## MEDICAL REVIEW – SOUTHERN SECTION III AUDITS AND INVESTIGATIONS DEPARTMENT OF HEALTH CARE SERVICES

# Kern Health Systems dba Kern Family Health Care

Contract Number:	03-76165
Audit Period:	August 1, 2016 Through July 31, 2017
Report Issued:	January 4, 2018

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# I. INTRODUCTION

Kern Health Systems (KHS) dba Kern Family Health Care (KFHC) is a public agency established to operate the local initiative for Kern County under the California Department of Health Services' Strategic Plan for expanding Medi-Cal Managed Care. Authority to establish KFHC as a public entity is found in the Welfare & Institutions Code, Section 14087.54. This section empowers a county to establish an organized health care system administered by a special commission. The purpose of this health care system is to effectively deliver publicly assisted medical care in the county while promoting quality of care and cost efficiency.

Kern Health Systems was established in 1993 and started operating as a County Health Authority structure in January 1995. Kern Health Systems received a Knox-Keene license on May 2, 1996. Kern Family Health Care began operations on July 1, 1996. The KHS Board of Directors is appointed by the Kern County Board of Supervisors.

Kern Health Systems serves all of Kern County with the exception of Ridgecrest. Health care services are provided through contracts and subcontracts with community clinics, medical groups, and individual physicians. Pharmacy services are provided through a contract with a Pharmacy Benefits Manager (PBM), Argus Health Systems, Inc. Vision services are provided through a contract with Vision Service Plan (VSP).

As of June 30, 2017, KHS Medi-Cal enrollment is 248,461 members.

# II. EXECUTIVE SUMMARY

Under the authority of the California Welfare and Institutions Code §14456, the Department of Health Care Services (DHCS), Audits & Investigations, Medical Review Branch, conducts annual medical audits of contracting health plans. These audits assist the Department with its overall monitoring effort, and identify areas of deficiencies that form the basis for corrective actions.

The DHCS medical audit was conducted for the period of August 1, 2016 through July 31, 2017. The audit confirmed the Plan acted upon prior findings and revised its policies and procedures.

Through a risk assessment, discussions with management, and review of documentation, the audit identified key areas with the greatest significance to include in this audit. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held with the Plan on December 5, 2017. The Plan was allowed fifteen (15) calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report findings. The Plan submitted supplemental information after the exit conference which is reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

## **Implementation of Prior Year Audit Recommendations**

The prior DHCS medical audit for the audit period of August 1, 2015 through July 31, 2016 identified deficiencies. The Plan addressed the deficiencies in a corrective action plan (CAP). The CAP closeout letter dated June 9, 2017 noted that all previous findings were closed.

The following section presents previous audit deficiencies and the actions the Plan took to implement the CAP recommendations.

While the Plan addressed deficient categories in the corrective action process, the Plan has not fully achieved compliance related to access and availability of care. This issue is reflected as an ongoing finding.

## Access and Availability of Care

The prior year audit found that the Plan failed to ensure members obtain specialty care appointments within the required timeframes. This was an ongoing finding.

To address this finding, the Plan increased its monitoring efforts by including specialists in its internal quarterly Provider Appointment Availability Survey beginning in 2017. In addition, the Plan invested in provider recruitment and retention activities through its grant

program. The Plan also notifies providers of its accessibility standards policy twice a year as a reminder of the timely access standards.

The current audit found that members' access to specialty care continues to be a challenge for the Plan. The Plan has difficulty with recruitment of providers to serve its members in rural areas.

#### Member's Rights

The prior year audit found that the Plan failed to process appeals for prior authorizations in accordance with contract requirements. The Plan allowed the qualified health professional who initially denied the prior authorization to make the final appeal decision.

To address the prior year audit findings, the Plan re-educated its clinical staff responsible for medical necessity reviews of the contract requirement. This training included: 1) A monthly nurses meeting agenda item to review the prior authorization process; and 2) Methods to alert physician reviewers to previous decisions in daily workflow.

