

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, 2014  
Through  
July 31, 2015

Report Issued: February 29, 2016

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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, which empowers a county to establish an organized health care system, administered by a special commission, 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 of 1995. Kern Health Systems received a Knox-Keene license 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 is dedicated to improving the health status of their members through an integrated managed health care delivery system.

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 May 31, 2015, KHS enrollment is 210,627 members.

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of August 1, 2014 through July 31, 2015. The on-site review was conducted from August 4, 2015 through August 14, 2015. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held with the Plan on February 4, 2016. 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.

The prior DHCS medical audit (for the period of July 1, 2012 through June 30, 2013, with on-site review conducted from September 10 through September 20, 2013) was issued February 11, 2014. The *corrective action plan* (CAP) closeout letter dated June 1, 2014 noted that all previous findings were closed. Overall, the Plan revised its policies and procedures and implemented much of the CAP as of this audit. **Repeat findings** were identified and appear in the body of the report.

The summary of the findings by category follows:

### **Category 1 – Utilization Management**

The Plan's delegation agreement with Vision Service Plan (VSP) excluded quarterly reporting language. The Plan did not monitor VSP's UM/QI activities.

### **Category 2 – Case Management and Coordination of Care**

The Plan was compliant with the requirements in this Category.

### **Category 3 – Access and Availability of Care**

The Plan did not ensure that appointments are available within the required time frames. The Plan's policies lacked procedures for follow-up on missed appointments.

### **Category 4 – Member's Rights**

The Plan's policies and procedures stated incorrect time frames to submit the "DHCS Privacy Incident Report." Time frames to report breaches were exceeded.

**Category 5 – Quality Management**

The Plan was compliant with the requirements in this Category.

**Category 6 – Administrative and Organizational Capacity**

The Plan was compliant with the requirements in this Category.

### **III. SCOPE/AUDIT PROCEDURES**

#### **SCOPE**

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 4 through August 14, 2015. 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 25 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review and communication of results to members and providers.

Notification of Prior Authorization Denial, Deferral, or Modification: 47 notification letters were reviewed for written notification requirements.

Appeal Procedures: 20 prior authorization appeals were reviewed for appropriate and timely adjudication.

#### **Category 2 – Case Management and Coordination of Care**

California Children's Services (CCS): 5 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Initial Health Assessment: 23 medical records were reviewed for completeness and timely completion.

Complex Case Management: 5 medical records were reviewed for evidence of coordination of care between the Plan and the providers.

### **Category 3 – Access and Availability of Care**

Appointment Availability: 13 providers from the Plan's Provider Network were reviewed. The third next available appointment was used to measure access to care.

Emergency Services and Family Planning Claims: 15 emergency service claims and 20 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.

### **Category 5 – Quality Management**

New Provider Training: 10 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

A description of the findings for each category is contained in the following report.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Kern Health Systems dba Kern Family Health Care

AUDIT PERIOD: August 1, 2014 through July 31, 2015

DATE OF AUDIT: August 4 through August 14, 2015

### CATEGORY 1 - UTILIZATION MANAGEMENT

1.5

#### DELEGATION OF UTILIZATION MANAGEMENT

##### **Delegated Utilization Management (UM) Activities:**

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.  
2-Plan Contract A.5.5

#### **SUMMARY OF FINDINGS:**

##### **1.5.1 Delegation Agreement**

The Plan is accountable for all quality improvement functions and responsibilities that are delegated to subcontractors. The Plan's and subcontractor's agreement shall include the Plan's reporting requirements and approval processes. This includes the subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. [Contract, Exhibit A, Attachment 4 (6)(A)(3)]

The Plan's *Policy 2.45.1, Delegation of Quality Improvement (QI), Utilization Management, Care and Case Management, and Pharmacy Activities and Responsibilities*, states any delegation of QI, UM, and/or Pharmacy activities must be pursuant to a mutually agreed upon, written, and signed agreement between the Plan and the delegate. This written delegation agreement must describe the responsibilities of the Plan and the delegated entity and require at least quarterly reporting by the delegate to the Plan.

The Plan delegates vision care to Vision Service Plan (VSP). However, the Plan's delegation agreement with VSP excluded language which requires quarterly reporting to the Plan or describes the process by which the Plan evaluates VSP's performance.

##### **1.5.2 Delegated Entity Monitoring**

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities, that evaluates subcontractor's ability to perform the delegated activities, ensures subcontractor meets standards set forth by the Plan and DHCS, and includes the continuous monitoring, evaluation and approval of the delegated functions. [Contract, Exhibit A, Attachment 4 (6)(B)(3)]

The Plan's *Policy 2.45-1, Delegation of Quality Improvement (QI), Utilization Management, Care and Case Management, and Pharmacy Activities and Responsibilities*, states any delegation of QI, UM, and/or Pharmacy activities must be pursuant to a mutually agreed upon, written, and signed agreement between the Plan and the delegate. This written delegation agreement must describe the responsibilities of the Plan and the delegated entity and the process by which the Plan evaluates the delegate's performance.

The Plan did not monitor one delegated entity. The Plan did not perform an oversight audit of VSP's UM/QI activities.

