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

Kern Family Health Plan
KHS Group Health Plan

Contract Number: 03-76165

Audit Period: July 1, 2012
Through
June 30, 2013

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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 14087.54, which empowers a county to establish an organized health care system, administered by a special commission, to effectively deliver publicly assisted medical care in the county, while promoting quality of care and cost efficiency.

Kern Health Systems was established in 1993, and started operating as County Health Authority structure in January of 1995. Kern Health Systems received a Knox-Keene license May 2, 1996. Kern Family Health Care began operation July 1, 1996. On July 1, 2005, operations of the Healthy Families Program in Kern County were assigned to the KHS Group Health Plan. Kern Health Systems administers the Healthy Families Program under a management service contract with the KHS Group Health Plan. The Board of Directors of Kern Health Systems is appointed by the County Board of Supervisors based on positions designated by the Board. Kern Health Systems is dedicated to improving the health status of their members through an integrated managed health care delivery system.

KHS serves all of Kern County with the exception of Ridgecrest. Health care services are provided through contracts and subcontracts with independent medical groups and individual physicians. Health care services not provided directly by primary care physicians are arranged through contracts with other medical groups/physicians, allied health service suppliers, and hospitals.

As of August 2013, Kern Health System's enrollment for Medi-Cal and Healthy Families was approximately 142,317 Members. Enrollment by product line was as follows:

- Medi-Cal Members: 132,421
- Healthy Families Members: 9,896

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period of July 1, 2012 through June 30, 2013. The onsite review was conducted from September 10, 2013 through September 20, 2013. The audit consisted of a documents review, verification studies, and interviews with Plan personnel.

The audit evaluated six categories of performance: Utilization Management, Continuity of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan does not have an active method to detect Under-Utilization of services nor are there measures to increase utilization when Under-Utilization is detected. The Plan's Medical Directors do not participate in Inter-rater Reliability testing to ensure consistency in applying and interpreting medical necessity guidelines; only the Utilization Management nurses participate.

A verification study of medical and pharmacy Prior Authorizations found that the reasons for decisions are not consistently clearly documented on the Notice of Action letters.

The Plan does not have a specific system to track all referrals, including open or unused referrals, as required by the Contract.

A verification study of the Prior Authorization Appeals process found that the Plan's Grievance Review Team minutes do not contain any details about the rationale behind the disposition of the appeal, nor do the appeal files themselves. In addition, the appeal files do not routinely contain the signature of the physician who reviewed the appeal, or participated in the discussion at the Grievance Review Team.

Category 2 – Case Management and Coordination of Care

In this Category, the verification study includes a review of medical records from a selection of the Plan's provider locations. The findings indicated the following:

- Lack of documentation for coordination of care between PCPs (Primary Care Physicians) and specialists for California Children's Services (CCS) and Early Intervention/Developmental Disabilities (EI/DD) Members.
- Lack of documentation for the completion of Initial Health Assessments (IHA) in the medical records.

Category 3 – Availability and Accessibility of Care

- The Plan's policies do not indicate that misdirected Emergency Services and Family Planning claims received by the Plan will be re-directed to the appropriate payer of service within ten working days.
- A verification study of Emergency Services claims found that the Plan is not monitoring procedures to ensure that the Emergency Services claims are processed in a timely manner.
- The Plan needs to continue monitoring procedures to ensure that drugs prescribed in emergency circumstances are provided to or received by Members.

Category 4 – Member's Rights

The grievance verification study revealed several cases where the grievance was closed without a complete investigation of the complaint. In addition, the Quality of Care grievances did not document physician review of the case; including a discussion by the physician of the resolution of the case.

The Plan's policies do not indicate that notification of potential security breaches be submitted to the Department of Health Care Services (DHCS) Information Security Officer as required by the Contract; and that such notifications be submitted to required DHCS personnel within the required time frame, as mandated by the Contract.

Category 5 – Quality Management

The Plan's Quality Improvement Department did not demonstrate its ability to consistently identify gaps in the quality of care delivered to Members, act upon those identified gaps, and address needed improvements in quality of care.

The Plan does not have ongoing procedures to ensure that all Providers are in good standing in the Medicare and Medicaid/Medi-Cal programs as required by the Contract.

The Plan does not perform adequate and routine oversight 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.

