deficiency as requested. The Plan has not provided evidence that all corrective actions have been or are being implemented within the Plan's 45-day response period. The proposed Plan's implementation of the corrective action will take longer than 45-days to be accomplished.

The Plan has stated that it will implement improved documentation with the minutes of the April 2002 Quality Improvement/Utilization Management meeting.

The QI/UM joint committee had not yet met when the Plan submitted its response, so this corrective action has not taken place. The next quarterly QI/UM committee meeting will be conducted in April, 2002 where the new format will be discussed. Implementation of the proposed format will begin then. Therefore, this deficiency has not been corrected.

The Department will evaluate full implementation of the Plan's corrective actions during the Follow-up Review.

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)]

Section 1367.01(h)(3), states in relative part, that decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision.

Department Findings: Seven of eight (88%) denial files reviewed contained no evidence of communication of the decision to providers within 24 hours of the decision. Plan staff confirmed

that they do not have a process in place to communicate decisions to requesting providers within 24 hours of making the decision.

Corrective Action 2: The Plan shall demonstrate that it consistently communicates 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.

Plan's Response and Compliance Efforts 2

The Plan has stated that it is purchasing a software program to supplement its current system for notifying providers of utilization management decisions. The proposed "IDXFAX" product is a computer fax line that will fax the final determination to the provider at the time the final status entry is completed in the system. The proposed software had not yet been installed at the time of the Plan's response.

Time Frame for Corrective Action: March 2002

Department's Response to Plan's Compliance Efforts 2:

Not Corrected.

The Plan's proposed Corrective Action Plan (CAP) is not adequate to remedy the deficiency as requested. The Plan has not provided evidence that all corrective actions have been or are being implemented within the Plan's 45-day response period. The proposed Plan's implementation of the corrective action will take longer than 45-days to be accomplished.

The proposed IDXFAX product appears to meet the requirement to notify providers of utilization management decisions within 24 hours of making the decision. However, the Plan had not implemented this system at the time that it responded to the deficiencies.

The Department will evaluate full implementation of the Plan's corrective actions during the Follow-up Review.

Deficiency 3: The Plan does not clearly specify the provisions in the contract that exclude that coverage when denials are based in whole or in part on a finding that the requested health care service is not a covered benefit. [Section 1368(a)(4)]

Section 1368(a)(4), states in relative part, that if a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

Department Findings: The Plan's benefit denial letters do not specify the provisions in the contract that exclude that coverage. One denial file reviewed contained a letter with no language regarding the specific provisions in the contract that exclude that coverage. Plan staff acknowledged that none of the benefit denials ever made would cite the provisions in the contract to exclude coverage in the denial letters. The staff further stated that there is no process in place to include the contract language in benefit denial letters.

Corrective Action 3: The Plan shall demonstrate that it clearly specifies the provisions in the contract that exclude that coverage when denials are based in whole or in part on a finding that the requested health care service is not a covered benefit.

Plan's Response and Compliance Efforts 3:

The Plan stated that since it contracts with multiple full service health plans that have different evidences of coverage to which the Plan does not have direct access, the only alternative for commercial subscribers would be for the Plan to add language to the denial letter that refers the member to the evidence of coverage sent to the subscriber at the time of enrollment. The Plan also stated that it would inform the member that the member could obtain an updated evidence of coverage by calling the full service health plan directly. The Plan is required to follow the CMA scripts for its senior subscribers.

The Plan submitted a blank sample letter that did refer the member to the evidence of coverage from the member's health plan.

Time Frame for Corrective Action: January 2002

Department's Response to Plan's Compliance Efforts 3:

Not Corrected.

The Plan's proposed Corrective Action Plan (CAP) is not adequate to remedy the deficiency as requested. The Plan has not provided evidence that all corrective actions have been or are being implemented within the Plan's 45-day response period. The proposed Plan's implementation of the corrective action will take longer than 45-days to be accomplished.

The Department finds that the Plan's proposed alternative to inform members about non-covered services is inadequate. While the Department understands the difficulty of not having an ongoing access to updated, hard copy evidences of coverage for all products of all contracting full service health plans, the intent of the regulation is clear. The regulation ensures that all enrollees be adequately informed to understand the reason for denying, modifying and delaying requested health care services.

It the Plan's responsibility to ensure that the explanation provided to the enrollee is specific regarding the reason for the denial (i.e., if the denial is for a non-covered benefit the Plan is responsible for providing the benefit limitation).

Required Action

The Plan shall revise its Corrective Action Plan (CAP) to demonstrate that its written policies and procedures establish the process by which the Plan notifies plan enrollees of modified, delayed, or denied requests by providers of health care services, specifically addressing the Department's finding as described above.

The Department will evaluate the implementation and effectiveness of the Plan's revised Corrective Action Plan (CAP) to correct the deficiency during the Follow-up Review.

Deficiency 4: Plan communications to physician or other health care provider of a denial, delay, or modification of a request do not include the name and telephone number of the health care professional responsible for the denial, delay, or modification. [Section 1367(h)(4)]

Section 1367.01(h)(4), states in relative part, that 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.

