State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

June 01, 2014

Carl Breining
Director of Compliance & Regulatory Affairs
Kern Family Health Plan
9700 Stockdale Highway
Bakersfield, CA 93311-3617

RE: CAP Close out Letter for Department of Health Care Services Medical Audit

Dear Mr. Breining:

The Department of Health Care Services (DHCS) Audits and Investigations Division, conducted an on-site medical audit of Kern Health Systems, a Managed Care Plan (MCP), from September 10, 2013 through September 13, 2013. The audit covered the review period of July 1, 2012, through June 30, 2013.

On May 16, 2014, the MCP provided DHCS with a response to its Corrective Action Plan (CAP) originally issued on April18, 2014.

A review of all remaining open items has been found to be in compliance and the CAP is hereby closed. The enclosed report will serve to provide as DHCS's final response to the MCP's CAP.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

If you have any questions, contact Mr. Edgar Monroy, Chief of Plan Monitoring Unit at (916) 449-5233 or edgar.monroy@dhcs.ca.gov.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Medical Monitoring and Program Integrity Section

cc: Jonathan Prince, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413

Kern Health Systems
Corrective Action Plan
DHCS Medical Review Audit
Period of Audit: July 1, 2012 through June 30, 2013

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
1.1 Utilization Management Program Requirements: (page CAF-7): The Plan has a Utilization Management (UM) program that ensures appropriate processes are in place to review and approve the provision of Medically Necessary Covered Services. Qualified staff are responsible for the UM program. Medical decisions are not influenced by fiscal and/or administrative management. The program has established evaluation criteria and standards to approve, modify, defer or deny services. The Plan has processes in place to ensure consistency in applying the criteria at the RN case manager level. Processes are in place to monitor for over-utilization of services. There is no active method to detect under-utilization of services nor are there measures to increase utilization when under-utilization is detected. (Contract reference: Exhibit A,				

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Attachment 5.4) The Plan currently does not have the Medical Directors participate in Inter-rater Reliability testing, to ensure the consistent application and understanding of the evidence based criteria in reviewing and approving the Medically Necessary Covered Services. (Contract reference: Exhibit A, Attachment 5.2.C) **DHCS Recommendations:** Identify, detect and monitor under-utilization of services and implement measures to correct under-utilization of services.	KHS will initiate quarterly audits performed by UM audit staff utilizing encounter and authorization data to detect under-utilization with the initial audit to be completed end of 1st quarter 3/31/2014. When aberrant utilization is detected, the assigned Primary Care Provider (PCP) will receive written notification from KHS detailing the identified under-utilization of services, the members involved, and type of utilization data reviewed. KHS staff will work in collaboration with the PCP to assist in coordinating receipt of authorized services and reduce barriers to the members.		The MCP has taken appropriate action to remedy the finding. Please submit the results of Q1 Audit of 2014 to close this item. This item	The MCP submitted "CAF 7- ID Detect" to identifying, detecting and monitoring underutilization services for this deficiency. This item is closed.

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Ensure that the Medical Directors participate in Inter-rater Reliability testing to ensure consistency in applying and interpreting medical necessity guidelines.	<u>Calendar of scheduled Audits 2014</u> Q1 2014 Q2 2014 Q3 2014 Q4 2014 KHS will extend annual Inter-relator Reliability (IRR) Testing with the same parameters currently mandated for the Case Management clinical staff to the Chief Medical Officer and all Medical Director Staff beginning March 2014. The Milliman 18th Edition topics were released late-February 2014 and IRR course evaluations will be completed by May 2014. Annual IRR training will be completed by all clinical staff involved with medical decision responsibility on or before May of the corresponding year. **Responsibility:** **Utilization Management** **Director of Health Services**	 04/15/2014 07/15/2014 10/15/2014 01/15/2015 5/31/2014	remains open. The MCP has taken appropriate action to address the finding. Please submit the roster of annual IRR training completed by all clinical staff to close this item. This item	The MCP submitted "CAF7 – UM IRR" as proof of clinical staff training. This item is closed.

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1.2 Prior Authorization Review Requirements (page CAF-9): The Plan has policies and procedures in place for the intake, evaluation, decision-making and response to prior authorization requests for medical and pharmaceutical services. Case managers can approve the authorization requests if they follow the established guidelines. Medical Directors can deny both medical and pharmacy prior authorization requests while pharmacists can only deny the pharmacy prior authorization requests. **DHCS Recommendations:** Ensure that Notice of Action letters explain the reason for the modification or denial of service in clear, concise and easily understood language without the use of medical terminology, and cite the specific criteria utilized in the decision.	KHS currently conducts Notice of Action (NOA) letter audits for all Case Management clinical staff responsible for medical decision notifications upon hire for a period of 3 months. During this audit period, each NOA letter is reviewed for clear, concise, and easily understood language by the UM Audit staff. Individual staff remain on audit until error rates are	Ongoing	remains open. The MCP has taken steps to correct the deficiency. Please submit samples of NOA letter post audit review to	The MCP submitted "CAF 9 – NOA" as a sample of NOA Sample letter for post audit review. This item is closed.

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	<10%. Upon staffs' release of audit, periodic random audits are initiated quarterly to ensure compliance with NOA language. If noncompliance with NOA requirements are identified, the clinical staff receives additional training and is again placed on an additional 3 month audit period or until error rate <10%.		close this item. This item remains open.	
For communications translated into Spanish and sent to Members, ensure that the entire Notice of Action letter is written in Spanish, including the specific reason for the modification or denial of services. Spanish versions of the Your Rights under Medi-Cal Managed Care and Form to File a State Hearing should be sent to these Members.	KHS has used these NOA letters in the past. As with all Member Notices, it requires DHCS approval before implementation. These letters had been approved previously by DHCS. They had also been subject to previous audits and were not identified as being out of compliance. Had KHS been advised earlier that they needed modification; we would have made efforts to correct them. As such, KHS is actively creating a process to establish translation of its external written communications and anticipates implementing a solution within the next 90 days or May 2014. Options currently under	6/20/2014	The MCP has taken appropriate action to remedy the finding. Please submit samples of NOA letters in Spanish after implementi ng a solution to	The MCP submitted "CAF 9 Project Charter Translation Services". This item is closed.

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
	review include but not limited to: 1. Outsourced service certified in translating the NOA letters in the required threshold (Spanish) language; or 2. Internal KHS staff certified in translating the NOA letters in the required threshold (Spanish) language; or 3. Software solution capable of dynamically translating and populating the NOA letters in the required threshold (Spanish) language. Spanish versions of the Your Rights under Medi-Cal Managed Care and Form to File a State Hearing are currently included to the member in the NOA mailing. **Responsibility:** **Utilization Management** **Director of Health Services**		close this finding. This item remains open.	

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Ensure that Pharmacy Notice of Action letters direct Members to the correct page of the Member Handbook regarding Pharmacy Benefits. **1.3 Referral Tracking System (page CAF – 10):**	The NOA letters were modified to a new format beginning in October, 2012. This was in conjunction with an implementation of an automated Pharmacy Workflow. New template letters which utilize ICE Medi-Cal approved language and have been authorized by our contract manager, now point to the specific policy (13.01- P) and regulations (Title 22, Section 51303). The reference to the page of the Member Handbook has been eliminated from the NOA letters. Per the 2013 audit, there was no issue with the new NOA letter format. **Please see attachment A:** ***13.01- P, Drug Utilization and Non-Formulary Treatment Request for attachments B-E.*** **Responsibility:** **Pharmacy** **Director of Pharmacy**	10/01/2012	The MCP has taken appropriate steps & provided 13.01- P, Drug Utilization and Non-Formulary Treatment Request for attachments B-E. to addressed the finding. This item is closed.	

