MEDICAL REVIEW – SOUTHERN SECTION III
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Kern Health Systems
dba
Kern Family Health Care

Contract Number:	03-76165
Audit Period:	August 1, 2017 Through July 31, 2018
Report Issued:	January 10, 2019

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I. INTRODUCTION

Kern Health Systems (KHS) dba Kern Family Health Care (KFHC) is a public agency established to operate the local initiative for Kern County under the California Department of Health Services' Strategic Plan for expanding Medi-Cal Managed Care. Authority to establish KFHC as a public entity is found in the Welfare & Institutions Code, Section 14087.54. This section empowers a county to establish an organized health care system administered by a special commission. The purpose of this health care system is to effectively deliver publicly assisted medical care in the county while promoting quality of care and cost efficiency.

Kern Health Systems, established in 1993, started operating as a County Health Authority structure in January 1995. Kern Health Systems received a Knox-Keene license on May 2, 1996. Kern Family Health Care began operations on July 1, 1996. The Kern County Board of Supervisors appoints the KHS Board of Directors.

Kern Health Systems serves all of Kern County with the exception of Ridgecrest. Health care services are provided through contracts and subcontracts with community clinics, medical groups, and individual physicians. Pharmacy services are provided through a contract with a Pharmacy Benefits Manager (PBM), DST Pharmacy Solutions. Vision services are provided through a contract with Vision Service Plan (VSP).

As of July 31, 2018, KHS Medi-Cal enrollment was 255,070 members.

II. EXECUTIVE SUMMARY

Under the authority of the California Welfare and Institutions Code §14456, the Department of Health Care Services (DHCS), Audits & Investigations, Medical Review Branch, conducts annual medical audits of contracting health plans. These audits assist the Department with its overall monitoring effort, and identify areas of deficiencies that form the basis for corrective actions.

This report presents the results of the DHCS full scope medical audit for the period of August 1, 2017 through July 31, 2018. The audit team conducted the on-site review from August 14, 2018 through August 17, 2018. The audit consisted of document review, verification studies, and interviews with Plan personnel and providers.

An exit conference was held with the Plan on December 6, 2018. The Plan was allowed fifteen (15) calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report findings. The Plan did not submit any supplemental information after the exit conference.

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 summary of the current findings by category follows:

Category 2 – Case Management and Coordination of Care

The Contract requires the Plan to provide Behavioral Health Treatment (BHT) services that are based upon a treatment plan that is reviewed no less than every six months by a qualified autism service provider. The approved BHT plan must meet criteria, including having a transition plan and crisis plan.

The Plan did not ensure that behavioral treatment plans were reviewed no less than every six months and included a transition plan and crisis plan.

Category 6 – Administrative and Organizational Capacity

The Contract requires the Plan to establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee accountable to senior management.

The Plan does not have a compliance committee that is accountable to senior management for all fraud and/or abuse issues.

Implementation of Prior Year Audit Recommendations

The prior DHCS medical audit for the audit period of August 1, 2016 through July 31, 2017

identified a deficiency. The Plan addressed the deficiency in a corrective action plan (CAP). The CAP closeout letter dated March 2, 2018 noted that DHCS has closed the previous finding.

The following section presents the previous audit deficiency and the actions the Plan took to implement the CAP recommendations.

Access and Availability of Care

The prior year audit found that the Plan failed to ensure members obtain specialty care appointments within the required timeframe. During the current audit, the Plan included specialists in its internal quarterly Provider Appointment Availability Survey to monitor appointment timeframes.

Results showed steady improvement with compliance rates for specialists. In addition, the Plan notified providers of its accessibility standards policy biannually.

Through the newsletter, members are informed to call the Member Services Department to inquire about timely access to care. The Plan established a Member Portal to assist members to schedule timely appointments. In addition, to assist with the demand of timely access in rural areas, the Member Portal can arrange transportation to and from medical appointments.

Furthermore, the Plan expanded its telemedicine in rural areas. The Plan proactively worked to streamline referrals and included specialists in the telehealth system.

The current audit found that the average appointment availability were within standards.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The Department of Health Care Services (DHCS), Medical Review Branch conducted this audit to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

The audit team conducted the on-site review from August 14, 2018 through August 17, 2018. 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 staff and providers.

