

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

REPORT ON THE MEDICAL AUDIT OF

KERN HEALTH SYSTEMS
dba
KERN FAMILY HEALTH CARE
2021

Contract Number: 03-76165

Audit Period: August 1, 2019
Through
July 31, 2021

Report Issued: February 7, 2022

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I. INTRODUCTION

Kern Health Systems dba Kern Family Health Care (Plan) was established in 1993 as a local initiative and operated through a Two-Plan Medi-Cal Managed Care Health Plan Model. The Plan began operating as a County Health Authority structure in January 1995. The Plan is a public agency, established by the Kern County Board of Supervisors. The Board of Supervisors appoints a Board of Directors who serve as the governing body.

In May 2, 1996, the Plan obtained its Knox-Keene license from the California Department of Managed Health Care. The Plan serves all of Kern County with the exception of Ridgecrest.

The Plan's provider network consists of approximately 440 primary care providers, 1,008 specialists, 621 behavioral health providers, 148 pharmacies, and 208 other service providers. The Plan contracts with 21 hospitals consisting of 11 acute care, eight tertiary, and two inpatient rehabilitation facilities.

Medi-Cal is the Plan's only line of business. As of July 31, 2021, the Plan served approximately 290,980 members.

II. EXECUTIVE SUMMARY

This report presents the results of the Department of Health Care Services (DHCS) medical audit for the audit period August 1, 2019 through July 31, 2021. The audit was conducted from September 13, 2021 through September 24, 2021. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on January 10, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in this report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

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

The prior DHCS medical audit issued on November 14, 2019 (audit period August 1, 2018 through July 31, 2019) identified deficiencies which were addressed in a Corrective Action Plan (CAP) close-out letter, dated May 15, 2020. This year's audit included review of documents to determine implementation and the effectiveness of the Plan's CAP.

The summary of the findings is as follows:

Category 1 – Utilization Management

In the prior year audit, the Plan's Notice of Action (NOA) letters sent to members did not include clear and accurate clinical reasons for pre-authorization decisions. The Plan did not have a system to monitor and ensure accurate NOA letters were generated. In response to the CAP, the Plan updated its policies and procedures to include additional monitoring activities for denial letters to ensure appropriate language is used. The Plan also updated its templates used to audit treatment requests. Review of Plan's response to the CAP yielded no findings.

The Plan is required to develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. The Plan did not ensure appropriate processes were used to review and approve the provision of medically necessary covered services. The Plan did not ensure that medical procedures approved were medically necessary.

The Plan is required to include within the UM program mechanisms to detect both under- and over-utilization of health care services. The Plan did not have systematic methods including policies and procedures for detecting under- and over-utilization of health care services.

The Plan is required to ensure member information is provided to members at a sixth grade reading level, or as determined appropriate through the Plan's group needs assessment, and approved by DHCS. The Plan did not have policies and procedures to ensure member information is provided to members at a sixth grade reading level.

The Plan is required to ensure that 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. The Plan did not consistently apply Medi-Cal criteria when processing prior authorization requests. In some cases, the Plan prioritized Milliman Criteria Guideline (MCG) instead of Medi-Cal criteria.

Category 2 – Case Management and Coordination of Care

In the prior year audit, The Plan did not have written procedures to monitor Initial Health Assessment (IHA) completion. An IHA is not complete without the inclusion of a Staying Healthy Assessment (SHA). The Plan did not ensure the SHA was included within the member's medical record. In response to the CAP, the Plan updated its policy to reflect a new process for member education and monitoring. This policy involves monitoring the IHA and SHA completion through monthly report reconciliation with claims data. This year's audit found the Plan did not ensure completion of comprehensive IHAs, to include documentation of comprehensive history, SHA, and colorectal, cervical, and blood lead screens. The Plan did not adhere to its policies and procedures and did not monitor the completion of IHAs.