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The Plan's policy 3.22, *Referral and Authorization Process*, defines the process and Plan requirements for referral and authorization of services. KHS tracks referral requests through the KHS computerized MIS system. As noted in the UM/QI Committee minutes, routine and urgent referrals are processed timely. However, the Plan does not track unused or open referrals; rather, the Plan delegates the responsibility to track all referrals to the Primary Care Provider. **DHCS Recommendation:** Implement a system to actively track all referrals, including open or unused referrals, as per Contract requirements. (Contract reference: Exhibit A, Attachment 1 F)	KHS will initiate quarterly audits performed by UM audit staff utilizing encounter and authorization data to identify open and/or unused referrals with the initial audit to be completed end of 1st quarter 3/31/2014. Data reviewed will include but not limited to all specialty, diagnostic, preventative, and previously authorized unused services. Upon identification, the assigned Primary Care Provider (PCP) will receive written notification from KHS detailing the unused	4/15/2014	The MCP has taken steps to correct the finding. Please submit the Q1 2014 results of UM audit to close	The MCP submitted "CAF 10 Active Tracking Referrals". This item is closed.

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	services, the members involved, and type of utilization data reviewed. In addition to provider reports currently supplied by the Provider Representative staff, KHS UM staff will work in collaboration with the PCP, in addition to the requesting provider, to assist with the coordination to ensure receipt of authorized services and reduce barriers to the members. <u>Calendar of scheduled Audits 2014</u> Q1 2014 Q2 2014 Q3 2014 Q4 2014 **Responsibility:** **Utilization Management** **Director of Health Services**	 04/15/2014 07/15/2014 11/15/2014 01/15/2015	this item. This item remains open.	
1.4 Prior Authorization Appeal Process (page CAF – 11): Appeals are handled as part of the Grievance system. The Provider Manual, which is sent by CD to all				

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Providers annually and to new Providers as part of their orientation, contains the Policy related to the appeal of denied services or medications. The Member Handbook also outlines the appeals process for Members. The QI/UM committee reviews all appeals for timeliness and disposition. The Plan had two Provider initiated appeals submitted during the audit period which were handled in a timely manner. However, there is no specific documentation in each appeal file of Medical Director review of the case. Rather, every Member appeal is reviewed by the Grievance Review Team (GRT), which meets weekly and at which both medical directors are in attendance. But there is no attendance log or roster maintained for the GRT meetings, so there is no documented record of the physician or physicians who are in attendance. The minutes of the GRT also do not contain any details about the rationale behind the				

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
disposition of the appeal, nor do the appeal files themselves, other than in the resolution letter that is mailed to the Member. Furthermore, the appeal files do not routinely contain the signature of the physician who reviewed the appeal, or participated in the discussion at the GRT. One of the few appeal cases reviewed that did have a physician signature, showed that the same physician had also reviewed the original prior authorization request. (Contract reference: Exhibit A, Attachment 14 2 G)				
DHCS Recommendations: Ensure that each appeal file documents the basis on which the appeal is upheld or overturned, and is signed by the reviewing physician. Ensure that every appeal is reviewed by a different physician than the one who reviewed the original prior	Policy 5.01-I *Member Grievance Process, Attachment M Medical Director Records/Response Recommendation Form,* shall be used to document the basis on which the appeal decision is upheld or overturned and shall be signed by the reviewing physician. This form shall serve as proof that the appeal review is performed by a different physician than the one who reviewed the	1/1/2014 1/1/2014	The MCP has provided related updated P&P. Please provide a sample. This item is closed. The MCP	The MCP submitted "CAF 11 – A Sample of Appeal". This item is closed.

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authorization. Ensure that attendance logs for the Grievance Review Team are maintained.	original prior authorization. The file contains the original prior authorization which will be used to confirm that the decision of the appeal is not performed by the physician who reviewed the original prior authorization. An attendance sign in sheet is presented and signed by all attendees of the Grievance Committee meeting on the date of the meeting. **Please see attachment B*:*** ***5.01-I, Member Grievance Process,*** ***Attachment M, Medical Director Records/Response Recommendation Form*** **Responsibility:** **Member Services** **Director of Marketing & Member Services**	1/1/2014	has provided related updated P&P. Please provide a sample. This item is closed. The MCP has provided related updated P&P, 5.01-I, Member Grievance Process, Attachment M, Medical Director Records/Response Recommendation Form. This	

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2.2 California Children's Services (CCS) (page CAF – 12): The Plan has developed policies for identifying and referring children with California Children's Services (CCS) eligible conditions to the local CCS program. The policy states that CCS program services must be provided by CCS paneled/approved providers. KHS does not give prior authorization for payment of services related to CCS eligible conditions. Authorization for such services must be received from the CCS program. The policy further states that KHS contracted Providers will be responsible for identifying and referring children with CCS eligible conditions to the local CCS program. Through the Member Handbook, the Plan informs the Members that the CCS Program provides health and case management services for certain serious medical conditions for Members less			item is closed.	

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than 21 years of age. If a child has a serious medical condition, he or she may be eligible for care under CCS. Members are informed that more information about the CCS program can be obtained by calling KHS Member Services. Through the Provider Manual, the Plan educates network providers about CCS through the use of office orientations, Provider Bulletins, and collaborative training efforts with the local CCS program. Medically necessary covered services, preventive services, specialty and/or ancillary services not authorized by the CCS program. Coordination of care with CCS specialty providers and the CCS program. **DHCS Recommendation:** Ensure that California Children's Services (CCS) eligible Members are monitored and tracked for coordination	Eligible medical conditions for CCS coordination is the responsibility of CCS as determined by the criteria contained within the Numbered Letters for each unique	4/1/2014	The MCP has taken appropriate steps to	The MCP submitted "CAF 12 CCS

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of care between Primary Care Providers (PCPs) and specialty providers occurs.	diagnosis. KHS does not determine CCS eligibility, but will continue to approve and provide medically necessary services for each member and forward all medically necessary supporting documentation to CCS for review and a final ruling of eligibility. Coordination of services will be a collaborative process between KHS and CCS to ensure member receive appropriate medical care and services without interruptions or barriers. All potentially CCS eligible conditions will be reviewed for medical necessity and if approved, will be forwarded to CCS for review. Every effort will be afforded to utilize CCS paneled providers to reduce continuity of care issues. If the provider is not KHS contracted, a Letter of Agreement will be drafted to ensure timely and appropriate delivery of care. An adjudicator code currently in place in our core claims adjudication system will allow for reporting and tracking of the	3/14/2014 Ongoing	address the finding. Please submit a copy of minutes of Bi-monthly meetings between KHS and CCS clinical personnel to close this item. This item remains open.	Monthly Job Meeting agenda". This item is closed.