The verification studies of medical records from the Plan's provider locations indicate that providers did not maintain complete and accurate medical records for all Members. In a separate verification study of Informed Consent (IC) documentation, the findings include improper completion of consent forms.

Category 6 – Administrative and Organizational Capacity

The Plan did not report a change in the status of the Medical Director to the Department of Health Care Services within ten (10) calendar days as required by Contract.

The Plan does not follow their own policies to ensure that new provider training is received

by all new providers as required by Contract.

The Plan’s policies do not indicate that preliminary investigation of fraud and abuse by the Plan or its subcontractors is reported to the Department of Health Care Services (DHCS) within the required time frame of 10 working days. In addition, the Plan’s policies do not ensure the procedures to track Suspended Providers. Furthermore, the Plan did not report a potential fraud and abuse case to DHCS within the required time frame.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch to ascertain that the medical services provided to Plan Members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Two-Plan Contract.

PROCEDURE

The onsite audit of Kern Family Health Plan (Kern Family) was conducted from September 10 through September 20, 2013. The audit included a review of the Plan's contract with the DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following reviews and Verification Studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 30 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness review, and communication of results to Members and Providers.

Appeals Process: The two Provider appeals for the audit period were reviewed for appropriate and timely adjudication. Upon review of 75 Member grievances from the grievance log for the audit period, 35 were found to be Member appeals. These appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

CCS Members: 15 of 15 records requested were received and reviewed to determine if coordination of care occurs between the Plan and the CCS providers.

EI/DD Services: 15 of 15 records requested were received and reviewed to determine if coordination of care occurs between the Plan and the Regional Center.

IHA: 91 of 91 records requested were received and reviewed to determine if IHAs were provided within the contractual time frame.

Category 3 – Availability and Accessibility of Care

Emergency Service Claims: 19 of the 19 emergency service claims requested were received and reviewed for appropriate and timely adjudication.

Family Planning Claims: 20 of the 20 family planning claims requested were received and reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 75 grievances requested were received and reviewed. 35 grievance/appeal and 40 grievance files were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

Medical Records: 91 medical records requested were received and reviewed for compliance with contract requirements.

Informed Consent: 28 of the 28 paid claims requested were received and reviewed for the completion of the Informed Consent form number PM 330.

Category 6 – Administrative and Organizational Capacity

New Provider Training: 15 of the 15 provider training records requested were received and reviewed for completion of new provider training within the required time frame.

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

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1 UTILIZATION MANAGEMENT PROGRAM

Utilization Management (UM) Program Requirements:
Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. …(as required by Contract)
2-Plan Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
2-Plan Contract A.5.2.C

Under- and Over-Utilization:
Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.
2-Plan Contract A.5.4

SUMMARY OF FINDINGS:

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, 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)

RECOMMENDATIONS:

- Identify, detect and monitor under-utilization of services and implement measures to correct under-utilization of services.
- Ensure that the Medical Directors participate in Inter-rater Reliability testing to ensure consistency in applying and interpreting medical necessity guidelines.

1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:
Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements…(as required by Contract)
2-Plan Contract A.5.2.A, B, D, F, H, and I.

Exceptions to Prior Authorization:
Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
2-Plan Contract A.5.2.G

Notification of Prior Authorization Denial, Deferral, or Modification:
Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.
2-Plan Contract A.13.8.A

SUMMARY OF FINDINGS:

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.

Review criteria are applied using national guidelines. Inter-rater Reliability Studies are used to ensure consistent application of utilization review criteria by the nurse case managers, but are not used by the Medical Directors (see the Recommendation for Section 1.1).

A total of fifty (50) prior authorizations, which includes thirty (30) medical and twenty (20) pharmacy prior authorizations, were received and reviewed for the Verification Study. All fifty prior authorizations reviewed were adjudicated timely. The prior authorization Notice of Action (NOA) letters were sent out on a timely basis. However, in many of the medical and pharmacy NOA letters reviewed for the Verification Study, the following was noted:

