

DEPARTMENT OF
**Managed
Health Care**
Help Center

DIVISION OF PLAN SURVEYS

**1115 WAIVER SENIORS AND PERSONS WITH
DISABILITIES (SPD) ENROLLMENT SURVEY**

**SURVEY REPORT
FOR THE
DEPARTMENT OF HEALTH CARE SERVICES**

**1115 WAIVER SURVEY
OF
KERN HEALTH SYSTEMS**

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: JANUARY 30, 2014

**1115 Waiver Survey Report of the SPD Enrollment
Kern Health Systems
A Full Service Health Plan
January 30, 2014**

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EXECUTIVE SUMMARY

The California Department of Health Care Services (“DHCS”) received authorization (“1115 Waiver”) from the federal government to conduct mandatory enrollment of seniors and persons with disabilities (“SPD”) into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The Department of Managed Health Care (the “Department”) entered into an Inter-Agency Agreement with the DHCS¹ to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California’s strong patient-rights laws. Mandatory enrollment began in June 2011.

On July 3, 2013, Kern Health Systems (the “Plan”) was notified that its Medical Survey had commenced and was requested to provide the Department with the necessary pre-onsite data and documentation. The Department’s survey team conducted the onsite portion of the Medical Survey from September 10, 2013 through September 13, 2013.²

SCOPE OF SURVEY

The Department is providing DHCS this written Summary Report of Medical Survey findings pursuant to the Inter-Agency Agreement and has identified potential deficiencies in Plan operations supporting SPD membership. This Medical Survey evaluated the following elements specifically related to the Plan’s delivery of care to the SPD population pursuant to the DHCS contract requirements and compliance with the Act:

I. Utilization Management

The Department evaluated Plan operations related to utilization management, including implementation of the Utilization Management Program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting over- and under-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

II. Continuity of Care

The Department evaluated Plan operations to determine whether medically necessary services are effectively coordinated both inside and outside the network, to ensure the coordination of special arrangement services, and to verify that the Plan provides for completion of covered services by a non-participating provider when required.

¹ The Inter-Agency Agreement (Agreement Number 10-87255) was approved on September 20, 2011.

² Pursuant to the Knox-Keene Health Care Service Plan Act of 1975, codified at Health and Safety Code section 1340, *et seq.*, Title 28 of the California Code of Regulations section 1000, *et seq.* and the Department of Health Care Services Two-Plan and GMC Boilerplate Contracts. All references to “Section” are to the Health and Safety Code unless otherwise indicated. All references to the “Act” are to the Knox-Keene Act. All references to “Rule” are to Title 28 of the California Code of Regulations unless otherwise indicated. All references to “Contract” are to the Two-Plan or GMC Boilerplate contract issued by the Department of Health Care Services.

III. Availability and Accessibility

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

IV. Member Rights

The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for Primary Care Physician (PCP) selection and assignment, and to evaluate the Plan’s ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

V. Quality Management

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care.

The scope of the survey incorporated review of health plan documentation and files from the period of July 1, 2012 through June 30, 2013.

SUMMARY OF FINDINGS

The Department identified **15** potential survey deficiencies during the current Medical Survey.

2013 SURVEY POTENTIAL DEFICIENCIES³

UTILIZATION MANAGEMENT	
#1	<p>The Plan has not developed utilization management criteria with involvement from actively practicing health care providers. Section 1363.5(b)(1) and DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 1(D) – Utilization Management Program.</p>
#2	<p>The Plan does not systemically and routinely analyze utilization management data (other than for HEDIS measures) to monitor for potential over- and under-utilization and take corrective action when indicated. Section 1367.01(j) and DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 4 – Review of Utilization Data.</p>

³ The *Discussion of Potential Deficiencies* section of this report contains a discussion of these deficiencies.

#3	<p>The Plan’s utilization management Notice of Action (NOA) denial letters do not consistently include:</p> <ul style="list-style-type: none"> • a clear and concise description of the reason for the denial, • a description of the criteria or guidelines used to make the decision, • the clinical reasons for the decisions regarding medical necessity, and • the anticipated date that a decision will be made for deferrals. <p>Section 1363.5(b)(4); Section 1367.01(h)(4) and (5); DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures; and DHCS Two-Plan Contract, Exhibit A, Attachment 13, Member Rights, Provisions 4(C) – Written Member Information, and 8(A) – Denial, Deferral, or Modification of Prior Authorization Requests.</p>
CONTINUITY OF CARE	
#4	<p>The Plan does not maintain the necessary methodologies and processes to ensure coordination and continuity of care.</p> <p>DHCS Two-Plan Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care, Provisions 1 – Comprehensive Case Management Including Coordination of Care Services, and 2 – Discharge Planning and Care Coordination.</p>
#5	<p>The Plan does not ensure that all medically necessary covered services are provided to members until California Children Services (CCS) eligibility is confirmed.</p> <p>DHCS Two-Plan Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 9(A)(4) – California Children Services (CCS).</p>
#6	<p>The Plan fails to maintain a dedicated liaison to coordinate with each regional center operating within the Plan's service area.</p> <p>DHCS Two-Plan Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 10(B) – Services for Persons with Developmental Disabilities.</p>
AVAILABILITY & ACCESSIBILITY OF SERVICES	
#7	<p>The Plan does not conduct an annual provider survey designed to solicit the perspectives and concerns of its providers regarding compliance with the timely access to care standards.</p> <p>Rule 1300.67.2.2(d)(2)(C) and DHCS Two-Plan Contract, Exhibit A, Attachment 9, Access and Availability, Provision 4(B) – Access Standards.</p>
#8	<p>The Plan does not adequately follow-up on potential access problems.</p> <p>Rule 1300.67.2 (e) and (f); Rule 1300.67.2.2(d)(2)(F)(3); Rule 1300.70(a)(1)(3); and DHCS Two-Plan Contract, Exhibit A, Attachment 9, Access and Availability, Provision 4 – Access Standards.</p>

<p>#9</p>	<p>The Plan does not maintain accurate tracking and monitoring systems to ensure that Physical Accessibility Reviews are conducted on primary care provider sites and all provider sites that serve a high volume of SPDs, and that the results are made available to members through the Plan’s website and provider directories. Additionally, the Plan’s Provider Directory does not, at minimum, display the level of access met by each provider site as either “Basic Access” or “Limited Access.”</p> <p>DHCS MMCD Policy Letter 12-006; DHCS MMCD Policy Letter 11-009; DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 10(A) – Site Review; and DHCS Two-Plan Contract, Exhibit A, Attachment 13, Member Services, Provision 4(D)(4) – Written Member Information.</p>
<p>MEMBER RIGHTS</p>	
<p>#10</p>	<p>The Plan does not maintain a grievance system that includes procedures to ensure that grievances involving an appeal of a clinical denial based on lack of medical necessity are resolved by a health care professional with appropriate clinical expertise, and that appeals are resolved by a person who did not participate in the prior decision.</p> <p>Section 1367.01(e); Section 1368(a)(1); DHCS Two-Plan Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 2(D) and (G) – Grievance System Oversight.</p>
<p>#11</p>	<p>The Plan does not consistently ensure that for appeals that uphold an original delay, modification, or denial of services, the Plan includes, along with its response, the required application for independent medical review (IMR) and instructions, including the Department’s toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care.</p> <p>Section 1300.68(d)(4); and DHCS Two-Plan Contract, Exhibit A, Attachment 14, Member Grievance System, Provisions 1 – Member Grievance System, and 4(B)(2) – Notice of Action.</p>
<p>#12</p>	<p>The Plan does not ensure that written member-informing materials, including notices pertaining to the denial of services, are translated into identified threshold languages. Additionally, the Plan has not established policies and procedures to enable members to make a standing request to receive all informing materials in a specified alternative format.</p> <p>Section 1367.04(b)(1)(B)(iv); Section 1367.04(b)(1)(C)(i); DHCS Two-Plan Contract, Exhibit A, Attachment 9, Access and Availability, Provision 14 (B)(2) – Linguistic Services; and DHCS Two-Plan Contract, Exhibit A, Attachment 13, Member Services, Provision 4(C)(1) and (3) – Written Member Information.</p>
<p>QUALITY MANAGEMENT</p>	
<p>#13</p>	<p>The Plan does not consistently ensure that quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.</p> <p>Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A)(B); Rule 1300.70(c); and DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement.</p>

#14	<p>The Plan does not conduct ongoing oversight to ensure that its delegates are fulfilling all delegated quality improvement responsibilities. Rule 1300.70(b)(2)(G)(1-4) and DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provisions 1 – General Requirement, and 6(A) and (B) – Delegation of Quality Improvement Activities.</p>
#15	<p>The Plan’s Quality Assurance Program does not include adequate staffing of physician and/or other appropriately licensed professionals to monitor the full scope of clinical services rendered and ensure that corrective action and follow-up is taken when indicated. Rule 1300.70(a)(1); Rule 1300.70(b)(2)(D), (E), and (F); DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provisions 1 – General Requirement, and 7(B), (E), (G), and (I) – Written Description.</p>

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

Kern Health Systems (the Plan) is a public agency established in 1993 to operate the Local Initiative for Kern County under the California Department of Health Services' Strategic Plan for expanding Medi-Cal Managed Care. The Plan serves approximately 71% of the Medicaid population enrolled in the two participating Medi-Cal Managed Care health plans in Kern County. The Plan has implemented the following policies and procedures designed specifically to assist SPD enrollees as well as projects benefiting its overall membership including SPD:

- A small subset of member services agents has been created to focus specifically on new SPD enrollees.
- Because much of the Plan's service area is rural, making geographic access a challenge, the Plan is piloting a telehealth program that covers three specialties and is working toward expansion of that program.
- To foster quality of care and improve access to medical services, the Plan has provided grants to area facilities and providers for activities such as electronic record implementation, physician recruitment, facility repairs and expansion, office automation, and equipment purchases.
- The Plan created dedicated SPD case management teams to enhance its ability to meet the often complex case management needs of SPD enrollees. Provision of case management and coordination of health care services is required of physicians caring for SPD members per the Plan's policies.
- The Plan has established a pilot program to improve discharge planning in one of the five local hospitals that serve its members.
- The Plan offers a 24-hour telephone triage/nurse advice line to assist members with questions and 44% of members reported having used the service.
- Translation and interpretation services are provided through the use of bilingual employees and contracts with Bakersfield College.

2013 KERN HEALTH SYSTEMS: DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s utilization management processes including:

- a. The development, implementation, and maintenance of a Utilization Management Program.
- b. The mechanism for managing and detecting over- and under-utilization of services.
- c. The methodologies and processes used to handle prior authorizations appropriately while complying with the requirements specified in the contract as well as in state and federal laws and regulations.
- d. The methodologies and processes used to evaluate utilization management activities of delegated entities.

Potential Deficiency #1: The Plan has not developed utilization management criteria with involvement from actively practicing health care providers.

Statutory/Regulatory/Contract Reference(s): Section 1363.5(b)(1) and DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 1(D) – Utilization Management Program.

Section 1363.5(b)(1) 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.”

