State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Carl Breining
Director of Compliance & Regulatory Affairs
Kern Family Health Plan
9700 Stockdale Highway
Bakersfield, CA 93311-3617

RE: CAP Close out Letter for 1115 Waiver SPD Enrollment Survey

Dear Mr. Breining:

The Department of Managed Health Care (DMHC) conducted an onsite 1115 Medicaid Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey of Kern Health Systems, a Managed Care Plan (MCP), from September 10, 2013 through September 13, 2013. The audit covered the review period of July 1, 2012, through June 30, 2013.

On July 2, 2014, the MCP provided DHCS with a response to its Corrective Action Plan (CAP) originally issued on March 19, 2014.

A review of all remaining open items has been found to be in compliance and the CAP is hereby closed. The enclosed report will serve to provide as DHCS's final response to the MCP's CAP.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

If you have any questions, contact Mr. Edgar Monroy, Chief of Plan Monitoring Unit at (916) 449-5233 or edgar.monroy@dhcs.ca.gov.

Sincerely,

Originally Signed By Nathan Nau

Nathan Nau, Chief
Medical Monitoring and Program Integrity Section

cc: Tereza Majkovica, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413

CORRECTIVE ACTION PLAN

Plan Name: Kern Health Systems

Review Type: 1115 Waiver SPD Enrollment Survey **Review Period: July 1, 2012 through June 30, 2013**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
UTILIZATION MANAGEMENT Potential Deficiency 1 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.	The development of new medical criteria and guidelines for use in determining medical necessity will be vetted with the Physician's Advisory Committee (PAC). Once final recommendations and approval have been confirmed by the PAC of each criteria, the pending criteria will be presented to the QI/UM committee for final implementation. The discussions will be documented in the PAC and QI/UM minutes, which will reflect the involvement of actively practicing health care providers thereby documenting the involvement of actively practicing health care professionals. PAC Meeting Schedule 2014: Jan 8 Jul 2 Feb 5 Aug 6 Mar 5 Sept 3 Apr 2 Oct 1 May 7 Nov 5 June 4 Dec 3 ***Please see Attachment A:*** ***Plan Policy 3.25-I, Authorization Review and Approval Levels*** ***Plan Policy 3.26-I, New Medical Technology Coverage***	3/7/2014	The MCP submitted its P&P 3.25-I, Authorization Review and Approval Levels, P&P 3.26-I, New Medical Technology Coverage Decisions, and P&P 13.04-I - Formulary Process and Drug Utilization. The MCP has taken appropriate action to address this deficiency. In order to close this item, please submit the final version of P&P 3.26-I, New Medical Technology Coverage Decisions, and minutes of March 5th PAC meeting. This item remains open. **Update 7/2/14:** The MPC submitted the final version of P&P 3.26-I, New Medical Technology Coverage

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
	Decisions ***Plan Policy 13.04-I, Formulary Process and Drug Utilization*** ***Responsibility:*** ***Utilization Management*** ***Director of Health Services***		Decisions, and minutes of March 5th PAC meeting. **This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
Potential Deficiency 2 Plan does not systematically and routinely analyze utilization management data (other than HEDIS) to monitor for potential over- and –under utilization and take corrective action when indicated. Section 1363.5(b)(1) and DHCS Two-Plan Contract, Exhibit A, Attachment 5, Utilization Management, Provision 4 – Review of Utilization Data	The Plan will initiate quarterly audits performed by UM audit staff utilizing encounter and authorization data to detect over- and under-utilization with the initial audit to be completed end of 1st quarter 3/31/2014. When aberrant utilization is detected, the impacted provider will receive written notification from KHS detailing the identified over- or under-utilization of services, the member(s) involved, and the type of utilization data reviewed. KHS staff will work in collaboration with the provider to assist in coordinating receipt of under-utilized authorized services and reduce barriers to the members. Provider education on appropriate service requests to avoid over –utilization of services is supported through sharing of criteria and discussion. Calendar of scheduled Audits 2014: Q1 2014 Q2 2014 Q3 2014 Q4 2015 Members are case managed internally by the Case Management team specifically created for Seniors and Persons with Disabilities (SPD) or any other member identified as high risk in need of case management services via the Member Health Summary (MHS).	Ongoing 4/15/2014 7/15/2014 10/15/2014 01/15/2015 Ongoing	The MCP submitted its P&P 2.26-I, Hospital Re-admissions – Identification of Potential Quality of Care Issues, P&P 3.61-I, Comprehensive Case Management and Coordination of Care, and PowerPoint Slides titled, "Innovations in Addressing the Needs of Low-Income Populations." The MCP has taken appropriate action to address this deficiency. In order to close this item, please submit the Q1 2014 Audit results. This item remains open. **Update 7/2/14:** The MCP submitted Q1 2014 Audit results for over and underutilization of services.

