DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

1115 WAIVER SENIORS AND PERSONS WITH DISABILITIES

MEDICAL SURVEY REPORT OF

KERN FAMILY HEALTH CARE

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: JANUARY 9, 2017

1115 Waiver SPD Medical Survey Report
Kern Family Health Care
A Full Service Health Plan
January 9, 2017

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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 DHCS then entered into an Inter-Agency Agreement[1] with the Department of Managed Health Care (the "Department") 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 of SPDs into managed care began in June 2011.

On June 15, 2016, the Department notified Kern Family Health Care ("Plan") that its medical survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department's medical survey team conducted the onsite portion of the medical survey from August 29, 2016 through September 1, 2016.

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreement, the Department provides the 1115 Waiver SPD Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the SPD population. This medical survey evaluated the following elements specifically related to the Plan's delivery of care to the SPD population as delineated by the DHCS-Plan Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations: [2]

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 under- and over-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

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] All references to "Contract" are to the County Organized Health System, Geographic Managed Care, and Two-Plan contracts issued by the DHCS. All references to "Section" are to the Knox-Keene Act of the Health and Safety Code. All references to "Rule" are to Title 28 of the California Code of Regulations.

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.

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 selection and assignment, and to evaluate the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

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 medical survey incorporated review of health plan documentation and files from the period of August 1, 2015 through July 31, 2016.

SUMMARY OF FINDINGS

The Department identified **3** potential deficiencies during the current medical survey.

2016 MEDICAL SURVEY POTENTIAL DEFICIENCIES

AVAILABILITY & ACCESSIBILITY

1

The Plan fails to ensure it satisfies required provider-to-member ratios.
DHCS-Plan Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and Attachment 6 – Provider Network, Provision 3 – Provider to Member Ratios; Rule 1300.70(a)(3), (b)(2)(B).

MEMBER RIGHTS

2

The Plan's Board of Directors does not periodically review the written record of grievances and document its review.
DHCS-Plan Contract, Exhibit A, Attachment 14, Member Grievance System – Provision 1 – Member Grievance System; Rule 1300.68.

3

The Plan's urgent grievance policies do not specify it will respond to the Department within 30 minutes during working hours and within 1 hour during non-work hours, after initial contact from the Department.
DHCS-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68.01(b).

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

- The Plan implemented a medical management system (Zomega) that brings together utilization management, case management, disease management, behavioral health management, health education, and pharmacy into a single system that creates a 360-degree view of the SPD member. This information will be made available in the provider portal to ensure PCPs have the information at the point of service needed to optimize care for this vulnerable population.
- The Plan implemented an interdisciplinary team (IDT) including the medical director, case managers, social workers, pharmacists, if available the PCP, and, if requested by the member, an advocate. The IDT meets weekly to address high-risk cases with the goal of helping the member maintain function across the psychosocial, physical, and domiciliary domains of their lives. The IDT develops a plan of care with goals of care that are member centric.
- The Plan implemented an in-house case management program to work with the SPD population. By adding case managers to the internal system the Plan has developed a system whereby the members can be managed, tracked, trended, and interventions initiated within a much shorter period.
- The in-house case management program has identified the top 1000 highest risk members for whom the Plan is developing specific strategies that meet the needs of these highest risk members.
- The Plan has developed non-emergent transportation options for SPD members who have transportation issues that may prevent them from keeping appointments.

DISCUSSION OF POTENTIAL DEFICIENCIES

AVAILABILITY AND ACCESSIBILITY

Potential Deficiency 1: The Plan fails to ensure it satisfies required provider-to-member ratios.

Contractual/Statutory/Regulatory Reference(s): DHCS-Plan Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and Attachment 6 – Provider Network, Provision 3 – Provider to Member Ratios; Rule 1300.70(a)(3), (b)(2)(B).

DHCS-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 Title 28, CCR, Section 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.

Attachment 6 – Provider Network
3. Provider to Member Ratios
A. Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:
   1) Primary Care Physicians 1:2,000
   2) Total Physicians 1:1,200
B. If Non-Physician Medical Practitioners are included in Contractor's provider network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/patient caseload of one provider per 1,000 patients.

Rule 1300.70
(a) Intent and Regulatory Purpose…
(3) 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…
(b) Quality Assurance Program Structure and Requirements…
(2) Program Requirements. In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan

documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

Supporting Documentation:

- Accessibility Standards Policy 4.30-P (07/31/2015)
- Kern Response Letter to Dalia Fong, July 20, 2016, Re: Quarterly Medi-Cal Network Assessment, Fourth Quarter of 2015, from Carl Breining
- Board of Directors Meeting Minutes (Sep 17, 2015 through Jun 9, 2016)

Assessment:

The Department reviewed the Plan's Accessibility Standards Policy that describes the Plan's process for monitoring appointment availability, including use of the ICE Provider Appointment Availability Survey. However, nothing in the Plan's policy included a procedure for determining full-time equivalency (FTE) in determining the capacity of its primary care providers (PCPs).