The audit team conducted the following verification studies:

Category 1 – Utilization Management

Prior Authorization Requests: 20 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review and communication of results to members and providers.

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

Category 2 – Case Management and Coordination of Care

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

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

Initial Health Assessments: 20 medical records were reviewed for completeness and timely completion.

Behavioral Health Treatment: 21 medical records were reviewed for evidence of care coordination between the Plan and providers.

Category 3 – Access and Availability of Care

Appointment Availability: 15 providers from the Plan's Provider Network were reviewed. The first available appointment was used to measure access to care.

Emergency Services and Family Planning Claims: 9 emergency service claims and 10 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 30 grievances (15 Quality of Care and 15 Quality of Service) were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: Nine Health Insurance Portability and Accountability Act (HIPAA) / Protected Health Information (PHI) breach and security incidents were reviewed for processing and reporting requirements.

Category 5 – Quality Management

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: 11 fraud and abuse cases were reviewed for processing and reporting requirements.

A description of any non-compliance is contained in the following report.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.5	EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT): BEHAVIORAL HEALTH TREATMENT (BHT) / NON-EMERGENCY NON-MEDICAL TRANSPORTATION

For Members under 21 years of age diagnosed with Autism Spectrum Disorder (ASD), or for Members under 3 years of age with a rule out or provisional diagnosis, Contractor shall cover Medically Necessary BHT services as defined in the federally approved State Plan, and in accordance with Health and Safety Code sections 1374.72 and 1374.73, 28 California Code of Regulations 1300.74.72, APL 15-019, and APL 15-025 to the extent that they are consistent with the State Plan. APLs superseding APL 15-019 and APL 15-025 that clarify the delivery of BHT services shall be incorporated herein by this reference and become part of this Contract as of their effective date.

1) Contractor shall provide Medically Necessary BHT services as stated in the Member's treatment plan and/or continuation of BHT services under continuity of care with the Member's BHT provider.

2) For Members 3 years or older, Contractor shall require a Comprehensive Diagnostic Evaluation before Members receive BHT services.

3) BHT services must be based upon a treatment plan that is reviewed no less than every six (6) months by a qualified autism service provider as defined by Health and Safety Code Section 1374.73(c)(3) and by the federally approved State Plan.

4) Contractor shall provide continuity of care for Members diagnosed with ASD as stated below and in accordance with this Section G.

a) For Members who had received BHT through a regional center prior to September 15, 2014, Contractor shall not provide BHT services until such time as the Member may be safely transitioned into Contractor's provider network in accordance with the BHT services transition plan approved by DHCS and the Department of Developmental Services (DDS). If a Member, or a Member's parent or legal guardian, chooses to access BHT services from Contractor's network provider prior to the transition of regional center clients to the Contractor for BHT services, Contractor shall provide Medically Necessary BHT services from Contractor's network provider.

b) If Members received BHT services outside of Contractor's network prior to September 15, 2014, and the Member or the Member's parent or legal guardian request continued access to their existing BHT provider, Contractor shall ensure continuity of care in accordance with APL 15-019 and APL 15-025.

Contractor must offer continuity of care with an out-of-network BHT provider if all of the following conditions are met:

i. The Member has an existing relationship with a qualified autism service provider. An existing relationship means the Member has seen an out-of-network BHT provider at least one time during the six (6) months prior to Contractor assuming responsibility of BHT services from the regional center or the date of the Member's initial enrollment with Contractor if enrollment occurred on or after September 15, 2014;

ii. The provider can agree to Contractor's rate or the Medi-Cal FFS rate, whichever is higher, for the appropriate BHT service;

iii. The provider does not have any documented quality of care issues that would cause exclusion from Contractor's network;

iv. The provider is a qualified provider under Health & Safety Code Section 1374.73 and the approved State Plan; and

v. The provider supplies Contractor with all relevant treatment information, for purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

c) Contractor shall continue to authorize Medically Necessary BHT services in accordance with the Member's treatment plan at the time of the request for continuity of care during the continuity of care period.

d) Contractor's network provider may update the BHT treatment plan upon completion of the assessment and discontinue BHT services if the evaluation determines that the authorization of BHT services is not Medically Necessary.