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
	The MHS is a workflow software program resource developed to provide a centralized mechanism of information and communication for member data and care coordination. The MHS monitors inpatient admissions, thirty (30) day readmissions, and SPD case management needs. Care plans are created and forwarded to the member's assigned PCP. Barriers to care are evaluated and if indicated, internally generated authorization of services is secured and communicated via the current authorization policy. Created in mid-2012, the Transition of Care team approach consists of an in hospital concurrent review RN, Discharge Planner, Pharmacist supported medication reconciliation, and Post Discharge Physician supervised clinic. The Quality Improvement Department revised the process of reviewing thirty (30) day readmissions to include the assignment of a specific QI/RN to review the records for each member exhibiting high utilization. Having a specific QI/RN who reviews each admission of the member(s) assigned to them allows for a more thorough review and the opportunity to identify trends and potential root causes of readmissions. Summaries now include discharge plans for each discharge. The	11/2013 12/2013	**This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
	above referenced process was trialed November 2013 and has subsequently been adopted for all QI review summaries. When no quality of care issue has been identified, members with high utilization of hospital resources are reviewed for enrollment in Care Management, Disease Management, or Health Education services. This began December 2013 and is ongoing. Various methods of tracking both quality of care and high utilization have been trialed with varying success. Currently, once members with high utilization are identified, all admissions and ER visits are tracked. Additionally, days between admissions are tracked to determine if the interventions trialed are successful in decreasing utilization. ***Please see attachment B:*** ***Plan Policy 2.26-I, Hospital Re-admissions – Identification of Potential Quality of Care Issues*** ***Plan Policy 3.61-I, Comprehensive Case Management and Coordination of Care*** ***PowerPoint Slides titled, "Innovations in Addressing The Needs of Low-Income Populations."*** ***Responsibility:Utilization Management*** ***Director of Health Services***	Ongoing	

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
Potential Deficiency 3 Plan's utilization management NOA denial letter do not consistently include: 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. Section 1363.5(b)(4); Section 1367.01(h)(4) and (5); 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.	The Plan currently conducts Notice of Action (NOA) letter audits for all Case Management clinical staff responsible for medical decision notifications upon hire for a period of three (3) months. During the audit period, each NOA letter is reviewed for clear, concise, and easily understood language by the UM Audit staff. Individual staff continues to be audited until an error rate of less than 10% is achieved. Upon staffs' release of audit, periodic random audits are initiated quarterly to ensure compliance with NOA language. If non-compliance with NOA requirements are identified, the clinical staff receives additional training and is again placed on an additional three (3) month audit period or until error rate <10%. Please refer to the attachment for an Audit of Q4' 2013 with 100% compliance. Clinical staff has received additional education and training for completing the date of anticipated decision field on delay NOA letters. Additionally, this is a point of audit review for compliance. The Plan ceased use of Medical Director Review as a permissible criterion cite for NOA letter notification. Audits are currently conducted on a quarterly basis and reported to the QI/UM committed on the following measures; timeliness of member and provider notification, presence of MD signature, and criteria	Ongoing	The MCP submitted its Q4' 2013 Delayed DDM Template for delay NOA letters and has taken appropriate action to address this deficiency. **This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
	referenced included in the notification. <u>Calendar of scheduled Audits 2014:</u> Q1 2014 Q2 2014 Q3 2014 Q4 2015 ***Please see Attachment C:*** ***Q4' 2013 Delayed DDM*** ***Template for delay NOA letters*** ***Responsibility:*** ***Utilization Management*** ***Director of Health Services***	 4/15/2014 7/15/2014 10/15/2014 01/15/2015	