In the prior year audit, the Plan did not have a system to monitor and ensure member notification letters include all the required Continuity of Care (COC) transition information. In response to the CAP, the Plan updated its policies and procedures to include periodic audits to review COC NOA letters. The Plan re-educated UM staff on selection of appropriate COC decisions within their medical management platform. Notice of COC approval letters were updated to instruct members that the Plan will help members choose a new provider 30 days prior to the end of the COC approval. Review of Plan's response to the CAP yielded no findings.

Category 3 – Access and Availability of Care

The Plan is required to ensure all network providers are enrolled in the Medi-Cal program. The Plan may allow providers to participate in their network for up to 120 days, pending the outcome of the enrollment screening process. The Plan did not ensure Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) providers were enrolled in the Medi-Cal program. The Plan did not monitor pending enrollment of transportation providers into the Medi-Cal program.

Category 4 – Member’s Rights

In the prior year audit, The Plan did not effectively implement procedures to ensure grievances related to medical Quality of Care (QOC) issues were referred to the Plan’s Medical Director. Exempt grievances involving medical QOC issues were resolved without the review of a Medical Director. In response to the CAP, the Plan updated policies and procedures to prevent potential QOC grievances from being categorized as exempt grievances. This year’s audit found the following:

The Plan is required to implement and maintain procedures to ensure that every grievance submitted is reported at an appropriate level. Grievances related to medical QOC issues shall be referred to the Plan’s Medical Director. The Plan did not ensure grievances were accurately classified as QOC and misclassified them as exempt grievances. Consequently, these grievances were not referred, investigated, and reviewed by a Medical Director as required.

The Plan is required to ensure the immediate submittal of all medical QOC grievances to the Medical Director for action. In addition, the Plan’s written resolution shall contain a clear and concise explanation of the Plan’s decision. The Plan did not ensure that all QOC grievances were resolved by a Medical Director and that members received a clear and concise explanation of the Plan’s decision. The Plan did not adhere to their policy and procedure.

The Plan is required to classify and process expressions of dissatisfaction as grievances. Grievance means an oral or written expression of dissatisfaction about any matter. The Plan did not properly classify members’ expressions of dissatisfaction as grievances. The Plan did not adhere to the Contract and its own policy.

Category 5 – Quality Management

The Plan is required to implement an effective Quality Improvement System (QIS) to monitor, evaluate, and take effective action to address needed improvements in the QOC delivered by its providers. The Plan did not monitor, evaluate, identify, and take effective action to address needed improvements in QOC delivered by providers. The Plan did not ensure that a QOC problems are identified and corrected for all provider entities. The Plan did not properly investigate and ensure corrective action of potential inappropriate care issues before closure.

In the prior year audit, the Plan did not have procedures to ensure training presented to newly contracted providers included information on member’s rights. The Plan updated its provider orientation tool to include information on member’s rights. Review of Plan’s response to the CAP yielded no findings.

Category 6 – Administrative and Organizational Capacity

The Plan is required to provide prompt notification to DHCS when it receives information about a change in a network provider's circumstances that may affect the provider's eligibility to participate in the Medi-Cal Managed Care Program (MCP), including the termination of their provider agreement. The Plan did not notify DHCS of changes in network provider's circumstances that affect the provider's eligibility to participate in the Medi-Cal MCP, including the termination of their provider agreement with the Plan.

The Plan is required to verify whether services that have been represented to have been delivered by network providers were received by members. The Plan did not have policies and procedures to verify the services that have been represented to have been delivered were received by members.

The Plan is required to notify the Medi-Cal MCP/Program Integrity Unit within ten working days of removing a suspended, excluded, or terminated provider from its provider network, and confirm that the provider is no longer receiving payments in connection with the Medicaid program. The Plan did not adhere to its policy to ensure notification to the Medi-Cal MCP/Program Integrity Unit within ten working days of removing a suspended, excluded, or terminated provider from its provider network.

The Plan is required to 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 within ten working days of the date when the contractor first becomes aware of or is on notice of such activity. The Plan did not report all cases of suspected fraud and/or abuse and forward results of investigations to the DHCS within ten working days of initial awareness of suspected fraud and/or abuse activity.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS-Medical Review Branch conducted this audit to ascertain medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the Two-Plan Contract.

