MEDICAL REVIEW BRANCH – RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

KERN HEALTH SYSTEMS
dba
KERN FAMILY HEALTH CARE

Contract Number: **03-76165**

Audit Period: August 1, 2018
Through
July 31, 2019

Report Issued: November 14, 2019

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I. INTRODUCTION

Kern Health Systems dba Kern Family Health Care (Plan) was established in 1993 as a local initiative Medi-Cal Managed Care Health Plan in Kern County and began operating as a County Health Authority structure in January 1995. After receiving the Knox-Keene license on May 2, 1996, the Plan continued operations on July 1, 1996. The Plan serves all of Kern County with the exception of Ridgecrest.

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. Authority to establish the Plan as a public entity is found in Welfare & Institutions Code, section 14087.54.

The Plan provides health care services through contracts and subcontracts with community clinics, medical groups, and individual physicians. Pharmacy services are provided through a contract with a Pharmacy Benefits Manager, DST Health (formerly Argus Health, Inc). Vision services are provided through a contract with Vision Service Plan.

As of June 2019, the Plan had a total enrollment of 247,228 Medi-Cal members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit of the Plan for the period of August 1, 2018 through July 31, 2019. The onsite review was conducted from August 6, 2019 through August 9, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on October 09, 2019. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address preliminary audit findings. The Plan submitted supplemental information after the Exit Conference. The results of our 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 report (for audit period August 1, 2017 through July 31, 2018) was issued January 10, 2019. The Corrective Action Plan (CAP) closeout letter sent to the Plan on April 11, 2019 disclosed that previous audit findings were closed.

The summary of findings by category are as follows:

Category 1 – Utilization Management

The Plan did not have a system to monitor and ensure Notice of Adverse Benefit Determination (NOA) letters sent to members included clear and accurate clinical reasons for denial of care decisions.

Category 2 – Case Management and Coordination of Care

The Plan did not have written procedures to monitor completion of required member Initial Health Assessments (IHAs) conducted by primary care providers.

The Plan did not have a system to monitor and ensure member notification letters include all the required Continuity of Care (COC) transition information.

During the prior year audit, the Plan did not review Behavioral Health Treatment (BHT) plans within the required timeframe. In response to the CAP, the Plan revised and implemented procedures to address the finding. Our current audit confirmed the Plan has a system to ensure BHT plans are reviewed within the required timeframe.

Category 3 – Access and Availability of Care

Review of the Plan's access and availability of care program yielded no findings during this audit period.

Review of the Plan's appropriate and timely adjudication of claims yielded no findings during this audit period.

Category 4 – Member's Rights

The Plan did not ensure grievances involving quality of care and clinical issues were referred to the Medical Director for final resolution.

Category 5 – Quality Management

The Plan did not have procedures to ensure training presented to newly contracted providers included all required information.

Category 6 – Administrative and Organizational Capacity

During the prior year audit, the Plan did not have an established Anti-Fraud and Abuse program that contained a Compliance Committee accountable to senior management. In response to the CAP, the Plan developed a Compliance Committee to address the findings. Our current audit confirmed the Plan has an established Anit-Fraud and Abuse Compliance Committee that meets quarterly and reports to senior management.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Medical Review Branch, conducted this audit of the Plan, to ascertain medical services provided to Plan members, including Seniors and Persons with Disabilities (SPD), comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Two-Plan Contract.

PROCEDURE

The onsite review was conducted from August 6, 2019 through August 9, 2019. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. 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: DHCS reviewed 20 medical (including seven SPD) and 15 pharmacy (including three SPD) prior authorization requests for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeals Process: DHCS reviewed 20 medical (including seven SPD) and 14 pharmacy (including four SPD) prior authorization appeal requests for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Complex Case Management: DHCS reviewed ten medical records (including six SPD) for evidence of continuous tracking, monitoring, and coordination of services provided to members.

Behavioral Health Treatment: DHCS reviewed ten BHT charts for compliance with BHT provision requirements.

Initial Health Assessment: DHCS reviewed 13 adult medical records (including three SPD) and 13 pediatric medical records to confirm timely completion.

Category 3 – Access and Availability of Care

Appointment Availability: DHCS reviewed 15 contracted providers from the Provider's Directory. The third next available appointment method was used to measure access to care. The Provider's Directory was reviewed for accuracy and completeness.

Emergency Service and Family Planning Claims: DHCS reviewed 20 emergency service claims (including 15 SPD) and all four family planning claims (including two SPD) for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: DHCS reviewed 15 quality of service grievances (including three SPD) and 72 quality of care grievances (including 19 SPD) for timely resolution, appropriate response to complaint, and submission to the appropriate level for review.

Category 5 – Quality Management

Provider Qualifications: DHCS reviewed ten contracted providers to determine if they received Medi-Cal Managed Care program training within the required time frame.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: DHCS reviewed all seven cases in the audit period for proper reporting of suspected fraud, waste, or abuse to DHCS within the required time frame.