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
CONTINUITY OF CARE Potential Deficiency 4 The Plan does not maintain the necessary methodologies and processes to ensure coordination and continuity of care. 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.	The Plan has implemented various coordination and continuity of care methodologies and processes to maintain the necessary service to ensure member continuity of care and coordination of care. Members are case managed internally by the Case Management team specifically created for Seniors and Persons with Disabilities (SPD) or any other member identified as high risk in need of case management services via the Member Health Summary (MHS). MHS is a workflow software program resource developed to provide a centralized mechanism of information and communication for member data for continuity and care coordination. In addition, staff are trained to utilize research resources such as SPD data received from Fee For Service MCAL as well as any historical data contained within in KHS Alchemy system (data depository) and MHC (core claim system) is reviewed prior to determining new or ongoing services to ensure continuity of care. The MHS Workflow monitors inpatient admissions, thirty (30) day readmissions, and SPD case management needs. Care plans are created and forwarded to the member's assigned PCP. Barriers to care are evaluated and as necessary, internally generated authorizations for services are secured and communicated per the current authorization policy. Created in mid-2012, the Transition of Care team approach consists of an in hospital concurrent review	Ongoing	The MCP submitted its P&P 2.26-I, Hospital Re-admissions-Identification of Potential Quality of Care Issues and P&P 3.61-I, Comprehensive Case Management and Coordination of Care. The MCP has taken appropriate action to address this deficiency. In order to close this item, please submit a sample of actual beneficiary continuity of care workflow (please redact beneficiary's identifying information). This item remains open. **Update 7/2/14:** The MCP submitted a sample of actual beneficiary continuity of care workflow.

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
	RN, Discharge Planner, Pharmacist supported medication reconciliation, and Post Discharge Physician supervised clinic. The Quality Improvement Department revised the process of reviewing thirty (30) day readmissions to include the assignment of a specific QI/RN to review the records for each member exhibiting high utilization. Having a specific QI/RN who reviews each admission of the member(s) assigned to them allows for a more thorough review and the opportunity to identify trends and potential root causes of readmissions. Summaries now include discharge plans for each discharge. The above referenced process was trialed November 2013 and has subsequently been adopted for all QI Review Summaries. When no quality of care issue has been identified, members with high utilization of hospital resources are reviewed for enrollment in Care Management, Disease Management, or Health Education services. This began December 2013 and is ongoing. Various methods of tracking both quality of care and high utilization have been trialed with varying success. Currently, once members with high utilization are identified, all admissions and ER visits are tracked. Days between admissions are tracked to determine if the	11/01/2013 12/01/2013	**This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
	interventions trialed are successful in decreasing utilization. ***Please see attachment D:*** ***2.26-I, Hospital Re-admissions-Identification of Potential Quality of Care Issues*** ***3.61-I, Comprehensive Case Management and Coordination of Care*** ***Responsibility:*** ***Utilization Management*** ***Director of Health Services***		

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
Potential Deficiency 5 The Plan does not ensure that all medically necessary covered services are provided to members until California Children's Service's (CCS) eligibility is confirmed. DHCS Two-Plan Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 9(A)(4)- California Children Services (CCS).	All potentially CCS eligible conditions will be reviewed for medical necessity, and if approved, will be forwarded to CCS for review. KHS will endeavor to use CCS paneled providers to reduce continuity of care issues. If a provider is not KHS contracted, a Letter of Agreement will be drafted to ensure timely and appropriate delivery of care. KHS will cover all eligible medically necessary services until California Children's Services (CCS) eligibility is confirmed. An adjudicator code currently in place in our core claims adjudication system will allow for reporting and tracking of the approved CCS conditions. The CMS SAR system is utilized to research approved or denied decisions rendered by CCS. Updates to the member's treatment plan and authorization history will be completed to ensure accuracy. KHS and CCS clinical personnel will meet bi-monthly beginning 4/1/14 to ensure timely eligibility determination and financial responsibility for the services rendered. ***Attachment E:*** ***3.16-P, California Children's Services*** ***Responsibility:*** ***Utilization Services - Director of Health Services***	3/14/2014

