CONTRACT AND ENROLLMENT REVIEW DIVISION
NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

KERN HEALTH SYSTEMS
dba
KERN FAMILY HEALTH CARE

2022

Contract Number:	03-76165
Audit Period:	November 1, 2021 Through October 31, 2022
Dates of Audit:	November 28, 2022 Through December 9, 2022
Report Issued:	May 5, 2023

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I. INTRODUCTION

Kern Health Systems dba Kern Family Health Care (Plan) was established in 1993 as a local initiative and operates as a Two-Plan Medi-Cal Managed Care Health Plan Model. The Plan began operating as a County Health Authority structure in January 1995. The Plan is a public agency, established by the Kern County Board of Supervisors. The Board of Supervisors appoints a Board of Directors who serve as the governing body.

In May 2, 1996, the Plan obtained its Knox-Keene license from the California Department of Managed Health Care. The Plan serves all of Kern County with the exception of Ridgecrest.

The Plan's provider network consists of approximately 431 primary care providers, 1,749 specialists, 603 behavioral health providers, 145 pharmacies, and 101 other service providers. The Plan contracts with 21 hospitals consisting of 11 acute care, eight tertiary, and two inpatient rehabilitation facilities.

Medi-Cal is the Plan's single line of business. As of January 20, 2023, the Plan served approximately 351,149 members, 17,906 of which are Seniors and Persons with Disabilities (SPD).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of November 1, 2021 through October 31, 2022. The audit was conducted from November 28, 2022 through December 9, 2022. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on April 11, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management (CM) 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 August 1, 2019 through July 31, 2021 was issued on February 7, 2022. This audit examined documentation for compliance and to determine to what extent the Plan has implemented their Corrective Action Plan (CAP).

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 includes procedures and requirements for the Plan's UM program including delegation of UM, prior authorization review, and appeal process.

The Plan is required to follow the supplemental changes in *All Plan Letter (APL) 17-006 Emergency State Fair Hearing (SFH) Timeframe Changes* to notify members receiving a Notice of Appeal Resolution (NAR) that they have an additional 120 days over and above the initial 120 days allowed to request a SFH. The Plan did not notify members receiving a NAR that they have an additional 120 days allowed to request a SFH.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements for Initial Health Assessment (IHA) and coordination of mental health services.

The Plan is required to cover and ensure the provision of an IHA, which consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA). The Plan did not ensure the provision of a complete IHA for each new member.

The Plan is required to identify individuals requiring alcohol and/or Substance Use Disorder (SUD) treatment services and arrange referral for substance use treatment. The Plan is required to make good faith efforts to confirm whether members receive referred treatments. The Plan did not make good faith efforts to confirm whether members received referred treatments for alcohol and SUD.

The Plan is required to cover outpatient mental health services that are within the scope of practice of Primary Care Providers (PCP) and mental health care providers. The Plan's policies and procedures shall define and describe the services provided by PCPs. The Plan policy did not define and describe what outpatient mental health services are to be provided by the PCPs.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding member access to care, adjudication of Family Planning (FP) and emergency services claims, and provision of Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT).

The Plan is required to have a process for documenting and implementing prompt investigation and corrective action when the Plan's network is not in compliance with timely access and network adequacy standards. The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in network providers' offices and waiting times for providers to answer and return telephone calls. The Plan did not conduct prompt investigation and corrective action for providers found to be non-compliant with access standards in the annual Provider Appointment Availability Survey (PAAS). The Plan did not monitor appointment wait times in providers' offices and did not monitor the time it took for providers to answer and return telephone calls from members.

The Plan is required to pay for FP services received by members from non-contracting providers. The Plan improperly denied FP claims from non-contracting providers.

The Plan is required to provide medically appropriate NEMT services and to implement a prior authorization process for NEMT ambulance, wheelchair, and litter van services. The Plan did not require prior authorization for NEMT ambulance, wheelchair, and litter van services.

Category 4 – Member's Rights

Category 4 includes requirements to protect member's rights by properly handling grievances, providing Cultural and Linguistic (C&L) services, and reporting suspected security incidents of Protected Health Information (PHI).

The Plan is required to have a grievance system in place that provides written acknowledgement to members within five calendar days of receipt of a grievance, and grievance resolution within 30 calendar days. The Plan is required to fully investigate and resolve grievances prior to sending resolution letters and the written resolution must contain a clear and concise explanation of the Plan's decision. The Plan did not send grievance acknowledgment letters and resolution letters within the required timeframes and did not ensure grievance resolution letters were clear and concise. The Plan did not fully investigate and resolve grievances prior to sending resolution letters. In the event the resolution is not reached within 30 calendar days, the Plan is required to notify the member in writing of the status of the grievance and the estimated date of resolution. The Plan also did not send written notification of grievance resolution delays when the grievance exceeded the 30 calendar day timeframe.

The Plan is required to classify and process expressions of dissatisfaction as grievances. If the Plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance. The Plan did not properly classify members' expressions of dissatisfaction as grievances.

Members or authorized representative acting on behalf of a member may file a grievance with the member's written consent. The Plan did not obtain written consent from the member when someone other than the member filed a grievance on behalf of the member

The Plan is required to designate a discrimination grievance coordinator, but the Plan did not have a designated grievance coordinator. The Plan must adopt grievance procedures that provide for the prompt and equitable resolution of discrimination-related grievances including submission of discrimination-related grievances to DHCS within ten calendar days of mailing the resolution letter to a member. The Plan did not correctly classify and process discrimination grievances. The Plan did not notify DHCS within ten calendar days of mailing a discrimination grievance resolution letter to a member.

The Plan is required to develop and implement policies and procedures for assessing the performance of bilingual employees and contracted staff who provide linguistic services. The Plan did not assess the linguistic performance of bilingual employees and contracted staff who provide linguistic services.

The Plan is required to notify the DHCS Program Contract Manager (PCM), the DHCS Privacy Officer and the DHCS Information Security Officer (ISO) within 24 hours of the discovery of any suspected security incident, send an updated Privacy Incident Report (PIR) within 72 hours of discovery, and send a complete report of the investigation within ten working days of discovery. The Plan did not submit PIR forms to the required DHCS contacts within the required timeframe. The Plan also did not report all suspected security incidents to DHCS.

Category 5 – Quality Management

Category 5 includes requirements to maintain an effective Quality Improvement (QI) system including delegation of QI (such as credentialing) and provider training.

The Plan is required to collect and review its subcontractors' ownership and control disclosure information. The Plan did not collect and review ownership and control disclosure information of its subcontractors delegated UM and/or credentialing functions. The Plan is required to maintain a system to ensure accountability for delegated QI activities including the continuous monitoring, evaluation and approval of the delegated functions. The Plan did not adequately implement its delegated credentialing oversight policy and procedures. The Plan did not consistently conduct monitoring and evaluation of the credentialing functions delegated to subcontractors.

The Plan is required to conduct training for all network providers within ten working days after the Plan places a newly contracted provider on active status. The Plan did not adequately document provider trainings was completed within ten working days of newly contracted providers being placed on active status. The Plan is accountable for all QI functions and responsibilities such as provider training that are delegated to subcontractors. All subcontracts shall be in writing and in accordance with the requirements. The Plan did not have written agreements addressing the provision and oversight of delegated new provider training responsibilities. The Plan informally delegated provider training to some of its subcontractors and did not conduct oversight of the delegated function.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to implement and maintain a health education program.

The Plan is required to conduct appropriate levels of program evaluation and monitor performance of providers contracted to deliver health education services to ensure effectiveness. The Plan did not conduct appropriate levels of program evaluation and monitor performance of providers of health education services.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the DHCS to ascertain that the medical services provided to Plan members complied with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

The audit was conducted from November 28, 2022 through December 9, 2022. 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: Seven approved and 18 denied medical prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Prior Authorization Appeal Procedures: Eight overturned, one partially overturned, and 16 upheld medical prior authorization appeals including 14 SPD cases were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Health Risk Assessment (HRA): 15 files were reviewed to confirm fulfillment of HRA requirements.

IHA: 20 files including two SPD members were reviewed to confirm the performance and completeness of assessment.

Complex CM: Five medical records were reviewed to verify CM and coordination of care.

