



Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

Department of Managed Health Care
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May 19, 2014

SENT VIA FACSIMILE: (323) 889-6279
& U.S. MAIL

Anna Tran, CEO
Care 1st Health Plan
601 N. Potrero Grande Drive
Monterey Park, CA 91755

RE: ENFORCEMENT MATTER NUMBER 12-032

LETTER OF AGREEMENT

Dear Ms. Tran:

The Office of Enforcement within the Department of Managed Health Care (the "Department") has concluded its investigation of Care 1st Health Plan (the "Plan") concerning the above matter. This investigation concerned the Plan's violations of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), and violations of regulations promulgated in support of the Knox-Keene Act. The pertinent facts are sent forth below.

The enrollee, a special-needs adult in his 40's, was diagnosed with prostate cancer in mid-2011 and was being followed by a urologist. A bone scan done on July 15, 2011, showed no evidence of metastasis. The urologist saw the enrollee in his office many times over the next few months, and discussed treatment options with the enrollee and his mother, but they could not decide on a treatment plan.

The enrollee changed plans, and the new plan, Care 1st Health Plan ("the Plan") authorized additional visits with the urologist. The enrollee eventually decided to follow the urologist's recommendation that he undergo a robotic laparoscopic radical prostatectomy, a procedure that urologist does not perform. The urologist recommended that the procedure be done by providers at City of Hope hospital, an out-of-network hospital. The primary care provider (PCP) faxed a Treatment Authorization Request ("TAR") marked "routine" to the Plan requesting authorization for the robotic procedure at City of Hope. The Plan denied the request, but authorized a second opinion with an in-network urologist.

Letter of Agreement
Matter ID: 12-032
Doc. No.: 138133

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MANAGED HEALTH CARE
ENFORCEMENT OFFICE
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 DBA: Care 1st Dental Plan
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The enrollee saw the in-network urologist who agreed that the enrollee needed the robotic surgery at the City of Hope. On December 1, 2011, the PCP faxed the in-network urologist's TAR to the Plan. The TAR was marked "urgent" by the PCP, but the Plan's medical director crossed out "urgent" and marked the request "routine." The enrollee's mother called the Plan eight times between December 1 and December 21, each time asking when the procedure would be approved. Each time the Plan simply told the mother that the request was being processed, but took no action to confirm the status of the request. Nor did the Plan initiate a grievance in response to any of the eight telephone calls. The Plan approved the procedure on December 27, 2011, but modified the request to an in-network provider at a contracted facility. The enrollee had the necessary surgery in February 2012.

Health and Safety Code section 1367(d). This section requires a plan to provide a "ready referral of patients to other providers at times as may be consistent with good professional practice." In this matter the Plan required the enrollee to seek a second opinion with a provider who did not have experience with the robotic procedure the first urologist had recommended. The Plan should have either authorized the procedure, as recommended by the first urologist, or referred the enrollee to an in-network urologist with experience performing the recommended procedure who could have advised the enrollee of the risks and benefits of the procedure.

Health and Safety Code section 1367.01(h)(4). This section requires a plan to provide a "clear and concise" explanation of the reasons for its decision denying a requested service. When the denial is based on lack of medical necessity, the written denial must contain a description of the criteria or guidelines used, and the clinical reasons for the decision. In this matter the Plan's November 7, 2011, denial notice stated that the enrollee's condition did not meet the Medi-Cal definition of medical necessity, but the notice failed to explain under what circumstances the robotic procedure would be medically necessary to treat prostate cancer, and failed to explain why the enrollee's specific clinical picture did not meet this standard.

Health and Safety Code section 1367.01(h)(1). This section requires a plan to approve, modify, or deny a request for services within five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In this matter the Plan received the PCP's TAR marked "urgent" on December 1, but failed to act on the request until December 27, 2011. Before receiving the December 1 TAR the Plan had already required the enrollee to obtain a second opinion from its in-network urologist, and presumably had all the information it needed by December 1 to approve, modify, or deny the request for the robotic procedure.

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Health and Safety Code section 1368(a)(1). This section requires a plan to establish and maintain a grievance system that has reasonable procedures that ensure adequate consideration of enrollee grievances and rectification when appropriate. **Section 1300.68(a)(1) of title 28, California Code of Regulations** defines "grievance" as a "written or oral expression of dissatisfaction regarding the plan and/or provider. If the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance." Here the Plan failed to give adequate consideration to the grievance when, even after the mother called the Plan eight times after December 1 to find out when her son's procedure would be approved, the Plan simply assured her that the TAR was "in process." The Plan violated Health and Safety Code section 1368(a)(1), and section 1300.68(a)(1) of title 28, California Code of Regulations.

Health and Safety Code section 1368(a)(4)(A) and Section 1300.68(d)(1) of title 28, California Code of Regulations require plans to send the complainant a written acknowledgement of a grievance within five calendar days. In this matter, because the Plan failed to initiate a grievance in response to any of the mother's post-December 1 phone calls, it also failed to issue the required acknowledgment letter.

Health and Safety Code section (a)(5) and Section 1300.68(d)(3) of title 28, California Code of Regulations require plans to send a written response to a grievance to the complainant within 30 calendar days of receipt. In this matter, Plan failed to resolve the grievance, in writing, within 30 days.

The Plan has acknowledged its failure to comply with the Knox-Keene Act and/or Title 28 of the California Code of Regulations in this enforcement matter. The Department determined that an administrative penalty of \$75,000 is warranted. The Plan advised the Department that it implemented and completed a Corrective Action Plan ("CAP") that involved modifying its computer system to warn before deadlines are missed; counseling the customer relations employee who failed to treat the phone calls as grievances; counseling the provider involved in the authorization process in this matter; training physician reviewers regarding criteria for second opinions; and additional training on the authorization process and related time frames. The Department has accepted the CAP. The Plan fully implemented its requirements, and stipulates to payment of the aforementioned penalty. The Department agrees that performance of the CAP to the Department's satisfaction and payment of the penalty will settle all issues, accusations, and

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claims pertaining to this enforcement matter. This Letter of Agreement may not be used as an admission by the Plan in any other civil or criminal proceedings; however, it may be used by the Department in future administrative proceedings.

Sincerely,

Dated: May 27, 2014

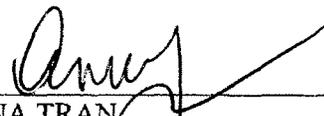


Carol L. Ventura
Deputy Director | Chief Counsel
Office of Enforcement

KSD:saw

Accepted by CARE 1ST HEALTH PLAN

Dated: 5/27/14



ANNA TRAN
CEO
Care 1st Health Plan

MAY 27 11:11 AM
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CARE 1ST HEALTH PLAN

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