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
Potential Deficiency 6 The Plan fails to maintain a dedicated liaison to coordinate with each regional center operating within the Plan's service area. DHCS Two-Plan Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 10(B)- Services for Persons with Developmental Disabilities.	The Policy 3.03-P, *Kern Regional Center Services,* identified the Chief Health Services Officer (CHSO) as the liaison responsible for Regional Center coordination for receipt of services. The position of CHSO was eliminated in 2012 and the responsibility was transferred to the Director of Health Services who oversees UM's Clinical Intake Coordinator and Social Worker staff. The Clinical Intake Coordinator and Social Worker staff serves in the liaison role between KHS and Kern Regional Center. ***Please refer to attachment F:*** ***3.03-P, Kern Regional Center Services*** ***Responsibility:*** ***Utilization Services*** ***Director of Health Services***	Ongoing	The MCP submitted its P&P 3.03-P, Kern Regional Center Services. The MCP has taken appropriate action to address this deficiency. In order to close this item, please submit the final version of P&P 3.03-P, Kern Regional Center Services. This item remains open. **Update 7/2/14:** MCP submitted the final version of P&P 3.03P and Kern Regional Center Services. **This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
<u>AVAILABILITY & ACCESSIBILITY OF SERVICES</u> <u>Potential Deficiency 7</u> 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. 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.	KHS will conduct an annual contracted provider survey, in accordance with *4.30-P, Accessibility Standards, Section 4.4, Provider Survey,* to solicit feedback regarding compliance with timely access standards. KHS will use modified talking points from the ICE Appointment Availability Survey to conduct an annual contracted provider survey. In accordance with *4.30-P, Accessibility Standards, Section 5.0, Reporting,* the survey will be sent out annually (July) with a final report to Executive Staff and QI/UM Committee no later than December of the same year. Please see the attached survey. ***Please see attachment G:*** ***4.30-P, Accessibility Standards*** ***2.22-P, Facility Site Review*** ***Responsibility:*** ***Provider Relations*** ***Director of Provider Relations***	July 2014	The MCP submitted its P&P 4.30-P, Accessibility Standards and P&P 2.22-P, Facility Site Review. The MCP has taken appropriate action to address this deficiency. In order to close this item, please submit the final revision of P&P 4.30-P and P&P, 2.22-P, and a sample of Provider Survey. This item remains open. **Update 7/2/14:** The MCP submitted the final version of P&P 2.22 Facility Site Review, an unsigned revision of P&P 4.30-P Accessibility Standards, and a template for provider Survey. Please submit the final revision of P&P 4.30. **This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
Potential Deficiency 8 The Plan does not adequately follow-up on potential access problems. Rule 1300.67.2(e) and (f); Rule 1300.67.2.2(d)(2)(F)(3); and DHCS Two-Plan Contract, Exhibit A, Attachment 9, Access and Availability, Provision 4- Access Standards.	The Plan will comply with investigative and follow up procedures for potential access issues identified and reported to the Provider Relations Department in accordance with Policy 4.30-P, *Accessibility Standard*, specifically section 4.1.2: Any contracted provider found to be out of compliance with an access standard will be issued a letter notifying the provider of non-compliance along with a copy of the access policy. Any providers found to be out of compliance a second time, may be issued a Corrective Action Plan (CAP) as described in *2.04-P, Provider Disciplinary Action.* KHS will use the following sources to validate compliance with access standards: • Appointment Availability Survey Program Access grievances/1000 member months • Member Service Data • Member Satisfaction Survey • Annual Provider Survey • Access grievances/1000 member months The UM Department routinely reports information regarding access to specialists sharing this information with the: Provider Relations Director, Provider Relations	3/6/2014	The MCP submitted its P&P 2.04-P, Provider Disciplinary Action, P&P 4.30-P, Accessibility Standards, QI/UM Committee Agenda, and 2014 Quality Management Improvement Work Plan. The MCP has taken appropriate action to address this deficiency. In order to close this item, please submit the final version of P&P 4.30-P, Accessibility Standards. This item remains open. **Update 7/2/14:** The MCP submitted a version of P&P 4.30-P, Accessibility Standards which is not finalized. Please submit the finale version of this document. **This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
	Supervisor, Medical Director and CEO. Additionally, the Director of QI, Health Education, and Disease Management reviews all reports submitted for inclusion in the QI/UM Committee agenda to identify opportunities for improvement. ***Please see attachment H:*** ***2.04-P, Provider Disciplinary Action*** ***4.30-P, Accessibility Standards*** ***QI/UM Committee Agenda*** ***2014 Quality Management Improvement Work Plan*** ***Responsibility:*** ***Provider Relations*** ***Director of Provider Relations***		