Category 3 – Access and Availability of Care

Claims: 20 emergency services and 20 FP claims were reviewed for appropriate and timely adjudication.

NEMT: 30 records were reviewed to confirm compliance with the NEMT requirements.

NMT: 30 records were reviewed to confirm compliance with the NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: 45 Quality of Service (QOS), 35 Quality of Care (QOC), two expedited, 45 exempt, and ten discrimination grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review. 23 member calls from inquiry logs were reviewed for appropriate classification and processing.

Confidentiality Rights: 10 Health Insurance Portability and Accountability Act (HIPAA) suspected breach and security incidents were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

Potential Quality Issues: 20 cases were reviewed for appropriate reporting, timely evaluation, and proper resolution.

New Provider Training: 15 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 15 fraud and abuse cases were reviewed for appropriate reporting and processing.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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CATEGORY 1 - UTILIZATION MANAGEMENT

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 State Fair Hearing Request

The Plan is required to comply with all existing final Policy Letters (PLs) and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

Supplement to *APL 17-006: Emergency SFH Timeframe Changes* (from 03/20), stated that during the COVID-19 Public Health Emergency (PHE) period, the Plan is required to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days over and above the initial 120 days allowed to request a SFH (i.e. initial 120 day timeframe plus an additional 120 days, for a total of 240 days). If the Plan is unable to include this temporary SFH rights information with the NAR at the time of the mailing, it must call the member at the time the NAR is being mailed to notify the member of the right to request a SFH within 240 days from the date of the NAR. As the PHE was extended, the timeframe to file a SFH continued to be 240 days according to *APL 20-004 Emergency Guidance for Medi-Cal Managed Care Health Plan in Response to COVID-19* dated 09/09/21.

The Covid-19 State of Emergency proclaimed on March 4, 2020 was lifted on February 28, 2023. (A Proclamation By The Governor Of The State Of California Terminating State Of Emergency)

Finding: The Plan did not comply with existing APLs to notify members receiving a NAR that upholds an adverse benefit determination, that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH.

A verification study of 25 appeal samples revealed 16 appeals that were upheld due to an adverse benefit determination by the Plan. For six of the 16 upheld samples, the NARs stated that the member had 120 days to request a SFH; however, there was no mention of the additional 120 days that the member was allowed during the PHE.

In an interview, the Plan acknowledged that it had not notified its members of the extended timeframe to file a SFH due to staff error on these cases.

The Plan’s failure to notify members of the extended timeframe information could negatively impact the care, service, and rights of members.

Recommendation: Develop and implement policy and procedures to ensure members receive timely and accurate information about their rights.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Provision of an IHA

The Plan must cover and ensure the provision of an IHA in conformance with *California Code of Regulations (CCR), Title 22, Section 53851(b)(1)* to each new Member within timelines stipulated in *Provision 5A Provision of IHAs for Members under Age 21* and *Provision 6A IHAs for Adults*. *(Contract, Exhibit A, Attachment 10 (3)(A))*

An IHA consists of a history and physical examination and an IHEBA that enables a provider of primary care services to comprehensively assess the member's current acute, chronic and preventive health needs and identify those members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this Contract. *(Contract, Exhibit A, Attachment 10 (3))*

Plan policy *3.61-I Comprehensive CM and Coordination of Care* (revised 10/19/20) stated that a PCP is required to perform an IHA with a Medi-Cal member within 120 days of enrollment. The Plan covers and ensures that an IHA for adult member is performed by the PCP within 120 calendar days of enrollment. The IHA will be comprised of but is not limited to:

- Comprehensive history and exam
- Preventive services
- Diagnosis and plan of care
- IHEBA

Finding: The Plan did not ensure the provision of a complete IHA to each new member.

In a verification study, 2 of 20 samples did not contain a complete IHA since there was no documentation of an IHEBA.

During the audit period, the Plan monitored IHA completion through their Medical Records Review. For 2021 fourth quarter, the Plan identified five percent of the records were non-compliant with IHA completion requirements. In an interview, the Plan cited challenges during the Covid-19 PHE as a reason why the IHAs were incomplete.

Subsequent to the Exit Conference, the Plan stated it has numerous methods for attempting to ensure the provision of a complete IHA to each new member including provider and member incentives; provider education; discussion during new member welcome calls, and the sampling review. However, the verification study revealed that completed IHAs were missing required elements.

When the Plan does not ensure the provision of a complete IHA that includes the IHEBA, the provider cannot identify and treat the member's mental, physical, psychological, and preventative health needs.

Recommendation: Implement policy and procedures to ensure the provision of a complete IHA to each new member.

2.5	MENTAL HEALTH AND SUBSTANCE ABUSE

2.5.1 Alcohol and Substance Use Disorder Treatment Services

The Plan must identify individuals requiring alcohol and/or SUD treatment services and arrange for their referral to the county department responsible for substance use treatment, or other community resources when services are not available through counties, and to outpatient heroin detoxification providers available through the Medi-Cal Fee-For-Service (FFS) program, for appropriate services. (*Contract, Exhibit A, Attachment 11 (7)).*

The Plan must make good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment. If a member does not receive referred treatments, the Plan must follow up with the member to understand barriers and make adjustments to the referrals if warranted. The Plan should also attempt to connect with the provider to whom the member was referred to facilitate a warm hand off to necessary treatment. *(APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment)*

Plan policy *3.14-P Mental Health Services* (revised 10/31/19) stated the Plan will ensure that members who, upon screening and evaluation, meet criteria for an alcohol use disorder, or whose diagnosis is uncertain, are referred for further evaluation and treatment to the County Department for alcohol and SUD treatment services or DHCS-certified treatment program.

Finding: The Plan did not make good faith efforts to confirm whether members received referred treatments for alcohol and SUD.

In an interview, the Plan stated it is challenging to coordinate or follow up because the county SUD administrator will not inform the Plan if the member was referred due to lack of member consent to release information. In addition, the Memorandum of Understanding between the Plan and SUD administrator stated the SUD administrator must protect substance abuse information according to protections afforded by *42 Code of Federal Regulations (CFR) Part 2 Confidentiality of SUD Patient Records*.

In a written response, the Plan stated they are working with the county SUD administrator on a new process that will have all Drug Medi-Cal Organized Delivery System (DMC-ODS) providers completing Releases of Information, members signing authorization giving consent to share information with the Plan for coordination of care. The county SUD administrator is setting up protocols and training providers on the new process. The Plan has monthly meetings with SUD administrator to discuss ongoing implementation and DMC-ODS coordination.

When the Plan does not make good faith efforts to confirm whether members receive referred alcohol and drug treatment services, members may not obtain the assistance they need and may suffer adverse health effects as a result.

Recommendation: Develop a policy and procedure to ensure the Plan makes a good faith effort to confirm whether members receive referred treatments for alcohol and drug use disorder.

2.5.2 Primary Care Provider Scope of Practice

The Plan must cover outpatient mental health services that are within the scope of practice of PCPs and mental health care providers, in accordance with the outpatient mental health services requirements as defined in Exhibit E, Attachment 1, Definitions. Plan's policies and procedures shall define and describe what services are to be provided by PCPs. *(Contract, Exhibit A, Attachment 10 (E)(1))*

The member may be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the member to a mental health provider, first attempting to refer within the Plan network. *(APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services)*

Plan policy *3.14-P Mental Health Services* (revised 10/31/19) stated PCPs are required to provide outpatient mental health services within their scope of practice. These include services for members diagnosed with minor depression, minor anxiety, or uncomplicated grief reaction.

Finding: The Plan policy did not define and describe what outpatient mental health services are to be provided by the PCPs.

Plan policy *3.14-P Mental Health Services* did not define and describe what outpatient mental health services are to be provided by the PCPs as defined in Exhibit E, Attachment 1, Definitions that include the following: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.

In an interview and written response, the Plan stated that PCPs have different scopes of services. The Plan allows PCPs to decide what is in their scope practice. The scope of practice for each PCP is typically determined by the licensing entities and is dependent on the PCP's training, education, experience, certifications, etc.