PROCEDURE

The audit was conducted from September 13, 2021 through September 24, 2021, covering the audit period August 1, 2019 through July 31, 2021. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine policies were implemented and effective. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 40 medical and 24 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Prior Authorization Appeal Process: 20 medical and 20 pharmacy prior authorization appeal requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

IHA: 15 adult medical records and 13 pediatric medical records were reviewed to confirm timely and proper completion of IHAs.

COC: Ten member files were reviewed to confirm members received COC and fulfillment of requirements.

Category 3 – Access and Availability of Care

Emergency Service and Family Planning Claims: 30 emergency service claims and ten family planning claims were reviewed for appropriate and timely adjudication.

NEMT/NMT: 15 NEMT and 15 NMT records were reviewed for compliance.

NEMT/NMT: 17 Contracted NEMT/NMT providers' records were reviewed for Medi-Cal enrollment.

Category 4 – Member’s Rights

Grievance Procedures: 20 quality of service, 19 QOC, and 45 exempt grievances cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review. 20 member calls from inquiry logs were reviewed for appropriate classification and processing.

Category 5 – Quality Management

QIS: Five Potential Quality Issues were reviewed for evaluation and effective action.

Provider Qualifications: 15 new provider training records were reviewed for timeliness.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: 12 cases were reviewed for proper reporting of suspected fraud, waste, or abuse to DHCS within the required time frame.

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

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.1

**UTILIZATION MANAGEMENT PROGRAM
REFERRAL TRACKING SYSTEM / DELEGATION OF UM
MEDICAL DIRECTOR AND MEDICAL DECISIONS**

1.1.1 Approval of Medically Necessary Covered Services

The Plan shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. (*Contract, Exhibit A, Attachment 5(1)*).

Plan policy *3.22-P Referral and Authorization Process* (revised 12/13/2018) stated that contracted providers are required to obtain prior authorization, unless special circumstances require use of a non-contracted provider, pre-arranged by the Plan or determined by the Plan to be emergent or urgent in nature. Furthermore, it stated that the referral and authorization process would conform to statutory, regulatory, and contractual requirements. Additionally, it stated that a prior authorization request submitted must include pertinent medical records and member data, which support the referral.

The Plan's 2020 UM Program stated that most non-urgent specialty care must be pre-authorized by the Plan in accordance with Plan referral policy and procedure.

Finding: The Plan did not ensure appropriate processes were used to review and approve the provision of medically necessary covered services. The Plan did not ensure that medical procedures approved were medically necessary.

During interviews, the Plan stated that during the audit period it implemented a Direct Approval Pilot program that allowed for authorization of certain requests without review if there was a 90 percent or higher approval rate in regular clinical reviews. The pilot began on February 22, 2021. Examples of services on the auto-approval list included but not limited to: imaging studies (cat scans, magnetic resonance imaging) of various body parts, surgical procedures, and other scans to detect cancer such as bone and gallium scans.

In a written statement, the Plan stated the pilot began as a week- long temporary remedy to address the volume of outpatient authorizations. There were concerns about both member and physician requests being addressed within the state-required timeframes. The pilot was then extended for a duration of 90 days. Hyaluronan, an

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injection that is used for pain associated with osteoarthritis of the knee, was included despite the majority of prior authorizations being denied when reviewed by medical directors. The Plan admitted this was an oversight and should not have been included. The pilot was stopped on September 19, 2021 by the Plan's UM Nurse Director. The Plan stated that they will be evaluating the results of the pilot to determine if it was successful and whether it should be put into policy and practice.

The Plan also started a Cite Automatic Authorization trial tool that allowed one particular oncology group to go online and view the same criteria as the UM staff. The provider was able to select symptoms and the selection was approved if it met MCG criteria. The Plan stated it intends to introduce the tool to other providers but admitted that it has yet to develop a system to monitor and verify medical records or confirm medical necessity as required by Medi-Cal criteria. The trial is still ongoing.