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
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." 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.	The Plan will implement an improved tracking and monitoring mechanism that will allow clear documentation of Physical Accessibility Reviews. At least annually, KHS will use internal claims data from the past twelve (12) months to identify all specialists who served a KHS SPD member. A report will be created that includes at a minimum, the following data categories: provider name, NPI number, tax identification number, KHS internal provider ID number, KHS internal vendor ID number, Medi-Cal specialty description, place of service, and the number of SPD related claims. KHS will total the number of claims for each specialty types and, determine the average the number of claims for all specialties as a whole. Specialty types, whose claim numbers exceed the established average, will be considered High Volume SPD Specialties. The provider sites in each of these specialties will then be required to undergo a Physical Accessibility Review Survey within 90 days of being notified by KHS. The Plan updated the Provider Directory and website's Provider Search feature to include all necessary and appropriate accessibility language. To be released in March 2014, the new website will list basic access (BA), limited access (LA), or Medical Equipment Access (MEA) for each applicable provider	3/14/2014 March 2014	The MCP submitted its P&P 2.22-P, Facility Site Review, P&P 4.30-I, Accessibility Standards, and MCAL Provider1_2014_FINAL_PAGE 4-5. The MCP has taken appropriate action to address this deficiency. In order to close this item, please submit the final version of P&P 2.22-P, Facility Site Review and P&P 4.30-I, Accessibility Standards. This item remains open. **Update 7/2/14:** The MCP submitted the final, signed version of P&P 2.22P and a copy of 4.30P, however, this P&P is not signed/approved. Please submit the final version of this document.

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
	on the doctor search. For the 2014-15 Provider Directory (PD), the BA, LA, MEA was added with an explanatory narrative. For future PDs the three (3) additional codes will be added under each applicable provider. ***Please see attachment I:*** ***Plan Policy 2.22-P, Facility Site Review*** ***Plan Policy 4.30-I, Accessibility Standards*** ***MCAL Provider1_2014_FINAL_PAGE 4-5*** ***Responsibility:*** ***Provider Relations*** ***Director of Provider Relations***		**This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
MEMBER RIGHTS 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. 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.	Plan Policy 5.01-I, *Member Grievance Policy,* was revised to make clear the sections of the policy that provide that the appropriate mechanisms and practices used by the Plan are in compliance with Department regulations. Policy 5.01-I, *KHS Member Grievance Process,* to make clear that *Section 2.3.5, Medical Review*, provides that medical records and documentation pertaining to the subject of the grievance are forwarded to the Plan's Medical Director, who is a medical doctor with appropriate clinical expertise, for review prior to the Grievance Committee meeting; the final decision is determined by an individual who has not participated in any prior decisions related to the grievance. Attachment M, *Medical Director Records/Response Recommendation* form, of this policy is used to document the Medical Director's review of the grievance. This form serves as proof that the appeal decision is resolved by an individual who did not participate in the prior decision. The presence of Plan's Medical Director and/or Associate Medical Director at the Grievance Committee meeting is mandatory. ***Please see attachment J*: *Plan Policy 5.01-I, KHS Member Grievance Process*** ***Attachment M, Medical Director Records/Response Recommendation form*** ***Responsibility: Member Services - Director of Marketing and Member Services***	3/13/2014	The MCP submitted its P&P 5.01-I, KHS Member Grievance Process with Medical Director Records/Response Recommendation form. The MCP has taken appropriate action to address this deficiency. In order to close this deficiency, please submit the final version of P&P 5.01-I, KHS Member Grievance Process. This item remains open. **Update 7/2/14:** The MCP submitted a signed/approved copy of P&P 5.01-I, which, in section 2.3.5, contains the requirement for medical records and documentation for appeals of clinical denial to be forwarded to the MCP Medical