DHCS Two-Plan Contract, Exhibit A, Attachment 5 – Utilization Management

1. Utilization Management Program

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

- D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Referral and Authorization Process Policy, UM 3.22-P (revised March 2013, effective June 1, 2013)
- 2012 Kern Family Health Care Utilization Management Program Evaluation (October 1, 2011 through September 30, 2012)

- Quality Improvement/Utilization Management Committee minutes (April 26, 2012; August 30, 2012; October 25, 2012; December 20, 2012; January 9, 2013; and June 27, 2013)
- Physician Advisory Committee minutes (July 6, 2012; August 1, 2012; September 5, 2012; March 6, 2013; and June 5, 2013)

Assessment: Policy UM 3.22-P indicates that the Plan utilizes a variety of review criteria, including, but not limited to: Milliman Health Care Management guidelines, hospice criteria, DME criteria, Medi-Cal and Medicare guidelines, and internally developed criteria. The policy also specifies that these criteria be developed with involvement from Plan committees, which are made up of practicing health care providers.

The Plan's 2012 Utilization Management Program Evaluation states, "Practitioner attendance and participation in the QI/UM Committee or subcommittees is required. The participating practitioners must represent a broad spectrum of specialties. Practitioners must participate in clinical UM activities, *guideline development* [emphasis added], peer review committees and clinically related task forces....Presently there are 167 internally created medical guidelines referenced by the staff for decision making. Forty seven new internal guidelines based on Medi-Cal and other evidence based sources were drafted in 2011 by the Director of Health Services and implemented by the KHS Chief Medical Officer to provide additional support in the decision making process."

However, review of the QI/UM Committee minutes (April 26, 2012; August 30, 2012; October 25, 2012; December 20, 2012; January 9, 2013; and June 27, 2013) provide no indication that there was any discussion, approval, or input from practicing health care providers in the development of these existing guidelines.

Therefore, the Department requested Plan staff to provide documentation that medical necessity criteria were developed/adopted with input from practicing providers. In interviews, the Associate Medical Director and the Director of Health Services stated that the Physician Advisory Committee (PAC) reviews these criteria. The Plan provided, and the Department reviewed, the minutes from July 6, 2012, August 1, 2012, September 5, 2012, March 6, 2013, and June 5, 2013 PAC meetings. However, only the minutes from the June 5, 2013 meeting had any notation that the Committee had reviewed criteria. The minutes stated, "Presentation/Discussion on MRI & CT Protocols by Girish Patel, MD." (Dr. Patel is a board-certified radiologist). A list of CPT codes for CT examinations and MRI examinations was attached to the minutes with a footnote that stated, "When approving the codes for CT/MRI on the referrals, please note in the commentary the study authorized (CT/MRI) and the determination of the appropriate study will be made at the radiologist (*sic*) discretion." Although the minutes further stated, "Discussion and possible action for MRI and CT protocols—RECEIVED AND FILE," the actual discussion was not included. Therefore, it is not clear whether the Committee was considering medical necessity criteria or a request from a participating provider to modify the referral process for radiology referrals for MRI and CT scans.

Section 1363.5(b)(1) and DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 1(D) – Utilization Management Program require that criteria or guidelines used for utilization review be developed with involvement from actively practicing health care providers. Because the Plan did not provide any documentation that the QI/UM Committee, PAC, or any other practicing physicians had reviewed and had input into the initial and annual review of the Milliman Health Care Management guidelines, hospice criteria, DME criteria, and internally developed criteria, the Department finds the Plan in violation of these regulatory and contractual requirements.

Potential Deficiency #2: The Plan does not systemically and routinely analyze utilization management data (other than for HEDIS measures) to monitor for potential over- and under-utilization and take corrective action when indicated.

Statutory/Regulatory/Contract References: Section 1367.01(j) and DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 4 – Review of Utilization Data.

Section 1367.01(j) states, “A 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.”

DHCS Two-Plan Contract, Exhibit A, Attachment 5 – Utilization Management

4. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor’s internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Referral and Authorization Process Policy, UM 3.22-P (revised March 2013, effective June 1, 2013)
- 2012 Kern Family Health Care Utilization Management Program Evaluation (October 1, 2011 through September 30, 2012)
- 2012 Quality Improvement (QI) Program Evaluation (October 1, 2011 through September 30, 2012)
- Quality Improvement/Utilization Management Committee minutes (April 26, 2012; August 30, 2012; October 25, 2012; December 20, 2012; January 9, 2013; and June 27, 2013)

Assessment: The Plan meets the DHCS contractual requirements of Exhibit A, Attachment 4, Quality Management, Provision 9(B) – External Quality Review Requirements and reports rates for over- and under-utilization based upon selected HEDIS Use of Service measures or other developed utilization measures that are selected by DHCS on an annual basis. The Plan’s Utilization Department also routinely reviews and reports to the Quality Improvement/Utilization Management (QI/UM) Committee approved admissions, denied admissions, medical-surgical average length of stay for adults and children, and Cesarean section rates. The Plan maintains reports containing the number of approved and denied referrals and the three most frequent referral specialties for both adults and children, as well.

However, despite the Plan’s efforts to analyze HEDIS Use of Service measures, and gather and report data to the QI/UM Committee, the Plan does not perform an actual analysis of the data it collects to detect under- and over-utilization for these specific issues so that corrective actions can be implemented when indicated. For example, the Plan monitors hospital readmission rates within 30 days of discharge and treats these as potential quality issues. Hospital medical records from each readmission within 30 days are sent to the Quality Improvement Department where the Medical Director or Associate Medical Director reviews the original admission and readmission hospital records to determine if there were quality issues during either stay. The 2012 Quality Improvement (QI) Program Evaluation reports on the Plan’s findings regarding readmissions as follows:

“314 Re-admissions occurred within 30 days of discharge

119 No quality of care issues required medical record review (Track & Trend)

195 Quality Reviews were warranted

50 had no quality of care issues identified by the Medical Officer. All cases have been closed with the exception of 144 cases pending review: 63 are pending Medical Director review and 81 are pending medical record review. One issue found, letter sent via certified mail with no further action required.”

Although this data includes a breakdown of hospital readmissions as it pertains to quality issues, there is no process in place to determine whether readmissions could have been prevented or avoidable to begin with. For example, there is no discussion of whether discharge planning from the original admission was adequate or not, or investigation of the events occurring between the discharge and subsequent admission to identify issues that may have contributed to the readmission (e.g., housing, transportation, access to pharmacy, timely provision of home health services, etc.).

Further, the 2012 Quality Improvement (QI) Program Evaluation states:

“KHS’ contract with the Medi-Cal Managed Care Division (MMCD) requires participation in a statewide collaborative known as All-Cause Readmissions. The goal of the collaborative is to reduce the number of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days for members 21 years of age and

older. The plan's overall readmission rate for Medi-Cal members 21 years of age and older during the 1/1/2011-12/31/2011 period is 11.24 percent, with 1512 admissions and 170 readmissions. Within this group, the readmission rate for the SPD population is 17.14 percent, with 70 admissions and 12 readmissions. The rate for the Non-SPD population is 10.96 percent with 1442 admissions and 158 readmissions. The QIP (Quality Improvement Project) is in the study design phase and the plan's historical data (CY2011) was submitted to the EQRO⁴ in September 2012."

Therefore, although it is the goal of the All-Cause Readmissions statewide collaborative to reduce the number of readmissions within 30 days, the Plan is not analyzing and addressing the root causes of its readmissions. This negatively impacts the quality of life for enrollees who experience preventable readmissions as well as the Plan who must then incur costs in excess due to readmissions.

Section 1367.01(j) requires each plan to establish as part of its quality assurance program a process to conduct evaluation of complaints, assess trends, implement actions to correct identified problems, communicate actions and results to the appropriate health plan employees and contracting providers, and evaluate corrective action plans to measure performance. DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 4 – Review of Utilization Data requires each plan to include within the utilization management program mechanisms to detect both under- and over-utilization of health care services. Because the Plan does not routinely perform "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," the Department finds the Plan in violation these regulatory and contractual requirements.

Potential Deficiency #3: The Plan's utilization management Notice of Action (NOA) denial letters do not consistently include:

- a clear and concise description of the reason for the denial,
- a description of the criteria or guidelines used to make the decision,
- the clinical reasons for the decisions regarding medical necessity, and
- the anticipated date that a decision will be made for deferrals.

Statutory/Regulatory/Contract References: Section 1363.5(b)(4); Section 1367.01(h)(4) and (5); DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures; and DHCS Two-Plan Contract, Exhibit A,

⁴ The External Quality Review Organization (EQRO) is an independent organization with whom DHCS contracts with to produce an annual aggregate report on the External Accountability Set (EAS) of Healthcare Effectiveness Data and Information Set (HEDIS[®]) performance measurement results, produce a summary report on the biennial Member Satisfaction Survey (CAHPS[®]) results, conduct quality reviews of plans and produce annual plan specific evaluation reports, support collaborative quality improvement projects (QIPS), and produce quarterly QIP status reports. The Health Services Advisory Group (HSAG) is DHCS' current EQRO.

Attachment 13, Member Rights, Provisions 4(C) – Written Member Information, and 8(A) – Denial, Deferral, or Modification of Prior Authorization Requests.

Section 1363.5(b)(4) states, in pertinent part, “If [criteria or guidelines by plans are] used as the basis of a decision to modify, delay, or deny services in a specified case under review, [the criteria or guidelines shall] be disclosed to the provider and the enrollee in that specified case.”

Section 1367.01(h)(4) states, in pertinent part, “. . . 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 to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or 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. . . .”

Section 1367.01(h)(5) states, in pertinent part, “If the health care service Plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) . . . the Plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the Plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. . . .”

DHCS Two-Plan Contract, Exhibit A, Attachment 5 – Utilization Management

2. Pre-Authorizations and Review Procedures

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

D. Reasons for decisions are clearly documented.

DHCS Two-Plan Contract, Exhibit A, Attachment 13 – Member Services

4. Written Member Information

C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.”

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

A. Contractor shall notify Members of a decision to deny, defer, or modify request for Prior Authorization by providing written notification to Members and/or authorized

representative, regarding any denial deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Referral and Authorization Process Policy, UM 3.22-P (revised March 2013, effective June 1, 2013)
- NOA denial letters from 18 appeal files that were included as part of the random sample for standard grievances and appeals (for the review period July 2012 through June 2013) for which the original denial was upheld
- NOA letter template for Deferrals

Assessment: The Department reviewed the Plan’s initial denial documentation from 18 appeal files that were part of the random sample for standard grievances and appeals from the review period for which the original denial was upheld.

Clear and Concise Explanation of Reasons for the Plan’s Decision

Of the 18 initial NOA denial letters reviewed, 11 (39%) failed to include a clear and concise explanation of the reasons for the plan’s decision. For example, one pharmacy denial for File #50 was confusing in its explanation. The reason for the denial was as follows:

“Kern Family Health Care cannot approve the request because the medical justification supporting statement provided did not include: Exceeds plan limits, Plan allows this medication for members between the ages 4-16 years old.

Your medical condition and/or medical needs as described by the documentation reviewed by Kern Family Health Care is determined to be not medically necessary and/or does not meet the definition of medical necessity (as noted in Kern Family Health Care Policy 13.01-P set forth in Title 22, California Code of Regulations, Section 51303(a) for the following reason(s): The drug that you have requested requires prior authorization. Supporting documentation and/or medical records provided do not contain sufficient clinical information to establish that the severity of the condition requires the use of the requested drug. Based on the information provided, medical necessity has not been demonstrated. If you have any questions or if you would like a copy of the actual benefit provision, guideline, protocol or other similar criterion on which our decision was based...”