Subsequent to the Exit Conference, the Plan submitted an updated version of Plan policy *3.14-P* (revised 05/10/22). The policy was updated to comply with various APLs, including *APL 22-006*, however, it still did not have definitions and descriptions of outpatient mental health services to be provided by PCPs.

If the Plan does not have a policy that defines and describes the outpatient mental health services to be provided by PCPs, it may lead to inappropriate levels of care for members.

Recommendation: Revise and implement policy and procedures to define and describe what outpatient mental health services are to be provided by the PCPs.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 Timely Access and Network Adequacy Corrective Actions

The Plan is required to ensure the provision of acceptable accessibility standards in accordance with *Title 28 CCR Section 1300.67.2.2 Timely Access to Non-Emergency Health Care Services*. The Plan must communicate, enforce, and monitor network providers' compliance with these standards. *(Contract, Exhibit A, Attachment 9 (4))*

The Plan is required to have a process for documenting and implementing prompt investigation and corrective action when compliance monitoring discloses that the Plan's network is not sufficient to ensure timely access and network adequacy as required by this Rule. The Plan's quality assurance process shall ensure the Plan takes all necessary and appropriate action to identify the cause(s) underlying identified timely access and network adequacy deficiencies and to bring its network into compliance. *(CCR, Title 28, Section 1300.67.2.2(d)(3)*

Plan policy *4.30-P Accessibility Standards* (revised 09/13/22) stated the Plan will take action as applicable including appropriate provider education; if a provider continues to be found out of compliance based on the results of the quarterly review, the provider may be issued a CAP.

Finding: The Plan did not conduct prompt investigation and corrective action for providers' found to be non-compliant with access standards in the annual PAAS.

In an interview, the Plan stated that it does not take action against providers found to be non-compliant in the annual PAAS. The Plan only uses the data from the annual PAAS for comparison with other Plans. Result of the PAAS was included in the Provider Network Management (PNM) Network Review, however, the report did not state any action taken against non-compliant providers. The PNM Network Review was included in the QI/UM Committee Meeting but there was no mention of action taken against non-compliant providers.

Subsequent to the Exit Conference, the Plan explained that it utilizes the annual PAAS to ensure compliance with Timely Access Reporting Requirements and to assess the Plan's compliance with timely access standards. The Plan does not automatically take action against individual providers identified as noncompliant as the result of this survey. The Plan reviews the results to identify appointment availability issues within Plan's network amongst the provider types surveyed.

If the Plan does not take action in response to non-compliant providers found in the annual PAAS, the Plan cannot ensure providers will meet access standards for member appointments.

Recommendation: Revise and implement policy and procedures to conduct prompt investigation and corrective action for providers found to be non-compliant with timely access and network adequacy standards in its access monitoring activities, including the annual timely access report.

3.1.2 Monitoring Provider Office Wait Times

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 IHAs. (*Contract, Exhibit A, Attachment 9 (3)(A))*

The Plan must develop, implement, and maintain a procedure to monitor waiting times in the Network Providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments. (*Contract, Exhibit A, Attachment 9 (3)(C))*

Plan policy *4.30-P Accessibility Standards* (revised 9/13/22) stated office waiting time maximum for urgent and routine care is one hour for primary care services including obstetrics and gynecology, specialty care services, diagnostic testing, mental health services and ancillary providers.

Finding: The Plan did not monitor appointment wait times in providers' offices.

In an interview, the Plan stated that wait times in providers' office are monitored through the grievance process. The quarterly access survey included a report which contained access related grievances, however, this report only contained access related grievances submitted by members and did not specifically monitor office wait times. Furthermore, the annual access survey did not demonstrate monitoring of office wait times.

Review of Plan policy *4.30-P Accessibility Standards* and Plan policy 5*.01-I KHS Member Grievance and Appeal System* found that the policies did not include a process for the Plan to monitor appointment wait times in providers' offices.

Subsequent to the Exit Conference, the Plan stated that it monitor office wait times through reviewing the grievances where members expressed dissatisfaction with the provider wait times (access grievances). However, the Plan did not provide documentation or evidence for monitoring the in-office wait time through the grievance process.

If the Plan does not monitor office wait times for appointments, the Plan cannot ensure that members are seen by providers in a timely manner.

Recommendation: Develop and implement policy and procedures to monitor and track the wait times in providers' offices.

3.1.3 Monitoring Telephone Access

The Plan must develop, implement, and maintain a procedure to monitor waiting times in the network providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments. *(Contract, Exhibit A, Attachment 9 (3)(C))*

Plan policy *4.30-P Accessibility Standards* (revised 09/13/22) stated patients must be able to call the office number for information regarding physician availability, on call provisions or emergency services. An answering machine or service must be made available after normal business hours with direction in non-emergency and emergency situations. Contracted providers must answer or design phone systems that answer phone calls within six rings.

Finding: The Plan did not monitor the time it took for providers to answer and return telephone calls from members.

The Plan used the quarterly access survey to monitor the number of rings to answer telephone calls, but did not measure the amount of time to answer or return telephone call. During the interview, the Plan stated that return telephone calls are monitored through the grievance process.

The quarterly access survey included a report which contained access related grievances, however, this report only contained access related grievances submitted by members and did not specifically monitor waiting times for providers to answer and return members' telephone calls.

Review of Plan policy *4.30-P Accessibility Standards* and Plan policy *5.01-I KHS Member Grievance and Appeal System* found that the policies did not include a process for the Plan to monitor the time it took for providers to answer and return telephone calls from members.

Subsequent to the Exit Conference, the Plan stated that it did monitor through reviewing the grievances where members expressed dissatisfaction with the provider answering or returning of member telephone calls (access grievances). The quarterly access report, did not specifically monitor waiting times for providers to answer and return telephone calls, but instead had a general category for technology and telephone related grievances.

If the Plan does not monitor providers' time to answer and return telephone calls, the Plan cannot ensure that members have timely telephone access to providers and may cause barriers to care.

Recommendation: Revise and implement policy and procedures to monitor and track the time it takes to answer and return member telephone calls.

3.6 EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

3.6.1 Family Planning Claims Denial

The Plan must reimburse non-contracting FP providers at no less than the appropriate Medi-Cal FFS rate. *(Contract, Exhibit A, Attachment 8 (9))*

The Plan must not improperly deny or contest a claim or portion thereof. For each claim that is denied or contested, the Plan must provide an accurate and clear written explanation of the specific reasons. *(CCR, Title 28, section 1300.71 (d)(1)(h))*

Plan policy *3.21-P FP Services and Abortion* (revised 08/31/20) stated that non-contract providers are paid for services provided to Medi-Cal members based on the appropriate Medi-Cal FFS rates.

Plan policy *6.01-P Claims Submission and Reimbursement* (revised 05/01/22) stated if the group or site is non-participating and the attending provider is non-participating. Claims will be processed in accordance with *CCR, Title 28, section 1300.71 Claims Settlement Practices*.

Finding: The Plan improperly denied FP claims.

In a verification study of 20 FP claims, three samples were improperly denied.

- Two samples were manually denied because of out-of-network provider.
- One sample was auto-denied because provider did not include the evidence of benefit of the member's primary insurance. However, the member only had Medi-Cal insurance.

During the DHCS audit, the Plan corrected the claim errors identified. The Plan explained that auto-denied claims are not manually reviewed unless selected for an internal audit.

If the Plan improperly denies covered FP services, it may discourage providers from providing appropriate care to members.

Recommendation: Revise and implement policy and procedures to ensure FP claims are not improperly denied.

3.8 NON-EMERGENCY MEDICAL TRANSPORTATION

3.8.1 Prior Authorization for NEMT

All PLs and APLs issued by DHCS subsequent to the effective date and during the term of this Contract shall provide clarification of Plan's obligations pursuant to this Contract, and may include instructions to the Plan regarding implementation of mandated obligations pursuant to changes in state or federal statutes or regulations, or pursuant to judicial interpretation. *(Contract, Exhibit E, Attachment 2 (1)(D))*

NEMT services such as transport by wheelchair, litter van and non-emergency ambulance are subject to prior authorization. The member must have an approved Physician Certification Statement (PCS) form authorizing NEMT by the provider. For Plan covered services requiring recurring appointments, Plans must provide authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months. Plans must ensure that there are no limits to receiving NEMT as long as the member's services are medically necessary and the member has prior authorization for the NEMT. *(APL 22-008 Non-Emergency Medical and NMT Services and Related Travel Expenses)*

Plan policy *5.15-I Member Transportation Assistance* (revised 12/15/21) stated NEMT litter van services are covered and do not require prior authorization when the member's medical and physical condition does not meet the need for NEMT ambulance. NEMT wheelchair van services are covered and do not require prior authorization when the member's medical and physical condition does not meet the need for litter van services.