Department Findings: The Plan's written communication does not provide the name and telephone number of the health care professional responsible for the denial delay or modification of health care services. None of eight denial files reviewed contained written communication to the physician or other health care provider with the name and telephone number of the health care professional responsible for the denial, delay or modification. The Plan's staff stated that the Plan does not provide this information on benefit denial letters. The Plan provides a single telephone number (in the denial letter) for the physician or other health care provider to call to get the name and number of the health care professional responsible for the denial delay or modification.

Corrective Action 4: The Plan shall demonstrate that communications to physicians and other health care providers about a denial, delay, or modification of a request include the name and telephone number of the health care professional responsible for the denial, delay, or modification.

Plan's Response and Compliance Efforts 4:

The Plan responded that the name and direct phone line of the appropriate Medical Director, depending on the Medical Practice, will be included in all communications to physicians or other health care providers when the decision is rendered. The Plan provided a sample letter that clearly showed the name and telephone number of reviewing physician.

Time Frame for Corrective Action: January 2002

Department's Response to Plan's Compliance Efforts 4:

Corrected.

The Plan has provided evidence that this deficiency has been corrected as requested.

Deficiency 5: The Plan has not established, as part of the quality assurance program for utilization management, 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)]

Section 1367.01(j), states in relative part, that every health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, 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.

Department Findings: The Plan has specific defined processes for measuring and identifying potential quality concerns with respect to the utilization management program but no well-defined formal mechanism for correcting them. The Plan conducts both member and provider satisfaction surveys that contain questions related to referral activities. The Plan also tracks and trends complaints related to utilization management processes. The Plan monitors over and under utilization, turnaround times for authorization requests, and consistency and appropriateness of decision-making. Data is aggregated and reviewed by the Plan's UM/QM Committee to identify trends but the process of development and implementation of corrective actions is not well-specified or implemented with appropriate follow up. The Plan collects and reviews data but does not adequately analyze the data for potential quality concerns nor does it have a mechanism to develop and implement a corrective action to appropriately address any

identified issues. For instance, if the Plan reviews utilization data and determines that over or under utilization exists, the Plan has a process to determine that the number looks inappropriate compared to a threshold or benchmark, but has no defined process to determine the cause of the over or under utilization issue, or to take action to address it through systemic changes or through education/discussions with physicians. The Plan has no well-defined mechanism for follow-up to ensure that any identified issue has been resolved.

Corrective Action 5: The Plan shall demonstrate establishment of 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.

Plan's Response and Compliance Efforts 5:

The Plan has responded that, in conjunction with Deficiency 1, the Plan intends to utilize the work plan spreadsheet to clearly identify the process by which the issue or finding will be acted upon.

Time Frame for Corrective Action: June 2002

Department's Response to Plan's Compliance Efforts 5:

Not Corrected.

The Plan's proposed Corrective Action Plan (CAP) is not adequate to remedy the deficiency as requested. The Plan has not provided evidence that all corrective actions have been or are being implemented within the Plan's 45-day response period. The proposed Plan's implementation of the corrective action will take longer than 45-days to be accomplished.

The Plan's response does not present a procedure or process by which it will investigate potential quality problems in the utilization management process and correct confirmed quality issues. The proposed spreadsheet is not a procedure or process for identifying, investigating, and resolving quality issues although it can be an appropriate mechanism by which to track progress.

Required Action

The Plan shall revise its Corrective Action Plan (CAP) to demonstrate that its written policies and procedures establish the process by which the Plan identifies potential problems with utilization management processes and outcomes, implements actions to correct confirmed problems, implements mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provides for evaluation of any corrective action plan and the measurements of performance in accordance with the requirements of Section 1367.01(j).

The Department will evaluate the implementation and effectiveness of the Plan's revised Corrective Action Plan (CAP) to correct the deficiency during the Follow-up Review.

Appendix A List of Surveyors

The Survey Team consisted of the following persons:

Department of Managed Health Care Representatives:

Debra Burgess, RN, MPH
Ed Foulk, RN, MBA, Ed.D

Senior Health Plan Analyst
Associate Health Plan Analyst

Managed Healthcare Unlimited, Inc. Representatives:

Rose Leidl, RN, BSN, CHCA
Bernice Young
Margaret Beed, MD, FAAP
Margaret Beed, MD, FAAP
Laurence Ikeda, MD
Ruth Martin, MBA, MPH

Project Manager
Program Director
Grievances and Appeals Surveyor
Utilization Management Surveyor
Quality Management Surveyor
Access and Availability Surveyor

Appendix B

Plan Interview List

The following are the titles of key Plan officers and staff who were interviewed during the on-site survey at the Plan's administrative offices on October 15-18, 2001:

President
Medical Director and V.P.
Associate Medical Director and V.P, Quality Improvement
Director, Managed Care Operations
Director, Compliance, Finance
Manager, Quality Improvement
Manager, Utilization Management
Manager, Provider Relations
QI Coordinator

Appendix C Provider Interview List

The following IPA/MGs, providers and staff were visited and interviewed during the on-site survey on October 15-18, 2001:

Chris Kuhn, CEO, Penn Medical Group, Inc.,
Michael Van Buskirk, M.D., Family Practitioner, Scripps Encinitas Clinic; and
Gary Landry, Chief Operating Officer, Scripps Clinics