- 9 of 30 NOA letters for medical prior authorizations failed to cite the specific criteria utilized as the basis for the denial, and rather cited only, “Medical Director Review”. Occasional letters also employed medical terminology, which made the denial reason ambiguous. (Contract reference: Exhibit A, Attachment 5, 2.D; Health and Safety Code 1367.01 h4; and CCR, Title 22, section 53894) **This is a repeat finding from the 2006 DHCS audit.**
- 1 of 30 NOA letters for medical prior authorizations contained a typographical error which caused the denial letter to read as if the denied service was medically necessary.
- 30 of 30 NOA letters, for both medical and pharmacy prior authorizations, written in Spanish were incompletely translated. The body of the letter was written in Spanish, but the specific reason for the denial was in English. Additionally, 5 of 20 pharmacy NOA letters contained only English versions of the Your Rights Under Medi-Cal Managed Care and Form to File a State Hearing inserts, rather than both English and Spanish versions (accompanied letters written in both English and Spanish) (Contract reference: Exhibit A, Attachment 5, 2.D; Health and Safety Code 1367.01 h4; and CCR, Title 22, section 53894)
- 5 of 20 Pharmacy NOA letters referred Members to the wrong page in the Member Handbook for an explanation of pharmacy benefits.

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.
- 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.
- 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

Referral Tracking System:
Contractor is responsible to ensure that the UM program includes: … An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers.

Contractor shall ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures.

2-Plan Contract A.5.1.F

SUMMARY OF FINDINGS:

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.

In an interview with Plan personnel it was stated that the Plan does not track open or unused referrals. It appears that only the timeliness of processing of referrals is being tracked, along with the tracking of referrals via paid claims. In past audit periods, the UM department would send a list of open authorizations to each primary care provider on a quarterly basis. However, per the interview with UM staff, the Plan is not currently performing this function. The Primary Care Physician (PCP) is responsible for tracking the referral and follow-up care to the Member, per the Plan. The Quality Improvement Department reviews the PCP follow-up during the Facility Site Review.

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)

1.4 PRIOR AUTHORIZATION APPEAL PROCESS

Appeal Procedures:
There shall be a well-publicized appeals procedure for both providers and patients.
2-Plan Contract A.5.2.E

Grievance System Oversight:

Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance and is a health care professional with clinical expertise in treating a Member's condition or disease if any of the following apply:

1) A denial based on lack of medical necessity;
2) A grievance regarding denial of expedited resolutions of an appeal;
3) Any grievance or appeal involving clinical issues.

2-Plan Contract A.14.2.G

SUMMARY OF FINDINGS:

Appeals are handled as part of the Grievance system. The Provider Manual, which is sent by CD to all 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. Review of 75 Member grievances revealed 35 Member initiated appeals 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 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)

Appeals Verification Study:

Thirty Five (35) Member initiated appeals were reviewed; all appeals processed timely; numerous appeals without specific physician signature and no appeals with documentation of any discussion surrounding the disposition of the appeal. For one of 35 appeals reviewed, it was noted that the original denied prior authorization was reviewed by the same physician who reviewed the subsequent appeal, in violation of the Contract (Contract reference: Attachment 14, 2 G).

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 authorization.
- Ensure that attendance logs for the Grievance Review Team are maintained.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.2 CALIFORNIA CHILDREN'S SERVICES (CCS)

California Children's Services (CCS):
Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program….(as required by Contract)

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program…for the coordination of CCS services to Members.
2-Plan Contract A.11.9.A, B

SUMMARY OF FINDINGS:

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 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.

A total of fifteen (15) medical records for Kern Family Members with CCS-eligible conditions were requested and reviewed for this verification study. Medical Records for Kern Family Members with CCS-eligible conditions lacked documentation of:

- 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
- The compliance rate for the 15 medical records reviewed for the items described in the above bullets was 81%.

RECOMMENDATION:

Ensure that California Children's Services (CCS) eligible Members are monitored and tracked for coordination of care between Primary Care Providers (PCPs) and specialty providers occurs.

2.3 EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

Services for Persons with Developmental Disabilities:
Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers…for the coordination of services for Members with developmental disabilities.
2-Plan Contract A.11.10.A, C, E

Early Intervention Services:
Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program….Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.
2-Plan Contract A.11.11

SUMMARY OF FINDINGS:

The Plan has developed and 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 developmental disabilities. The Plan and Regional Center facilitate coordination of comprehensive services and medical care for the Regional Center and Early Start eligible Members.

A total of fifteen (15) medical records of Kern Family Members with EI/DD-eligible conditions were requested and reviewed for this Verification Study. Based on the review, it was found that Kern Family Health Plan was 79% compliant for care coordination documentation. Members are receiving appropriate services for their medical conditions. However, the medical records were lacking documentation of coordination of care between local programs and the Primary Care Provider (PCP).