A DHCS approved PCS form is required to determine the appropriate level of NEMT service for members. The completed form is accepted as an approval for NEMT wheelchair and litter van services, and is required before NEMT services are rendered.

Finding: The Plan did not require prior authorization for NEMT ambulance, wheelchair, and litter van services.

In an interview, the Plan stated that it does not have a prior authorization process for NEMT wheelchair and litter van services. Instead, the Plan used the PCS form in lieu of prior authorization process. The Plan stated that only a completed PCS form is required for transportation service. The NEMT verification study confirmed that the Plan only collected PCS forms. Of the 30 NEMT samples, 17 samples had completed PCS forms.

If the Plan does not conduct prior authorization review of NEMT services, it can not ensure that the members receive appropriate services.

Recommendation: Develop and implement policy and procedures to ensure that prior authorization review is conducted for NEMT services.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Resolution Timeframe

The Plan is required to have a grievance system in place in accordance with state and federal regulations, and Contract requirements. The Plan is required to provide a notice of resolution to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance, and notify the member of the grievance resolution in a written member notice. (*Contract, Exhibit A, Attachment 14 (1)(B))*

The Plan must comply with the state's established timeframe of 30 calendar days for grievance resolution. In the event that resolution of a standard grievance is not reached within 30 calendar days as required, the Plan must notify the member in writing of the status of the grievance and the estimated date of resolution. Even though federal regulations allow for a 14 calendar day extension for standard and expedited appeals, this allowance does not apply to grievances. *(APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan must adopt grievance procedures that provide for the prompt and equitable resolution of discrimination-related grievances. The Plan discrimination grievance procedures must follow the requirements outlined in *APL 21-011* including timely resolution of discrimination grievances. *(APL 21-004 Standard for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services).*

Plan policy *5.01-P KHS Member Grievance Process* (revised 08/26/22) stated the grievance is reviewed by the Grievance Review Committee (GRC), and a resolution is provided to the member within 30 calendar days of receipt of the grievance. Upon the grievance resolution, a written response will be mailed to the member within 30 calendar days.

Plan policy *5.01-I KHS Member Grievance and Appeal System* (revised 08/26/22) stated grievances and appeals unable to be resolved within 30 calendar days are considered pended grievances or appeals. In such cases, members are sent a Member Notice of Pending Grievance which includes the status of the grievance or appeal and estimated completion date of resolution, which shall not exceed 14 calendar days.

Finding: The Plan did not resolve standard grievances within the required 30-calendar day timeframe.

A verification study of 90 standard grievances revealed 15 QOC samples and 53 QOS samples were not resolved within the 30 calendar day timeframe. The samples exceeded the 30 day resolution by five to 278 days.

In an interview and written response, the Plan stated that employee error and delayed provider responses were the reasons why the cases took more than 30 days to resolve. There were 57 of 90 grievance samples that were extended while waiting for providers' responses or medical records. The Plan stated that these grievances were not late because they can extend the resolution up to 14 days according to APL 21-011. The Plan incorrectly applied the extension criteria described in APL 21-011.

When the Plan does not send grievance resolution letters within the required timeframe, it may lead to delayed care and decision-making.

Recommendation: Revise and implement policy and procedures to ensure standard grievance resolutions are sent to the member within the 30 calendar day timeframe.

4.1.2 Grievance Resolution

The Plan is required to have in place a member grievance system in accordance with *CCR, Title 28, section 1300.68 Grievance System and 1300.68.01 Expedited Review of Grievance. (Contract, Exhibit A, Attachment 14 (1))*

The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the Plan, or any provider or entity with delegated authority to administer and resolve the Plan's grievance system. "Resolved" means that the grievance has reached a conclusion with respect to the member's submitted grievance, and there are no pending member appeals within the Plan's grievance system, including entities with delegated authority. *(CCR, Title 28, section 1300.68 (a)(4))*

Plan policy *5.01 KHS Member Grievance Process* (revised 6/10/22) stated, "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated in state regulations. The Plan's written resolution must contain a clear and concise explanation of the Plan's decision. Providers shall respond to request for information to the Plan within ten business days. If the requested response is not received by the grievance coordinator by the tenth business day, the provider shall be sent a request for provider response five-day notice. If the requested

response is not received by the fifth business day, the grievance may be resolved in favor of the member due to no response received from the provider. If the GRC so chooses, the Plan may elect to keep the case open pending receipt of a response from the provider or clinic.

Finding: The Plan did not fully investigate and resolve grievances prior to sending resolution letters.

A verification study showed that 30 of 35 QOC grievance samples were closed prior to the Plan receiving medical records for review. If a case was identified as being a potential QOC concern, it was Plan procedure to close out the grievance without a resolution and then forward the case to the QI committee for further investigation, even if no medical records had been received. In an interview, the Plan stated that it does not always obtain a response from the provider for QOC cases. This request was left to the discretion of the medical director reviewing the grievance case.

In addition, 12 of 45 QOS grievance samples were closed due to the Plan not receiving a response from the provider. In an interview, the Plan stated the grievance department contacts the Plan's Provider Networker Management (PNM) team for assistance in obtaining provider responses; however, in these cases, the PNM team was also not able to obtain provider responses. It was Plan procedure for the GRC to close out the grievance without resolution when they did not receive a provider response.

Examples of the Plan's resolution language include:

- "We have reached out to your doctor for more information. We have not heard back from your doctor. Based on the review, our Medical Director determined the care you received may not have been appropriate. We will send the issue to our quality team for further review."

- "Kern Family Health Care's (KFHC) Grievance Committee has reviewed your case and it was determined that you may not have received the appropriate services. A written response was requested from [provider] to get their interpretation of the events that led to your dissatisfaction; however, a response has not been received to date. Please be advised your complaint will be forwarded to the KFHC Provider Relations (PR) Department for further tracking and trending."

In an interview, the Plan stated that according to its Plan policy *5.01 KHS Member Grievance Process* (revised 6/10/22), if the Plan does not receive a provider response or medical records, the grievance may be resolved in favor of the member due to no response received from the provider.

The Plan's resolution responses indicated that these cases were closed without a full investigation of the evidence relating to the grievances. A conclusion cannot be adjudicated if medical records or provider responses are not reviewed.

If the Plan closes grievances before fully reviewing all the information pertaining to the grievance, it may result in missing information that may delay or negatively impact care for members.

Recommendation: Develop and implement policy and procedures to ensure that all grievances are fully investigated and resolved prior to closing them.

4.1.3 Notice of Grievance Resolution Delay

The Plan must ensure timely acknowledgement for grievance and provide a notice of resolution to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. The Plan must notify the member of the grievance resolution in a written member notice. *(Contract, Exhibit A, Attachment 14(1)(B))*

The Plan must comply with the state's established timeframe of 30 calendar days for grievance resolution. In accordance with state law, even though federal regulations allow for a 14 calendar day extension for standard and expedited appeals, this allowance does not apply to grievances. In the event that resolution of a standard grievance is not reached within 30 calendar days as required, the Plan must notify the member in writing of the status of the grievance and the estimated date of resolution. *(APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (III)(C))*

Finding: The Plan did not send written notification informing members of grievance status and an estimated resolution date when standard grievances exceeded the 30 calendar day resolution timeframe.

A verification study of 35 QOC grievance samples revealed 15 exceeded the 30 calendar day resolution timeframe. Of these 15 samples, seven did not contain a written notification of resolution delay. Additionally, a verification study of 55 QOS grievance samples revealed 53 exceeded the 30 calendar day resolution timeframe. Of these 53 samples, three did not include a notification of grievance resolution delay letter.

In a written statement, the Plan reported that employee error was the reason for the oversight in sending written notification of grievance resolution delays in these cases.