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	approved CCS conditions. The CMS SAR system is utilized to research approved or denied decisions rendered by CCS. Updates to the member's treatment plan and authorization history will be completed to ensure accuracy. Bi-monthly meetings between KHS and CCS clinical personnel will be initiated 4/1/14 to ensure timely eligibility determination and financial responsibility for the services rendered. **Please see attachment C:** ***3.16-P, California Children's Services (CCS)*** **Responsibility:** **Utilization Management** **Director of Health Services**	4/1/2014		
2.3 Early Intervention Services/Developmental Disabilities (page CAF – 14): The Plan has developed and				

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implemented systems to identify children who may be eligible to receive services from the Early Start Program. These Members are being referred to the local Early Start Program. Members are identified by certain medical conditions and/or medical history. A collaboration of services was identified between the Plan and Kern Regional Center. The Plan has developed and implemented procedures for the identification of Members with developmental disability. The Plan identifies key medical conditions and medical history during this process. Members are referred to Kern Regional Center for non-medical services; there is participation between the Plan and Regional staff in the development of service plans as shown in case management notes. Memorandum of Understanding (MOU) between KHS and Kern County and between KHS and Kern Regional Center delineates the responsibilities in coordinating services for Members with				

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developmental disabilities. The Plan and Regional Center facilitate coordination of comprehensive services and medical care for the Regional Center and Early Start eligible Members. **DHCS Recommendation:** Improve the monitoring system to ensure that the EI/DD (Early Intervention/Developmentally Disabled) eligible Members receive primary care services and coordination of care between Primary Care Provider (PCP) and EI/DD specialists.	Identified medical conditions for EI/DD coordination is a shared responsibility between Kern Regional Center (KRC) and KHS. KHS will provide medically necessary services for each member and forward all medically necessary supporting documentation to KRC for review and a final ruling of eligibility. Coordination of services will be a collaborative process between KHS and KRC to ensure members receive appropriate medical care and services without interruptions or barriers. All potentially KRC identified conditions will be reviewed for medical necessity and will be forwarded to KRC for review for final determination of services required and financial responsibility.	4/1/2014 3/14/2014	The MCP has taken appropriate steps to address the finding. Please submit a copy of Quarterly meeting in April between KHS and KRC clinical personnel to close	The MCP submitted "CAF 14 - Early Intervention Services/Developmental Services". This item is closed.

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			this item.	
	An adjudicator code currently in place in our core claims adjudication system will allow for reporting and tracking of the potential KRC eligible services. Updates to the member's treatment plan and authorization history will be completed to ensure accuracy.	Ongoing	This item remains open.	
	Quarterly meetings between KHS and KRC clinical personnel will be initiated 4/1/14 to ensure timely eligibility determination, coordination of care, and financial responsibility for the services rendered. KHS uses certified DHCS/MMCD Site reviewers to review Facility Sites per the attached policies: CP 231 *Facility Site Review – Medical Record Review*, 2.22-P *Facility Site Review*, and supporting documents.	4/1/2014		
	Policy 2.22-P, *Facility Site Review* has been revised. Section 11 has been added to reflect the practice that additional information is collected during the Focused	2/28/2014		

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	Review process. In addition to the Medical Record Review performed during Full Site Reviews, Focused Reviews will include medical record review on a sample of members' charts to ascertain that practice continues to match establish processes and meet standards set by DHCS. Data obtained during the Facility Site and Focused Review Medical Record review will be aggregated and reported to the QI/UM committee quarterly and then to the KHS Board of Directors. Provider specific data will be made available to the credentialing process. Both electronic and hard-copies of reviews, CAPs and other communication is kept by the Department of Quality Improvement, Health Educations and Disease Management Additionally, the Plan follows Policy 3.03-P, *Kern Regional Center Services (Developmental Disabilities and Early Intervention)* section 5.0, tracking and monitoring. This monitoring is done by the	2/27/2014		

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2.4 Initial Health Assessment (page CAF – 16):	Quality Improvement Department. **Please see attachment D:** ***CP 231 Facility Site Review – Medical Record Review*** ***Medical Record Review Survey 2012 Tool*** ***Policy 2.22-P Facility Site Review*** ***KRC Audit Tool*** ***Focus Review – 4th Quarter Report (reported to QI/UM Committee 2/27/2014)*** ***3.03-P Kern Regional Center Services (Developmental Disabilities and Early Intervention*** ***KHS Focus Reviews Critical Elements Monitoring*** **Responsibility:** **Utilization Management** **Director of Health Services** **Responsibility:** **Quality Improvement** **Director of Quality Improvement**			

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The Plan's Policy 3.05-P, *Preventative Medical Care,* addresses the completion of the Initial Health Assessment (IHA) for Members. The policy addresses both the content and the time frame for the IHA completion requirements. Through the Member Handbook, the Plan informs the Members to contact their "doctor for an appointment within 120 days" after being enrolled. Children under 18 months should see their Primary Care Physician (PCP) within 60 days of becoming a Member. The Preventive Care Guide indicates the requirements of the performance of the initial history and physical exam.				
DHCS Recommendations: Develop a process to effectively monitor the completion rate of Initial Health Assessment (IHA) within the required time frame.	IHA completion rate is monitored on a quarterly basis and compliance with this measure is reported to providers via the KHS Provider Portal as part of the Pay-for-Performance Program per KHS Policy 2.43-I. The report available to providers includes their compliance rating and the number of	Ongoing	The MCP has provided Staying Healthy Assessment Bulletin,	

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	incomplete IHAs; a listing of all assigned members is available to the provider on the KHS Provider Portal. (Include screenshot of the Provider Scoreboard Measure Summary and a copy of the P4P Audit Report) In addition, telephone contact is attempted with all new members within 45 days through the Member Services New Member Entry (NME) Program. The NME Program includes that the Member Services Representative is to go over the importance of scheduling the IHA and will assist the member with scheduling an appointment at the time of the call if the member agrees.		Audit Report-3rd Quarter 2013, Provider Scoreboard -Measure Summary Screen-print, and Staying Healthy Assessment Provider Webinar Training to address this finding. This item is closed.	
Ensure that providers document the IHA requirements in the Members' medical records.	Member medical records are monitored for compliance with the inclusion of sufficient documentation with regard to the IHA per KHS Policy 2.22-P, *Facility Site Review, Attachment A, Medical Record Review Survey Tool* which includes specific focus of documentation of the IHA within the member's record. The Reviewer discusses the findings of the medical record review with the site contact and provides feedback	Ongoing		

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	on areas of needed improvement and the need for a corrective action plan. KHS Policy 2.43-I, *Pay For Performance Program*, includes that KHS audits a statistical sample relevant to the population of each of the measures is quarterly and that continued statistical error rates may result in a suspension from the pay for performance program for the remainder of the year. The results of this audit are forwarded to the KHS Provider Relations Department for review and tracking. Provider Bulletins regarding a Staying Healthy Assessment Provider Webinar Training for the SHA tool developed by the DHCS have been implemented to assist and encourage contracted providers to use the tool. **Please see attachment E:** ***293-Staying Healthy Assessment Bulletin*** ***P4P Audit Report-3rd Quarter 2013*** ***Provider Scoreboard-Measure Summary Screen-print*** ***Staying Healthy Assessment Provider Webinar Training***	3/03/2014 11/4/2013		