In addition, it is difficult to ascertain the actual reason for the denial as the first paragraph cites the enrollee’s age as the reason for the denial but then the second paragraph indicates that the medical necessity has not been demonstrated by the documentation submitted by the requesting physician. The appeal decision upheld the initial denial and in that NOA letter, the Medi-Cal age limit criteria was cited as the reason, not medical necessity.

Description of the Criteria Used and Clinical Reasons for Decisions Regarding Medical Necessity

Of the 18 appeals files reviewed, six files were original benefit denials and 12 files were original medical necessity denials.

Of the 12 NOA denial letters reviewed for medical necessity, 10 (83%) did not contain a description of the criteria or guidelines used to make the decision and eight (67%) did not specify the clinical reason for the denial. The following are two examples that did not contain a description of the criteria used or include a clinical reason for the denial:

- In appeal File #13, the referring physician requested a pain management evaluation. The reason for denial was “Documentation submitted by your Provider, does not meet medical criteria for the above request. Please call your Provider for more information. The following criterion has been provided to your provider: Kern Health System Policy and Procedure.” However, the letter does not explain what criteria was used or even reference or attach any specific policy or procedure.
- In appeal File #42, the referring physician requested a Positron Emission Tomography (PET) scan and a computerized tomography (CT) scan of the neck, chest, abdomen, and pelvis. The reason for the denial was “The documentation received does not support a medical need for the requested imaging at this time. The following criterion has been provided to your provider: Medical Director Review.” Again, the letter does not explain what criteria was used. The subsequent appeal determination NOA letter cited National Cancer Consortium Center criteria as the criteria used for the denial with no further explanation.

Decision Deferrals

The Plan’s Referral and Authorization Process Policy, UM 3.22-P, references that “authorization requests needing additional medical record may be deferred, not denied, until the requested information is obtained. If deferred, the Case Manager follows-up with the referring provider within 14 calendar days from the receipt of the request if additional information is not received...” However, the policy does not address the process for notifying the member of the anticipated date on which a decision may be rendered. Moreover, the Plan’s NOA letter template for deferrals does not include a notification to the referring physician and enrollee of the anticipated date for the Plan’s decision. The Director of Health Services confirmed that the NOA letter sent to both the physician and enrollee of deferral notification does not contain the anticipated date that the decision will be made.

Because the Plan’s NOA denial letters did not consistently provide a clear and concise description of the reason for the denial, a description of the criteria or guidelines used to make the decision, the clinical reasons for the decisions regarding medical necessity, or the anticipated date for the Plan’s decision for decision deferrals, the Department finds the Plan in violation of Section 1363.5(b)(4); Section 1367.01(h)(4) and (5); DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures; and DHCS Two-Plan Contract, Exhibit A, Attachment 13 Member Rights, Provisions 4(C) – Written Member Information, and 8(A) – Denial, Deferral, or Modification of Prior Authorization Requests.

CONTINUITY OF CARE

In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s continuity of care processes including:

- a. The methodologies and processes used to coordinate medically necessary services within the provider network.
- b. The coordination of medically necessary services outside the network (specialists).
- c. The coordination of special arrangement services including, but not limited to, California Children’s Services, Child Health and Disability Prevention, Early Start and Regional Centers.
- d. Compliance with continuity of care requirements in Section 1373.96 of the Health and Safety Code.

Potential Deficiency #4: The Plan does not maintain the necessary methodologies and processes to ensure coordination and continuity of care.

Statutory/Regulatory/Contract References: DHCS Two-Plan Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care, Provisions 1 – Comprehensive Case Management Including Coordination of Care Services, and 2 – Discharge Planning and Care Coordination.

DHCS Two-Plan Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care

1. Comprehensive Case Management Including Coordination of Care Services
Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member. Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.
2. Discharge Planning and Care Coordination
Contractor shall ensure the provision of discharge planning when a SPD beneficiary is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver....”

Supporting Documentation:

The Department requested and reviewed the following documentation:

- 2012 Quality Improvement (QI) Program Evaluation (October 1, 2011 through September 30, 2012)

- 51 files for cases identified by the Plan as potential quality issues (PQIs)⁵. The cases were randomly selected from the universe of 141 PQIs (files received during the review period from July 2012 through June 2013 for which the Plan had *completed* its review)
- 14 files for cases identified by the Plan as PQIs. The cases were a targeted sample selected from the universe of 71 *pending* PQIs (files received during the review period from July 2012 through June 2013 for which the at the time the survey was initiated, the Plan had not yet completed review)

Assessment: The Plan recognizes that readmissions may signal potential quality issues such as poor discharge planning, inadequate follow-up post hospitalization, etc. and therefore has several quality improvement activities in place to address this for its SPD members. For example, the Plan’s contract with the Medi-Cal Managed Care Division (MMCD) requires participation in a statewide collaborative known as All-Cause Readmissions. The goal of the collaborative is to reduce the number of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days for members 21 years of age and older. The Plan has also established a pilot program with one local hospital to improve discharge planning. However, despite these efforts, review of PQI cases revealed the following examples of poor discharge planning and care coordination that placed the member in potential medical jeopardy:

- PQI #24: The patient was admitted for a decubitus ulcer on his right foot. He was placed on IV antibiotics and discharged with orders to continue the Tobramycin at home with orders to the home health organization to continue his IV Tobramycin. However, orders were never sent to the Plan for authorization and when the home health nurse arrived two days after the member’s discharge, she discovered that the he did not have any IV access. Therefore, Tobramycin was not administered in a timely manner. The Plan identified the case as a quality issue and issued a letter to the hospital indicating that discharge planning was inadequate. The letter states, “We would appreciate follow up on the discharge planning that took place for this patient. We feel these series of events need the attention of your Quality Improvement process. Please contact KHS if we can be of any assistance in this process.” However, no response was ever received from the hospital and in a case note, the Associate Medical Director stated the following, “No response was received from this letter, however the case will be closed at this time.”
- PQI #68: The patient was admitted with an inability to walk, severe dysphagia (difficulty swallowing), and dyspnea (difficulty breathing). She was diagnosed with dermatomyositis (connective tissue disease). After an extended stay, the patient was discharged with orders for home health care to: manage wound care, replace a broken BPAP machine (breathing machine), and supply durable medical equipment (which included a Hoyer lift, slide bar, wheel chair, as well as other necessary equipment and supplies). She was discharged with medication for a nebulizer; however, no nebulizer was actually provided. In addition, she had a PICC line (intravenous port access) even though no orders were given for appropriate management of the PICC line. The case was identified as a PQI and the Plan sent a letter to the facility requesting that it look into its

⁵ Cases, providers, processes or concerns identified through enrollee grievances and other sources as having *potential quality issues* that require investigation are often referred to as PQIs.

discharge planning. A 24/7 telephone number was provided to the facility so that contact could be made with the Plan's case managers. However, a corrective action plan was never initiated by the Plan even though it had identified the case as a PQI where the facility's ineffective discharge planning placed the member at risk.

- PQI #10: A 400lb female patient was admitted with a co-morbid diagnosis of CO₂ narcosis (inability to breath). The discharge summary indicates that the member's breathing machine at home is old and is not working properly. Discharge case notes document the need for either repair or replacement of her existing machine. Notes further indicate that the hospital case manager was made aware of this. However, the patient was instead discharged with only new supplies ordered. There was no documentation of coordination of care to demonstrate that the member was discharged with a functioning breathing machine at home. The patient was re-admitted within a few days through the emergency room. The "Readmission Review Worksheet [for] Readmission for Same or Related Conditions Within 30 days of Discharge" requires the reviewer to answer the following questions by checking either "yes" or "no":
 - Were discharge orders appropriate?
 - Could readmission have been prevented by outpatient intervention/follow-up?

Although the nurse reviewer leaves all of these fields blank with no response, a final determination of "no quality issue" is noted.

- PQI #71: A 61-year-old male was initially admitted via the emergency room on 5/26/13 for a suicide attempt. The member ingested 60 Coumadin pills, 4 Vicodin, 4 Tylenol, 4 NyQuil, metoprolol, Motrin, as well as an unknown amount of alprazolam. He stated that his intent was to die. The member gave a history of severe depression for the three months prior to admission that was documented in his record. He described depressive symptoms and revealed a recent history of having a myocardial infarction (heart attack). The member reported "occasional" use of alcohol. His past medical history included a recent heart attack, hypertension, anemia, back surgery, and a cholecystectomy. The patient was placed on an involuntary psychiatric hold on admission.

A medical social worker completed a follow-up note on 5/28/13 indicating that a self-harm reassessment was conducted and the member scored a 4 (moderate risk). The member confirmed persistent symptoms of helplessness and anhedonia (absence of pleasure). The social worker recommended that the member's "sitter" be removed as he no longer appeared to be a danger to himself while in the hospital. She stated that social service would follow up as needed.

However, the member was formally discharged home on 5/29/13 with only instructions to follow up with outpatient gastroenterology, continue his previous medications, and return to see his primary care physician in one or two weeks. The discharge plan included no mental health follow-up despite documentation in medical literature that co-morbid major depression can occur after a heart attack. Hospital case notes did state that

the medical social worker provided the member with the phone number for mental health services, but no intent for follow-up or assistance provided to the member was indicated.

The next encounter with the patient was a readmission on 5/31/13 (2 days after discharge). He was admitted in a cardiac arrest (heart stopped) and was resuscitated. It was not documented why he had a cardiac arrest or whether this was due to ingesting medications or not taking prescribed medications. He was discharged on 6/15/13.

Possible quality concerns include the patient being admitted post myocardial infarction (heart attack) for a life threatening suicide attempt with no attempt to treat the patient for his co-morbid psychiatric disorder prior to initial discharge. There was no attempt to evaluate his use of alcohol with narcotics prescribed. This demonstrates a lack of coordination between the Plan and carved out mental health services for coordination of care. Plan staff indicated that they were not responsible for mental health or substance abuse since these services were “carved out.”

These case summaries demonstrate either lack of discharge planning or inadequate discharge planning that resulted in readmissions. The Plan’s action in two of the four cases described above (PQIs #24 and #68) was to send a letter to the facility regarding the failure of discharge planning. Neither of these two case examples generated a corrective action plan from the Plan to the hospitals. (See Potential Deficiency #13 for additional discussion of the Plan’s failure to consistently request/implement corrective actions for confirmed quality problems.) The other two cases referenced above (PQIs #10 and #71) were still in pending review status at the time of the Department’s survey.

DHCS Two-Plan Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 1 – Comprehensive Case Management Including Coordination of Care Services requires each plan to ensure the provision of Comprehensive Medical Case Management to each member and to maintain procedures for monitoring the coordination of care provided to members through either basic or complex case management activities based on the medical needs of the member. Provision 2 – Discharge Planning and Care Coordination further specifies that each plan ensure the provision of appropriate discharge planning, including ensuring that necessary care, services, and supports are in place in the community upon discharge, scheduling outpatient appointments and conducting follow-up. Because the Plan’s readmission cases demonstrate a lack of adequate discharge planning and coordination of services, the Department finds the Plan in violation of these contract provisions.

Potential Deficiency #5: The Plan does not ensure that all medically necessary covered services are provided to members until California Children Services (CCS) eligibility is confirmed.