Plan policy 5.01 KHS Member Grievance and Appeal System (revised 06/10/22) stated, grievances or appeals unable to be resolved within 30 calendar days are considered pended. In such cases, members are sent a Member Notice of Pending Grievance which includes the status of the grievance or appeal and estimated completion date of resolution, which shall not exceed 14 calendar days. This policy incorrectly applies the APL 21-011 14-day extension to grievances and uses this as the standard for the estimated date of resolution in written notifications informing members of grievance status when standard grievances exceeded the 30 calendar day resolution timeframe.

Failure to send written notification of grievance resolution delays may result in delay of services and care for members.

Recommendation: Revise and implement policies and procedures to ensure the Plan sends written notification informing members of grievance status and an estimated resolution date when standard grievances exceeded the 30 calendar day resolution timeframe.

4.1.4 Grievance Acknowledgement Letters

The Plan is required to have a grievance system in place in accordance with state and federal regulations, and contract requirements. The Plan must ensure timely acknowledgement for grievance. (*Contract, Exhibit A, Attachment 14 (1))*

In accordance with state law, the Plan must provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of the grievance. *(APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy *5.01-P KHS Member Grievance Process* (revised 08/26/22) stated the Plan is required to send a written acknowledgement to the member within five calendar days from receipt, informing them that their grievance or appeal has been received and is in process.

Finding: The Plan did not send grievance acknowledgment letters to members within the required five calendar day timeframe.

A verification study of 90 standard grievances revealed four QOC samples and 12 QOS samples exceeded the five calendar day timeframe for sending grievance acknowledgment letters.

In an interview and written response, the Plan stated the delay was due to employee error.

When the Plan does not send written grievance acknowledgement letters to members within five calendar days, it may result in delayed information needed for health care decision-making.

Recommendation: Implement policy and procedure to ensure grievance acknowledgment letters are sent to members within the required five calendar day timeframe.

4.1.5 Grievance Resolution Letters

The Plan is required to have a grievance system in place in accordance with state and federal regulations, and Contract requirements. Notice of resolutions for grievances should be in a format and language that, at a minimum, meets *42 CFR 438.10 Information Requirements* and *Exhibit A, Attachment 13, Provision 4* of the Contract for member written information. (*Contract, Exhibit A, Attachment 14 (1)(G))*

The Plan's written resolution must contain a clear and concise explanation of the Plan's decision. *(APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy *5.01-P KHS Member Grievance Process* (revised 08/26/22) stated the grievance coordinator completes a written grievance resolution form which shall contain a clear and concise explanation of the Plan's decision.

Plan policy *5.01-I KHS Member Grievance and Appeal System* (revised 08/26/22) stated the written response shall contain a clear and concise explanation of the Plan's decision and shall include in its written response the reasons for its determination including, clearly stating the criteria, clinical guidelines, or medical policies used in reaching the determination.

Finding: The Plan did not ensure grievance resolution letters were clear and concise.

In a verification study of 90 standard grievances, there were ten QOS samples and two QOC samples that were not clear and concise:

- Resolution letters included medical terminology without explanation or definition such as LeFort Colpocleisis, Levator Myorrhaphy, diagnosis of Otalgia, Otolaryngologist (ENT) specialist.

- Eight QOS samples resolution letters included non-relevant and unclear information:

    - In one sample, the grievance was about the member's preference for telehealth and in-home appointments; however, the resolution included information regarding prior request for attendance and medical records, social security insurance forms, and unrelated information regarding the member's behavior during previous calls with the Plan.

    - In another sample, the grievance was about a nurse practitioner providing a substandard level of care for member's severe back pain in February and March of 2022. The resolution contained unrelated medical information from August 2021 to January 2022.

In an interview, the Plan stated the grievance coordinator is responsible for ensuring the resolutions are clear and concise and the grievance coordinator leads conduct a final review of the resolutions; however, they do not use any criteria or guidance for determining if a resolution is clear and concise. The grievance coordinator leads' final review is not documented. The Plan acknowledged the resolutions were lengthy, and this is an opportunity for improvement.

When the Plan does not send clear and concise grievance resolution letters to members, it may cause member confusion and misunderstanding about their health care.

Recommendation: Revise and implement policy and procedures to ensure grievance resolution letters are clear and concise.

4.1.6 Written Member Consent for Grievances

Members, or a provider or authorized representative acting on behalf of a member and with the member's written consent, may file a grievance, or request an appeal, with the Plan either orally or in writing. (*Contract, Exhibit A, Attachment 14 (1)(A))*

Plan policy *5.01-P KHS Member Grievance Process* (revised 08/26/22) stated a grievance or appeal from a member or a member's representative may be submitted either verbally or in writing. If the member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the member, as appropriate, may submit the grievance or appeal as the agent of the member. A "patient advocate" or ombudsperson may also be used for assistance with submitting a grievance. The provider may join with or otherwise assist the member in submitting a grievance or appeal, and may advocate on behalf of the member. Following the submission of the grievance or appeal, the member or member's agent may authorize the provider to assist, including advocating on behalf of the member.

Finding: The Plan did not obtain written consent from the member when someone other than the member filed a grievance on behalf of the member.

A verification study of 45 QOS grievance samples revealed two samples had no written member consent.

- In one sample the member's social worker filed a grievance without obtaining their written consent.

- In another sample a member's relative filed a grievance on the member's behalf without the member's written consent. Additionally, the resolution letter indicated that the member was not aware that a complaint had been filed. There was no appointment of representative form on file for the member's relative.

In an interview, the Plan stated anyone can file on behalf of the member, family or friend, even with no written or verbal consent. In a written response, the Plan referenced *APL 21-011* which stated Plans must not discourage the filing of grievances. A member need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and processed as a grievance by the Plan. However, in these two cases, the grievance was not expressed by the member and the Plan did not obtain the member's written consent.

Review of Plan policy *5.01-P KHS Member Grievance Process* revealed that the policy did not include the requirement to obtain consent when someone other than the member filed a grievance.

If the Plan allows anyone to file a grievance on behalf of the member without their written consent, it may be a violation of the member's rights and privacy.

Recommendation: Develop and implement policy and procedures to ensure member written consent is obtained before allowing others to file a grievance on behalf of the member.

4.1.7 Designated Discrimination Grievance Coordinator

The Plan is required to have a grievance system in place in accordance with state and federal regulations, and Contract requirements. (*Contract, Exhibit A, Attachment 14 (1) (G))*

The Plan must designate a discrimination grievance coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements. The Plan's discrimination grievance coordinator must investigate grievances alleging any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination laws. The Plan's discrimination grievance coordinator must be available to

- Answer questions and provide appropriate assistance to Plan staff and members regarding the Plan's state and federal nondiscrimination legal obligations.
- Advise the Plan about nondiscrimination best practices and accommodating persons with disabilities.
- Investigate and process any Americans with Disabilities Act (ADA), section 504, section 1557, and Government Code section 11135 grievances received by the Plan.

(APL 21-004 Standard for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)

Plan policy *5.01-P KHS Member Grievance Process* (revised 08/26/22) stated the Plan will designate a discrimination grievance coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements.

Finding: The Plan did not have a designated discrimination grievance coordinator.

During the interview, the Plan stated they lost their designated grievance coordinator in November 2021. The Grievance Supervisor and Director of Member Services carried out the duties while staff were trained. The Plan stated that the two new discrimination grievance coordinators did not start until September 2022. Therefore, the Plan was out of compliance for 10 months.

Review of the Plan's Grievance Department Organization Chart found the designated discrimination grievance coordinator position was not mentioned or specified in the chart.

If the Plan does not have a designated discrimination grievance coordinator then members may not have their discrimination grievances addressed properly and this could lead to barriers to care and services.

Recommendation: Develop and implement policy and procedures to ensure the Plan designate a discrimination grievance coordinator responsible for all discrimination grievances.