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	Responsibility: **Utilization Management** **Director of Health Services** **Responsibility:** **Quality Improvement** **Director of Q.I/Health Education/Disease Management**			
3.5 Emergency Service Providers (Claims) (page CAF – 18): The Plan's Policy 3.31-P, Emergency Services indicates that the Plan provides payment for Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Contractor's network. These services shall not be subject to prior authorization requirements. The Plan is required to pay for all Emergency Services that are Medically Necessary until the Member is stabilized. The Plan shall also pay for any screening examination services conducted to determine whether an Emergency				

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Medical Condition exists. The Plan's Policy 6.01-P, Claims Submission and Reimbursement indicates that 90% of clean claims from providers who are in individual or group practices or who practice in shared health facilities will be processed within 30 calendar days of the date of receipt. In addition, the Plan shall reimburse each completed claim, or portion thereof, as soon as possible, but no later than 45 working days after the date of receipt of the complete claim. Furthermore, the policy states that the date of receipt shall be the date KHS receives the claim, as indicted by its date stamp on the claim. The date of payment shall be the date of the check or the form of payment. Although the Plan has developed and implemented policies and procedures for Emergency Services claims, Policy 6.01-P does not indicate how				

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appropriate payers are informed of any misdirected ER claims as required by California Code of Regulations, Title 28, section 1300.71(b) (B) and the Contract. Through the Member Handbook, the Plan informs Members that Emergency Services, which includes emergency ambulance service and professional service, are covered by the Plan. It further adds that "Emergency Services are also covered for mental health emergencies along with the care and treatment to relieve or eliminate a psychiatric emergency health condition within the capability of the facility." And that if a Member finds his/her life or health to be in danger; he/she can call 911 without calling Kern Family or the PCP first. Through policies and procedures, the Plan informs Providers about Emergency Room coverage. Contracted				

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practitioner/providers claims are reimbursed at the appropriate contract rates. Non-contracted practitioner/provider claims submitted without supporting documentation are reimbursed at the 99283 level. Procedure codes 99284-99285 require medical review and should be submitted with an emergency room report. Emergency service claims for contracted and non-contracted practitioner/providers are processed according to guidelines established by the Plan. **DHCS Recommendation:** Update Policy 6.01-P, Claims Submission and Reimbursement to include a stipulation that all misdirected claims received by the Plan will be directed to the appropriate payer of service within ten working days.	Policies *6.01-P, Claims Submission and Reimbursement, and 60.01-I, Claims Submission and Reimbursement – Internal*, were updated to include language that KHS will forward any incorrectly received claim to the appropriate payor within ten (10) working days.	3/4/2014	The MCP has provided its revised 6.01-P, Claims Submission and Reimbursement, and 60.01-I, Claims	The MCP submitted "CAF 18 - Emergency Service Provider Claims". This item is closed.

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3.6 Family Planning: (Payments)(page (CAF – 20) : *The Plan's Policy 3.21-P, Family Planning Services and Abortion,* indicates that Members have the right to access Family Planning services through any family planning provider without prior authorization. In addition, the	**Please see attachment F:** ***6.01-P, Claims Submission and Reimbursement, and 60.01-I, Claims Submission and Reimbursement – Internal.*** **Responsibility:** **Claims** **Director of Claims**		Submission and Reimbursement – Internal P&P. Please provide a sample of forwarding any incorrectly received claim to the appropriate payer within 10 days. This item is closed.	

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
same policy states that the contractor shall inform its Members in writing of their right to access any qualified family planning provider without prior authorization, in its Member Services Guide. Members may also receive these services from non-participating providers, per the policy. The Plan's Policy 6.01-P, *Claims Submission and Reimbursement* indicates that 90% of clean claims from providers who are in individual or group practices or who practice in shared health facilities will be processed within 30 calendar days of the date of receipt. In addition, the Plan shall reimburse each completed claim, or portion thereof, as soon as possible, but no later than 45 working days after the date of receipt of the complete claim. Furthermore, the policy states that the date of receipt shall be the date KHS receives the claim, as indicted by its date stamp on the claim. The date of				

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payment shall be the date of the check or the form of payment. Through the Member Handbook, the Plan informs Members of their rights to access family planning services and that they do not require prior authorization. Members may access family planning services either by self-referral to an appropriate qualified practitioner/provider or by calling Member Services. Family planning services offered to Members are provided to individuals of child bearing age for the purposes of temporarily or permanently preventing or delaying pregnancy. Through policies and procedures, the Plan informs Providers about Family Planning services. Non-contract practitioners/providers are paid for services provided to Members based on the appropriate Medi-Cal Fee-For-Service rates. Contracted practitioners/providers are reimbursed according to the contract agreement.				

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Member's eligibility with KHS is determined on a month-to-month basis. A maximum of three cycles of oral contraceptives will be reimbursed per visit for family planning services. Based on the interview with Plan personnel, the misdirected claims are sent to the responsible party within 10 working days of receipt by the Plan. However, the Plan's policy does not indicate how appropriate payers are informed of any misdirected Family Planning claims as required by California Code of Regulation, Title 28, section 1300.71(b) (B) and the Contract. **DHCS Recommendation:** Update Policy 6.01-P, Claims Submission and Reimbursement to include a stipulation that all misdirected claims received by the Plan will be re-directed to the appropriate payer of service within ten working days.	Policies *6.01-P, Claims Submission and Reimbursement, and 60.01-I, Claims Submission and Reimbursement – Internal*, were updated to include language that KHS will forward any incorrectly received claim to the appropriate payor within ten (10) working days.	3/4/2014	The MCP has provided its revised 6.01-P, Claims Submission and Reimburse ment, and 60.01-I,	The MCP submitted CAF 20 – Family Planning Payment, Misdirect Claim Sample". This item is closed.

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3.7 Access to Pharmaceutical Services (page CAF – 22): The Pharmacy function is overseen by the Chief Medical Officer in collaboration with the Pharmacy and Therapeutics (P&T) Committee to conduct its continuous oversight in developing and maintaining the drug formulary, prior authorization guidelines, and other pharmacy services. Discussion of such oversight matters take place in the Plan's Quality Improvement/Utilization Management (QI/UM) Committee to whom the P&T committee reports.	**Please see attachment G:** ***6.01-P, Claims Submission and Reimbursement, and 60.01-I, Claims Submission and Reimbursement – Internal.*** **Responsibility:** **Claims** **Director of Claims**		Claims Submission and Reimbursement – Internal P&P. Please provide a sample. This item is closed.	

