DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SAN DIEGO SECTION

REPORT ON THE MEDICAL AUDIT OF

Kern Health Systems
dba
Kern Family Health Care

2023

Contract Number:	03-76165
Audit Period:	November 1, 2022 through October 31, 2023
Dates of Audit:	November 27, 2023 through December 8, 2023
Report Issued:	March 25, 2024

TABLE OF CONTENTS

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.

On 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.

Medi-Cal is the Plan's single line of business. As of October 2023, the Plan served approximately 364,474 members.

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, 2022, through October 31, 2023. The audit was conducted from November 27, 2023, through December 8, 2023. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on February 27, 2024. 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, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit issued on May 5, 2023, (audit period November 1, 2021, through October 31, 2022) identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The prior year CAP was open during the audit period. The audit examined documentation for compliance to determine the extent of the Plan's CAP implementation.

The summary of findings by category follows:

Category 1 – Utilization Management

No findings were noted for this audit period.

Category 2 – Case Management and Coordination of Care

No findings were noted for this audit period.

Category 3 – Access and Availability of Care

No findings were noted for this audit period.

Category 4 – Member's Rights

No findings were noted for this audit period.

Category 5 – Quality Management

No findings were noted for this audit period.

Category 6 – Administrative and Organizational Capacity

The Plan is required to refer any potential Fraud, Waste, or Abuse (FWA) identified and report to DHCS, the results of its preliminary investigation within ten working days. The Plan did not report to DHCS the results of their preliminary investigations of potential FWA identified within ten working days.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted this audit 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 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.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Appeal Procedures: 14 overturned and 21 upheld medical prior authorization appeals including eight Seniors and Persons with Disabilities (SPD) cases were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Appointment: 20 medical records including 5 SPD member's medical records were reviewed to confirm the performance and completeness of assessment.

Category 3 – Access and Availability of Care

Claims: 15 emergency services and 26 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 20 Quality of Service, 25 Quality of Care, 5 expedited, and 10 exempt grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review. Ten member calls from inquiry logs were reviewed for appropriate classification and processing.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: 15 fraud and abuse cases were reviewed for proper reporting of suspected FWA to DHCS within the required time frame.

Encounter Data: Five encounter data records were reviewed for complete, accurate, reasonable, and timely encounter data submissions.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Kern Health Systems dba Kern Family Health Care

AUDIT PERIOD: November 1, 2022, through October 31, 2023
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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD AND ABUSE

6.2.1 Fraud and Abuse Reporting

The Plan shall make prompt referral of any potential FWA that it identifies to the DHCS Audits and Investigations Intake Unit. The Plan shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected FWA within ten working days of the Plan first becoming aware of, or is on notice of, such activity. (*Contract Exhibit E, Attachment 2, Provision 26(B)(7))*

Plan policy 14.04-P, *Prevention, Detection, and Reporting of Fraud, Waste, or Abuse* (revised December 2022), states the Plan will refer all suspected FWA it identified in a preliminary report to the DHCS Program Integrity Unit (PIU) within ten working days from the date of discovery or when the Plan is notified of such activity. In addition, the policy states that Plan employees who identify or receive reports of potential FWA should report it to the Compliance Department within two-working-days of internal identification or receiving the report.

According to the Plan's policy, 14.04-P, suspicious activities may be reported by phone, in writing, or in person to the Compliance Department. The Compliance Department's contact information is available on the Plan's website, Member Handbook, and Provider Manual. An Internal FWA Referral form is also available for staff to report allegations to the Compliance Department via an internal communication system, email, or fax.

Finding: The Plan did not report potential FWA to DHCS within ten working days.

During the audit period, the Plan received 108 potential FWA allegations; however, it did not adhere to its policy to report these to DHCS within the required timeframes. A verification study of 15 potential FWA cases revealed that 2 cases were reported to DHCS between 20 and 27 working days after the Plan first became aware of the activity.

The audit found that the Member Services and Grievances Departments received potential FWA allegations and coordinated an exchange of information to the Plan's Compliance Department. However, a delay from the Member Services and Grievances Departments to the Compliance Department contributed to untimely reporting to the DHCS.

Failure to promptly refer potential FWA to DHCS may compromise the integrity of the Plan and the Medi-Cal program.

Recommendation: Report potential FWA to the DHCS PIU within ten working days from the date of discovery or when the Plan is notified of such activity.

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REPORT ON THE MEDICAL AUDIT OF

Kern Health Systems
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Kern Family Health Care

2023

Contract Number:	03-75798 and 22-20467 State Supported Services
Audit Period:	November 1, 2022 through October 31, 2023
Dates of Audit:	November 27, 2023 through December 8, 2023
Report Issued:	March 25, 2024

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the audit findings of Kern Health Systems dba Kern Family Health Care (Plan) State Supported Services Contract Numbers 03-75798 and 22-20467. The State Supported Services Contract covers abortion services for the Plan.

The audit was conducted from November 27, 2023, through December 8, 2023, for the audit period of November 1, 2022, through October 31, 2023. The audit consisted of document reviews, verification study, and interviews with Plan staff.

The audit reviewed 15 service claims for appropriate and timely adjudication.

An Exit Conference with the Plan was held on February 27, 2024. 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.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Kern Health Systems dba Kern Family Health Care

AUDIT PERIOD: November 1, 2022, through October 31, 2023
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STATE SUPPORTED SERVICES

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Coding System Codes 59840 through 59857 and Health Care Finance Administration Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract. *(State Supported Services Contract, Exhibit A(4))*

The Plan's policy, 3.21-P, *Family Planning Services* (revised August 31, 2023), states that members may access abortion services from the provider of their choice without prior authorization. The Plan defines abortion services as a "sensitive service" and assures members' confidentiality and accessibility. Prior authorization is required if the member has requested inpatient hospitalization for the performance of an abortion.

The Member Handbook informs members that some providers may have a moral objection to abortion and have a right not to offer this service. However, members can contact the Plan for assistance. Members are also informed that referrals or prior authorization are not needed from primary care physicians for abortion and abortion-related services.

The Provider Manual informs providers of the members' freedom of choice in obtaining sensitive services, such as abortion services, without prior authorization.

The audit found no discrepancies in this section.

Recommendation: None.