5) Contractor shall provide all necessary Member treatment information to the Member's regional center to enable care coordination, as permitted by federal and State law, APL 15-022, and this Contract.

6) Contractor shall enter into a Memorandum of Understanding (MOU) with each local regional center in accordance with Exhibit A, Attachment 12, Provision 2 of this Contract, to facilitate the coordination of services for Members with developmental disabilities, including ASD, as permitted by federal and State law, and specified by DHCS in APL 15-022. If Contractor is unable to enter into an MOU, Contractor shall inform DHCS why agreement with the regional center was not reached and demonstrate that a good faith effort was made by Contractor to enter into an MOU with the regional center.

Two-Plan Contract A.10.5.G

The Plan is required to cover and ensure the provision of medically necessary Behavioral Health Treatment (BHT) services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.

On July 1, 2018, DHCS will transition the provision of medically necessary BHT services for eligible members under 21 years of age without an Autism Spectrum Disorder (ASD) diagnosis from Regional Centers (RCs) to the MCPs. Beginning on July 1, 2018, the authorization and payment of BHT services will transition from the RCs to the MCPs.

MCPs must:

1) Inform members that EPSDT services are available for members under 21 years of age.
2) Provide access to comprehensive screening and prevention services, at designated intervals or at other intervals indicated as medically necessary, in accordance with the most current Bright Futures periodicity schedule, including but not limited to:
    a. A health and developmental history
    b. A comprehensive unclothed physical examination
    c. Appropriate immunizations
    d. Lab tests and lead toxicity screening
    e. Screening services to identify developmental issues as early as possible.
3) Provide access to medically necessary diagnostic and treatment services, including but not limited to, BHT services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist.

The provision of EPSDT services for members under 21 years of age, which includes medically necessary, evidence-based BHT services that prevent or minimize behavioral conditions and promote, to the maximum extent practicable, the functioning of a member, will become the responsibility of MCPs effective on the date of the member's transition from the RC or, for new members, upon MCP enrollment. MCPs must ensure that appropriate EPSDT services are initiated in accordance with timely access standards.

Criteria for BHT Services
In order to be eligible for BHT services, a Medi-Cal member must meet all of the following overage criteria:

1) Be under 21 years of age.
2) Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary.
3) Be medically stable.
4) Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

MCPS are responsible for coordinating the provision of services with other entities to ensure that MCPs and other entities are not providing duplicate services.

Covered Services
Medi-Cal covered BHT services must be:

1) Medically necessary to correct or ameliorate behavioral conditions as defined in Section 1905(r) of the SSA and as determined by a licensed physician and surgeon or licensed psychologist.
2) Delivered in accordance with the member's MCP-approved behavioral treatment plan.
3) Provided by California State Plan approved providers as defined in SPA 14-026.
4) Provided and supervised according to an MCP-approved behavioral treatment plan developed by a BHT service provider credentialed as specified in SPA 14-026 ("BHT Service Provider").

BHT services are provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific member being treated and that has been developed by a BHT Service Provider. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider. The behavioral treatment plan may be modified if medically necessary. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

Behavioral Treatment Plan
BHT services must be provided, observed and directed under an approved behavioral treatment plan.

The approved behavioral treatment plan must meet the following criteria:

1) Be developed by a BHT Service Provider for the specific member being treated.

2) Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
3) Be person-centered and based upon individualized, measureable goals and objectives over a specific timeline.
4) Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
5) Identify measureable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
6) Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
7) Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal, as met, not met, modified (include explanation).
8) Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
9) Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.
10) Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.
11) Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
12) Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and community.
13) Include an exit plan/criteria.

All Plan Letter 18-006

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SUMMARY OF FINDINGS:

2.5.1 **Behavioral Health Treatment Plans**

The Plan is required to provide Behavioral Health Treatment (BHT) services that are based upon a treatment plan that is reviewed no less than every six months by a qualified autism service provider. APLs superseding APL 15-019 and APL 15-025 that clarify the delivery of BHT services shall be incorporated herein by this reference and become part of this Contract as of their effective date. [Contract, Exhibit A, Attachment 10, 5(G)]

APL 18-006, *Responsibilities for BHT Coverage for Members under the Age of 21*, supersedes APL 15-025. The APL specifies BHT services are provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific member being treated and must meet criteria, including having a transition plan and crisis plan.