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The Plan has a contractual agreement with Argus Health Systems, Inc. to provide pharmaceutical services and prescribed drugs to Members in accordance with the Medi-Cal Contract. The Member Handbook includes information regarding the Plan's Formulary and formulary process. A list of contracted pharmacies is found in the Provider Directory on the Plan's website. There are an adequate number of pharmacies available in all areas for the Plan Members; Wal-Mart pharmacy is the only pharmacy retailer not available to KFHC Members. The Plan's Policy 13.04-I, *Formulary Process and Drug Utilization Review*, indicates that compliance with the emergency drug provision requirement is to be monitored through the formulary process. The Plan covers and ensures the provision of prescribed drugs and medically necessary pharmaceutical				

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services. Policies and procedures for pharmaceutical services and prescription drugs comply with contract requirements and applicable laws and regulations. During the audit period, it does not appear the Plan had proactive monitoring procedures to ensure the delivery of-medications in emergency circumstances. **This is a repeat finding from the 2003 and 2006 DHCS audit.** The Plan has a hospital contract with Fee-for-Service Facilities providers. However, there is no stipulation that contracting hospitals are required to provide a sufficient quantity of emergency drugs until the Member can reasonably be expected to have a prescription filled. **DHCS Recommendation:** Continue monitoring procedures to ensure the provision of prescribed drugs	The Audits and Investigations Compliance Department will perform an audit on a bi-annual basis to ensure the provision of prescribed drugs in emergency	Ongoing	Please submit the results of bi-annual audit of	The MCP submitted "CAF 22 – Access to Pharmaceutic

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
in emergency circumstances. **Category 4 – Member's Rights** **4.1 Grievance System (page CAF – 24):** Policy 5.01-I *KHS Member Grievance Process*, defines and communicates the grievance process, and how the Plan monitors and reports grievances. It specifies that Member grievances are documented, investigated, and resolved	circumstances. The requirement for emergency supplies is written in policy 13.01-P, *Formulary Process and Drug Utilization Review*, section 5.1 pursuant to CCR Title 22 section 53854(2). This audit is part of the KHS Annual Audit Plan. **Please see attachment H**: ***13.01- P, Drug Utilization and Non-Formulary Treatment Request*** **Responsibility:** **AIS Compliance** **Director of Compliance & Regulatory Affairs**		this finding in order to close this item. This item remains open.	al, Provision for Emergency Drug Audit". This item is closed.

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within thirty (30) calendar days. Members are informed of the grievance process through the Member Handbook and Member Newsletters. The grievance process can be initiated by phone, in writing, online and by fax. The Medical Directors review all clinical issues and conduct follow-up with providers. Administrative issues (including access and availability) are referred to Provider Relations, and clinical issues are referred to Quality Management for follow-up. However, the decisions are documented only in the resolution letter to the Member; there is no separate documented discussion of the grievance resolution by the Plan, particularly with regards to Quality of Care grievances. The outcomes determined in the Grievance Review Team are recorded on the grievance log and in the grievance file, but no details of the				

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
decision are provided. Based on the review of the cases, acknowledgement letters were issued to the complainants within 5 days, and resolution letters within 30 days, all within compliance time frame parameters. However, physician review and documentation was absent from the Quality of Care case files. The Grievance Review Team (GRT) has no attendance record to verify who was present for the discussion of specific cases. The physician involved in adjudicating the case is not identified by the GRT minutes. In addition, the notes detailing the discussion and reasoning for the decisions for each case were not present in the grievance case files. Two of five Quality of Care cases had an incomplete investigation. (Contract reference: Exhibit A, Attachment 14, 2 D and E). **DHCS Recommendations:**				

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Ensure all Quality of Care cases demonstrate a complete investigation. Ensure that a physician documents review of every Quality of Care case, including details to substantiate the disposition of the case, and that the review is contained with the individual grievance file. Ensure that attendance logs for the Grievance Review Team are maintained.	Grievance files involving quality of care issues shall be reviewed internally, on a quarterly basis to confirm that each investigation is complete and the appropriate documentation is consistently included. Policy *5.01-I Member Grievance Process,* Attachment M *Medical Director Records/Response Recommendation Form,* shall be used to document physician review of all cases involving quality of care issues. A new process was implemented whereby a standard Grievance Review Meeting Sign-in sheet is used. All members of the Grievance Review Team sign their name, title, and department. The weekly log is forwarded to the lead Grievance Coordinator for safe-keeping. Upon review of the DHCS recommendations a thorough review of the grievance Team Review Meeting was undertaken. Prior to the start of each	1/1/2014 1/1/2014 1/1/2014 1/1/2014	The MCP has taken appropriate steps and provided 5.01-I Member Grievance Process, Attachment M Medical Director Records/Response Recommendation Form to address this finding. Please provide a sample of physician review. This item is closed.	

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	meeting a determination was made that all required departments had a representative present. However a sign-in sheet was not passed around for signature of all attendees. All cases were thoroughly reviewed and discussed, however the Meeting Proceedings did not reflect this often lengthy review process. When additional information is required, either from the provider (s) or from the Plan, a resolution was not made at the initial meeting, but is reviewed again at the next meeting. Again this is not reflected in the Proceeding Summary. Changes made in response to the above Recommendations: 1- A sign-in sheet is now passed around at each meeting to document attendance. 2- There are generally two Medical Directors present at each meeting. The Medical Director not involved with the initial quality of care			

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	determination is responsible for filling out a new Form which will document a summary of the discussion leading up to the resolution of the case. It will also clearly state what the resolution is. 3- We will now have an Administrative Assistant to take minutes during the meeting – and she will incorporate the written physician statement into the Proceeding, and then the form can be placed into the individual grievance file. 4- The Meeting Proceedings will now more clearly reflect the activities of the committee. They will document if additional services are required, that the appropriate department has been notified to authorize the service, and that the member will be notified directly by Member Services /grievance team when additional services are authorized.			

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4.3 Confidentiality Rights (page CAF – 26): Policy 14.03-I, *Protected Health Information* stipulates the Plan's responsibility to maintain a written information privacy and security program that includes administrative, technical, and physical safeguards. The Plan's Compliance Officer serves as the KHS Privacy Official. Policy 2.27-P, *Medical Records and Other Protected Health Information – Content, Maintenance and Security,* stipulates that breaches of security are notified to the Department of Health	**Please see attachment I:** ***5.01-I Member Grievance Process,*** **Attachment M *Medical Director Records/Response Recommendation Form*** **Responsibility:** **Member Services** **Director of Marketing and Member Services**			

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Care Services (DHCS) Privacy Officer and the DHCS Contract Manager by email or phone within twenty-four (24) hours, during a work week, of discovery by KHS. However, the Plan's policy does not indicate that such notification also be submitted to the DHCS Information Security Officer within 24-hours during a work week for suspected breaches as required by the Contract. The Compliance Officer is responsible for overseeing the reporting and investigation of the privacy breaches. The Plan provides HIPAA Compliance annual training for new hires at the Plan facility. A Code of Conduct is maintained by the Plan to illustrate the importance of safeguarding Protected Health Information (PHI) in the office. Through the Member Handbook, the Plan's Notice of Privacy Practices (NPP) is given to new Members upon enrollment and distributed annually to				

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
all Members. The Plan has established Provider policies and procedures to comply with HIPAA requirements. The Provider Administrative Manual as well as Confidentiality Policy 2.27-P, *Medical Record and Other PHI-Content, Maintenance, and Security*, and Policy 5.05-P, *Member Rights and Responsibilities* establish the need to preserve the confidentiality of Member rights. **DHCS Recommendations:** Update the language in Policy 2.27-P, Medical Records and Other Protected Health Information – Content, Maintenance and Security to include the contractual stipulation that the initial notification of discovery of breach will be submitted within 24 hours by telephone, e-mail, or fax to the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) Contracting Officer,	Policy *2.27-P, Medical Records and Other Protected Health Information,* was updated to include the DHCS contractual requirement that the initial notification of discovery of breach will be submitted within 24 hours by telephone, e-mail, or fax to the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer.	3/3/2014	The MCP has provided its updated P&P, 2.27-P, Medical Records and Other Protected Health Information – Content,	

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the DHCS Privacy Officer and the DHCS Information Security Officer. Ensure that the initial notification of Patient Health Information (PHI) breach is submitted to the required DHCS personnel within the required time frame as stipulated in the Contract. **5.1 Quality Improvement System (page CAF – 27):** The plan monitors quality of care through various activities in accordance with California Code of Regulations, Title 28, section 1300.70, including review of all hospital readmissions,	The Audits and Investigations Compliance Department has added a Compliance Analyst position to the Department. This position will be responsible for ensuring compliance with the PHI breach contractual requirement. **Please see attachment J:** ***2.27-P, Medical Records and Other Protected Health Information – Content, Maintenance, and Security*** **Responsibility:** **AIS Compliance** **Director of Compliance & Regulatory Affairs**	3/10/2014	Maintenance, and Security, to address this finding. This item is closed.	