4.1.8 Classification of Discrimination Grievances

The Plan is required to have a grievance system in place in accordance with state and federal regulations, and Contract requirements (*Contract, Exhibit A, Attachment 14 (1) (G)*

The Plan must adopt grievance procedures that provide for the prompt and equitable resolution of discrimination-related grievances. Plan discrimination grievance procedures must follow the requirements outlined in *APL 21-011*, including timely acknowledgment and resolution of discrimination grievances. *(APL 21-004 Standard for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan policy *5.01-P KHS Member Grievance Process* (revised 08/26/22) stated the Plan will designate a discrimination grievance coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements. The policy also stated that the Plan will also adopt grievance procedures that provide for the prompt and equitable resolution of discrimination-related grievances.

Finding: The Plan did not adopt procedures that provide for prompt and equitable resolution of discrimination grievances.

A verification study of 45 standard QOS grievances revealed two grievances in which members expressed they experienced discrimination but these grievances were processed as provider/staff attitude grievances instead of discrimination grievances. In the interview and written response, it was not until May 2022 that the Plan updated their desktop procedure to include the procedures for potential discrimination grievances. This desktop procedure was not in place when the Plan received the two grievances stated above.

If the Plan does not correctly classify and process discrimination grievances then members may experience barriers to access care and services.

Recommendation: Revise and implement policy and procedures to ensure all member complaints about discrimination are correctly classified and processed as discrimination grievances.

4.1.9 Notification of Discrimination Grievances

The Plan is required to have in place a system in accordance with *CCR, Title 28, section 1300.68 Grievance System and 1300.68.01 Expedited Review of Grievance, CCR, Title 22, section 53858 Member Grievance Procedure , Exhibit A, Attachment 13, Provision 4, Paragraph F.13 Right to File a Grievance, and 42 CFR 438.402-424 Requirements for Grievance and Appeal System*. (*Contract, Exhibit A, Attachment 14 (1)(G))*

The Plan must submit detailed information regarding the grievance to the DHCS Office of Civil Rights designated discrimination grievance email within ten calendar days of mailing a discrimination grievance resolution letter to a member. *(APL 21-004 Standard for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan policy *5.01-P KHS Member Grievance Process* (revised 08/26/22) stated the Plan will submit detailed information regarding the discrimination grievance to DHCS within ten calendar days of mailing a discrimination grievance resolution letter to a member.

Finding: The Plan did not notify DHCS within ten calendar days of mailing a discrimination grievance resolution letter to a member.

A verification study of ten discrimination grievances revealed three grievances in which the notification to DHCS was sent late; the notification was sent between 12-22 days after sending the resolution letter to the member. In a written response, the Plan explained this was due to employee error.

If the Plan does not notify DHCS of discrimination grievances within the ten calendar day timeframe then DHCS will not able to address the situation timely which may lead to a delay of care.

Recommendation: Implement policy and procedure to ensure the Plan notifies DHCS within ten calendar days of mailing a discrimination grievance resolution letter to a member.

4.1.10 Classification of Grievances

The Plan is required to have in place a system in accordance with *CCR, Title 28, section 1300.68 Grievance System and 1300.68.01 Expedited Review of Grievance, CCR, Title 22, section 53858 Member Grievance Procedure, and 42 CFR 438.402-424 Requirements for Grievance and Appeal System*. (*Contract, Exhibit A, Attachment 14 (1)(G))*

A grievance is any expression of dissatisfaction about any matter other than an adverse benefit determination while an inquiry is a request for information that does not include an expression of dissatisfaction. If the Plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance. A member need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and processed as a grievance by the Plan. (*APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy *5.01-I KHS Member Grievance and Appeal System* (revised 08/26/22) stated grievance means a written or oral expression of dissatisfaction regarding the Plan and/or provider, including QOC concerns, and shall include a complaint, dispute, and request for reconsideration or appeal. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Finding: The Plan did not properly classify members' expressions of dissatisfaction as grievances.

A verification study of 23 inquiries samples revealed seven samples where members expressed dissatisfaction but were not classified as grievances. The seven samples occurred from February 2022 through August 2022. In a written response, the Plan confirmed these seven samples were not sent to the grievance coordinators to be processed and members were not offered to file a grievance.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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As a CAP to the 2021 audit finding, 4.1.3 Classification of Grievances, the Plan reminded staff monthly and updated scheduled briefings to remind Member Service Representatives (MSR) on how to identify and submit to grievance coordinators. In addition, the Plan updated policy *5.01-I* to include language about the member not needing to use the term “grievance”, had quarterly presentations to member services staff, created a MSR report on closed out grievance calls, and started to conduct quarterly audit of call inquiries in Q2 2022. During a February 2022 member services staff meeting, it was indicated the Plan was still finding dissatisfaction grievance calls that were being closed out by the MSR instead of being processed as grievances.

This is a repeat finding of 2021 finding 4.1.3 Classification of Grievances.

If the Plan does not classify members’ expressions of dissatisfaction as grievances then members cannot exercise their right to file a grievance and may experience barriers to care.

Recommendation: Implement policy and procedures to ensure member expressions’ of dissatisfaction are classified as grievances.

4.2 CULTURAL AND LINGUISTIC SERVICES

4.2.1 Monitoring of Linguistic Performance

The Plan is required to assess and track the linguistic capability of bilingual employees and contracted staff. The Plan is required to develop and implement policies and procedures for assessing the performance of bilingual employees and contracted staff who provide linguistic services. *(Contract, Exhibit A, Attachment 9 (13)(B)(F))*

Plan policy *3.70-I C&L Services* (revised 01/07/18) stated that linguistic services are coordinated by the health education cultural & linguistic specialist. The representative oversees the educational programs developed for staff and contracted providers, implementation of bilingual proficiency guidelines, and the coordination and monitoring of interpreter services. Monthly, the vendor's invoice is compared to phone and interpreter tracking log to validate proper billing.

Finding: The Plan did not assess the linguistic performance of bilingual employees and contracted staff who provide linguistic services.

In an interview, the Plan stated they monitor bilingual staff through annual internal audit and the grievance process. The Plan assessed bilingual staff's knowledge on how to connect members to linguistic vendors; it did not include an assessment of linguistic services performed by bilingual staff.

The Plan also explained that linguistic vendors are contractually required to assess their employees through linguistic verification and credentialing of employees. Review of the linguistic verification and credentialing process showed that two of four vendors did not include monitoring the performance of individuals who provide linguistic services. One vendor indicated ongoing evaluations, monitoring, rating and tracking of linguistic staff. Another vendor indicated that interpreters are continuously trained, retrained, and individually evaluated. However, the Plan does not regularly obtain and review documentation from the two vendors monitoring the performance of interpreters.

Subsequent to the Exit Conference, the Plan referred to its C&L Program Plan, which stated that all bilingual staff must pass a verbal bilingual assessment before being hired or during employment. The Plan also referred to policy *3.70-I* section 1.2, which stated Plan staff that are utilized as interpreters or translators are required to pass an assessment for their linguistic skills. Although the C&L Program Plan and the policy *3.70-I* addressed the Plan's process for assessing the linguistic capabilities of their employees and contracted staff, it did not include procedures for evaluating the performance of its bilingual employees and linguistic vendors.

Without an evaluation of its linguistic services, the Plan cannot ensure that services provided are adequate and effective in its communication with members.

Recommendation: Develop and implement policy and procedures to monitor the performance of linguistic services provided by bilingual employees and contracted staff.

4.3	CONFIDENTIALITY RIGHTS

4.3.1 PHI Breach Notification to DHCS

The Plan is required to notify DHCS immediately by telephone call plus email or fax the DHCS PIR within 24 hours upon discovery of a breach of unsecured PHI or Personal Information (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. The Plan must submit an updated PIR form within 72 hours of discovery. The complete report of the investigation must be submitted within ten working days of the discovery. All PIR forms must be submitted to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS ISO. (*Contract, Exhibit G (III) (J) and APL 09-014 Exhibit G, HIPAA)*

Plan policy *14.03-I PHI – Privacy, Use, and Disclosure* (revised 04/01/22) stated the Plan will immediately notify DHCS by telephone plus email or fax upon the discovery of a breach of unsecured PHI or PI in electronic media. Plan will notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident. Notification will be made using the most current DHCS PIR and will be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS ISO. An updated DHCS PIR of the investigation will be provided to DHCS within 72 hours of the discovery by Plan. A complete PIR of the investigation will be provided to DHCS within ten working days of discovery of the breach or unauthorized use or disclosure.