#### **RECOMMENDATIONS:**

1.5.1 Include quarterly reporting language in delegation agreements.

1.5.2 Conduct oversight audits to evaluate all delegated UM and QI activities.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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### CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

#### 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;

4) 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 Time Frames**

The Plan is required to ensure that appointments are available for routine care, specialty care, and initial prenatal care within certain time frames. [Contract, Exhibit A, Attachment 9 (3)(B) and (4)(B)]

The Plan did not ensure that appointments are available within the required time frames.

The DHCS Medical Audit included an appointment availability verification study. The study to verify member wait times to obtain appointments for routine, specialty, and prenatal care illustrated non-compliance with access standards. The auditor reviewed thirteen providers from the Plan's Provider Directory. The *third next available appointment* was used to measure access to care.

According to the *National Quality Measures Clearinghouse*, "Access is a measure of the patient's ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Counting the *third next available appointment* is the healthcare industry's standard measure of access to care and indicates how long a patient waits to be seen. This measure is used to assess the average number of days to the third next available appointment for an office visit for each clinic and/or department. This measure does not differentiate between "new" and "established" patients."

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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The verification study found a total of nine providers non-compliant with access standards. The results of the verification study are as follows:

Provider Type	Contract Standards	Average Third Next Available Appointment
Non-urgent primary care	within ten business days of request	14.2 business days
Specialty care	within 15 business days of request	16.2 business days for both new and established patients
First prenatal visit for a pregnant member	within two weeks upon request	21.2 calendar days

In addition to the verification study results, these factors indicate providers were not in compliance with timely access requirements:

- The Plan's 2013 Member Satisfaction Survey, which incorporates questions recommended by the Consumer Assessment of Health Plans Survey (CAHPS®), showed that 30.4 percent of members surveyed responded that their primary care providers were noncompliant with provider access standards of receiving an appointment within ten business days of request and 25.7 percent of members surveyed responded that they were sometimes or never able to easily get appointments with Specialists within 15 business days of request.
- The Plan monitored appointment wait times for routine and specialty care appointments in 2014 through an Appointment Availability Survey. The Plan surveyed 277 providers; 173 providers responded. The survey showed providers were unable to offer timely appointments. Among the results, 19 percent of primary care providers surveyed were unable to offer members timely routine appointments within ten business days of requests. Additionally, 28 percent of specialty providers surveyed were unable to offer members timely specialty appointments within 15 business days of request.

### 3.1.2 Missed Appointments Follow-up

The Plan is required to implement and maintain procedures for members to obtain appointments. This includes procedures for follow-up on missed appointments. *[Contract, Exhibit A, Attachment 9 (3)(A)]*

The Plan did not have policies and procedures for follow-up on missed appointments. During the medical audit, the Plan acknowledged this issue. The Plan stated it assists providers in making three attempts to encourage members to keep their appointments, including coordinating transportation and providing incentives such as *Kern Regional Transit* passes and movie tickets. Missed appointments are flagged in the Provider Portal and the normal practice is for providers to conduct follow-up calls. However, these procedures were not found in the Plan's policies.

### **RECOMMENDATIONS:**

- 3.1.1 Continue to monitor that members are offered appointments for routine care, specialty care, and initial prenatal care within the required time frames.
- 3.1.2 Update policies to include procedures for follow-up on missed appointments.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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### CATEGORY 4 – MEMBER’S RIGHTS

4.3

#### CONFIDENTIALITY RIGHTS

##### **Members’ Right to Confidentiality**

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

- 1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
- 2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

2-Plan Contract A.13.1.B

##### **Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:**

Business Associate agrees:

Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

2-Plan Contract G.III.C.2.

**Breaches and Security Incidents.** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS.** (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.
2. **Investigation and Investigation Report .** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated “DHCS Privacy Incident Report” containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
3. **Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

2-Plan Contract G.III.J

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### **SUMMARY OF FINDINGS:**

#### **4.3.1 Breach Incident Reporting Policy**

The Plan is required to submit an updated "DHCS Privacy Incident Report" within 72 hours and a completed report within ten (10) working days to DHCS. *[Contract, Exhibit G (III) (J)(2) and (3)][All-Plan Letter 09-014]*

The Plan's *Policy 2.28-P, Medical Records and Other Protected Health Information*, lacked these reporting time frames. The policy currently contains incorrect time frames in which to submit a written report. It states that the Plan will submit to DHCS an updated "DHCS Privacy Incident Report" within five working days and a completed report within 15 working days from the date of discovery.

#### **4.3.2 Breach Incident Reporting Time Frames**

Upon discovery of any breach or security incident, the Plan is required to notify the Department of Health Care Services (DHCS) within 24 hours and submit an updated "DHCS Privacy Incident Report" within 72 hours of the discovery. *[Contract, Exhibit G (III) (J)(1) and (2)]*

During the audit period, the Plan did not notify DHCS within the required 24-hour time frame in four cases. Two cases were submitted three (3) days after the discovery and two cases were submitted four (4) days after the discovery.

In two (2) of the four cases above, the Plan did not submit the updated report within the required 72-hour time frame. Both cases were submitted four (4) days after the discovery.

### **RECOMMENDATIONS:**

4.3.1 Update policy to reflect the correct time frames for submitting the "DHCS Privacy Incident Report."

4.3.2 Notify DHCS and submit an updated Privacy Incident Report within the required time frames.