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
grievance tracking and trending, evaluation of HEDIS parameters, Facility Site Reviews (FSR), medical record reviews, and credentialing and re-credentialing of providers. Quality of service is monitored through FSRs, access surveys, and Member satisfaction surveys. Corrective actions are assigned when compliance falls below the Plan's stated standards and follow-up is initiated. Both inpatient and outpatient care, including emergency room services, as well as provider offices and the Plan's after-hours triage provider, Nurse Response, are monitored and reported to the QI/UMC and Board of Directors. Preventative health guidelines based on nationally recognized standards support quality improvement standards and are distributed to Members and Providers through Member mailings and newsletters, and the collection of documents that constitute the Provider				

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Manual. Despite these monitoring efforts, the Plan seems to have gaps in its ability to "monitor, evaluate and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting", as mandated by the Contract (Contract reference: Exhibit A, Attachment 4.1). Based on review of QI/UMC minutes, under-utilization with regards to the fluoride varnish program was identified; the numbers of claims for this service were repeatedly extremely low throughout several reporting periods (including zero claims for two quarters). In addition, the numbers for post-partum visits were also very low. **DHCS Recommendation:** Develop a mechanism by which the quality improvement department is able not only to identify gaps in the quality	<u>Topical Fluoride Varnish Treatments</u> A. KHS will continue to monitor topical fluoride varnish treatment utilization through the quarterly health education activities report.		The MCP has provided its P&P, 3.63-P Topical	The MCP submitted "CAF 27 – Quality Improvement System".

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of care delivered to Members, but to act upon those identified gaps and to address needed improvements in quality of care.	B. KHS will continue to facilitate member education on the importance of topical fluoride varnish treatments through the member newsletter, preventive care guide, member handbook and KHS website. C. KHS will promote the fluoride varnish application and trainings through provider bulletins and the KHS website. D. KHS will collaborate with the local CHDP program to coordinate member outreach education efforts and provider trainings, when available. E. KHS will survey pediatricians to determine which providers are providing the topical fluoride varnish to members. **Please see attachment K:** ***3.63-P Topical Fluoride Varnish*** ***Fluoride Varnish Provider Bulletin*** <u>Postpartum Visits</u> • KHS will continue to monitor	3/13/2014 4/30/2014	Fluoride Varnish, Fluoride Varnish Provider Bulletin, 3.24-I Pregnancy and Maternity Care, KHS 2014 Pay For Performance Program, and Postpartum Visit Provider Bulletin to address this finding. Please provide a sample for Fluoride Varnish Treatment. This item is	This item is closed.

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	postpartum visits through the OB Case Management project and site reviews during the pregnancy practitioner re-credentialing process which include evaluation of compliance with KHS standards for obstetric medical records. • KHS will continue to facilitate member education and appointment scheduling assistance for the postpartum visit through the OB Case Management project, member newsletter and health education mailings. Members that are not successfully contacted by phone will continue to be mailed letters asking to contact KHS. Members that are successfully contacted will receive follow up calls to assess completion of the postpartum visit or offered assistance with rescheduling the appointment. • KHS will continue to implement the postpartum exam member incentive. Members that complete their postpartum visit within 21-56 days following		closed.	

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	delivery are eligible to receive a baby onesies and a thermometer. • KHS will continue to facilitate provider education through Provider Bulletins and the KHS website. • KHS will continue with a provider pay for performance incentive to ensure KHS members receive timely and appropriate postpartum care. **Please see attachment L:** ***3.24-I Pregnancy and Maternity Care*** ***KHS 2014 Pay For Performance Program*** ***Postpartum Visit Provider Bulletin*** **Responsibility:** **Quality Improvement** **Health Education Manager**	3/13/2014		
5.2 Provider Qualifications (page CAF – 28): The Plan's Policy 4.01-P, *Credentialing*, outlines the credentialing process to ensure that providers are appropriately qualified to provide services to its				

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Members. Provider applications are submitted to the Physician Advisory Committee (PAC) and Medical Director for review; the Board of Directors approves, denies or defers each application, upon the recommendations of the PAC. Providers are re-credentialed every three years and on an as needed basis. Performance review data is incorporated into the re-credentialing review including grievance and appeals data, member satisfaction surveys, UM data, and facility site review results. However, the Plan does not, as a matter of policy, check the Medical Board of California website, the Office of the Inspector General (OIG) List of Excluded Providers and the Medi-Cal Suspended and Ineligible Providers list on a routine, monthly basis to ensure that all of its contracted Providers are in good standing to participate in its network. (Contract reference: Exhibit A				

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.4.12.A) Potential quality improvement issues are evaluated by the Medical Director. Corrective Action Plans are issued and followed by the QI/UM Committee. Findings are subsequently reported to the Board of Directors. **DHCS Recommendation:** Ensure all Providers are in good standing in the Medicare and Medicaid/Medi-Cal programs by monthly monitoring of the appropriate websites; amend relevant policies and procedures to reflect the modification in practice.	The Plan does manually monitor the Medi-Cal Suspended and Ineligible Providers list on a monthly basis. Upon initial and re-credentialing, the plan also checks the NPDB and Office of the Inspector General (OIG) websites. The Plan also performs a check for any claims history regarding provider malpractice. Physicians are also obligated by Provider Contract section 6.18 (b) (1) to notify Plan immediately if (1) Any action taken (and the reasons therefor) to restrict, suspend or revoke any of the Physician's licenses, certifications, accreditations, medical staff memberships or clinical privileges, Physician's Controlled Substance Permit, or Physician's		The MCP has taken appropriate steps and has provided its P&P, 4.01-P, Credentialing to address this finding. Please provide a sample. This item is closed.	