The Department also reviewed the Plan's Board of Directors Meeting Minutes. The Plan's December 10, 2015 Board of Directors meeting minutes showed that the Plan monitors the provider-to-member ratio annually and performs an analysis to determine where there was a shortage of providers. However, during onsite interviews, the Plan stated that its methodology for determining FTE is to add the total number of contracted providers, without regard to the amount of time each provider practices, full-time or part-time. The Plan further stated it was not aware of a method for determining the FTE of its PCPs.

Several of the Plan's provider groups that included multiple PCPs, including Federally Qualified Health Centers (FQHCs), required the Plan to assign each member to a single physician or to the name of the FQHC. While the Plan established limits on the number of members it assigned to individual providers, the Plan does not monitor the provider-to-member ratio based on an FTE analysis. Without ensuring that the Plan satisfies the FTE ratios required in its DHCS-Plan contract, the Plan is unable to monitor or ensure that the provision and utilization of services meets professionally recognized standards of practice, as required by Rule 1300.70(a)(3).

The DHCS-Plan Contract requires the Plan to ensure that its network continuously satisfies prescribed FTE provider-to-member ratios. Rule 1300.70(a)(3), (b)(2)(B) requires that the Plan's quality assurance program address accessibility and availability of care and that written documents delineate QA functions "and provide evidence that the plan has established quality assurance activities." Because the Plan has failed to ensure its networks continuously satisfy the prescribed provider to member ratios by failing to adopt policies to ensure providers do not exceed their capacity, including a defined method for determining FTE, the Department finds the Plan out of compliance with these contractual and regulatory provisions.

MEMBER RIGHTS

Potential Deficiency 2: The Plan's Board of Directors does not periodically review the written record of grievances and document its review.

Contractual/Statutory/Regulatory Reference(s): DHCS-Plan Contract, Exhibit A, Attachment 14, Member Grievance System – Provision 1 – Member Grievance System; Section 1368(a)(1); Rule 1300.68

DHCS-Plan Contract, Exhibit A, Attachment 14, Member Grievance System – Provision 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).

Rule 1300.68
Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.
(b) The plan's grievance system shall include the following:…
(5) A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to section 1300.69, and by an officer of the Plan or his designee. This review shall be thoroughly documented.

Section 1368(a)(1)
Every plan shall do all of the following:
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….

Supporting Documentation:

- Member Grievance Process Policy 5.01-I (rev 6/26/14)
- Board of Directors Meeting Minutes (QTR 3 2015 through QTR 2 2016)
- Public Policy Meeting Minutes (QTR 3 2015 through QTR 2 2016)
- QI/UM Committee Meeting Minutes (QTR 2 2015 through QTR 1 2016)

Assessment:
The Department reviewed the Plan's Member Grievance Process Policy. The policy states: "A written record of tabulated grievances is reviewed quarterly by the CEO, Board of Directors, QI/UM Committee, and the Public Policy Committee." The DHCS-Plan contract requires the Plan to comply with Rule 1300.68, which incorporates Section 1368. Section 1368(a)(1) requires plans' grievance systems to have reasonable procedures that comply with the Rules. Rule 1300.68(b)(5) requires plans to record each grievance received and require the plan's governing body to periodically

review the record of grievances and document its review. Here, the Plan has a policy indicating that its governing body reviews a record of grievances quarterly. Thus, the Plan's written procedure complies with Rule 1300.68(b)(5). However, the Department found that in practice, the Plan is not implementing its policy in a manner that complies with the Rule.

Specifically, the Department reviewed the Plan's quarterly Board of Directors (BOD) meeting minutes for the survey review period. None of the meeting minutes documented review of a written record of grievances. There was documentation in the minutes of three meetings[3] showing that the BOD received QI/UM[4] Committee meeting minutes, which documented that the QI/UM Committee received quarterly grievance summaries and tabulated grievance reports. These BOD meeting minutes therefore show that the BOD received periodic QI/UM Committee meeting minutes, but do not show that the BOD reviewed the actual grievance record of summaries and reports or that the BOD documented its review, as required by Rule 1300.68(b)(5).