Finding: The Plan did not submit PIR forms to the required DHCS contacts within the required timeframe.

A verification study of ten samples of PHI breaches and security incidents revealed two samples did not meet all notification requirements. The following are the findings for the two samples:

- In one sample, the Plan did not submit each immediate, updated, and complete PIR forms for an electronic PHI breach to the required DHCS contacts within the required timeframe. When the PIR form was completed, the Plan notified DHCS staff 40 working days after discovery.

- In another sample, the Plan did not submit the PIR form for electronic PHI breach within 24 hours of discovery and did not notify the DHCS Program Contract Manager. In addition, the Plan did not submit an updated PIR form within 72 hours. The Plan submitted the completed PIR form to DHCS contacts 77 working days after discovery.

In an interview, the Plan stated it assesses a breach or security incident once it receives notification of the breach or security incident. The Plan then notifies DHCS of any confirmed breach or security incident.

When the plan does not submit notifications of breach or security incidents to the required DHCS contacts within the required timeframe, it may delay additional investigation and places sensitive member information at risk.

Recommendation: Revise and implement policy and procedures to ensure notifications and PIRs are sent to all the required DHCS contacts within the required timeframe.

4.3.2 Notification of Security Incident and Unauthorized Disclosure of PHI

The Plan is required to notify DHCS by email or fax the DHCS PIR within 24 hours upon discovery of any suspected security incident, intrusion, or unauthorized access, use, or disclosure of PHI or PI. The Plan must submit an updated PIR form within 72 hours of discovery. The complete report of the investigation must be submitted within ten working days of the discovery. All PIR forms must be submitted to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS ISO. *(Contract, Exhibit G (III)(J)* and *APL 09-014 Exhibit G, Health Insurance Portability and Accountability Act)*

Plan policy *14.03-I PHI – Privacy, Use, and Disclosure* (revised 04/01/22) stated that the Plan would immediately 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 in violation of the DHCS Contract.

Finding: The Plan did not notify any DHCS contacts nor submit any PIRs upon the discovery of unauthorized disclosures of PHI or security incident.

A verification study of ten samples revealed DHCS did not receive notifications nor PIRs from the Plan for three of the samples upon the Plan's discovery of unauthorized disclosures of PHI or security incident before and after investigating the incidents. The three samples include:

- In the first sample, a member received another member's PHI in the mail.
- In the second sample, a network provider had a locked box, which contained member's PHI stolen from an employee's car.

- In the third sample, a retail pharmacy dispensed medication to the wrong person disclosing a member's PHI on the prescription bottle.

In an interview, the Plan stated it uses its HIPAA breach decision tool and risk assessment document form to help evaluate incidents involving unauthorized disclosure of PHI. The tool assesses the risk to the member and whether it warrants reporting to DHCS.

When the Plan does not submit notifications of suspected breach or security incidents to the required DHCS staff in the required timeframe, it may delay additional investigation and places sensitive member information at risk.

Recommendation: Revise and implement policy and procedures to ensure DHCS receives notifications and PIRs for any suspected security incidents.

CATEGORY 5 – QUALITY MANAGEMENT

5.2	DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

5.2.1 Ownership Disclosure of Subcontractors

In accordance with *42 CFR 438.608(c) Program Integrity Requirements*, the Plan shall collect and review subcontractors' disclosures on ownership and control as required under *42 CFR 455.104 Information on Ownership and Control*. (*Contract, Exhibit E, Attachment 2 (33))*

The Plan and any subcontractor must provide written disclosures of information on ownership and control required under *section 455.104* of this chapter. (*42 CFR 438.608(c))*

The Plan requires subcontractors to provide the following disclosures:

- The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

- Date of birth and Social Security Number (in the case of an individual).

- Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent or more interest.

- The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(42 CFR 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.)

The Plan shall collect and review their subcontractors' ownership and control disclosure information as set forth in *42 CFR section 455.104*. (*APL 17-004 Sub-Contractual Relationships and Delegation)*

Plan policy *2.45-I Delegation of Quality Improvement, UM, Care and CM and Pharmacy Activities and Responsibilities* (revised 01/23/19) stated each delegated entity would sign a delegation agreement that describes the responsibilities of the Plan, the delegated entity, the evaluation process of the delegated entity's performance, and all other criteria outlined in this policy.

Finding: The Plan did not collect and review ownership and control disclosure information of its subcontractors.

The Plan did not collect ownership and control disclosure forms for five of the seven subcontractors. The ownership and control disclosure forms collected from the other two subcontractors did not include all the required information.

- One subcontractor did not disclose the social security number, date of birth, and address of executives and managing members.

- Another subcontractor, which is a not-for-profit corporation, did not disclose any of the members of the Board of Directors or executive leadership.

Review of Plan policy *2.45-I* found it did not address the Plan's procedures for collecting and reviewing ownership and control disclosure requirements from its subcontractors. The Plan stated they have a process to collect and review ownership and control disclosure; however, the Plan did not have any documentation that demonstrated the process is implemented.

If the Plan does not review ownership and control interest information of its subcontractors, the Plan cannot ensure required information is completely and accurately disclosed, and mitigate any conflict of interests that may exist.

Recommendation: Develop and implement policy and procedures to collect and review ownership and control disclosure information of its subcontractors.

5.2.2 Monitoring of Delegated Entities

The Plan is required to maintain a system to ensure accountability for delegated QI activities, including the continuous monitoring, evaluation and approval of the delegated functions. *(Contract, Exhibit A, Attachment 4 (6)(B)(3))*

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Kern Health Systems dba Kern Family Health Care

AUDIT PERIOD: November 1, 2021 through October 31, 2022
DATES OF AUDIT: November 28, 2022 through December 9, 2022

Plan policy *4.32-P Delegated Credentialing* (revised 09/09/19) stated that prior to delegation and annually thereafter, the Plan will conduct a review and audit of the credentialing and re-credentialing activities to ensure that the delegated entity is in accordance with the Plan's approved policies and procedures, and established criteria. The Plan will conduct an annual evaluation and audit of all delegates. The evaluation and audit will include a review of applicable credentialing & quality assurance policies and procedures related to the delegated function. If the delegate is National Committee for Quality Assurance (NCQA) accredited or possesses NCQA certification, the Plan may use the NCQA Accreditation audit in its annual evaluation; however, the NCQA accreditation or certification is not the sole method for determining if the group is deemed capable to complete the specific delegation functions (i.e., credentialing and re-credentialing).

Finding: The Plan did not consistently conduct monitoring and evaluation of the credentialing functions delegated to subcontractors.

Review of the Plan's UM/QI Committee minutes revealed that the Plan performed an audit of its credentialing delegates except for its vision services delegate. In a written statement, the Plan stated that the Compliance Department did not complete an audit of its vision services delegate during the audit period. The Plan did not provide an explanation for not conducting an evaluation of the vision services delegate.

When the Plan does not monitor its delegates credentialing responsibilities, the Plan cannot ensure that providers are qualified to provide services to members.

Recommendation: Implement policy and procedures to ensure accountability of delegated credentialing responsibilities.

5.3	PROVIDER QUALIFICATIONS

5.3.1 New Network Provider Training

The Plan is required to conduct training for all network providers within ten working days after the Plan places a newly contracted network provider on active status. The Plan shall ensure training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. *(Contract, Exhibit A, Attachment 7(5)(A))*

The Plan will maintain such records and documents necessary to disclose how the Plan discharged its obligations under this Contract. The Plan and its subcontractors shall maintain all of these records and documents to a minimum of ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later. *(Contract, Exhibit E, Attachment 2(19))*

Plan policy *4.23-P Provider Education* (revised 12/09/20) stated provider orientations will be conducted for all Plan contracted providers and their staff within ten days after Plan has placed a newly contracted provider on active status. The contracted provider is made aware that they may not provide services to Plan members, until the provider completes training.

Finding: The Plan did not document provider trainings were completed within ten working days of newly contracted providers being placed on active status.

In an interview, the Plan stated telephone and web based provider training were the available methods as an alternative to in person sessions. Furthermore, the Plan confirmed that all 15 providers in the samples for the verification study attended web-based provider training sessions. However, the Plan has no written process or policies and procedures to guide staff on how to schedule, conduct, and maintain records of new provider training whether for in-person, phone, or web-based sessions.