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: August 1, 2018 through July 31, 2019 **DATE OF AUDIT: August 6, 2019 through August 9, 2019**

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Clear Pre-Authorization decision explanation

The Plan is required to ensure pre-authorization review procedures include clearly documented reasons for the decision. Also, notification to members must meet contractual requirements as specified in Exhibit A, Attachment 13. *(Contract, Exhibit A, Attachment 5(2)(D-E))*

The Contract further stipulates written information regarding denied, deferred, or modified referrals shall ensure members' understanding of the health plan processes and ensure the members' ability to make informed health decisions.
(Contract, Exhibit A, Attachment 13(4)(C))

In addition, California Health and Safety Code (HSC) requires that responses regarding decisions to deny, delay, or modify health care services be communicated to the enrollee in writing, and shall include clear and concise explanation of the reasons for the plan's decision, description of the criteria or guidelines used, and the clinical reasons for the decision. *(HSC CA HLTH & S section 1367.01(h)(4))*

Finding: The Plan's NOA letters sent to members did not include clear and accurate clinical reasons for pre-authorization decisions. The Plan did not have a system to monitor and ensure accurate NOA letters were generated.

Although the Plan's policy and procedures state NOA letters contain all required elements for both provider and member including a clear and concise explanation of the reason for the decision, pharmacy prior-authorization NOA letters sent to members contained incorrect clinical reasons for the Plan's decisions.

The Plan's pharmacy technicians enter data for prior authorization denials and approvals into a computer system. The technician enters the decision and selects the denial reason from a drop down prompt, and based on the selection, the NOA letter template is generated. The audit team conducted a verification study and identified four cases in which NOA letters contained incorrect denial reasoning for the Plan's decision.

During the onsite interview, Plan staff explained the pharmacist makes prior-authorization decisions and gives them to pharmacy technicians to enter into the computer system in order to generate NOA letters. The Plan attributed the problem to staff selecting the incorrect denial reason and their lack of a system to monitor and ensure accurate NOA letters are generated.

Incorrect clinical reasoning contained in pharmacy NOA letters could lead to member confusion, delay in prescribing formulary alternatives, delay in physician follow-up, and ultimately cause members to make poor health care decisions.

Recommendation: Implement procedures to monitor and ensure the NOA letter generated is clear, concise, and contains the correct clinical reasons for the Plan's decision.

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: Kern Health Systems dba Kern Family Health Care
AUDIT PERIOD: August 1, 2018 through July 31, 2019 **DATE OF AUDIT: August 6, 2019 through August 9, 2019**

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	BASIC CASE MANAGEMENT/ CALIFORNIA CHILDREN'S SERVICES (CCS)/ EARLY INTERVENTION/DEVELOPMENTAL DISABILITIES/ INITIAL HEALTH ASSESSMENT

2.1.1 Written procedures to monitor IHA completion

The Plan is required to cover and ensure the provision of an IHA, which includes a complete history and physical examination in conformance with *California Code of Regulations, Title 22, section 53851(b) (1)* to each new member within the stipulated timelines. The Contract also requires the Plan to ensure that the IHA includes an Individual Health Education Behavioral Assessment (IHEBA)/ Staying Healthy Assessment (SHA) using an age appropriate DHCS approved assessment tool. The Plan is required to ensure that member's completed IHA and IHEBA tools are contained in the member's medical records**.** *(Contract, Exhibit A, Attachment 10(3)(A-C))*

According to *MMCD Policy Letter 08-003*, the Plan is required to have written procedures for monitoring IHA completion within the required timeframes.

Finding: The Plan did not have written procedures to monitor IHA completion. An IHA is not complete without the inclusion of a SHA, and the Plan did not ensure the SHA was included within the member's medical record.

The Plan has policies and procedures to provide new members' IHAs within the required timeframe; however; review of 13 medical records revealed seven IHAs that did not include the required SHA. The Contract requires that a completed IHA includes a SHA in the member's medical record.

During the onsite interview, the Plan confirmed the lack of written procedures to monitor IHA (including the required SHA) completion. When the SHA is not included with the IHA, members may not receive important medical and behavioral health screenings, and potentially delay necessary services and referrals. Without written and implemented procedures, the Plan cannot effectively monitor new member IHA completion.

Recommendation: Develop and implement written procedures to monitor IHA completion and ensure inclusion of SHA in the members' medical record.

2.5	CONTINUITY OF CARE

2.5.1 Continuity of Care notification letter

California HSC requires the Plan to provide completion of covered services for serious and chronic conditions. The Plan is required to provide covered service for a period of time necessary to complete the course of treatment and to arrange for a safe transfer to another provider. Completion of services shall not exceed 12 months from the effective date for a newly covered enrollee.
(HSC CA HLTH & S section 1373.96(c)(2))

According to *APL 18-008*, the Plan is required to notify members within seven calendar days of the request approval for continuity of care; the duration of the COC arrangement; the transition process that will occur at the end of the COC period; and the member's right to choose a different provider from the Plan's network. The Plan is also required to notify members about the transition process 30 calendar days prior to the end of the COC period.

Finding: The Plan did not notify members of the complete COC transition process. The Plan did not have a system to monitor and ensure COC approval letters contained all the required information.