If appropriate processes are not in place to approve health care services, this may lead to members receiving unnecessary procedures, which may introduce risk and lead to poor health outcomes as well as increased costs.

Recommendation: Revise and implement policies and procedures to ensure appropriate processes are used to review and approve the provision of medically necessary covered services.

1.1.2 Under and Over-Utilization of Health Care Services

The Plan shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. (*Contract, Exhibit A, Attachment 5 (4)*).

The Plan's 2020 UM Program stated that it monitored under and over-utilization of services through various aspects of the UM process. Through the referral authorization process, the UM Clinical Intake Coordinator/UM Nurse monitored under and over-utilization of services and intervened accordingly. Additionally, it stated that the UM department monitored under-utilization of health services through collaboration with the Quality Improvement Department. Over-utilization of services was monitored through several functions and reports were reviewed to analyze unfulfilled authorizations or gaps in care in care to determine interventions directed to ameliorate any identified adverse trends.

Finding: The Plan did not have systematic methods including policies and procedures for detecting under- and over-utilization of health care services.

In interviews, the Plan stated that they do not have systems in place to gather data and develop under and over-utilization reports. One Medical Director stated that he made his own notations of services requested in high volume or questionable in nature and

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maintained his own tracking list. If the cases went on a trend list, he would report them to the Director of UM and sometimes the Chief Medical Officer, or compliance department.

A review of UM, Quality Improvement (QI), and board meeting minutes demonstrated a lack of discussion in regards to under and over-utilization. Furthermore, the Plan did not submit any under and over-utilization reports to the auditor for review and it could not provide any policies that discussed under and over-utilization.

Monitoring of under and over-utilization of health care services is a top key component to any UM program. If utilization of services and procedures provided by a health plan are not monitored, this may lead to poor QOC and unnecessary costs.

Recommendation: Develop and implement comprehensive and systematic methods including policies and procedures for detecting under- and over-utilization of services throughout the Plan.

1.1.3 Written Member Letters

The Plan is required to ensure that all member information is provided to members at a sixth grade reading level or as determined appropriate through the Plan's group needs assessment and approved by DHCS. The member information shall ensure members' understanding of the health plan processes and ensure the member's ability to make informed health decisions. (*Contract, Exhibit A, Attachment 13(4)(C)*)

Finding: The Plan did not have policies and procedures to ensure member information is provided to members at a sixth grade reading level.

The Plan's letter processing desktop procedure stated, "All letters must be written at an elementary grade level (sixth grade). Write your letters as if you are speaking to your member." However, the Plan does not have a defined process to check readability level nor a monitoring system to ensure this criteria is met.

The Plan's member informing letters are written above the sixth grade reading level with confusing medical terminology and long complex sentence structure. For example, letters had undefined terms such as, magnetic resonance imaging, lumber spine, nerve biopsy, MCG Health LLC, etc. In the verification study, written member informing letters were not clear, concise and understandable. These letters were written at Flesch-Kindcaid 10th grade or higher readability demonstrated in:

- 32 Medical Notices of Adverse Benefit,
- 20 Pharmacy Notices of Adverse Benefit
- 20 Medical Notices of Appeals

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- 20 Pharmacy Notices of Appeals
- 19 QOC Grievance Resolution letters

If written information to members is not clear, concise and at a sixth grade reading level they will not understand the health plan processes and their ability to make informed health decisions.

Recommendation: Develop and implement policies and procedures to ensure all written materials are provided to members are clear, concise, and at a sixth grade reading level.