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.

2.4 INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.
2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21
For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.
2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
   a) blood pressure,
   b) height and weight,
   c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
   d) clinical breast examination for women over 40,
   e) mammogram for women age 50 and over,
   f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
   g) chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
   h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
   i) health education behavioral risk assessment.

2-Plan Contract A.10.6

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.
2-Plan Contract A.10.3.D

<u>SUMMARY OF FINDINGS:</u>

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.

A total of ninety-one (91) medical records of Kern Family Members for the Initial Health Assessment (IHA) were collected and reviewed. Based on the review of the medical records, it was found that:

- Twenty-one (21) of 91 of the IHAs found in the medical records exceeded the required time frame for completion, making the total compliance rate for IHA completion 87%
- Four (4) of 91 medical records had insufficient documentation of an IHA (complete history and physical examination) to reflect a comprehensive office visit.

RECOMMENDATIONS:

- Develop a process to effectively monitor the completion rate of Initial Health Assessment (IHA) within the required time frame.
- Ensure that providers document the IHA requirements in the Members' medical records.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.5 EMERGENCY SERVICE PROVIDERS (CLAIMS)

Emergency Service Providers (Claims):
Contractor shall pay for emergency services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge….
2-Plan Contract A.8.13.C

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D).
2-Plan Contract A.8.13.E

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section…Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.

Contractor shall pay 90% of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.

2-Plan Contract A.8.5

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.
2-Plan Contract A.9.7.A

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).
CCR, Title 28, Section 1300.71(g)

Claim Filing Deadline: (iii)….The plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan shall forward the claim to the appropriate capitated provider.
CCR, Title 28, Section 1300.71(b)(B)

SUMMARY OF FINDINGS:

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 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 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 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.

In the verification study, nineteen (19) Emergency Services claims were reviewed. Based on the review, all 19 claims had the date of receipt stamp on the claims and were paid appropriately. There were no denials of service for Medical Necessity. Thirteen (13) out of 19 claims were paid within the required time frame; six (6) paid claims exceeded the 30-day time frame. (Contract reference: Exhibit A, Attachment 8.5)

RECOMMENDATIONS:

- 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.
- Ensure that the Emergency Services claims are processed within the time frame.

3.6 FAMILY PLANNING (PAYMENTS)`

Family Planning: (Payment):
Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate….(as required by Contract)
2-Plan Contract A.8.9

Claims Processing—

Contractor shall pay all claims submitted by contracting providers in accordance with this section…Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36. B.

Contractor shall pay 90% of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.

2-Plan Contract A.8.5

Claim Filing Deadline: (iii)….The plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan shall forward the claim to the appropriate capitated provider.
CCR, Title 28, Section 1300.71(b)(B)

SUMMARY OF FINDINGS:

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 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 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. 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.

A verification study was conducted; twenty (20) Family Planning claims were reviewed. All 20 claims had the date of receipt stamp on the claims and the claims were paid appropriately and within the required time frame. There were no denials of service based on medically necessity.

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.

3.7 ACCESS TO PHARMACEUTICAL SERVICES

Pharmaceutical Services and Prescribed Drugs:
Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.
2-Plan Contract A.10.8.G.1

SUMMARY OF FINDINGS:

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.

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 services. Policies and procedures for pharmaceutical services and prescription drugs comply with contract requirements and applicable laws and regulations.

Of the 10 contracted hospitals with emergency room facilities, none had 24-hour pharmacies nearby. This information was cited by the Plan during the interview when asked to provide the name of all contracted hospitals.

Based on the interview with the Plan personnel, compliance with the emergency drug provision requirement is also monitored through claims and Member grievances and any issues are discussed at quarterly P&T Committee meetings. Plan personnel confirmed that there were no grievance cases related to emergency drug provision during the audit period.

On the 2012 Member Satisfaction Survey, 52.9 percent of Members who answered question #40 reported that they did not receive the medication they needed to start the treatment.

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's personnel stated that they initiated monitoring procedures during the audit period for the dispensing of emergency medications.

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.

RECOMMENDATION:

Continue monitoring procedures to ensure the provision of prescribed drugs in emergency circumstances.