Additionally, the Plan revised Policy 3.73-I, Medical Decision Making, to include the following language: "any decision based on medical necessity or otherwise shall be reviewed by a different Medical Director, or Physician Reviewer, who did not take part in any prior decision making processes".

During the audit period, the Plan implemented the recommendations from the prior audit. The current audit did not find any deficiencies in the Plan's appeal process. The Plan has an appropriate system to process its prior authorization appeals.

# III. SCOPE/AUDIT PROCEDURES

# <u>SCOPE</u>

This audit was conducted by the Department of Health Care Services (DHCS), Medical Review Branch to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

# PROCEDURE

The on-site review was conducted from August 15, 2017 through August 18, 2017. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

## **Category 1 – Utilization Management**

Prior Authorization Requests: 20 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review and communication of results to members and providers.

Appeal Procedures: 19 prior authorization appeals were reviewed for appropriate and timely adjudication.

## Category 2 – Case Management and Coordination of Care

Initial Health Assessments: 19 medical records were reviewed for completeness and timely completion.

Behavioral Health Treatment: 15 medical records were reviewed for evidence of care coordination between the Plan and providers.

## Category 3 – Access and Availability of Care

Appointment Availability: 15 providers from the Plan's Provider Network were reviewed. The first available appointment was used to measure access to care.

Emergency Services and Family Planning Claims: 10 emergency service claims and 10 family planning claims were reviewed for appropriate and timely adjudication.

## Category 4 – Member's Rights

Grievance Procedures: 40 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

A description of any non-compliance is contained in the following report.

## PLAN: Kern Health Systems dba Kern Family Health Care

AUDIT PERIOD:

3.1

DATE OF AUDIT:

August 1, 2016 through July 31, 2017

August 15 through August 18, 2017

# CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

# APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

## **Appointment Procedures:**

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments. 2-Plan Contract A.9.3.A

Members must be offered appointments within the following timeframes:

3) Non-urgent primary care appointments – within ten (10) business days of request;

Appointment with a specialist – within 15 business days of request;

2-Plan Contract A.9.4.B

# Prenatal Care:

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

2-Plan Contract A.9.3.B

# Monitoring of Waiting Times:

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments...

2-Plan Contract A.9.3.C

## **SUMMARY OF FINDINGS:**

#### 3.1.1 **Appointment Availability**

The Plan is required to implement and maintain procedures for members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments, according to the contract. Members must be offered appointments for routine primary care within 10 business days of a request, for specialty care within 15 business days of request, and for a first prenatal visit within two weeks upon request. [Contract, Exhibit A, Attachment 9(3)(A), (4)(B), and (3)(B)].

While the Plan's policies and procedures detail the required appointment timeframes, the Plan did not meet the timeframes for specialty care appointments for members. This is an ongoing finding.

COMPLIANCE AUDIT	FINDINGS (CAF)
PLAN: Kern Health Systems dba Kern Family Health Care	
AUDIT PERIOD: August 1, 2016 through July 31, 2017	DATE OF AUDIT: August 15 through August 18, 2017

The auditor conducted a telephone survey of providers that included five specialists. The auditor surveyed the providers to obtain the dates for the first available appointments. The average first available appointment was used to measure access to care.

The results of the verification study are summarized as follows:

Provider Type	Contract Appointment Standards	Average First Available Appointment
Specialty Care	Within 15 business days of request	New patients – 17.8 business days

The Plan monitors access to care through surveys (provider appointment availability, member satisfaction, and provider satisfaction) and its grievance system.

The Plan implemented an internal quarterly provider appointment availability survey in the third quarter of 2016 due to the findings of the prior year's audit. The survey focuses on a rotational sample of its primary care provider network. The survey is similar to the verification study conducted by the Department. The Plan extended the survey to include specialists in 2017. The Plan's survey results in the first quarter of 2017 show five (5) of fifteen specialists surveyed were non-compliant. In the second quarter of 2017, two (2) of fifteen specialists surveyed were non-compliant. The Plan sent notices of non-compliance to those speciality providers. Non-compliant providers will be included in succeeding surveys.

The Plan's 2016 Member Satisfaction Survey, conducted by a third party vendor, SPH Analytics Consulting Services, targets members to measure their satisfaction with the Plan. The summary rate score of the survey for specialty care was 74.9%. This measures if a member obtained an appointment to see a specialist as soon as they needed.

The Plan's Provider Satisfaction Survey is another method used to monitor and assure compliance. For 2016, the Plan outsourced the survey to a vendor who is in the process of generating the results. Thus, the 2016 survey results are unknown at this time.

COMPLIANCE AUDIT	FINDINGS (CAF)
PLAN: Kern Health Systems dba Kern Family Health Care	
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The Plan completes grievance summary reports at the end of each quarter. The Plan provides additional training to contracted providers found to be deficient in access standards based on member complaints. The Plan received thirty-one access to care member grievances during the review period.

In 2015, the Plan implemented a recruitment and retention program in an effort to increase its provider network in rural locations. It is difficult for members to obtain access to care in rural areas. The program allows the Plan to offer incentives to providers in specialties with low numbers of providers. The Plan intends to continue the program for as long as grants are available or until the lack of specialists within the Plan's provider network is no longer an issue.

Plans are responsible to ensure services are available and accessible for members. Failure to adhere to required timeframes and monitor the availability of appointments may result in adverse effects on members' health.

# **RECOMMENDATION:**

3.1.1 To meet the Contract requirements for the provision of access to routine specialty appointments within the required timeframes, continue to monitor and improve appointment availability for members.

MEDICAL REVIEW – SOUTHERN SECTION III AUDITS AND INVESTIGATIONS DEPARTMENT OF HEALTH CARE SERVICES

# Kern Health Systems dba Kern Family Health Care

Contract Number: 03-75798

Audit Period: August 1, 2016 Through July 31, 2017

Report Issued: January 4, 2018

State Supported Services

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II.	COMPLIANCE AUDIT FINDINGS

# I. INTRODUCTION

This report presents the audit findings of Kern Health Systems dba Kern Family Health Care State Supported Services contract No. 03-75798. The State Supported Services contract covers contracted abortion services with Kern Family Health Care.

The on-site audit was conducted from August 15, 2017 through August 18, 2017. The audit period is August 1, 2016 through July 31, 2017 and consisted of document review of materials supplied by the Plan and interviews conducted on-site.

# **COMPLIANCE AUDIT FINDINGS (CAF)**

PLAN: Kern Health Systems dba Kern Family Health Care

AUDIT PERIOD: August 1, 2016 through July 31, 2017 DATE OF AUDIT: August 15 through August 18, 2017

# STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

#### Abortion

Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:

Current Procedural Coding System Codes\*: 59840 through 59857 HCFA Common Procedure Coding System Codes\*: X1516, X1518, X7724, X7726, Z0336

\*These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.

State Supported Services Contract Exhibit A.1

## **SUMMARY OF FINDINGS:**

The Plan's *Policy 321-P, Family Planning Services and Abortion*, states that the Plan provides abortion services and supplies to members without prior authorization. Abortions are required to be provided in accordance with State and Federal law and are considered by the California Department of Health Care Services to be a "sensitive service".

The Plan provides Medi-Cal members timely access to abortion services from any qualified contracting or non-contracting Provider without prior authorization. Minors do not need an adult's consent or referral to access pregnancy termination services.

The Plan's Staff Supported Services billing code sheet includes Current Procedural Terminology codes 59840 through 59857 and Healthcare Common Procedure Coding System codes A4649-U1, A4649-U2, S0190, S0191, S0199 (formerly known as codes X1516, X1518, X7724, X7726, Z0336) as billable pregnancy termination services as required by the Contract.

The audit found no discrepancies for this section.