1.2.1 Written Criteria or Guidelines for Medical Prior Authorizations

The Plan shall ensure that the covered services and other services required in this Contract are provided to a member in an amount no less than what is offered to beneficiaries under Fee-For-Service. (*Contract, Exhibit A, Attachment 10(1)(A)*)

The Plan shall ensure that 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. (*Contract, Exhibit A, Attachment 5(2)(D)*)

Plan's UM 2020 Program *Description* stated the Plan utilizes nationally recognized evaluation criteria and standards in making decisions to approve, modify, defer, deny or terminate services. The Plan will also review and present internally generated and other outside criterions to the QI/UM Committee for direction in the development and/or adoption of specific criteria to be utilized by Plan staff. In addition, it stated that the Plan utilizes several approved sources to determine benefit coverage and to make decisions based on medical necessity. Further, it stated that medical directors have the direct responsibility for prior authorization review and medical necessity determinations based on application of evidence based medical criteria and Medi-Cal established guidelines.

Finding: The Plan did not consistently apply Medi-Cal criteria when processing prior authorization requests. In some cases, the Plan prioritized MCG instead of Medi-Cal criteria.

The verification study showed that two of 40 medical prior authorizations and one of 20 requests from the appeals files were determined using MCG criteria instead of Medi-Cal criteria. These cases showed the following:

- Two cases involved Hyaluronan injections, which are injections used for pain associated with osteoarthritis of the knee. The Plan used MCG criteria to make their determination and stated "there are currently no clinical benefits" as their

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reason for denial. However, if members meet Medi-Cal criteria, the manual does allow for approval of the medication.

- In another case, a cough stimulating device was denied based on MCG criteria instead of Medi-Cal criteria.

During the interview, the Plan stated that it used the MCG suite to determine medically necessary covered services. Nurses utilized MCG criteria for their decision-making and recommendations. If the Medical Directors felt it was necessary, they looked at other criteria such as Up-To-Date (an online evidence based clinical support resource) or conducted their own literature review.

If the Plan does not use Medi-Cal criteria first when making medical determinations, there is a risk that members will be inappropriately denied services, which could lead to poor health outcomes.

Recommendation: Develop and implement policies and procedures to ensure that all UM staff uses Medi-Cal criteria first to make medical authorization decisions. Criteria should be based on sound medical evidence, consistently applied, regularly reviewed, and updated.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT
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2.1.1 Comprehensive Initial Health Assessment (IHA) Completion

The Plan shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 California Code of Regulations (CCR) Section 53851. Plan shall ensure that the IHA includes an Individual Health Education Behavioral Assessment (IHEBA) using an age appropriate DHCS-approved assessment tool. Plan shall ensure that members' completed IHA and IHEBA tool are contained in the members' medical record and available during subsequent preventive health visits. *(Contract, Exhibit A, Attachment 10 (3)(A-C))*

The Plan shall ensure the latest edition of the Guide to *Clinical Preventive Services* is used to determine the provision of clinical preventive services to asymptomatic, healthy adult members [age 21 or older]. All preventive services identified as United States Preventive Services Task Force (USPSTF) "A" and "B" recommendations must be provided. *(Contract, Exhibit A, Attachment 10 (6)(B)(1))*

The Plan shall cover and ensure the provision of a blood lead screening test to members at ages one and two in accordance with Title 17, Division 1, Chapter 9, Articles 1 and 2, commencing with Section 37000. The Plan shall document and appropriately follow up on blood lead screening test results. *(Contract, Exhibit A, Attachment 10(5)(D))*

Plan policy 3.61-I, *Comprehensive Case Management and Coordination of Care* states "An IHA consists of a history, physical examination, and an IHEBA. Completed IHA and IHEBA tools are to be contained in the members' medical record. The Plan notifies members during the new member entry process to complete the IHA and the SHA within the required timeframe. Plan will monitor the IHA and SHA completion through monthly report reconciliation with claims data, and if not completed, outreach will be performed to promote gap closure."

Plan policy 3.05-P, *Preventative Medical Care (revised 04/26/2016)* states "Medi-Cal Managed Care Health Plans (MCPs) are contractually required to cover a wide range of preventive services and screenings in accordance with (USPSTF) grade "A" or "B" recommendations, as well as American Academy of Pediatrics/Bright Futures for members under the age of 21."