The Plan did not ensure that BHT treatment plans were reviewed no less than every six months. In addition, the Plan did not ensure treatment plans included a transition plan and crisis plan.

A transition plan provides guidance of actions to take when it has been determined that a member may require another level of care; or services are to be discontinued as clinically appropriate. A crisis plan includes procedures to follow if an unexpected situation should occur or there is a threat to the members' health or safety.

According to the Plan's policy, *Behavioral Health Therapy and Behavioral Intervention Services (3.72-P)*, the behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Provider. The approved behavioral treatment plan must meet criteria: including having a transition plan and crisis plan. In addition, the policy indicated the Plan is responsible for ensuring that its delegates comply with contract requirements and other DHCS guidance, including APLs.

During the Plan interviews, Plan staff stated there is a specialized BHT team in Utilization Management (UM), which monitors BHT services to members. The BHT team oversees referrals, reviews treatment plans, and works with providers to maintain coordination of care. When the Plan's BHT team approves a treatment plan, the BHT provider will deliver services according to that treatment plan. The BHT provider is required to submit a treatment plan of members' progress every six months or as needed to determine ongoing medical necessity to the Plan's BHT team. However, the Plan's procedures do not include a method to identify and follow-up on treatment plans past due for the six-month review or monitor compliance with treatment plan criteria.

According to the Plan, 271 members were identified for BHT referrals and deemed eligible for BHT services during the audit period. A verification study was conducted to determine the Plan's compliance related to BHT requirements.

The Department requested twenty-three sample records from the Plan for review in the verification study. Analysis revealed 2 members had 2 files each. Therefore, the nurse evaluator actually reviewed 21 member records and determined that 4 of those members did not initiate BHT services because either the member did not qualify for BHT services or the Plan was not successful in reaching the member. Fourteen of the seventeen members receiving BHT services were due to have treatment plans reviewed six months after the previous treatment plan. The Plan could not provide evidence that treatment plans were reviewed no less than every six months for 3 of the 14 members receiving BHT services. In addition, 2 members did not have a transition plan and 4 members did not have a crisis plan included in the members' treatment plans.

The audit team followed-up with the Plan to seek clarification about the Plan's BHT monitoring process. The Plan explained that its BHT team monitors the timely submission of treatment plans from providers by tracking all BHT requests in its Medical Management System (MMS). The system does not discern between BHT-related authorizations and other authorizations. The BHT authorizations are valid for six months. The Plan counts the six months from the authorization date, when the Plan approves a treatment plan, which may or may not be the same as the date on the treatment plan. The Plan's Licensed Clinical Social Worker reviews the MMS manually once a month. If a treatment plan is identified as past due, the Plan can contact the provider. If there were treatment plans due between the reviews, the Plan may identify it during the next monthly review. The MMS does not have any "pop-ups" or "red flags" to notify the Plan when a treatment plan is past due. The Plan stated that the MMS has a functionality to send alerts for expired authorizations; however, the Plan has not yet implemented this capability for BHT services.

The Plan reviews treatment plans for measureable goals and progress in six-month intervals when the provider submits an authorization request. Services can be modified or terminated based on review and discussion with the provider. However, the Plan was unable to provide evidence that it had an effective system in place to monitor treatment plans due at six-month intervals. In addition, the Plan did not have any documentation that the Plan followed-up with providers on past due treatment plans as requested.

The Plan provided clarification regarding provider notification of behavioral treatment plan requirements and how compliance is monitored. The Plan stated that it notifies providers through public notices, agendas, and minutes of the Physician Advisory Committee and

Quality Improvement Committee, as well as through provider bulletins, policies, internet links, and individual provider education. The Plan monitors compliance by validating receipt of services as authorized at each review period. Treatment plans are reviewed to ensure criteria are met, including having a transition plan and crisis plan. The Plan will follow-up with the provider and request documentation if components within the treatment plan are not present. The Plan stated, "constant communication between the BHT providers and the BHT team ensure understanding of documentation requirements and reasoning for decisions." However, the committee agenda/minutes and provider bulletins during the audit period did not show evidence that the Plan notified providers of the required criteria of a treatment plan. In addition, interviews with providers confirmed that they were not informed by the Plan.