Statutory/Regulatory/Contract References: DHCS Two-Plan Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 9(A)(4) – California Children Services (CCS).

The DHCS Two-Plan Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care.

9. California Children Services (CCS)

- A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:
- 4) Ensure that Contractor continues to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- California Children’s Services Policy, 3.16-P (revised February 2011, effective February 14, 2011)

Assessment: Policy 3.16-P states: “KHS provides all medically necessary covered services to the members *until CCS eligibility is confirmed* [emphasis added]. In addition, KHS UM staff continues to follow the care of the member, process referrals for care, and obtain all necessary and required medical documentation from the appropriate providers to facilitate a timely evaluation of eligibility by the local CCS program.”

In contrast to this policy, discussion during interviews about coordination with CCS revealed that CCS eligible services were denied by the Plan if the Plan staff person believed that CCS would eventually determine the enrollee eligible. The Plan instead refers all potentially eligible patients to CCS to obtain services.

The DHCS Two-Plan Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 9(A)(4) – California Children Services (CCS) requires each plan to refer members who may have a CCS eligible condition to CCS and coordinate care with CCS. The Plan is required to continue to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed. Because the Plan does not provide services to members until CCS eligibility is confirmed, the Department finds the Plan in violation of this contract provision.

Potential Deficiency #6: The Plan fails to maintain a dedicated liaison to coordinate with each regional center operating within the Plan's service area.

Statutory/Regulatory/Contract References: DHCS Two-Plan Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 10(B) – Services for Persons with Developmental Disabilities.

DHCS Two-Plan Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care

10. Services for Persons with Developmental Disabilities

- B. Contractor shall maintain a dedicated liaison to coordinate with each regional center operating within the plan's service area to assist Members with developmental

disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution as required by W & I Code Section 14182(c)(10).

Supporting Documentation: The Department requested and reviewed the following documentation:

- Memorandum of Understanding between Kern Health Systems (KHS) and Kern Regional Center (KRC) (December 21, 2011)

Assessment: Regional Centers provide educational and support services for persons with developmental disabilities. Plans are required to coordinate their medical services with the non-medical services provided by these centers in order to provide optimal care to members with developmental disabilities.

The Memorandum of Understanding between Kern Health Systems (KHS) and Kern Regional Center (KRC) states,

“KHS has a designated liaison who will be responsible for the coordination of care between KRC and KHS. The liaison will confer with KRC if conditions are unclear so those KHS members with special needs are appropriately referred. The KHS liaison will refer members who do not meet criteria for Kern Regional services to other community services, as appropriate. ...KHS has a liaison who will meet with KRC annually and/or upon request with KRC to monitor this agreement.”

However, in interviews, the Plan’s medical director and quality management team indicated that the Plan has not identified a staff person who acts as the designated Regional Center liaison.

The DHCS Two-Plan Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 10(B) – Services for Persons with Developmental Disabilities requires that the Plan maintain a dedicated liaison to coordinate with each regional center operating within the Plan's service area. Because the Plan does not maintain a liaison, the Department finds the Plan in violation of this contract provision.

AVAILABILITY AND ACCESSIBILITY

In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s processes to support access and availability including:

- a. The availability of services, including specialists, emergency, urgent care, and after-hours care.
- b. Health plan policies and procedures for addressing a patient’s request for disability accommodations.

Potential Deficiency #7: The Plan does not conduct an annual provider survey designed to solicit the perspectives and concerns of its providers regarding compliance with the timely access to care standards.

Statutory/Regulatory/Contract Reference: Rule 1300.67.2.2(d)(2)(C) and DHCS Two-Plan Contract, Exhibit A, Attachment 9, Access and Availability, Provision 4(B) – Access Standards.

Rule 1300.67.2.2(d)(2)(C) states that each plan’s quality assurance program shall address “...Conducting an annual provider survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to solicit, from physicians and non-physician mental health providers, perspective and concerns regarding compliance with the standards set forth at subsection (c).”

DHCS Two-Plan Contract, Exhibit A, Attachment 9 – Access and Availability

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers’ compliance with these standards.

B. Standards for Timely Appointments

Members must be offered appointments within the following timeframes:

1. Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
2. Urgent appointment for services that do require prior authorization – within 96 hours of a request;
3. Non-urgent primary care appointments – within ten (10) business days of request;
4. Appointment with a specialist – within 15 business days of request;
5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Accessibility Standards Policy, 4.30-P (revised August 2011, effective August 12, 2011)
- Plan’s 2013 submission to Timely Access Regulation Reporting Portal (for reporting year 2012)

Assessment: Policy 4.30-P indicates that the Plan will conduct an Annual Provider Survey asking providers to report their satisfaction on:

- the referral and/or prior authorization process necessary for their patients to obtain covered services,
- access to urgent care,
- access to non-urgent primary care,
- access to non-urgent specialty services,
- non-urgent ancillary diagnostic and treatment services.

However, upon the Department's request, Plan staff were unable to provide results to the 2012 Annual Provider Survey. Plan staff confirmed in interviews that a provider survey had not been conducted during the one-year survey look-back period, and they expressed uncertainty as to when and why the provider survey was discontinued. Staff indicated that they had recently discussed re-implementing the survey every two years instead of annually.

The Department noted that while the Plan does have in place a "mystery caller" telephone survey of provider offices to gather information about appointment availability, this activity does not fully meet the requirements of Rule 1300.67.2.2(d)(2)(C). Specifically, the call protocol does not include provisions for gathering information about a provider's "perspective and concerns regarding compliance with the standards" (i.e., generally termed a provider satisfaction survey).

Rule 1300.67.2.2(d)(2)(C) requires each plan to conduct an annual provider survey to solicit providers' perspective and concerns regarding compliance with the appointment availability standards set forth in subsection (c). The Plan did not conduct an annual provider satisfaction survey nor did it include provisions for obtaining provider perspective and concerns in its mystery caller survey; therefore, the Department finds the Plan in violation of the requirements of Rule 1300.67.2.2(d)(2)(C) and DHCS Two-Plan Contract, Exhibit A, Attachment 9, Access and Availability, Provision 4(B) – Access Standards.

Potential Deficiency #8: The Plan does not adequately follow-up on potential access problems.

Statutory/Regulatory/Contract Reference: Rule 1300.67.2 (e) and (f); Rule 1300.67.2.2(d)(2)(F)(3); Rule 1300.70(a)(1)(3); and DHCS Two-Plan Contract, Exhibit A, Attachment 9, Access and Availability, Provision 4 – Access Standards.

Rule 1300.67.2 states, in pertinent part, "within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board...

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments."

Rule 1300.67.2.2(d)(2)(F)(3) states, in pertinent part, “A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan’s provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance...”

Rule 1300.70(a)(1)(3) states, in pertinent part, that a plan’s Quality Assurance (QA) program “must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.... A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.”

DHCS Two-Plan Contract, Exhibit A, Attachment 9 – Access and Availability

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers’ compliance with these standards.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- 2012 Member Satisfaction Survey Results
- 2012 Mystery Shopper Results
- Accessibility Standards Policy, 4.30-P (revised August 2011, effective August 12, 2011)
- Plan’s 2013 submission to Timely Access Regulation Reporting Portal (for reporting year 2012)
- Health Plan Pre-Onsite Survey Questionnaire (July 5, 2013)
- 2013 QI Workplan

Assessment: The Plan conducted an annual member survey during the review period that included questions designed to determine member satisfaction with access to care and quality of care. The 2012 Member Satisfaction Survey Results indicated several areas of potential non-compliance in regards to appointment availability as well as other area of member dissatisfaction. For example:

- “How soon are you able to get an appointment with your PCP for non-urgent (routine) care?” (The timeframe required by Rule 1300.67.2.2(c)(5)(C) is within 10 business days.) In the survey, 21% of members responded “2-4 weeks” and an additional 11.2% responded “over 4 weeks.” Therefore, a combined 32.2% of members reported that their PCPs were out of compliance.
- “How soon are you able to get an appointment with your PCP for urgent care?” (The timeframe for urgent care conditions required by Rule 1300.67.2.2(c)(5)(A) is within 48 hours.) In the survey, 6.4% of members responded “3 days” and an additional 12.3%

responded “over 3 days.” Therefore, a combined 18.7% of members reported that their PCPs were out of compliance.

- *“In the last 12 months, how often were you able to easily get appointments with specialists?”* (The timeframe for specialty referrals required by Rule 1300.67.2.2(c)(5)(D) is within 15 business days.) In the survey, 10.5% of members responded “never” and an additional 17% responded “sometimes.” Because the provision does not list a specific number of days, it is not possible to assess compliance with the standard. Nevertheless, a combined 27.5% of members reported that their specialists were not readily available.

The Plan was unable to provide documentation to substantiate that any follow-up action had been taken to investigate the results of the survey to identify barriers to access and/or implement corrective actions if necessary. Further, based upon its review of the Plan’s 2013 submission to Timely Access Regulation Reporting Portal (for reporting year 2012), the Department identified concerns with the Plan’s mystery call results and had sent a comment letter to the Plan (prior to the onsite survey dates) that stated:

“The Plan’s mystery caller program showed a 68% overall compliance rate for OB/GYN providers; however, the Plan did not note any further investigation or corrective actions other than recalls to individual providers for this issue. Please indicate whether further investigation has occurred and, if so, whether any corrective actions have been implemented. The Plan also identified a 77% compliance rate for specialists. Please indicate whether any specific specialties have been identified as concerns and, if so, please identify the specialties.”

In its September 11, 2013 response to the Department’s comment letter, the Plan stated, “No further investigation occurred.” In interviews during the survey, Plan staff also reported that there had been no follow-up to these results.

Rule 1300.67.2 requires that services be readily available and accessible to members and mandates that each plan have a documented system for monitoring and evaluating accessibility of care, including waiting time and appointments, and for addressing problems. Rule 1300.70(a) confirms the requirement to identify problems and take effective action where deficiencies are identified. It specifically requires that each plan address service elements, including accessibility and availability of care. Rule 1300.67.2.2(d)(2)(F)(3) requires the plan to implement prompt investigation and corrective action based on the results of that survey and other monitoring. The Plan’s enrollee survey and its mystery caller program identified potential problems in the timely availability of both urgent and routine appointments; therefore, the Plan was required to investigate and evaluate these concerns and take appropriate actions to address them. Because the Plan did not conduct further investigation and implement corrective actions, the Department finds the Plan in violation of these regulatory requirements.

Potential Deficiency #9: The Plan does not maintain accurate tracking and monitoring systems to ensure that Physical Accessibility Reviews are conducted on primary care provider sites and all provider sites that serve a high volume of SPDs, and that the results are made available to members through the Plan’s website and provider directories. Additionally, the Plan’s Provider Directory does not, at minimum, display the level of access met by each provider site as either “Basic Access” or “Limited Access.”

Statutory/Regulatory/Contract Reference: DHCS MMCD Policy Letter 12-006; DHCS MMCD Policy Letter 11-009; DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 10(A) – Site Review; and DHCS Two-Plan Contract, Exhibit A, Attachment 13, Member Services, Provision 4(D)(4) – Written Member Information.