Plan policy 3.13-P, *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services and Targeted Case Management (revised 11/12/2020) Blood Lead Anticipatory Guidance and Screening Requirements* states "Federal law requires

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states to screen children enrolled in Medicaid for elevated blood lead levels as part of required prevention services offered through the EPSDT program. The Plan is contractually required to cover and ensure that network providers provide blood lead screening tests in accordance with the CCR.”

Finding: Plan did not ensure completion of comprehensive IHAs, to include documentation of comprehensive history, SHA, and colorectal, cervical, and blood lead screens. The Plan did not adhere to its policies and procedures and did not monitor the completion of IHAs.

A verification study of 15 adults and 13 pediatrics medical records reviewed revealed:

- Ten adult medical records did not have comprehensive IHAs. There was no documentation of preventive services required by the USPSTF “A” and “B” recommendations.
- Ten adult and seven pediatric medical records did not have IHEBA and/or SHA documentation.
- Three pediatric medical records did not include blood lead screening documentation.

During the audit period, the Plan utilizes claims data to identify members that need an IHA completion. During the interview, the Plan acknowledged there was no monitoring of its claim data as part of the system. The Plan also stated they had limited staff to monitor and ensure IHAs were properly completed. The Plan did not adhere to its policies and procedures to properly monitor the completion of IHA and SHA.

Failure to ensure complete and comprehensive IHAs may lead to missed or delayed medical service referrals, consequently leading to substandard medical care and member harm.

Recommendation: Implement policies and procedures to ensure completion of comprehensive IHAs. Develop a monitoring system including proper staffing to ensure these policies and procedures are implemented and effective.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8

NON-EMERGENCY MEDICAL TRANSPORTATION AND NON-MEDICAL TRANSPORTATION (NEMT/NMT)

3.8.1 NEMT/NMT Providers Medi-Cal Enrollment Status

The Plan shall implement an effective QIS in accordance with Title 28, CCR, Section 1300.70 and 42 CFR 438.330. The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the QOC delivered by all providers rendering services on its behalf, in any setting. The Plan shall be accountable for the quality of all covered services regardless of the number of contracting and subcontracting layers between the Plan and the provider. (Contract, Exhibit A, Attachment 4 (1))

Managed Care Organizations execute network provider agreements and must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of 120 day period without enrollment of the provider, and notify affected enrollees. (Code of Federal Regulations, Title 42, Section 438.602(b)(2))

The Plan's network providers must enroll in the Medi-Cal program. (APL 19-004, provider Credentialing/Re-credentialing and Screening/Enrollment, page 3). MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process. (APL 19-004, Provider Credentialing/Re-credentialing and Screening/Enrollment.

Plan policy *4.43-P, Medi-Cal Enrollment Policy* (revised 1/15/2020) requires that all Plan contracted providers enroll in the Medi-Cal program. Plan contracted providers have the option to enroll with the Medi-Cal program through the DHCS, Fee-For-Service, another MCP, or through Plan' Medi-Cal enrollment process. Ensuring provider's Medi-Cal enrollment process is the responsibility of the Plan's Provider Relations Department.

Finding: The Plan did not ensure NEMT/NMT providers were enrolled in the Medi-Cal program. The Plan did not monitor pending enrollment of transportation providers into the Medi-Cal program.

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The Plan contracts with transportation providers in the Medi-Cal program. However, there were multiple transportation providers rendering services that were not enrolled or pending enrollment in the Medi-Cal program. Although, the Plan may allow providers to participate in their network for up to 120 days, pending the outcome, review of 17 transportation providers showed six participated beyond the 120 days limit. The Plan did not adhere to its policy and did not monitor applications that were pending beyond 120 days or denied by Medi-Cal.

If transportation providers are not enrolled in the Medi-Cal program, there are risks that drivers and vehicles may not meet safety requirements, which can result in members receiving unsafe transportation.

Recommendation: Revise and implement policy and procedure to ensure all transportation providers are enrolled in the Medi-Cal program.