A verification study of 15 samples of new network providers revealed:

- In 14 samples, there was no records and documents, which validated the provision of provider training.

- The web based training sessions did not record the date the providers' signed the attendance sheet as evidence of completion except for one sample.

- The Plan could not demonstrate date of completion or timeliness of the training.

Subsequent to the Exit Conference, the Plan stated it did document provider trainings and that the trainings were completed within ten working days of the new contracted provider being placed on active status. However, there were no new information submitted that supported their claim. The Plan's *Provider In-Service Sign-in Sheets* did not capture the dates providers signed and received the training, therefore the training date could not be validated. The Plan also did not submit requested correspondence with new providers to schedule and send training materials.

When the Plan does not maintain records and documents to show timely completion of new provider training then the Plan cannot ensure that new providers are informed of the Plan's policies and procedures.

Recommendation: Develop and implement new provider training policy and procedures that includes maintaining records and documents to demonstrate compliance with timely completion of new provider training.

5.3.2 Delegation Requirements

The Plan is required to conduct training for all network providers within ten working days after the Plan places a newly contracted network provider on active status. The Plan shall ensure training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. *(Contract, Exhibit A, Attachment 7(5) (A))*

The Plan is accountable for all QI functions and responsibilities that are delegated to subcontractors. If the Plan delegates QI functions, the written agreement shall include the Plan's oversight, monitoring, and evaluation processes and the subcontractor's agreement to such processes. *(Contract, Exhibit A, Attachment 4(6))*

Plan policy *14-55-I Delegated Oversight Monitoring* (revised 02/15/19) stated the Plan would oversee and remain accountable for any functions and responsibilities delegated to the subcontracted entity.

Finding: The Plan did not have written agreements addressing the provision and oversight of delegated new provider training responsibilities.

A review of the two delegated agreements do not include procedures for provision and oversight of new provider training conducted by its delegated entities.

In an interview, the Plan stated two of seven delegates provided training to their own providers. The Plan acknowledged that it did not have a process to verify that the entities were conducting new provider training.

When the Plan's written agreements with delegated providers do not specify the provision and oversight of provider training activities, the Plan cannot ensure newly contracted providers receive training on policies and procedures.

Recommendation: Develop and implement policies and procedures to ensure delegation agreements meet all requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Kern Health Systems dba Kern Family Health Care
AUDIT PERIOD: November 1, 2021 through October 31, 2022 **DATES OF AUDIT:** November 28, 2022 through December 9, 2022

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.1	HEALTH EDUCATION PROGRAM

6.1.1 Monitoring of Health Education Services

The Plan is required to conduct appropriate levels of program evaluation and monitor performance of providers that are contracted to deliver health education services to ensure effectiveness. *(Contract, Exhibit A, Attachment 10 (8)(A)(8))*

Plan policy *11.24-I Health Education* (revised 06/06/21) stated the Plan monitors its health education services by reviewing member grievances, three-month follow up calls after health education classes are completed, and through an annual review of programs participating in the network to identify changes or additions to program offerings.

Finding: The Plan did not conduct appropriate levels of program evaluation nor monitor performance of providers of health education services.

Health education services provided by the Plan includes wellness and nutrition, smoking cessation classes. Health education services provided by contracted providers include diabetes, nutrition, education, smoking tobacco, prenatal, perinatal and postpartum educational intervention, in-home asthma assessment, remediation and education.

In an interview and written response, the Plan explained that they monitor the effectiveness of their health education services by conducting a three-month follow up survey call to members. Members who participated in wellness and nutrition health education were asked their weight and height while those who participated in smoking cessation health education were asked if they smoke cigarettes, cigars, and e-cigarettes; chew tobacco; and if they used the smoking quitting aid. Pre and post service responses are compared to evaluate whether the service was effective in helping the member manage their health.

The Plan stated that they do not monitor the performance nor evaluate the educational interventions provided by contracted providers.

If the Plan does not monitor the performance of health education services provided by the Plan and its contracted providers, the Plan cannot ensure the effectiveness of health education services provided to members.

Recommendation: Revise and implement policy and procedures to conduct appropriate levels of health education program evaluation and monitor performance of providers of health education services.

CONTRACT AND ENROLLMENT REVIEW DIVISION
NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

KERN HEALTH SYSTEMS
dba
KERN FAMILY HEALTH CARE

2022

Contract Number:	03-75798 State Supported Services
Audit Period:	November 1, 2021 Through October 31, 2022
Dates of Audit:	November 28, 2022 Through December 9, 2022
Report Issued:	May 5, 2023

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of November 1, 2021 through October 31, 2022. The audit was conducted from November 28, 2022 through December 9, 2022. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on April 11, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

20 State Supported Services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Kern Health Systems dba Kern Family Health Care

AUDIT PERIOD: November 1, 2021 through October 31, 2022
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STATE SUPPORTED SERVICES

SSS.1 Claim Denial

The Plan is bound by all applicable terms and conditions of the primary contract as of the effective date of Hyde Contract. *(Hyde Contract, Exhibit E (1)(A))*

The Plan shall not improperly deny or contest a claim or portion thereof. For each claim that is denied or contested, the Plan shall provide an accurate and clear written explanation of the specific reasons. *(California Code of Regulations (CCR), Title 28, section 1300.71 (d)(1) and (h))*

Plan policy *6.01-P Claims Submission and Reimbursement* (revised 5/1/22) stated if a member has other medical coverage, the provider must file the claim with the primary insurance carrier before filing with the Plan. Upon receipt of partial payment or denial from the primary insurance, the provider should submit the claim to the Plan along with documentation of payment or denial from the primary insurance. The claims department requires a copy of the other Plan's payment determination prior to releasing payment for those members covered by another insurance. Claims will be processed in accordance with *CCR, Title 28, section 1300.71*.

Finding: The Plan improperly denied a state supported services claim.

In a verification study of 20 state supported services claims, one claim was improperly denied because the member had a primary insurance or other medical coverage besides Medi-Cal. The review showed that the provider submitted the claim along with documentation of denial from the primary insurance to the Plan. After a manual review by the Plan, the claim was denied. The Plan improperly denied a covered state supported services claim.

In a written response, the Plan stated they have a process to handle disputes including the overturning of a denied claim. However, the Plan does not have guidelines or criteria for claims examiners to follow when conducting a manual review of claims denied by its system.

If the Plan improperly denies covered state supported services, it may discourage providers from providing care to members and lead to negative impacts on their health.

Recommendation: Revise and implement policy and procedures to ensure state supported services claims are not improperly denied.

SSS.2 Interest Payment and Late Fee

The Plan is bound by all applicable terms and conditions of the primary contract as of the effective date of Hyde Contract. *(Hyde Contract, Exhibit E (1)(A))*

Late payments on all other complete claims shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late. A Plan that fails to automatically include the interest due on a late claim payment shall pay the provider $10 for that late claim in addition to any amounts due. *(CCR, Title 28, section 1300.71(i)(2)(j))*

Plan policy *60.05-I Payment of Interest on Late Claims* (revised 12/1/10) stated late payments for all other complete claims shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late beginning with the first calendar day following the 45th working day. The Plan calculates and pays interest within five working days of the payment of the associated claim without requiring the provider to make a request. Failure to meet the five working day time limit results in an additional $10 late fee per claim.

Finding: The Plan did not pay interest and late fee for state supported services claims processed beyond 45 working days.

In a verification study of 20 state supported services claims, one claim was processed late by 59 days and the Plan did not pay interest and a late fee. When the claim was denied, the provider submitted a provider dispute. The Plan then manually reviewed the dispute and overturned the denial. The Plan paid the claim to the provider but did not include accumulated interest and late fee payments. The Plan improperly used the provider dispute submission date instead of the original submission date for the claim.

If the Plan does not properly pay claims including any accrued interest and late fees, it may cause financial harm to a provider's practice and limit members' access to care.

Recommendation: Revise and implement policy and procedures to ensure payment, including any accrued interest and late fees, for any state supported services claims processed beyond 45 working days.