The Plan has COC policies and procedures in place allowing members with pre-existing provider relationships and transitioning from Medi-Cal Fee-For-Service into the Managed Care Plan, the option to continue treatment for up to 12 months. The Plan notifies members of COC decisions via approval letters. The Plan's notification letter informs members of the approved service, approved provider, and expiration of the COC period. However, the Plan's COC approval letters sent to members did not contain information regarding transition of care at the end of the COC period nor the members' right to choose a different provider from the Plan's network.

During the onsite interview, the Plan confirmed COC approval letters did not contain all the required transition information. The Plan further explained these letters are computer generated templates that have not been revised to include all required information. If these templates are not corrected, they will continue to produce incomplete COC approval letters.

Lack of complete information regarding the COC transition process may cause delays in member care that could potentially lead to poor health outcomes.

Recommendation: Implement procedures to monitor and ensure member notification letters include all the required COC transition information.

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: Kern Health Systems dba Kern Family Health Care
AUDIT PERIOD: August 1, 2018 through July 31, 2019 **DATE OF AUDIT: August 6, 2019 through August 9, 2019**

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Clinical grievance resolutions

The Contract requires the Plan to ensure grievances related to medical quality of care issues are referred to the Plan's Medical Director. The Plan is also required to ensure the final decision for the proposed resolution of a grievance involving clinical issues, is made by a health care professional with clinical expertise in treating a member's condition or disease. *(Contract, Exhibit A, Attachment 14(2)(E;G))*

Finding: The Plan did not effectively implement procedures to ensure grievances related to medical quality of care issues were referred to the Plan's Medical Director. Exempt grievances involving medical quality of care issues were resolved without the review of a Medical Director.

A verification study found 42 grievances involving medical quality of care issues that were inaccurately identified and classified as exempt. These grievances were not referred to the Plan's Medical Director for final resolution. Although the Plan's policy, *5.01-I Member Grievance and Appeal System,* stipulates the Medical Director shall provide a complete and documented review of all grievances that may relate to quality of care, non-clinical member service representatives received and resolved exempt grievances containing medical quality of care issues without referral to the Plan's Medical Director.

During the onsite interview the Plan explained member service representatives are trained to receive and categorize grievance calls as standard, expedited, or exempt. When a grievance has been identified as a potential quality of care issue, but the member does not want to file a formal complaint, the member service representative will categorize the call as an exempt grievance and resolve the issue within 24 hours in order to maintain the members' anonymity from the provider.

Without the review of a Medical Director, the Plan cannot ensure medical quality of care grievances receive appropriate resolution. Poor member health outcomes may result if clinical quality problems are not recognized and corrective actions prescribed.

Recommendation: Implement procedures to ensure the identification and classification of quality of care grievances and referral to the Plan's Medical Director for final resolution.

CATEGORY 5 – QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

5.2.1 Provider Training to include member's rights

The Plan is required to ensure provider training includes information on all member's rights specified in *Exhibit A, Attachment 13*, *Member Services*, including the right to full disclosure of health care information and the right to actively participate in health care decisions. *(Contract, Exhibit A, Attachment 7(5)(A))*

Finding: The Plan did not have procedures to ensure training presented to newly contracted providers included all required information. The Plan's provider training packets did not include information on member's rights.

Although the Plan's Provider Manual outlines member's rights, the Plan did not ensure this information was included in the training packets presented to newly contracted providers. The Plan did not have procedures to ensure provider training included information on member's rights as specified by the Contract. During the onsite interview, the Plan verified their provider training packets do not include information on member's rights as required. The Plan further explained this was an implementation oversight.

Without ensuring training includes member's rights, newly contracted providers may not be properly informed, which can potentially lead to inappropriate care or delay in member care.

Recommendation: Implement procedures to ensure the inclusion of member's rights in provider training.

MEDICAL REVIEW BRANCH – RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

KERN HEALTH SYSTEMS
dba
KERN FAMILY HEALTH CARE

Contract Number: 03-75798
State Supported Services

Audit Period: August 1, 2018
Through
July 31, 2019

Report Issued: November 14, 2019

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II. COMPLIANCE AUDIT FINDINGS 2

INTRODUCTION

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

The audit period was August 1, 2018 through July 31, 2019. The onsite audit was conducted from August 6, 2019 through August 9, 2019.

An Exit Conference with the Plan was held on October 09, 2019.

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services: Current Procedural Coding System Codes*: 59840 through 59857 HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336 **These codes are subject to change upon the Department of Health Care Services (DHCS) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.* State Supported Services Contract Exhibit A.1

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 (DHCS) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.
(Contract, Exhibit A, (1))

The Plan provides Medi-Cal members' timely access to abortion services from any qualified contracting or non-contracting provider without prior authorization unless inpatient hospitalization is requested to perform the abortion. Minors do not need consent or referral to access pregnancy termination services. According to the Plan's *Policy 3.20-P*, *Sensitive Services*, the Plan maintains procedures to ensure confidentiality and access to sensitive services for all members including minors in a timely manner and without prior authorization requirements.

The Plan's procedure code guidelines for State Supported Services and claims payment system include the required pregnancy termination procedure codes. There were no deficiencies noted during this audit period.