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	qualification to serve as either a Medicare or Medi-Cal provider (summary actions shall be deemed to have occurred upon the date of initial imposition, regardless of whether or not any procedural rights are pending). The Plan will use its provider credentialing software to monitor and query the appropriate websites on a monthly basis. The Credentialing Senior Support Clerk, on a monthly basis, reviews the ineligible/suspended Provider list from the DHCS Medi-Cal Website at https://files.medi-cal.ca.gov on a monthly basis to research any Medi-Cal Suspensions and or Ineligible Providers. The Plan has further amended Credentialing Policy 4.01-P, *Credentialing* to include documentation of the aforementioned monitoring (see attached). The Credentialing Senior Support Clerk will continue to verify the Medical License within the Medical Board of California website at https://www.Breeze.ca.gov . The	2/3/2014 2/27/2014		

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5.4 Delegation of Quality Improvement Activities *(*page CAF – 30*)*: The Plan has a contract with McKesson to provide care management and complex case management services to its Members; the program was launched on February 1, 2012. McKesson provides daily reports on the hospitalized patients and monthly reports on the Members in the case	Plan will continue to research Facilities, Ancillary providers, and will include PCP's and Specialists through the Office of the Inspector General (OIG) website at http://oig.hhs.gov/exclusion/index.asp. A hard copy will be placed in the Provider file or tracked in the Credentialing Database. **Please see attachment M:** ***4.01-P, Credentialing*** **Responsibility:** **Provider Relations** **Director of Provider Relations**			

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management program. However, no reports from McKesson were available for review from the QI/UM minutes. There is no provision in Kern's contract with McKesson to perform any type of oversight audit to ensure that McKesson is performing its functions in compliance with Kern's contractual requirements with DHCS. Because McKesson is providing services (complex case management) on Kern's behalf, that are mandated in Kern's contract with DHCS, Kern must perform the usual oversight of delegated entities, as outlined in the Contract (Exhibit A, Attachment 4.6). There is no documentation in the QI/UM committee minutes or the Board of Director meeting minutes of receipt and review of these reports to demonstrate oversight of the delegated entity. **DHCS Recommendation:** Perform adequate and routine oversight	KHS entered into a hybrid responsibility	2/28/2014	The MCP has	The MCP submitted

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of the contracted entity, McKesson, to ensure that they are providing the contracted services in a way that it is compliant with the Plan's contractual obligation to Department of Health Care Services.	with a delegated entity, McKesson, to perform Care and Complex Case Management services in February 2012. McKesson currently provides multiple daily and monthly reports to the Director of Health Services and Supervisor of Case Management for review and analysis. Prior to 1/1/14, this responsibility belonged with the Director of Quality Improvement (QI). Beginning on February 28, 2014, quarterly reports from 2013 were presented and reviewed at the QI/UM meeting and are reoccurring scheduled agenda reports for each QI/UM meeting. KHS will initiate and perform the usual oversight of delegated entities as defined in KHS Policy 2.45 (see attached), and as outlined in the Contract (Exhibit A, Attachment 4.6). **Please see attachment N:** ***McKesson Monthly Reporting Documents (7/1/12-6/30/13).*** ***2.45-I, Delegation of Quality Improvement, Utilization Management,***		provided McKesson Monthly Reporting Documents (7/1/12-6/30/13) and P&P, 2.45-I, Delegation of Quality Improvement, Utilization Management, Care and Case Management and Pharmacy Activities and Responsibilities. Please confirm that KHS has performed the usual	"CAF 30 – Quality Improvement Activity, McKesson Care Management Report". This item is closed.

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	Care and Case Management and Pharmacy Activities and Responsibilities **Responsibility:** **Utilization Management** **Director of Health Services**		oversight of delegated entities as defined in KHS Policy 2.45 to close this finding. This item remains open.	
5.5 Medical Records (page CAF – 32*):* The Plan's Policy 2.27-P, *Medical Records and Other Protected Health Information – Content, Maintenance and Security*, lists the requirements for medical record documentation, storage and access as required by the Contract. Also, the Plan has developed the procedures to maintain patient medical records and to safeguard the confidentiality of medical records and information. In addition, the Plan has established standards for the				

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
administration and maintenance of medical records by individual practitioners to facilitate communication, coordination and continuity of care and to promote efficient and effective care. Furthermore, the policy states that the Plan will ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care. Facilities visited had properly secured medical records and had a designated person responsible for securing medical records. Facility Site Reviews provided by the Plan showed 80% or greater compliance rate. There were no corrective action plans mandated to these contracted Providers. **DHCS Recommendations:** Ensure that a complete medical record is maintained for each Member.	KHS uses certified DHCS/MMCD Site reviewers to review Facility Sites per the attached policies CP 231 *Facility Site*	Ongoing	The MCP has taken appropriate steps to address the	

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Ensure that the monitoring system of record keeping is maintained.	*Review – Medical Record Review*, 2.22-P, *Facility Site Review* and supporting documents. During these reviews, DHCS mandated forms are used to evaluate the provider office and medical records during the Full Site Review and KHS forms are used for the Focused Review. The *Full Site Review 2012 CAP Tool* is mandated by the State and is given to the provider following his/her full site review and the other copy goes to the State. The QI/RN returns in 45 days to evaluate any deficiencies. The Focus Review Critical Element CAP is used if any of nine (9) critical elements are deficient. If this CAP is issued, the QI/RN performs a return visit in the (10) days. This form is reported to the state when found during the full site review. The *Focus Review CAP* form is always left with the provider whether or not corrective action is necessary. When no deficiencies are found, the CAP is marked closed and	2/27/2014 2/27/2014	finding. It also provided Policy CP 231 Facility Site Review – Medical Record Review (Reviewed, unchanged except dates), Medical Record Review Survey 2012 tool, Policy #2.22 Facility Site Review (revised), Full Site Review 2012 CAP	

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	the rest of the form is left blank. If corrective action is necessary, the deficiency is noted on the form and the QI/RN returns in 45 days. The provider signs the last page and returns it to KHS Quality Improvement, Health Education and Disease Management Department. Data obtained during the Facility Site and Focused Review Medical Record review is aggregated and reported to the QI/UM committee quarterly and then to the KHS Board of Directors. For the period July 1st 2012 through June 30th 2013, Attachment J shows both the numbers of Full Site Reviews/Medical Records reviews and subsequent follow-up. This information was obtained from the Full Site Review Quarterly Report sent to the QI/UM Committee meeting. Provider specific data is made available to the credentialing process. Both electronic and hard-copies of reviews, CAPs and other communication is kept by the Department of Quality Improvement, Health Educations and Disease Management	12/31/2013 Ongoing	tool, Focus Review Critical Element CAP, Focus Review CAP, and CAPs report 7_12-6_13. This item is closed.	

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	Data obtained during the Facility Site and Focused Review Medical Record review is aggregated and reported to the QI/UM committee quarterly and then to the KHS Board of Directors. Provider specific data will be made available to the credentialing process. Both electronic and hard-copies of reviews, CAPs and other communication is kept by the Department of Quality Improvement, Health Educations and Disease Management Further medical record review is performed during quarterly Pay-For-Performance compliance audits per Policy 2.43-I, *Pay-For-Performance Program – Compliance Audit Process.* **Please see attachment O:** ***Policy CP 231 Facility Site Review – Medical Record Review (Reviewed, unchanged except dates)*** ***Medical Record Review Survey 2012 tool*** ***Policy #2.22 Facility Site Review (revised)*** ***Full Site Review 2012 CAP tool.*** ***Focus Review Critical Element CAP***			