DHCS MMCD Policy Letter 12-006, August 9, 2012 states, in pertinent part, “Plans are to make the results of FSR Attachment C available to members through their websites and provider directories. The information provided must, at a minimum, display the level of access results met per provider site as either Basic Access or Limited Access. Additionally, Plans must indicate whether the site has Medical Equipment Access as defined in the FSR Attachment C and identify whether each provider site has or does not have access in the following categories: parking, building exterior, building interior, exam room, restroom and medical equipment (height adjustable exam table and patient accessible weight scales).”

DHCS MMCD Policy Letter 11-009, April 14, 2011 establishes policy and guidelines for use of standardized physical accessibility indicators in all provider directories to assist SPDs in locating physically accessible provider sites.

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

10. Site Review

- A. Contractor shall conduct Facility Site and Medical Record reviews on all Primary Care Provider sites in accordance with the Site Review Policy Letter, MMCD Policy Letter 02-02 and Title 22, CCR, Section 53856. Contractor shall also conduct Facility Site Physical Accessibility reviews on Primary Care Provider sites, and all provider sites which serve a high volume of SPD beneficiaries, in accordance with the Site Review Policy Letter, MMCD Policy Letter 10-016 and W & I Code 14182(b)(9).

DHCS Two-Plan Contract, Exhibit A, Attachment 13 – Member Services,

4. Written Member Information

- D. Contractor shall develop and provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of the covered health care services....The Member Services Guide shall include the following information:
 - 4) Compliance with the following may be met through distribution of a provider directory: The name, provider number, address and telephone number of each Service Location (e.g., locations of hospitals, Primary Care Physicians (PCP), specialists, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities, FQHCs, Indian Health Programs). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, provider number, address, and telephone number shall appear for each Physician provider: The hours and days when each of these

facilities is open, the services and benefits available, including which, if any, non-English languages are spoken, the telephone number to call after normal business hours, accessibility symbols approved by DHCS, and identification of providers that are not accepting new patients.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Online provider directory located at http://www.kernhealthsystems.com/uploads/129-MCalProvVersion_FINAL.pdf.
- PDF file for 2013 Provider Directory
- Log of Completed Attach C
- High Volume Specialist SPD listing
- Geographic Analysis (March 2013)

Assessment: Each Plan is required to conduct Facility Site Physical Accessibility Reviews on all PCP and specialist provider sites that serve a high volume of SPD beneficiaries and make resulting information available to members through the Plan’s website and provider directories. The Plan’s provider directories (both online and PDF versions) inform members of this contractual requirement and state, “Kern Family Health Care (KFHC) reviews the physical accessibility of its contracted primary care provider (PCP) offices, and specialist offices that are determined by KFHC to be a “high volume” provider for Seniors and Persons with Disabilities (SPDs). The State then requires KFHC to include the findings in its Provider Directories to help members who may need to identify provider offices that have more physically accessible facilities.”

However, the PDF version of the provider directory has 4 PCP entries and 51 specialist entries listed as “Accessibility: TBD” (to be determined). The online version displays similar results. For TBD entries, the legend informs members that the Plan has yet to review the PCP or “high volume” SPD office and that the Member Services Department may be contacted to find out whether updated information has been obtained since the last printing of the provider directory. Relying on the number of TBD entries to determine how many outstanding sites have yet to have the FSR completed, however, would not be accurate as the directory lists providers not only by clinic name, but by individual provider names, as well. Therefore, multiple provider entries may actually represent only one facility site requiring review. Utilizing information from the provider directory therefore does not provide a clear method for determining how many sites require the FSR and how many have actually been completed.

In an attempt to assess the Plan’s compliance with meeting this standard, and to also differentiate the actual number of sites that have yet to undergo review between those that have been completed (and simply have not been updated in the provider directory), the Department requested from the Plan a current listing of all sites that are *required* to undergo a physical accessibility review. From that list, the Department requested that the Plan identify those sites that have actually already undergone review (as evidenced by completion date) and those sites that have yet to be completed.

Primary Care Provider Sites

The Plan submitted a “Log of Completed Attach C” which listed 107 PCP sites as having had FSR Attachment C (for physical accessibility indicators) completed as evidenced by completion date. However, the log did not include the total number of PCP sites that were *required* to undergo review to begin with. Therefore, the Department was unable to assess how many sites remained outstanding. In order to estimate this, the Department reviewed the Plan’s Geographic Access Analysis (March 2013) which displayed the Plan’s network of 249 PCPs at 109 sites. Therefore, comparison of this report with the “Log of Completed Attach C” suggests that nearly all PCP sites have undergone review (107 completed sites versus approximately 109 locations). This corresponds roughly with the information displayed in the provider directory, which shows only four PCP as “Accessibility: TBD.”

Although the Department finds the Plan generally compliant for completion of FSRs for PCP sites, this determination was made based on the Department’s own assumption only after review of Geographic Analysis data. The Plan never was able to provide the Department with an accurate report of all PCP sites requiring review or a systematic approach for assuring that all sites have been completed (or are scheduled) and updated in the provider directory.

Specialist Sites

The “Log of Completed Attach C” listed 36 specialist sites as having had FSR Attachment C completed as evidenced by completion date. However, the log did not include the total number of specialist sites that were *required* to undergo review to begin with. Therefore, the Department was unable to assess how many sites remained outstanding. Although the Department reviewed the Plan’s Geographic Access Analysis (March 2013) which displayed the Plan’s network of 552 specialists at 195 locations, not all 195 locations represent sites that serve a high volume of SPD beneficiaries.

Therefore, to estimate the number of outstanding specialist sites, the Department requested and the Plan submitted a list titled “High Volume Specialist SPDs,” which represented 57 high volume specialist providers (excluding radiologists, whose sites are generally not visited by members, and non-participating providers) that required completion of Attachment C. However, of the 57 providers required to undergo review, only 15 (26%) had Attachment C completed (as indicated by “yes”), while 42 (74%) did not (as indicated by “no”). When the list was unduplicated by vendor identification number (in an attempt to filter out duplicate entries where multiple providers practice together at a single location), the results were similar – 36 of 49 sites (73%) did not have Attachment C completed. Therefore, it appears that for specialists, approximately three-quarters of required physical accessibility reviews have not been completed.

When asked for a schedule of when the Plan expects to complete any outstanding site reviews, Plan staff responded that the Plan “is in the process of revising the Policy and Methodology used to determine high volume specialists. This will help us to better identify actual high volume specialists and ensure the FSR is performed.”

In addition, cross-referencing of the “High Volume Specialist SPDs” list with the PDF and online provider directories revealed discrepancies and inaccuracies within the Plan’s own reporting system. For example:

- Three of the 15 “yes” providers (for which Attachment C had already been performed) were listed as “NA” (not applicable) in the provider directory. The provider directory indicates that “NA” means the provider is not required to undergo physical accessibility review because it is not a PCP or high volume provider for SPDs. However, this is inconsistent with the purpose of the “High Volume Specialist SPDs” list, which was supposed to be representative of all specialist sites *requiring* the FSR.
- Four (actually representing two facility sites) of the 15 “yes” providers (for which Attachment C had already been performed) were listed as “TBD” in the provider directory. This indicates that although Attachment C had been completed, the results were not yet displayed in the provider directory. However, the Plan’s Provider Relations Department verified that one of these provider sites still reflected “TBD” status in their system. This is inconsistent with the “yes” notation on the “High Volume Specialist SPDs” list that was indicative that Attachment C had in fact been completed.

Level of Access – “Basic Access” or “Limited Access”

Review of the Plan’s online and PDF provider directories revealed that although the Plan is displaying specific access indicators (P, EB, IB, R, E, T) met for those facilities where the FSR Attachment C have been conducted, it fails to specify the Level of Access (i.e., either Basic Access or Limited Access) as required by DHCS Policy Letter 12-006. Plan staff stated that the online directory was currently undergoing further development and that the requirement for specifying either Basic Access or Limited Access would be conveyed to appropriate programmers. Plan staff also noted that the printed version of the directory had been reviewed and approved by the Plan’s contract manager, leading Plan staff to believe that all requirements had been met.

DHCS MMCD Policy Letter 11-009; DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 10(A) – Site Review requires that plans conduct Facility Site Physical Accessibility Reviews on all Primary Care Provider sites and all provider sites which serve a high volume of SPD beneficiaries. Because the Plan has failed to maintain accurate tracking and monitoring systems in place to effectively ensure Physical Accessibility Reviews are conducted on primary care provider and specialty sites required to undergo such review, and failed to complete reviews on approximately three-quarters of its high volume specialist sites, the Department finds the Plan in violation of this contract provision.

DHCS Two-Plan Contract, Exhibit A, Attachment 13, Member Services, Provision 4(D)(4) – Written Member Information describes accessibility information that plans must make available to members through provider directories. DHCS MMCD Policy Letter 12-006 further specifies that each plan must make the results of the FSR Attachment C available by displaying, at minimum, the level of access results at each provider site as either Basic Access or Limited Access. Because the Plan does not specify the level of access (i.e., either Basic Access or Limited Access), the Department finds that it fails to comply with the requirements of the DHCS Two-Plan Contract and DHCS MMCD Policy Letters.

MEMBER RIGHTS

In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s member rights processes including:

- a. Compliance with requirements for a complaint/grievance system. Examination of a sufficient number of SPD member grievance files to ensure an appropriate audit confidence level.
- b. PCP selection and assignment requirements.
- c. Evaluation of available interpreter services and member informing materials in identified threshold languages.
- d. The health plan’s ability to provide SPDs access to the member services and/or grievance department in alternative formats or through other methods that ensure communication.

Potential Deficiency #10: The Plan does not maintain a grievance system that includes procedures to ensure that grievances involving an appeal of a clinical denial based on lack of medical necessity are resolved by a health care professional with appropriate clinical expertise, and that appeals are resolved by a person who did not participate in the prior decision.

Statutory/Regulatory/Contract Reference: Section 1367.01(e); Section 1368(a)(1); DHCS Two-Plan Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 2(D) and (G) – Grievance System Oversight.

Section 1367.01(e) states, in pertinent part, “No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity...”

Section 1368(a)(1) states, “Every plan shall do all of the following: (1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.”

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

2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below to monitor the Member’s grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.

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

- G. Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance and is a health care professional with clinical expertise in treating a Member's condition or disease...

Supporting Documentation:

The Department requested and reviewed the following documentation:

- 19 files for member appeals (The appeals cases were included as part of 59 files that were randomly selected from the universe of 246 standard grievances/appeals during the review period from July 2012 through June 2013)
- KHS Member Grievance Process Policy, 5.01-I (reviewed November 2012, effective November 12, 2012)
- Notes from the Plan's Grievance Review Committee (GRC) relating to 14 of the 19 appeals files in the sample. Dates of notes reviewed are as follows:
 - July 24, 2012
 - July 31, 2012
 - August 14, 2012
 - August 28, 2012
 - September 19, 2012
 - October 9, 2012
 - November 6, 2012
 - December 16, 2012
 - January 15, 2013
 - January 29, 2013
 - March 26, 2013
 - May 7, 2013
 - May 21, 2013
 - June 18, 2013
 - June 25, 2013
 - July 2, 2013
 - July 9, 2013

Assessment: Review of the Plan's appeals files revealed that zero of 19 files (0%) contained the identity of the individual who made the final decision. Therefore, the Department was unable to determine whether the final resolution was made by a health care professional with appropriate clinical expertise or whether the appeal was resolved by a person who did not participate in the prior decision. The Plan's Policy 5.01-I, Member Grievance Process, describes the activities of the Plan's Grievance Review Team (GRT) as follows:

"Grievances are presented to the Grievance Review Team GRT on a weekly basis (or more frequently as appropriate) for review and resolution. To ensure that grievances are resolved by a health care professional with appropriate clinical expertise in treating the member's condition or disease, the Medical Director is a member of the Grievance Review Team."