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CATEGORY 4 – MEMBER’S RIGHTS

4.1	GRIEVANCE SYSTEM
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4.1.1 Classification of Quality of Care Grievances as Exempt Grievances

The Plan is required to have procedures to ensure that every grievance submitted is reported to an appropriate level, i.e., QOC versus quality of service, and to ensure the participation of individuals with authority to require corrective action. Grievances related to medical QOC issues shall be referred to the Plan’s Medical Director. (Contract, Exhibit A, Attachment 14 (2)(C-D))

The Plan is required to ensure the immediate submittal of all medical QOC grievances to the Medical Director for action. (Title 22 CCR 53853(2))

Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day are exempt from the requirement to send a written acknowledgment and response. (All Plan Letter (APL) 17-006 Grievance and Appeal Requirements (III)(D))

Plan policy *5.01-I KHS Member Grievance Process* (revised 6/16/2020) defines an exempt grievance as grievances received over the telephone that are not potential QOC concerns, coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day. If such grievances meet the definition of “Exempt Grievance”, the grievance is then logged and periodically reviewed by the Plan. QOC grievances are defined as issues pertaining to the health care services of a member including, but not limited to any service involving professionally recognized standards of health care practices; whether appropriate health care services have been provided and whether the services have been provided in appropriate settings.

Finding: The Plan did not ensure grievances were accurately classified as QOC and misclassified them as exempt grievances. Consequently, these grievances were not referred, investigated, and reviewed by a Medical Director as required.

Member service representatives also utilize screening tools outlined in a document entitled *Grievance MSP Final* to identify grievances. However, the Plan still failed to identify QOC grievances.

A verification study of exempt grievances demonstrated 20 grievances that involved QOC issues were inaccurately classified as exempt. Examples of QOC grievances

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classified as exempt and closed without review included:

- Member reported dissatisfaction with a provider for being seen by different medical students at every appointment but would only get a real doctor if asked.
- Member went in to provider for sciatica (pinched nerve in the low back) and was prescribed medication. Despite still having pain, the provider continued the same treatment and never referred the member to see the specialist or for therapy.
- Member went in to provider due to leg hurting to point of not being able to ambulate. The provider responded it was all in member's head.

This improper categorization of QOC grievances as exempt grievances resulted in these grievances not being reviewed and resolved by the Plan's Medical Director. The Plan did not have a monitoring system to ensure QOC grievances inaccurately classified as exempt grievances were referred to a Medical Director for review.

When QOC grievances are not reviewed and resolved by a Plan Medical Director, substandard medical care by providers might not be identified and lead to potential member harm.

Recommendation: Revise and implement policies and procedures to ensure grievances are accurately classified, and that QOC grievances are reviewed by the Medical Director and properly resolved.

4.1.2 Quality of Care Grievance Process

The Plan shall have in place a 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 F and 42 CFR 438.402-422. Plan shall follow Grievance and Appeal requirements, and use of all notice templates included in APL 17-006. (Contract, Exhibit A, Attachment 14(1))

The Plan shall ensure the person making the final decision for the proposed resolution of Grievances and Appeals has clinical expertise in treating a member's condition or disease if deciding on any grievance or appeal involving clinical issues. (Contract, Exhibit A, Attachment 14(1)(D))

The Plan is required to ensure the immediate submittal of all medical QOC grievances to the Medical Director for action. (Title 22 CCR § 53858(2))

The Plan's written resolution shall contain a clear and concise explanation of the Plan's decision. (Title 28 CCR §1300.68 (a)(4))

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“Resolved” means that the grievance has reached a final conclusion with respect to the enrollee’s submitted grievance. (Title 28 CCR §1300.68 (d)(3))

Plan’s policy *5.01-I KHS Member Grievance Process* (revised 6/16/2020) states that all QOC grievances are reviewed by the Medical Director and the Grievance Coordinator addresses and submits a Notification of Grievance to the Medical Director. The Medical Director shall provide a complete and documented review of all grievances that may relate to QOC. The Medical Director response shall be completed upon final review of all potential QOC concerns. Once a grievance is identified as being a potential QOC concern, it is closed, with a resolution letter sent to the member informing them that their complaint was sent to the QI Department for further review and the results of the review will be kept confidential.