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
			Director, or Associate Medical Director, for review. It also states that the reviewer must not have participated in the original decision. The P&P also contains an attachment (Attachment L, incorrectly identified as Attachment M in the Plan of Action) which is the Medical Director Records/Response Recommendation form. **This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
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. Section 1300368(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.	The Plan has revised Policy 14.51-P, *Independent Medical Review* and Policy 5.01-I, *KHS Member Grievance Process* to include that *all* grievances involving an appeal for any delayed, modified or denied services shall include an application for an IMR, instructions and an envelope addressed to the DMHC with the resolution response. 14.51-P, *Independent Medical Review, Section 1.0, Qualifications for Independent Medical Review,* indicate that the IMR process is not available to Medi-Cal members for review of services denied as not a covered benefit. The 8 appeals described as inconsistent in the findings were closed as Coverage Dispute issues and were not determined to be an issue involving a denial, delay, or modification of a service based on Medical Necessity and, therefore, did not qualify for an IMR application, instructions and envelope addressed to DMHC. However, all grievance appeal acknowledgements include the required language and information regarding the Department of Managed Health Care's IMR process and of their right to file a complaint with the Department of Managed Health Care except where the grievance was received by the Plan through a filing of a Medi-Cal Fair Hearing. Documentation of acknowledgment and Resolution responses for grievances include the required language	3/13/2014	The MCP submitted its P&P 5.01-I, KHS Member Grievance Process and P&P 14.51-P, Independent Medical Review. The MCP has taken appropriate action to address this deficiency. In order to close this deficiency, please submit the final version of P&P 5.01-I, KHS Member Grievance Process. This item remains open. **Update 7/2/14:** The MCP submitted a copy of P&P 5.01-I, signed and approved. **This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
	that provides notice of the IMR process with the toll-free number to the DMHC and of the member's right to contact the DMHC. ***Please see attachment K:*** ***Plan Policy 5.01-I, KHS Member Grievance Process*** ***14.51-P, Independent Medical Review*** ***Responsibility:*** ***Member Services*** ***Director of Marketing and Member Services***		

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
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. 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.	Available in both English and Spanish, NOA letters include this required language: *"IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Kern Family Health Care's Member Services Department at 1-800-391-2000 right away."* Certified bilingual Member Services Department Call Center Representatives are available in person and via phone to assistance members with written materials. The Plan is developing a project charter for the implementation of a programmatic translation, which will be used for NOA letters. A copy of the initial project charter is attached. After the charter is finalized, the project will require ninety (90) days for completion. KHS Policy 11.01-I, *Cultural and Linguistic Services, Section 1.0 "Provision of Services"* was revised to include this language: "*Members who require materials in another language (English or Spanish) or in an alternative format (large print, audio, braille), may call the KHS Member Services Department at (661) 632-1590 (Bakersfield), (800) 391-*	Ongoing

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
	2000 (outside of Bakersfield) or through the TDD/TTY line at 711 during regular business hours. The Member Services Department will log the request for materials in alternative format in the KHS system. The request will also be forwarded via e-mail to the KHS Cultural & Linguistics Representative who will add the request to the "Member Material Alternative Format Request Log". This log will be available on the Marketing SharePoint site for all KHS staff. KHS staff will refer to the KHS system or the log when coordinating KFHC member mailings, so that materials are mailed in the appropriate format." ***Attachment L:*** ***Plan Policy 11.01-I, Cultural and Linguistic Services*** ***Project Charter Translation*** ***Alternative Format Requests Log*** ***Responsibility:*** ***Marketing*** ***Director of Marketing and Member Services***		