The Plan's Grievance Review Committee notes indicate that although these grievances are discussed amongst GRT members, and at least one of the Plan's two medical directors is always listed as present during each of the GRC meetings, there is no record in committee notes of who made the final resolution decision. In interviews with the Plan, Plan staff indicated that there is no single person who makes the final decision, as decisions are arrived at jointly "by consensus" and that the team is always in agreement. Plan staff also explained that the Plan's two medical directors make the initial denial decisions. Given that one or both medical directors are always at the GRC meetings, it is likely that the same medical director who made the initial denial decision is sometimes involved in meetings where the appeals resolution is made.

Section 1368(a)(1) requires every plan to provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate. More specifically, Section 1367.01(e) permits no individual, other than a licensed physician (or a licensed health care professional who is competent to evaluate the clinical issues involved) to deny or modify requests for authorization of services. DHCS Two-Plan Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 2(D) – Grievance System Oversight confirms that the appeal of a denial based on lack of medical necessity or an appeal that involves clinical issues shall be resolved by a health care professional with appropriate clinical expertise. While a committee may contribute to the investigation and consideration of an appeal, it is essential that a licensed physician (or a licensed health care professional who is competent to evaluate the specific clinical issues involved) take responsibility for any denial or modification of a request for authorization of services. Identifying this individual is essential should questions later arise regarding the rationale for the decision or should the requesting provider wish to discuss the case with the decision maker. Because the Plan does not clearly identify and document the name of the physician responsible for the determination, the Department finds it in violation of Section 1367.01(e) and DHCS Two-Plan Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 2(D) – Grievance System Oversight.

DHCS Two-Plan Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 2(G) – Grievance System Oversight further stipulates that the person making the final decision for resolution of a grievance must not have participated in any prior decisions related to the grievance. Because the same two physicians are involved in initial denials and are also members of the GRC and because the Plan does not document the name of the individual responsible for making the final resolution, it is impossible to determine whether the same physician was involved in both the initial denial and the appeal resolution. Therefore, the Department finds the Plan in violation this contractual requirement.

As a result of these concerns, the Department finds that the Plan has failed to establish and maintain a grievance system that provides reasonable procedures that adequately address member grievances as required by Section 1368(a)(1).

Potential Deficiency #11: The Plan does not consistently ensure that for appeals that uphold an original delay, modification, or denial of services, the Plan includes, along with its response, the required application for independent medical review (IMR) and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care.

Statutory/Regulatory/Contract References: Section 1300.68(d)(4); and DHCS Two-Plan Contract, Exhibit A, Attachment 14, Member Grievance System, Provisions 1 – Member Grievance System, and 4(B)(2) – Notice of Action.

Section 1300.68(d)(4) states, in pertinent part, “For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response...The plan’s response shall also advise the enrollee that the determination may be considered by the Department’s independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.”

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

1. Member Grievance System

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D. 13), and 42 CFR 438.420(a)-(c).

4. Notice of Action

B. If a Member receives a NOA, the Member has three options:

- 2) Members may request an independent Medical Review (IMR) regarding the NOA from the Department of Managed Health Care (DMHC). An IMR may not be requested if a State Fair Hearing has already been request for that NOA.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Independent Medical Review Policy, 14.51-P (reviewed March 2008; effective May 1, 2008)
- KHS Member Grievance Process Policy, 5.01-I (reviewed November 2012, effective November 12, 2012)
- 19 files for member appeals (The appeals cases were included as part of 59 files that were randomly selected from the universe of 246 standard grievances/appeals during the review period from July 2012 through June 2013)

Assessment: Policy 5.01-I indicates that it is Plan policy to include the following language describing the IMR process for all grievance documents and written communications to the grievant:

“... 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 (**1-817-688-9891**) for the hearing and speech impaired. The department’s Internet website (**<http://www.hmohelp.ca.gov>**) has complaint forms, IMR application forms and instructions online. ”

Policy 14.51-P further specifies that an envelope addressed to DMHC will be provided along with the IMR application:

“Grievance resolution letters that uphold a decision to deny, modify, or delay health care services, include the DMHC IMR application form and an envelope addressed to DMHC...”

The Department reviewed 19 appeals and found that 18 of the original denial decisions were upheld. Of the 18 upheld denial decisions, 8 (44%) of the appeal resolution letters did not include the required IMR application and envelope addressed to the DMHC.

DHCS Two-Plan Contract, Exhibit A, Attachment 14, Member Grievance System, Provision 4(B)(2) – Notice of Action indicates that the members can request an IMR from the Department when receiving a NOA denying, deferring, or modifying medical services. Section 1300.68(d)(4) further requires that an IMR application and envelope addressed to the Department be included in responses to grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary. Because the Plan was non-compliant for this standard in 44% of appeals files reviewed, the Department finds the Plan in violation of these regulatory and contractual provisions.

Potential Deficiency #12: The Plan does not ensure that written member-informing materials, including notices pertaining to the denial of services, are translated into identified threshold languages. Additionally, the Plan has not established policies and procedures to enable members to make a standing request to receive all informing materials in a specified alternative format.

Statutory/Regulatory/Contract References: Section 1367.04(b)(1)(B)(iv); Section 1367.04(b)(1)(C)(i); DHCS Two-Plan Contract, Exhibit A, Attachment 9, Access and Availability, Provision 14 (B)(2) – Linguistic Services; and DHCS Two-Plan Contract, Exhibit A, Attachment 13, Member Services, Provision 4(C)(1) and (3) – Written Member Information.

Section 1367.04(b)(1)(B)(iv) states, in pertinent part, “Specification of vital documents produced by the plan that are required to be translated... (iv) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal.”

Section 1367.04(b)(1)(C)(i) states, “For those documents described in subparagraph (B) that are not standardized but contain enrollee specific information, health care service plans shall not be required to translate the documents into the threshold languages identified by the needs assessment as required by this subdivision, but rather shall include with the documents a written notice of the availability of interpretation services in the threshold languages identified by the needs assessment as required by this subdivision.”

DHCS Two-Plan Contract, Exhibit A, Attachment 9 – Access and Availability

14. Linguistic Services

B. Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential members:

- 2) Fully translated written informing materials including, but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages.

DHCS Two-Plan Contract, Exhibit A, Attachment 13 – Member Services

4. Written Member Information

C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor’s group needs assessment and approved by DHCS. The written Member information shall ensure Members’ understanding of the health plan processes and ensure the Member’s understanding of the health plan processes and ensure the Member’s ability to make informed health decisions.

- 1) Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, Provision 13, Linguistic Services.
- 3) Contractor shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- Cultural and Linguistic Services Policy, 11.01-I (reviewed June 13, 2013)
- Cultural and Linguistics Services Plan (undated)
- 2012-2013 Member Handbook
- NOA denial letters from 18 appeal files that were included as part of the random sample for standard grievances and appeals (for the review period July 2012 through June 2013) for which the original denial was upheld

Assessment: Spanish is the Plan’s threshold language. DHCS Two-Plan Contract, Exhibit A, Attachment 13, Member Services, Provision 4(C)(1) – Written Member Information indicates that written member-informing materials must be translated into the Plan’s identified threshold languages, and Section 1367.04(b)(1)(B)(iv) specifies that this includes notices pertaining to the denials.

Translation into Threshold Languages

The Department reviewed 18 original NOA denial letters that were included as part of the random sample for standard grievances and appeals for which the original denial was upheld. Although only one file specified the member's primary language as something other than English (Spanish in this case), all 18 denials processed by the Utilization Management Department contained copies of NOAs in both English and Spanish to the enrollees. However, in the Spanish letters, the reasons for the denials were in English rather than in Spanish.

Standing Request

Policy 11.01-I provides general policies on how the Plan goes about arranging for provision services for Limited English Proficient (LEP) or hearing impaired members. It states,

“ KHS will monitor that LEP or hearing impaired members are not subjected to unreasonable delays in receiving appropriate interpreter services when the need for such services is identified by the provider or requested by the LEP or hearing impaired member.

Appropriate linguistic services will be available for medical and non-medical points of contact including membership services, appointment services and member orientation sessions.

During regular business hours, members who require assistance with their language needs may call...

Members who require after hours assistance...may call...”

The Plan's 2012-2013 Member Handbook similarly provides information to members on how to go about accessing various linguistic services. It states,

“IMPORTANT LANGUAGE INFORMATION: You can get an interpreter at no cost to help you talk to your doctor or to Kern Family Health Care. To get an interpreter or to ask about written information in your language, please call...Hearing or speech impaired members can call...through the TDD/TTY line at 711. If you need more help, call the HMO Help Line...”

However, although both the policy and EOC address the availability of services and/or materials in alternative formats and include instructions to members on how to access these, there is no process in Plan policies that specifically outlines how a member's "standing request" might be processed so that no future requests need to be made once a language preference for written materials is established.

In an interview with the Director of Marketing and Member Services, and the Director of Compliance and Regulatory Affairs, when asked about the Plan's policy and procedure regarding accommodation of members who make a "standing request" to receive all informative materials in an alternative format, they referred the surveyor to the inside cover of the Member Handbook.

However, as quoted and mentioned above, there is nothing that addresses processes in place for “standing requests.”

DHCS Two-Plan Contract, Exhibit A, Attachment 13, Member Services, Provision 4(C)(3) – Written Member Information requires that each plan establish policies and procedures to enable members to make a standing request to receive all informing material in a specified alternative format. Because the Plan has not established such policies and procedures, the Department finds that the Plan is in violation of this contractual requirement.

Further, because the Plan did not put the reasons for denial in Spanish (in the Spanish translated version of the NOA denial letters sent to enrollees), and Spanish is the Plan’s identified threshold language, the Department finds the Plan in violation of Section 1367.04(b)(1)(B)(iv), Section 1367.04(b)(1)(C)(i), and DHCS Two-Plan Contract, Exhibit A, Attachment 9, Access and Availability, Provision 14 (B)(2) – Linguistic Services.

QUALITY MANAGEMENT

<p>In accordance with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan’s quality management processes including:</p>
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|--|
| <ul style="list-style-type: none">a. Verifying that health plans monitor, evaluate, and take effective action to maintain quality of care and to address needed improvements in quality.b. Verifying that health plans maintain a system of accountability for quality within the organization.c. Verifying that health plans remain ultimately accountable even when Quality Improvement Plan activities have been delegated. |
|--|

Potential Deficiency #13: The Plan does not consistently ensure that quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.

Statutory/Regulatory/Contract Reference: Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A)(B); Rule 1300.70(c); and DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement.

Rule 1300.70(a)(1) states, in pertinent part, “The QA program ... must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.”

Rule 1300.70(b)(1)(A)(B) states, “To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that: (A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees; (B) quality of care problems are identified and corrected for all provider entities.”

Rule 1300.70(c) states, “In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department.”