Through interviews and the review of Plan documents, the audit team found that the Plan had a system for the provision of BHT services for its members. However, procedures were not established to identify and follow-up on treatment plans past due for the six-month review. In addition, the Plan did not ensure behavioral treatment plans met required criteria of having a transition plan and crisis plan.

The Plan's lack of monitoring and communication with providers regarding behavioral treatment plans is evident through documents submitted by the Plan. The verification study revealed 3 members did not have treatment plans reviewed six months after the previous plan. This has prevented the timely review of members' progress while utilizing BHT services and the determination of medical necessity for the continuation of those services, which has the potential to delay the identification of member needs and could result in poor behavioral outcomes. In addition, 2 members' records did not have a transition plan and 4 members' records did not have a crisis plan in the behavioral treatment plan. This has the potential to delay a member's transition to a more appropriate level of care and respond properly should a crisis arise.

RECOMMENDATION:

2.5.1 Develop written procedures to ensure BHT services are based upon a treatment plan that meets criteria, including having a transition plan and crisis plan, and that is reviewed no less than every six months in accordance with the Contract and APL 18-006.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD AND ABUSE

Fraud and Abuse Reporting
Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
2) Contractor shall provide effective training and education for the compliance officer and all employees.
3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity….

5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.

Two-Plan Contract E.2.26.B

References Cited:
42 CFR 438.608 – Program Integrity Requirements
42 CFR 438.610 – Prohibited Affiliations with Individuals Debarred by Federal Agencies

6.2.1 FRAUD AND ABUSE REPORTING

The Plan must meet requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. As part of this, the Plan is required to establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. [Contract, Exhibit E, Attachment 2, 26(B)]

The Plan does not have a compliance committee for fraud and/or abuse issues who is accountable to senior management.

While the Plan has a Compliance Department that implements and maintains an Anti-Fraud Plan, the Plan lacks a compliance committee who meets periodically and provides reports directly to senior management. The Plan's Compliance Department is comprised of the Director of Compliance, the Compliance Program Manager, and four Compliance Auditors. The Director of Compliance reports to the Chief Operating Officer and has access to the Chief Executive Officer, Chief Financial Officer, Plan legal counsel, and the Plan's Board of Directors. Although the Plan's Compliance Department functions similar to

a committee, the Plan has not established a compliance committee nor does the Compliance Department provide periodic reports directly to the governing body.

Subsequent to the onsite, the Plan submitted to auditors a Compliance Committee Charter establishing a compliance committee with its first meeting set for November 2018.

RECOMMENDATION:

6.2.1 Establish a compliance committee for all fraud and/or abuse issues that is accountable to senior management.

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Kern Health Systems
dba
Kern Family Health Care

Contract Number:	03-75798 State Supported Services
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I. INTRODUCTION

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

The on-site audit was conducted from August 14, 2018 through August 17, 2018. The audit period is August 1, 2017 through July 31, 2018 and consisted of document review of materials supplied by the Plan and interviews conducted on-site.

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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 Services' (DHS') 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*

SUMMARY OF FINDINGS:

The Plan's *Policy 3.21-P, Family Planning Services and Abortion*, states that the Plan provides abortion services and supplies to members without prior authorization. Abortions are required to be provided in accordance with State and Federal law and are considered by the California Department of Health Care Services to be a "sensitive service".

The Plan provides Medi-Cal members timely access to abortion services from any qualified contracting or non-contracting Provider without prior authorization. Minors do not need an adult's consent or referral to access pregnancy termination services.

The Plan's State Supported Services billing code sheet includes Current Procedural Terminology codes 59840 through 59857 and Healthcare Common Procedure Coding System codes A4649-U1, A4649-U2, S0190, S0191, S0199 (formerly known as codes X1516, X1518, X7724, X7726, Z0336) as billable pregnancy termination services as required by the Contract.

The audit found no discrepancies for this section.