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
5.6 Informed Consent *(*page CAF – 33*)*: The Plan's Policy 2.19-P, *Sterilization Consent,* indicates the criteria for eligibility of sterilization procedures. In addition, the policy states that the Plan's contracted providers will be required to obtain a sterilization consent form for the designated procedures prior to performing such procedures. The Plan has specific instructions for the completion of the Sterilization Consent Form (PM 330). Furthermore, the Plan has developed and implemented the criteria for sterilization procedure and they are listed in the policy. The Plan's Policy 3.21-P, *Family Planning Services and Abortion* states that the Plan will provide enrollees full	***Focus Review CAP*** ***CAPs report 7_12-6_13*** **Responsibility:** **Quality Improvement** **Director of Quality Improvement**			

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
access to Family Planning Services and the right to choose and access a qualified family planning practitioner/provider, either contracted or non-contracted, without prior authorization. The 2012-2013 Member Handbook informs Members of the family planning services available from any participating PCPs and OB/GYNs, both in and out of network, without prior authorization, as well as from non-participating providers. The Provider Library **"**Conditions Under Which Sterilization May Be Performed" section has requirements for medical record documentation. The Provider is instructed that the medical record must note that the booklet and a copy of the consent form were given to the Member. The Provider Library "Sterilization Overview**"** informs the Provider to				

Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
educate the Member regarding sterilization and the Member must be provided with the DHCS published brochure on sterilization. In addition, the Provider Library "Certification of Informed Consent for Reproductive Sterilization**"** informs the providers of the need to utilize the PM 330 form for Informed Consent. Furthermore, the Provider Library "Special Considerations for Hysterectomy" section informs the providers of the requirements of Hysterectomy. The Provider is instructed that if Hysterectomy is performed, a Hysterectomy Informed Consent form must be completed in addition to other required forms.				
DHCS Recommendations: Educate Providers and the claims department on the proper completion of the PM 330.	As outlined in the Plan's Provider Contract, providers are required to comply with the Plan's policies and procedures including policy 2.19-P "*Sterilization Consent"*, which details the sterilization consent	2/26/2014	The MCP has taken appropriate action to address the finding.	The MCP submitted "CAF 33 – Informed Consent" with 100%

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Educate Providers about the documentation requirements for the discussion regarding sterilization contained in the Provider Library. Ensure that the PM 330 Sterilization Consent forms are completed appropriately for claim submission.	requirements as well as providing a link to the PM330 form and DHCS webpage for support. The Plan has distributed a Provider Bulletin (see attached) specifically for PM 330 Sterilization Consent form which identifies the most common issues in claim submissions. Provider Relations Department provided a link from the Medi-Cal website http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/ster_m00i00o03.doc to further assist with instructions on how to fill out the PM 330 form. Refresh training for the Claims Examiners has been provided using the new Provider Bulletin. Additionally, KHS Claims Department has implemented a 100% audit of all sterilization claims to ensure correct completion of the form. **Please see attachment P:** ***Provider Bulletin, Sterilization Consent***	1/1/2014 1/1/2014	Please submit a copy of sterilization audit to close this item. This item remains open.	Sterilization Consent Form Audit. This item is closed.

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6.4 Provider Training *(page CAF – 35)*: The Plan's Policy 4.23-P, *Provider Education,* states that initial Provider orientation will be conducted for all contracted Providers and their staff within ten days after the Plan has placed a newly contracted provider on active status. These orientations are conducted one-on-one or in a group setting at contracted provider sites or in local facilities. Sign-in sheets for In-service trainings for new Providers were requested and obtained. The documents show the Initial Provider In-service, Language line In-service and Sensitivity Training,	***Form/ Hysterectomy Informed Consent*** **Responsibility:** **Provider Relations** **Director of Provider Relations** **Responsibility:** **Claims** **Director of Claims**			

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and Portal Training. A Power Point presentation is also used to illustrate the Plan's policies and procedures, claim submission processes, prior authorization processes, and other pertinent administrative matters. **DHCS Recommendation:** Ensure that all new Providers receive training within 10 working days after the Plan places a newly contracted Provider on active status.	The Plan will monitor all newly contracted providers to ensure a New Provider In-Service is conducted within ten (10) working days of the contract effective date, per Policy 4.23-P, *Provider Education*. Providers are also made aware that they cannot provide services to Plan members until they comply with this requirement. For those providers that have an unexpected emergency and cannot comply with the 10-day training timeframe, the contract effective date will be postponed. **Please see attachment Q:** ***4.23-P, Provider Education*** **Responsibility:**	2/18/2014 3/12/2014	The MCP has taken appropriate steps to address this finding. Please submit the monitoring results of newly contracted providers to close this item. This item remains open.	The MCP submitted "CAF 35 – Monitoring of all newly enrolled providers". This item is closed.

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Defiencies Identified:	Plan of Action:	Date of Completion	DHCS Comments	DHCS 2nd Comments
6.5 Fraud And Abuse (page CAF – 37*)*: The Plan's Policy 14.04-P, *Prevention, Detection, and Reporting of Fraud, Waste, or Abuse* indicates that the Audit and Investigation/Compliance (AIS/C) Department is responsible for developing and implementing an anti-fraud plan (the "Anti-Fraud Plan"). Plan staff is required to report all suspected cases of fraud and abuse relating to the rendering of covered services to the AIS/C Department promptly upon identification. However, the policy failed to include procedures for reporting all suspected Fraud and Abuse cases to DHCS within 10 working days of the date the Contractor first becomes aware of, or is on notice of, such activity as required by the Contract. (Contract reference: Exhibit E, Attachment 2.26.B)	**Provider Relations** **Director of Provider Relations**			

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The Plan's Policy14.04-P, *Prevention, Detection, and Reporting of Fraud, Waste, or Abuse* also failed to include procedures for tracking Suspended Providers. (Contract reference: Exhibit E, Attachment 2.26.B) The Member Handbook and Member Newsletters inform Members to contact Kern Family Health's Compliance Department for any awareness of suspected fraud or abuse. The Plan's website informs Providers that suspected cases of health care fraud and abuse by Providers or Members should be reported to the Plan's Compliance Department at 1(800) 391-2000. The Plan provides training to all staff and takes steps to deter and detect potential fraud and abuse perpetuated by employees through an anonymous employee hotline and a Code of				

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Conduct. **DHCS Recommendations:** Ensure and update Policy 14.04-P, Prevention, Detection, and Reporting of Fraud, Waste, or Abuse, that the results of the preliminary investigation of a suspected fraud case be reported to Department of Health Care Services within the required time frame of 10 working days. Update Policy 14.04-P, Prevention, Detection, and Reporting of Fraud, Waste, or Abuse, to include procedures for tracking Suspended Providers.	Policy 14.04-P, *Prevention, Detection, and Reporting of Fraud, Waste, or Abuse*, was updated to include contractual language that the results of the preliminary investigation of a suspected fraud case be reported to Department of Health Care Services within the required time frame of 10 working days. Policy 14.04-P, *Prevention, Detection, and Reporting of Fraud, Waste, or Abuse*, was updated with contractual language to include procedures for tracking Suspended Providers. **Please see attachment R:** ***14.04-P, Prevention, Detection, and Reporting of Fraud, Waste, or Abuse*** **Responsibility:** **AIS Compliance** **Director of Compliance & Regulatory Affairs**	3/3/2014	The MCP has updated its P&P, Policy 14.04-P, Prevention, Detection, and Reporting of Fraud, Waste, or Abuse. This item is closed.	

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Submitted by: _____ **Date:** _____

Title: _____