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

1. General Requirement

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

Supporting Documentation:

The Department requested and reviewed the following documentation:

- 2013 Quality Improvement Program Description
- 2013 Quality Improvement Work Plan
- 2012 Quality Improvement (QI) Program Executive Summary
- Organizational charts showing the relationship of the Quality Improvement Department and committees to the overall structure
- Minutes of the Quality Improvement/Utilization Management Committee (August 30, 2012; October 25, 2012; December 20, 2012; February 28, 2013; and June 27, 2013)
- Meeting minutes of Governing Body review of QI monitoring results
- Job description and résumé of physician who provides clinical direction to the QI Program
- 51 files for cases identified by the Plan as potential quality issues (PQIs). The cases were randomly selected from the universe of 141 PQIs (files received during the review period from July 2012 through June 2013 for which the Plan had *completed* its review)
- 14 files for cases identified by the Plan as PQIs. The cases were a targeted sample selected from the universe of 71 *pending* PQIs (files received during the review period from July 2012 through June 2013 for which the at the time the survey was initiated, the Plan had not yet completed review)

Assessment: To monitor the quality of care it provides, the Plan identifies cases for review as potential quality issues (PQIs) from a variety of sources, including complaints from members, mortalities, and readmissions. The Department identified the following concerns with the Plan’s operation of its PQI review system:

Quality of Care Reviews are not Conducted Timely

The Department requested a log of all cases that the Plan had identified as potential quality issues warranting investigation/clinical review for the survey review period from July 2012 through June 2013. The Plan submitted a log containing 222 cases received during the designated time period. However, at the time of receipt of the log (August 5, 2013), the Department found that the Plan had not yet completed review on 71 (32%) of these cases. The Department recognizes that a plan might reasonably need several weeks to collect pertinent medical records and conduct initial review, and if a problem is confirmed, additional weeks

thereafter to conduct further investigation and/or committee/peer review. Therefore, the Department isolated 180 cases for the period July 2012 through March 2013 (at least 5 months prior to receipt of the PQI log) to more fairly approximate and assess the proportion of cases that were still pending to examine associated lag times. However, the Department found that of these 180 earlier cases identified, 54 (30%) still had not been reviewed by the time the log was submitted. Even more significant, ten of these PQIs had been pending initial nurse review (i.e., had received no clinical/nurse or physician assessment) since October 2012 (*over nine months*); two PQIs had been pending since early November 2012 (*over eight months*); and nine PQIs had been pending since late February 2013 (*over five months*).

Review of PQI files revealed that the Plan experiences delays in making requests for and receiving information from providers (e.g., medical records) as well as with awaiting nurse/physician/committee review of cases. Examples of cases with specifically potential serious quality concerns and that did not undergo timely review include:

- PQI #58: This case involved an IV methamphetamine user with four admissions in a one-month span. The PQI was identified and referred for quality review on 10/17/12. Additional information was not requested until 3/8/13 (5 months later). Although additional records were received on 3/18/13 and assigned for nurse review, nurse review did not receive the file until 8/2/13 (5 months after request of documents). The case was finally reviewed by the nurse on 8/9/13 and then by the Associate Medical Director on 8/12/13 (10 months from case referral).
- PQI #64: This case involved a two year old with a history of recurrent Wilm's tumor. The PQI was identified 3/11/13. Medical records were initially requested on 3/19/13. Subsequent follow-up requests were made with all information eventually received on 8/2/13 (5 months later). The case remained "pending nurse review" status at the time of the Plan's onsite survey on 9/10/13 (6 months from case referral).
- PQI #52: This case involved a patient with cellulitis (infection). The PQI was identified and referred for quality review on 10/17/12. Additional information was requested on 12/10/12 and received on 3/18/13 (5 months after case referral). The case remained "pending nurse review" status at the time of the Plan's onsite survey on 9/10/13 (6 months from receipt of requested documents; 11 months from case referral).

All Quality Issues are not Identified

The Department reviewed 51 PQI files for which the Plan had completed its review and closed the case. Of the 51 files, 14 (27%) did not identify all potential quality issues involved. These cases (nearly three-quarters of the Plan's PQIs) involved readmissions to a hospital within 30 days from discharge. Plan staff stated that these types of readmissions (within 30 days from discharge) constitute over 14% of all readmissions during a one-year period span. Fifty-five percent of those occur within ten days from discharge of the patient. As part of its quality review process, the Plan routinely reviews the care rendered during the second admission; however, there is no documentation that evaluation of adequate discharge planning from the first admission is being reviewed. Therefore, although the PQI files document effective provision of medical treatment while in the hospital, they do not address any quality concerns regarding

inadequate discharge planning or examine why a discharge plan might have failed. As a result, with the exception of one hospital that utilizes a nurse case manager, no corresponding corrective action plans are ever implemented or analysis conducted of other barriers that may have contributed to readmission. For example:

- PQI #4: A homeless, pregnant female was admitted to the hospital and discharged without any assistance provided with obtaining shelter or medical follow-up. The patient had initially been identified as having sickle cell anemia, which was treated during the first admission. Discharge planning did not include any confirmed appointments for specialty referrals or follow-up for her hematological disease or high-risk pregnancy. There was also no social services involvement to address her homeless status. She was readmitted within two weeks from discharge. The “Readmission Review Worksheet [for] Readmission for Same or Related Conditions Within 30 days of Discharge” requires the reviewer to answer the following questions by checking either “yes” or “no”:
 - Were discharge orders appropriate?
 - Could readmission have been prevented by outpatient intervention/follow-up?

However, although the nurse reviewer leaves all of these fields blank with no response, a final determination of “no quality issue” is noted.

- PQI #10: A 400lb female patient was admitted with a co-morbid diagnosis of CO₂ narcosis (inability to breath). The discharge summary indicates that the member’s breathing machine at home is old and is not working properly. Discharge case notes document the need for either repair or replacement of her existing machine. Notes further indicate that the hospital case manager was made aware of this. However, the patient was instead discharged with only new supplies ordered. There was no documentation of coordination of care to demonstrate that the member was discharged with a functioning breathing machine at home. The patient was re-admitted within a few days through the emergency room. The “Readmission Review Worksheet [for] Readmission for Same or Related Conditions Within 30 days of Discharge” requires the reviewer to answer the following questions by checking either “yes” or “no”:
 - Were discharge orders appropriate?
 - Could readmission have been prevented by outpatient intervention/follow-up?

Although the nurse reviewer leaves all of these fields blank with no response, a final determination of “no quality issue” is noted.

Effective Action is not taken to Improve Care where Issues are Identified and Follow-Up is not Planned where Indicated

PQIs #24 and #68, both detailed in the Continuity of Care section of this report under Deficiency #4, exemplify the Plan’s failure to ensure that corrective actions were implemented for confirmed problems. In both cases, the Plan investigated and confirmed problems with the adequacy of discharge planning and sent letters to the facility requesting further investigation.

However, in both cases, the Plan did not require that corrective action be implemented. For example:

- PQI #24: The patient was admitted for a decubitus ulcer on his right foot. He was placed on IV antibiotics and discharged with orders to continue the Tobramycin at home with orders to the home health organization to continue his IV Tobramycin. However, orders were never sent to the Plan for authorization and when the home health nurse arrived two days after the member's discharge, she discovered that the he did not have any IV access. Therefore, Tobramycin was not administered in a timely manner. The Plan identified the case as a quality issue and issued a letter to the hospital indicating that discharge planning was inadequate. The letter states,

“It is expected that in the future, [the Plan] will be contacted with all admission to and discharges from [the facility]. It is further expected that any patient discharged with an order for home IV antibiotics would be discharged with safe and appropriate IV access.

We would appreciate follow up on the discharge planning that took place for this patient. We feel these series of events need the attention of your Quality Improvement process. Please contact KHS if we can be of any assistance in this process.”

However, no response was ever received from the hospital and in a case note, the Associate Medical Director stated the following, “No response was received from this letter, however the case will be closed at this time.” The Plan did not follow up with the provider to implement a corrective action plan even though a quality issue had been confirmed.

The following three cases involve a single provider with three separate PQIs. Although the Plan confirmed significant quality issues and sent a letter to the provider requesting response in only two of the three cases, collectively, these cases represent not only the Plan's failure to take effective action when individual quality issues are confirmed, but also failure to follow up when trends for a given provider are identified. For example:

- PQI #65: This case involved a heroin addict with a large abscess on his elbow. The physician took him from the emergency room to the operating room and did a debridement (drainage and cleaning of the abscess) under general anesthesia. However, the physician's credentialing file did not indicate that he had training for this procedure as he is not a surgeon and does not have authorization to perform surgery in the operating room. The Medical Director sent a letter to the physician on 6/19/13 stating,

“...When an abscess requires more than a bed side procedure; specifically when the patient requires a trip to the operating room and a general anesthetic, there are very few places on the body where an untrained operator is not at risk of doing significant damage.

If there is something in your training or background that we are missing that may support your ability to perform this kind of procedure please provide it to us in the next 30 days. Otherwise we will need a letter specifically outlining how you will not practice outside your training in the future.”

Case notes indicate that on 6/20/13, the file was calendared 30 days for provider response. Per instructions from the Medical Director, the case was subsequently calendared again for an additional 30 days on 7/30/13, 8/20/13, and 9/13/13 due to no response from the provider. The case was still pending at the time of the Department’s onsite survey with no response to the corrective action plan requested.

- PQI #5: This case involved a patient who was admitted and hospitalized due to uncontrolled diabetes and vertigo. The physician who treated her during the hospitalization was also her PCP. Management of the diabetes while the patient was in the hospital was identified as “poor” and the Plan sent a letter to the provider identifying numerous concerns regarding the member’s hospitalization and requested a response from the physician and the hospital. The hospital responded to the letter, providing a rationale for each point that the Plan had brought forth. Case notes state, “Received response from [hospital] (put in chart). Awaiting response from [PCP].” Although, response from the PCP was never received, case notes indicate that the Associate Medical Director reviewed the hospital’s response and immediately closed the case, stating, “5 items addressed separately – rather simplistic but did say that the Pharmacy department initiated a new process so that Toradol would not be given for more than 5 days. No further action is indicted [*sic*].”
- PQI #2: This case involved a patient who was undergoing chemotherapy for cancer of the cervix. She was admitted with cellulitis (infection) and an abscess. Her co-morbid medical conditions included sepsis, cervical cancer stage IB2, and post pulmonary embolism (blood clot – treated with Coumadin/blood thinner). The physician debrided (cleaned the abscess) and started her on Vancomycin antibiotic. The patient insisted on leaving the hospital against medical advice (AMA) and was therefore discharged. She was readmitted again within 30 days with urosepsis and neutropenia (infection and low white blood cell count). Although the case was identified as a PQI due to readmission, both hospitalizations were reviewed and no quality of care concerns were found.

During an interview, when asked about the pattern of PQI cases involving this individual provider, specifically PQI #65 where the provider was non-compliant with responding to the Plan’s request for corrective action, the Medical Director acknowledged that due to “political concerns,” the Plan did not elevate these issues to the Quality Improvement/Utilization Management Committee or Board of Directors.