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
QUALITY MANAGEMENT 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. 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 Requirements.	The in-patient nurse case management team has been coached to diligently evaluate quality of care issues during the daily review of the in-patient admissions. Any issues found are raised with the Medical and QI Directors. Policy 2.26-I, *Hospital Re-admissions*, was updated to reflect that answers to four (4) of the six (6) questions included in Attachment A, *Readmission Review Worksheet*, will determine if further review is warranted. Policy 2.26-I provides the UM/QI team with a guideline for identifying potential quality issues. Plan UM Case Managers (CM) located in four (4) main hospitals provide oversight and appropriate discharge planning. In-house CMs routinely engage with hospital employed CM in other hospitals where members may be admitted. The plan has a Case Manager Nurse on call 24-hours per day and a weekend nurse on site at the hospital with the highest number of admissions. This has greatly decreased omissions at discharge as home health orders, pharmacy TAR, and durable medical equipment are all arranged prior to member discharge. Additionally, a pharmacy review and a Transition of Care outpatient visit are both set up for discharging members. The Plan has the Care Management team call each member at home after discharge to identify any further	3/6/2014 8/31/2014	The MCP submitted its P&P 2.04-P, Provider Disciplinary Action and P&P 2.26-I, Hospital Re-admission – Identification of Potential Quality of Care Issues. The MCP has taken appropriate action to address this deficiency. **This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
	needs/concerns. The plan has implemented a thirty (30) day action/response requirement on the initial letter to a provider/facility when a letter is sent out regarding a quality of care concern. Follow-up to the response (or lack thereof) will be more carefully evaluated on an individual basis. ***Please see Attachment M:*** ***Plan Policy 2.04-P, Provider Disciplinary Action*** ***Plan Policy 2.26-I, Hospital Re-admission – Identification of Potential Quality of Care Issues*** ***Responsibility:*** ***Quality Improvement*** ***Director of Quality Management, Disease Management, and Health Education***	 3/14/2014	

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
Potential Deficiency 14 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.	Since February 28, 2014, quarterly reports from 2013 have been presented and reviewed at the QI/UM meeting. These reports are scheduled for each QI/UM meeting. KHS will initiate and perform the usual oversight of delegated entities as defined in KHS Policy 2.45-I, *Delegation of Quality Improvement, Utilization Management, Care and Case Management and Pharmacy Activities and Responsibilities* (see attached), and as outlined in the Contract (Exhibit A, Attachment 4.6). ***Please see Attachment N:*** ***McKesson Reporting for 7/1/12-6/30/2013*** ***2.45-I, Delegation of Quality Improvement, Utilization Management, Care and Case Management and Pharmacy Activities and Responsibilities*** ***Responsibility:*** ***Utilization Management*** ***Director of Health Services***	2/28/2014	The MCP submitted its McKesson Reporting for 7/1/12-6/30/2013, P&P 2.45-I, Delegation of Quality Improvement, Utilization Management, Care and Case Management and Pharmacy Activities and Responsibilities. The MCP has taken appropriate action to address this deficiency. In order to close this deficiency, please submit a copy of last QI/UM meeting minutes. This item remains open. **Update 7/2/14:** The MCP submitted a copy of last QI/UM meeting minutes. **This item is closed.**

Deficiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments
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. 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), and (I)- Written Description.	The QI Department hired a QI Supervisor and two (2) additional QI RNs. Currently, the Plan is conducting an executive search to fill the role of Chief Medical Officer.	11/1/2013 12/2/2013 Ongoing	The MCP hired a QI Supervisor and two (2) additional QI RNs and conducting search to fill the role of Chief Medical Officer. The MCP has taken appropriate action to address this deficiency. In order to close this deficiency, please acknowledge the hiring of the Chief Medical Officer. This item remains open. **Update 7/2/14:** The MCP submitted a copy of acknowledgement of hiring the Chief Medical Officer. **This item is closed.**

Submitted by: **Date:**
Title: