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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

March 2, 2018

Carl Breining, Director of Compliance and Regulatory Affairs
Kern Health System
9700 Stockdale Highway
Bakersfield, CA 93311

RE: Department of Health Care Services Medical Audit

Dear Mr. Breining:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Kern Health System, a Managed Care Plan (MCP), from August 15, 2017 through August 18, 2017. The survey covered the period of August 1, 2016 through July 31, 2017.

On January 30, 2018, the MCP provided DHCS with supporting documentation regarding its Corrective Action Plan (CAP) in response to the report originally issued on January 4, 2018.

All items have been reviewed and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Full implementation of the CAP will be monitored on the subsequent audit. The enclosed report will serve as DHCS' 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, feel free to contact me at (916) 552-8946 or Lyubov Poonka at (916) 552-8797.

Sincerely,

Jeanette Fong, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Cameron Showalter, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

ATTACHMENT A
Corrective Action Plan Response Form

Plan Name: Kern Family Health Care

Audit Type: Medical Audit **Review Period: 08/01/16 - 07/31/17**

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP via email in word format which will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require long term corrective action or a period of time longer than 30 days to remedy or operationalize, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comment
3. Access and Availability of Care				
3.1.1 The Plan is required to implement and maintain procedures to obtain appointments for routine care, urgent care, and routine	KHS will continue to monitor and improve appointment availability to members through the following Compliance efforts: ❖ Quarterly provider appointment availability survey/audits	As an example of the monitoring efforts KHS conducts, the Plan has attached: ➢ Q1 – Q3, 2017 Appointment	1/1/2017 and on-going.	**01/30/18 -** MCP submitted the following documentation to support its efforts to correct this finding: - "Appointment Availability Survey" (Q1-Q3 2017). The survey was conducted internally by KHS staff. A random sample of 15 PCP offices

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comment
specialty referral appointments, prenatal care, children's preventative 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)].	As part of the Plan's rigorous on-going monitoring activities, the Plan extended its comprehensive compliance survey methodology to include specialists in 2017. This compliance survey methodology entails having a Compliance Auditor contact specialists offices to assess appointment availability for first, second, and third appointments. Noteworthy, the Plan has seen a dramatic improvement in compliance results with the specialist offices. Should a specialty provider be out of compliance with the 15 day appointment availability standard, the Provider Relations Team will send a notice to the specialty provider, which serves to remind the provider of their obligation to adhere to the 15 day standard. In addition, the non-compliant provider is included in future appointment availability surveys. ❖ Member Satisfaction Survey The Plan currently uses a	Availability Survey Reports and applicable Outreach Letters for Non-Compliant Providers		and 15 specialist offices were surveyed each quarter. Results show steady improvement with compliances rates for specialists (75%, 87%, and 93% respectively for Q1, Q2, and Q3). - Seven sample letters to non-compliant specialists (spanning from 04/24/17 – 10/24/17) as evidence of MCP's follow-up action for non-compliant providers. - Two sample Provider bulletins that were sent by Provider Relations (04/19/17 and 06/14/17) as evidence of MCP's ongoing efforts to communicate contractual requirements to providers regarding timely access standards, including those for specialist appointments. - Member Newsletter (Fall 2017) as evidence that MCP also informs members of standards for timely access to care. Members are encouraged to call the Member Services department if the standards are not met. MCP's

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comment
	third party vendor, SPH Analytics, to conduct the Member Satisfaction Survey (MSS). This vendor compiles a comprehensive report for the Plan. Results from the MSS are used by management to effectively channel resources in order to maximize the beneficiaries experience with the Plan. The Plan's 2016 and 2017 Member Satisfaction Surveys, conducted by SPH Analytics, targets members to measure their satisfaction with the Plan. Certain questions in the survey are included and designed to measure beneficiary satisfaction with obtaining specialist appointments. KHS' access to Specialty Care results in 2016 and 2017 were not significantly different when compared to the 2016 Quality Compass, All Plans Benchmark. The 2016 Quality Compass, All	➢ Two (2) Access bulletins were sent to providers in 2017. ➢ Fall 2017 Member Newsletter	Ongoing Completed	written response (1/30/18) further explains that the Call Center now has a new Member Portal to assist members with scheduling more timely appointments and arranging transportation to and from medical appointments to help with the demand of timely access in rural areas. - "Access Grievance Review" summary reports (Q1 & Q2, 2017) and corresponding agenda and sign-in sheet for the Q1 meeting (05/12/17) as evidence of MCP's ongoing monitoring efforts to review all grievances related to access to care for tracking and trending purposes on a quarterly basis. Q1 review showed 9 grievances related to access to Care. 4 grievances were resolved in favor of the member and forwarded to the Provider Relations for further monitoring. PRD reaches out to identified providers to provide technical assistance and continued monitoring.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comment
	Plans Benchmark is a collection of CAHPS 5.0H mean summary ratings for those Medicaid adult plans allowing NCQA to use their data to be compiled into an aggregate, or national summary, without releasing their plan-level scores ❖ Provider Bulletins/ Member Newsletter Provider Bulletins and Member Newsletters are a powerful tool for outreach to the Plan's contracted providers and its beneficiaries. The Plan has proactively used these two print media to both remind and inform. During calendar year 2017, the Plan sent two (2) Provider Bulletins designed to remind providers of Timely Access Standards. These bulletins were sent to all contracted providers. Additionally, members are		Ongoing	- MCP's written response (01/30/17) which describes the expansion of Telemedicine in rural areas. MCP is proactively working to streamline referrals and include specialists in the telehealth system. DHCS will continue to monitor the MCP's continuous progress in subsequent audits. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comment
	made aware of important benefit changes and best practice recommendations via our member newsletter. The Fall-2017 Kern Family Health Care family health newsletter included Timely Access to Care standards. The Plan will include these standards in the member newsletter at least annually to remind beneficiaries of their right to timely care ❖ Telemedicine providers The Director of Provider Relations with support from KHS Executive and Clinical Management is expanding the use of Telemedicine, which should help with access to care particularity in more rural settings of Kern County. In addition to the expanded access to our rural areas, telehealth can also help with overall access. We	➢ Q1 & Q2, 2017 Access Grievance Review	1/1/2017	

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comment
	worked closely with a telehealth group to establish a clinic hub in metro Bakersfield in anticipation of expanded specialty access to our members. Our teams are in the process of streamlining the referral system for specialty care to include this telehealth resource ❖ Member Services/Call Center Member Services is able to leverage the Call Center and online resources, including our new Member Portal, to help meet the needs and demands of our Members. The Call Center provides assistance with scheduling medical appointments, locating alternative specialist providers that are able to provide more timely medical appointments and arranging transportation to and from medical appointments.			

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comment
	❖ Monitoring Access Related Grievances On a quarterly basis, KHS' Provider Relations Department reviews all grievances from the previous quarter that were categorized as "Access to Care" or "Difficulty Accessing a Specialist". These grievances are reviewed retrospectively against the previous year to track for any potential trends.			

Submitted by: **(Signature on File)** **Date:** **01/30/18**

Title: **Chief Executive Officer**