The Plan’s lack of guidance in its Quality Improvement Program Description contributes to the Plan’s ineffectiveness with addressing quality issues. Examination of this document indicates that there are no clear policies or procedures set in place for recourse when providers fail to respond to a corrective action plan. Neither the Quality Improvement Program Description or any Plan policies and procedures contain a full description describing the continuous quality of

care cycle (evaluation of the potential quality issue; identification of confirmed quality concerns; implementation of a corrective action plan; and reassessment to measure whether the original concern has been remedied or not). The Plan's failure to ensure timely and adequate investigation of potential quality issues and effectively implement corrective actions where concerns are confirmed, enables problems to reoccur among repeat providers, negatively impacting the quality of care delivered to enrollees.

Rule 1300.70(a)(1) requires each plan to document that the quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement also requires plans to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Because the Plan does not ensure that potential quality of care issues are reviewed in a timely manner, all quality issues are identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated, the Department finds the Plan violation of these regulatory and contractual requirements.

Potential Deficiency #14: The Plan does not conduct ongoing oversight to ensure that its delegates are fulfilling all delegated quality improvement responsibilities.

Statutory/Regulatory/Contract Reference: Rule 1300.70(b)(2)(G)(1-4) and DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provisions 1 – General Requirement, and 6(A) and (B) – Delegation of Quality Improvement Activities.

Rule 1300.70(b)(2)(G)(1-4) states, in pertinent part, “Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

- (1) Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the plan.
- (2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise, and budgetary resources.
- (3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.
- (4) Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's QA program, and be assured of the entity's continued adherence to these standards.”

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

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in 28 CCR 1300.70. Contractor shall monitor, evaluate, and take effective

action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider...

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum:

- 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
- 2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
- 3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
- 4) Contractor's actions/remedies if subcontractor's obligations are not met.

B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:

- 1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
- 2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
- 3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- 2013 Quality Improvement Program Description
- 2013 Quality Improvement Work Plan
- 2012 Quality Improvement (QI) Program Executive Summary
- 2012 Quality Improvement (QI) Program Evaluation
- Organizational charts showing the relationship of the Quality Improvement Department and committees to the overall structure
- Minutes of the Quality Improvement/Utilization Management Committee (August 30, 2012; October 25, 2012; December 20, 2012; February 28, 2013; and June 27, 2013)
- Meeting minutes of Governing Body review of QI monitoring results
- Case Management Vendor Contract (March 8, 2012)
- Population Summary Report from Case Management vendor (report end date August 1, 2013)

Assessment: The Plan delegates claims processing and some case management responsibilities to one particular vendor. Although these case management responsibilities are nowhere clearly defined, the Plan indicated that the delegate provides case management for high-risk enrollees, including SPDs. Additionally, the Plan delegates the operation of its Health Advice Line to a

second vendor. However, the Department found that the Plan could not demonstrate adequate oversight of either of these two delegates. For example:

- The Plan shared its case management vendor contract with the Department. However, the contract neither references the vendor's case management responsibilities nor addresses any auditing or oversight of case management activities at all. Instead, it appears to be an amendment to an agreement involving claims processing software.
- A brief audit report from the case management vendor to the Plan was also available for review. This was a two-page document that captures population statistics regarding members identified during the quarterly reporting period. However, this report, too, did not contain any comprehensive information or evidence of oversight monitoring for case management.
- No contracts or audit reports were available for review of the second delegate who operates the Plan's Health Advice Line.

Further, the Plan does not maintain delegation agreements that detail specific delegated services, administrative responsibilities, procedures for exchanging information/coordinating care, and reporting/monitoring responsibilities with each delegate. The Plan also does not ensure that the delegate's Quality Improvement Program includes standards for evaluating whether members receive health care consistent with professionally recognized standards of practice. Periodical reviews of the delegate's quality management work plan are not conducted.

The Plan was unable to produce documentation for either of the two delegates demonstrating ongoing oversight of performance such as comprehensive audits or periodic site visits for the previous year. As a result, there is no evidence to support that corrective actions are implemented or follow-up reviews conducted to address any identified deficiencies in the delegated entities.

Rule 1300.70(b)(2)(G) permits plans to delegate quality assurance activities to other entities, but requires plans that do so to retain responsibility for that care. It further requires plans to inform delegates of its quality assurance program, the scope of the delegate's quality assurance responsibilities, and how it will be monitored by the Plan. The Plan must conduct ongoing oversight to ensure that the delegate fulfills its responsibilities and that standards for evaluating that members receive health care consistent with professionally recognized standards of practice are included in the delegate's quality assurance program.

DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provisions 1 – General Requirement, and 6(A) and (B) – Delegation of Quality Improvement Activities reinforce that a plan is accountable for the quality of all subcontracted/delegated services. It further requires plans to incorporate specific elements in delegate contracts (e.g., descriptions of quality improvement responsibilities, specific delegated functions, plan oversight processes, reporting requirements, and actions/remedies for non-compliance with delegate obligations) and conduct ongoing oversight to ensure that delegates meet standards set forth by the Plan and DHCS.

Because the Plan does not maintain contracts with its delegated entities that delineate specific quality improvement responsibilities and functions, ensure that the delegate's Quality Improvement Program includes standards for evaluating whether members receive health care that are consistent with professionally recognized standards of practice, and demonstrate ongoing monitoring of delegate performance through activities such as audits, site visits, and progress/performance reports, the Department finds the Plan in violation of these regulatory and contractual requirements.

Potential Deficiency #15: The Plan's Quality Assurance Program does not include adequate staffing of physician and/or other appropriately licensed professionals to monitor the full scope of clinical services rendered and ensure that corrective action and follow-up is taken when indicated.

Statutory/Regulatory/Contract References: Rule 1300.70(a)(1); Rule 1300.70(b)(2)(D), (E), and (F); DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provisions 1 – General Requirement, and 7(B), (E), (G), and (I) – Written Description.

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."

Rule 1300.70(b)(2)(D) states, in pertinent part, "Implementation of the QA program shall be supervised by a designated physician(s),..."

Rule 1300.70(b)(2)(E) states, "Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved."

Rule 1300.70(b)(2)(F) states, "There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the plan and delegated entities."

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

1. General Requirement

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

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

- B. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QIS committee(s) and staff within the Contractor's organization.
- E. The role, structure, and function of the quality improvement committee.
- G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.
- I. Description of the activities, including activities used by members that are Seniors and Persons with Disabilities and chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

Supporting Documentation:

The Department requested and reviewed the following documentation:

- 2013 Quality Improvement Program Description
- 2013 Quality Improvement Work Plan
- 2012 Quality Improvement (QI) Program Evaluation
- Organizational charts showing the relationship of the Quality Improvement Department and committees to the overall structure
- Minutes of the Quality Improvement/Utilization Management Committee (August 30, 2012; October 25, 2012; December 20, 2012; February 28, 2013; and June 27, 2013)
- Meeting minutes of Governing Body review of QI monitoring results
- Job description and résumé of physician who provides clinical direction to the QI Program
- 51 files for cases identified by the Plan as potential quality issues (PQIs). The cases were randomly selected from the universe of 141 PQIs (files received during the review period from July 2012 through June 2013 for which the Plan had *completed* its review)
- 14 files for cases identified by the Plan as PQIs. The cases were a targeted sample selected from the universe of 71 *pending* PQIs (files received during the review period from July 2012 through June 2013 for which the at the time the survey was initiated, the Plan had not yet completed review)

Assessment: The Plan's lack of a sufficient qualified Quality Improvement staff is most clearly evident in its failure to handle PQIs in a timely and effective manner. Of the 180 PQI cases that the Department isolated for the period July 2012 through March 2013, the Department found that 54 (30%) still had not been reviewed by the time the log was submitted (August 2013). Even more significant, ten of these PQIs had been pending initial nurse review (i.e., had received no clinical/nurse or physician assessment) since October 2012 (*over nine months*); two PQIs had been pending since early November 2012 (*over eight months*); and nine PQIs had been pending since late February 2013 (*over five months*). (See Deficiency #13 for further details.)

Additionally, the Plan failed to conduct a number of activities, which are standard practice for quality management programs. For example:

- Follow-up of access survey results (See Deficiency #8).
- Ongoing oversight of its delegates (See Deficiency #14).
- Oversight of Member Services –Plan staff confirmed during interviews that the Quality Improvement Department has not provided written guidelines, oversight, or monitoring (auditing of sample cases, etc.) to ensure that call center staff are accurately identifying and referring potential quality of care concerns for clinical review.

The lack of clinical staff to carry out an effective Quality Improvement Program is further apparent in two vacant positions for Medical Director and nurse (in Quality Improvement). In an interview with the Plan, staff acknowledged that they are “stretched.”

Rule 1300.70(a)(1) requires that each plan’s quality assurance program 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. To fulfill these responsibilities, Rule 1300.70(b)(2) (D) states that the program shall be supervised by a designated physician(s) and subsection (E) states that professional participation must be adequate. Subsection (F) requires each plan to have sufficient qualified administrative and clinical staff support to carry out quality management activities. DHCS Two-Plan Contract, Exhibit A, Attachment 4, Quality Improvement System, Provision 1 – General Requirement supports these mandates by requiring plans to monitor, evaluate, and take effective action to address any needed improvements in quality of care. Because Plan staff are unable to perform key activities such as completing timely PQI reviews, following-up on access survey results, conducting ongoing oversight of its delegated activities, and monitoring internal processes such as member services oversight, the Department finds the Plan does not have adequate professional participation in its quality program and is in violation of these regulatory and contractual requirements.

A P P E N D I X A

APPENDIX A. SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS

Jeanette Fong	Survey Team Lead, (916) 255-3367
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MANAGED HEALTHCARE UNLIMITED, INC. TEAM MEMBERS

Patricia Schano, MEd	Access and Availability of Services
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Martin Glasser, MD	Continuity of Care, Quality Management
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Ruth Martin, MBA, MPH	Utilization Management
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Pamela Simpson, RN	Member Rights
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A P P E N D I X B

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED FROM: Kern Health Systems	
Doug Hayward	Chief Executive Officer
Remington Brooks, MD	Medical Director
Becky Davenport	Chief Operating Officer
Richard Pruitt	Chief Information Officer
Robin Plumb	Controller
Carl Breining	Director of Compliance & Regulatory Affairs
Trannie Ryan	Director of Claims
Deborah Murr, RN	Director of Health Services
Linda Howells, RN	Director of QI/Health Education/Disease Management
Bruce Wearda	Director of Pharmacy
Louis Iturrina	Director of Marketing and Member Services
Emily Silva	Director of Provider Relations
Veronica Barker	Accounting Supervisor
Isabel Silva	Health Education & Disease Management Manager
Nate Scott	Member Services Manager
Lela Criswell	Member Services Supervisor
Jake Hall	Provider Relations Supervisor
Astrid Enriquez	Marketing Cultural and Linguistics Lead Representative
Beth Espinoza	Compliance Business Analyst
Linda Lynd	AIS Compliance Auditor
Sheilah Woods	Executive Services Coordinator

A P P E N D I X C

APPENDIX C. LIST OF FILES REVIEWED

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

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Utilization Management	18	The Department selected a random sample of 59 standard Grievances & Appeals files, 19 of which were identified as Appeals. 18 of the 19 Appeals files contained denials upheld by the Plan.
Grievances & Appeals	27 Grievances 19 Appeals	The Department selected a random sample of 59 standard Grievances & Appeals files (40 Grievances & 19 Appeals).
PQIs	51 Closed 14 Pending	The Department selected a random sample of 51 closed PQI files and a targeted sample of 20 pending PQI files.