During onsite interviews with Plan staff, the Department asked for a description of where and how the BOD conducts and documents its review of written grievance reports. The Plan's Chief Medical Officer stated that any member of the Committee or the BOD could ask for more information on any Consent Agenda[5] item, and that public members are free to address the BOD with any grievances they may have. Additionally, the Plan's Associate Medical Director stated that the Public Policy Committee, an arm of the BOD, often discussed grievances at their meetings. However, the Plan was unable to demonstrate that its governing body performed a periodic review of the Plan's written record of grievances or that it documented its review. Accordingly, the Department finds the Plan out of compliance with DHCS-Plan Contract, Exhibit A, Attachment 14, Member Grievance System – Provision 1 – Member Grievance System for failing to maintain a member grievance system in accordance with Section 1368(a)(1) and Rule 1300.68(b)(5) for failing to demonstrate that the Plan's BOD periodically reviews the written record of grievances and documents that review.

Potential Deficiency 3: **The Plan's urgent grievance policies do not specify it will respond to the Department within 30 minutes during working hours and within 1 hour during non-work hours, after initial contact from the Department.**

Statutory/Regulatory Reference(s): DHCS-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68.01(b).

[3] BOD meeting minutes dated September 17, 2015, March 10, 2016 and June 9, 2016.
[4] Quality Improvement/Utilization Management
[5] A Consent Agenda allows a Board or Committee to approve a number of routine agenda items at one time with one vote; however, the reports and other matters for the Consent Agenda should be distributed with the agenda package in advance, in sufficient time to be read by all members prior to the meeting. Any member can ask to remove an item from the Consent Agenda so that the item can be considered in more detail by the whole Board or Committee. No copies of quarterly grievance reports were included in QI/UM Committee minutes in the Board packets distributed to Board members.

DHCS-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 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

Rule 1300.68.01(b)
Each plan's grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department.

Supporting Documentation:
- Member Grievance Process Policy 5.01-I (rev 6/26/14)
- Plan Contact List for Expedited Review of Grievances (06/2014)

Assessment:
The Plan provided its Member Grievance Process Policy which states, "KHS has staff on call at all times to respond to DMHC inquiries/requests regarding urgent grievances. During business hours, KHS staff responds within one hour."

However, Rule 1300.68.01(b) requires that "[e]ach plan's grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department."

During onsite interviews with Plan staff, the Director of Compliance and Regulatory Affairs stated he was not aware of the 30-minute response requirement during normal work hours and would correct the policy that indicates it is one hour. The Director also stated that Plan did not have a written policy on urgent grievance response times during non-work hours, but that one would be developed.

As a result, the Department finds the Plan out of compliance with DHCS-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Rule 1300.68.01(b).

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Joseph Marino	Medical Survey Team Lead
Jared Laiti	Medical Survey Team Attorney
WEISERMAZARS TEAM MEMBERS	
Geni Bennetts, M.D.	Utilization Management, Pharmacy, and Emergency Services Surveyor
Jim Hendrickson, M.D.	Quality Improvement and Continuity of Care Surveyor
Gerry Long	Availability & Accessibility of Care Surveyor
Anthony (Tony) Browne	Member Rights Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED	
Doug Hayward	Chief Executive Officer
Chandrakala Gowda, M.D., M.B.A.	Chief Medical Officer
Alan Avery, M.B.A.	Chief Operating Officer
Irwin Harris, M.D., M.B.A.	Associate Medical Director
Deborah Murr, R.N.	Administrative Director of Health Services
Carl Breining, CHC	Director of Compliance and Regulatory Affairs
Louis Iturriria	Director of Marketing and Member Services
Emily Silva	Director of Provider Relations
Bruce Wearda, RPh	Director of Pharmacy
Trannie Ryan	Director of Claims
Isabel Silva, M.P.H.	Health Education and Disease Management Manager
Melissa Lopez	Provider Relations Manager
Nate Scott	Member Services Manager
Jada Salamatian, R.N.	Quality Improvement Supervisor
Diane Lay, R.N.	Utilization Management Care Management Supervisor
Jake Hall	Provider Relations Supervisor
Amy Carrillo	Member Services Supervisor
Christina Espericueta	Administrative and Support Supervisor
Linda Lynd	AIS Compliance Auditor
Lela Criswell	Compliance Business Analyst

APPENDIX C. LIST OF FILES REVIEWED

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

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Standard Grievances	61	The Plan identified a universe of 242 files during the review period. Based on the Department's File Review Methodology, a random sample of 61 files were reviewed.
Inquiries	30	The Plan identified a universe of 421,759 files during the review period. Based on the Department's File Review Methodology, a random sample of 30 files were reviewed.
Exempt Grievances	1	The Plan identified a universe of 1 file during the review period.
Potential Quality Issues	41	The Plan identified a universe of 84 files during the review period. Based on the Department's File Review Methodology, a random sample of 41 files were reviewed.
UM Medical Necessity Denials	81	The Plan identified a universe of 6,825 files during the review period. Based on the Department's File Review Methodology, a random sample of 81 files were reviewed.