CATEGORY 4 – MEMBER'S RIGHTS

4.1 GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan Contract A.14.1

Contractor shall implement and maintain procedures…to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858….(as required by Contract)….

D. Procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues. To this end, Contractor shall ensure that any grievance involving the appeal of a denial based on lack of Medical Necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues shall be resolved by a health care professional with appropriate clinical expertise in treating the Member's condition or disease.
E. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Contractor's medical director.

2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
2-Plan Contract A.14.3.A

SUMMARY OF FINDINGS:

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 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.

Based on the interview with Plan personnel, the Grievance Review Team meets weekly and reviews all grievances received during the week, as well as all open grievances. All decisions are documented in the grievance files and kept by the Grievance Coordinator. 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 decision are provided.

In a Verification Study, seventy-five (75) grievance/appeal files were selected for review (35 appeals, 40 grievances).

- 5 Quality of Care Grievances: 2 in favor of Plan, 3 in favor of Member
- 35 Quality of Service Grievances: 16 in favor of Plan, 19 in favor of Member

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).

RECOMMENDATIONS:

- 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.

4.3 CONFIDENTIALITY RIGHTS

Members' Right to Confidentiality
Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

2-Plan Contract A.13.1.B

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:
Contractor agrees:

B. Safeguards—To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Contract…..

H. Notification of Breach—During the term of this Agreement:

1). Discovery of Breach. To notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract. Notification shall be provided to the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer…

2). Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer…

I. Notice of Privacy Practices. To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit…

2-Plan Contract G.3.B, H, and I

SUMMARY OF FINDINGS:

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 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 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.

Seven (7) HIPAA cases were received for the audit period. Based on a review of four (4) of the 7 cases, the Initial Notification of Breach was only sent to the DHCS Privacy Officer and the DHCS MMCD Contract Manager, but it was not submitted to the DHCS Information Security Officer as required by the Contract. In addition, this breach notification for one (1) of the 4 HIPAA cases was not submitted within the required 24-hour time frame. The other three (3) HIPAA cases were related to emails with PHI for inbound data transfers. Notification to DHCS was not necessary due to the Plan monitoring all data transfers of PHI data by its monitored electronic system by technical personnel at all times.

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, 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.

CATEGORY 5 – QUALITY MANAGEMENT

5.1 QUALITY IMPROVEMENT SYSTEM

General Requirements:
Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall 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. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.
2-Plan Contract A.4.1

SUMMARY OF FINDINGS:

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, 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 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.

During onsite interview with the Plan personnel, it was apparent that the Plan was unaware of the low numbers and did not provide a strategy to address needed improvements. Furthermore, there was no apparent outreach and education with regards to fluoride varnish, despite the Plan's own policy outlining such steps. Overall there appears to be a lack of continuous QI as it relates to such services as the fluoride varnish program and appointment availability. The Plan demonstrated its ability to identify gaps in the quality of care, but not its ability to take effective action and improve upon those gaps.

RECOMMENDATION:

Develop a mechanism by which the quality improvement department is able not only to identify gaps in the quality of care delivered to Members, but to act upon those identified gaps and to address needed improvements in quality of care.

5.2 PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:
Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.
Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
2-Plan Contract A.4.12

Provider Participation:
All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered….Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
2-Plan Contract A.4.12.A

Delegated Credentialing:
Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities…
2-Plan Contract A.4.12.B

Disciplinary Actions:
Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.
2-Plan Contract A.4.12.D

SUMMARY OF FINDINGS:

The Plan's Policy 4.01-P, *Credentialing*, outlines the credentialing process to ensure that providers are appropriately qualified to provide services to its 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 .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.

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.

5.4 DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

Delegation of Quality Improvement Activities:

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum:
   1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
   2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
   3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
   4) Contractor's actions/remedies if subcontractor's obligations are not met.

B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:
   1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
   2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
   3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

2-Plan Contract A.4.6

SUMMARY OF FINDINGS:

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 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).

RECOMMENDATION:

Perform adequate and routine oversight 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.

5.5 MEDICAL RECORDS

Medical Records

A. General Requirement
Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861 and MMCD Policy Letter 02-02.

B. Medical Records
Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:
1) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.
2) To ensure that medical records are protected and confidential in accordance with all Federal and State law.
3) For the release of information and obtaining consent for treatment.
4) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

C. On-Site Medical Records
Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

D. Member Medical Record
Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes:
1) Member identification on each page; personal/biographical data in the record.
2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
3) All entries dated and author identified; for Member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
4) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.
5) Allergies and adverse reactions are prominently noted in the record.
6) All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.
7) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.
8) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
9) For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.
10) Health education behavioral assessment and referrals to health education services.

2-Plan Contract A.4.13.A, B, C, D

SUMMARY OF FINDINGS:

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 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.

In a Verification Study, a total of ninety-one (91) Members' medical records were requested and reviewed according to the Contract requirements for documentation of medical services and coordination of care. The overall compliance rate for the 91 collected medical records was 87%. There were instances when the medical records did not contain a complete record of immunizations and health maintenance or preventive services rendered.

RECOMMENDATIONS:

- Ensure that a complete medical record is maintained for each Member.
- Ensure that the monitoring system of record keeping is maintained.

5.6 INFORMED CONSENT

Informed Consent
Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes: …All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.
2-Plan Contract A.4.13.D.6

Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3.
2-Plan Contract A.9.9.A.1

SUMMARY OF FINDINGS:

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 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 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.

A total of twenty-eight (28) sterilization claims and the corresponding medical records obtained from Provider offices were requested and reviewed for compliance with standards for this Verification Study; the findings are as follows:

- Two (2) of 28 paid claims lacked the Informed Consent form PM 330
- Three (3) of 28 paid claims did not meet the requirements for sterilization consent documentation.

Thus, based on the verification study the overall compliance rate for complete sterilization service documentation is 93%.

RECOMMENDATIONS:

- Educate Providers and the claims department on the proper completion of the PM 330.
- 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.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.1 MEDICAL DIRECTOR

Medical Director:
Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:

A. Ensuring that medical decisions are:
   1) Rendered by qualified medical personnel.
   2) Are not influenced by fiscal or administrative management considerations.
B. Ensuring that the medical care provided meets the standards for acceptable medical care.
C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
D. Developing and implementing medical policy.
E. Resolving grievances related to medical quality of care.
F. Direct involvement in the implementation of Quality Improvement activities.
G. Actively participating in the functioning of the plan grievance procedures.

2-Plan Contract A.1.6

Medical Director Changes:
Contractor shall report to DHCS any changes in the status of the medical director within ten (10) calendar days.
2-Plan Contract A.1.7

SUMMARY OF FINDINGS:

The Plan maintains a full time Chief Medical Officer (CMO) as required by the Contract and California Code of Regulations, Title 22, section 53857. The CMO reports directly to the Chief Executive Officer (CEO) and the KHS Board of Directors. As Chairperson of the QI/UMC and its subcommittees, the CMO provides direction for internal and external QI Program function, and supervision of the KHS staff.

At the time of the audit, the CMO position was vacant; the responsibilities of the CMO were assumed by the Medical Director and Associate Medical Director. However, the Plan failed to report the change in status of the Medical Director with ten (10) calendar days to the Department of Health Care Services. (Contract reference: Exhibit A, Attachment 1.7)

RECOMMENDATION:

Report to Department of Health Care Services any changes in the status of the Medical Director within ten (10) calendar days.

6.4 PROVIDER TRAINING

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status.
2-Plan Contract A.7.*5*

SUMMARY OF FINDINGS:

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.

Plan personnel confirmed that the Plan submits a welcome letter and training materials to new Providers within (10) working days; the new provider packet provides instructions for the provider to create a username and password to access the training materials.

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, 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.

Fifteen (15) new Providers were selected for review. Two (2) of the 15 new Providers sampled did not receive the training within ten (10) working days of being placed on active status. (Contract reference: Exhibit A, Attachment 7.5.A)

RECOMMENDATION:

Ensure that all new Providers receive training within 10 working days after the Plan places a newly contracted Provider on active status.

6.5 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….

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….

2-Plan Contract E.2.26.B

SUMMARY OF FINDINGS:

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)

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 Conduct.

Eleven Fraud and Abuse cases from the audit period were submitted by the Plan for review. Based on the review, the Plan failed to report four suspected fraud and abuse cases to DHCS within the time frame of ten (10) working days to comply with the contractual requirements. (Contract reference: Exhibit E, Attachment 2.26.B.4)

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.