Finding: The Plan did not ensure that all QOC grievances were resolved by a Medical Director and that members received a clear and concise explanation of the Plan’s decision. The Plan did not adhere to their policy and procedure.

In a verifications study, 20 of 20 QOC grievances were not reviewed by a Medical Director and members did not receive a clear notice of a final resolution of their grievance. Resolution letters sent to members were signed by grievance coordinators and did not contain a clear and concise final conclusion with respect to the submitted grievance. Instead, the resolution letters contained a template response that the issue would be reviewed in QI and, due to confidentiality issues, the member would not get any correspondence about further actions.

Failure to follow all Contract and legal requirements applicable to QOC grievances leads to diminished Medical Director input and involvement in the grievance process. Substandard and poor quality of medical care by providers might be missed, not adequately investigated and addressed, and lead to medical harm of members.

Recommendation: Revise and implement policies and procedures to ensure that all QOC grievances are resolved by a Medical Director and that members receive a clear and concise explanation of the Plan’s decision.

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4.1.3 Classification of Grievances

The Plan shall have in place a 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 F.13, and 42 CFR 438.402-424. Contractor shall follow grievance and appeal requirements, and use all notice templates included in APL 17-006. (Contract, Exhibit A, Attachment 14 (1))

The Plan shall implement and maintain procedures for grievances and the expedited review of grievances required under 42 CFR 438.402, 406, and 408, Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858. Members may file a grievance with the Plan at any time to express dissatisfaction about any matter other than an action resulting in a NOA. (Contract, Exhibit A, Attachment 14 2 (A))

Grievance means an oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an appeal, and may include, but is not limited to: the QOC or services provided, interpersonal relationships with a provider or the Plan's employee, failure to respect a member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by the Plan to make an authorization decision. (Contract, Exhibit E, Attachment 1)

A complaint is the same as a grievance. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. (APL 17-006 (C)(2))

An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other MCP processes. (APL 17-006 (C)(3))

Plan policy *5.01-I KHS Member Grievance and Appeal System* (revised 6/16/2020), defines grievance as "A member's verbal or written expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the QOC or services provided aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the Plan, to make an authorization decision. A complaint is the same as a grievance. When Plan is unable to distinguish between a grievance and inquiry, it shall be considered a grievance."

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Finding: The Plan did not properly classify members' expressions of dissatisfaction as grievances. The Plan did not adhere to the Contract and its own policy.

Five inquiries from the verification study were not escalated and evaluated as grievances. Two inquiries were added retroactively to the grievance log, and the other three inquiries were not processed as grievances. The Plan acknowledged in interviews that not all members' expressions of dissatisfaction were classified as grievances. Members' expressions of dissatisfaction were not escalated to grievances due to staff being new to their work positions, lack of training, not fully understanding the grievance process, and failure to implement policy 5.01-l.

Failure to capture, classify, and process members' expressions of dissatisfaction as grievances can result in the failure to identify substandard and poor quality of medical care with attendant possibility of member harm.

Recommendation: Revise and implement policies and procedures to ensure all member expressions of dissatisfaction are properly classified as grievances.

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CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM
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5.1.1 Potential Inappropriate Care (PIC) Process

The Plan is required to implement an effective QIS in accordance with the standards in CCR, Title 28, section 1300.70 and 42 CFR 438.330. The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the QOC delivered by all providers of all covered services. (Contract Exhibit A, Attachment 4(1))

The Plan is required to continuously review the QOC provided. Each Plan’s quality program shall be designed to ensure that a level of care which meets professionally recognized standards of practice is being delivered to all enrollees; QOC problems are identified and corrected for all provider entities, and licensed professional participation in the QI activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. (Title 28 CCR section 1300.70 (b)(1)(A-B))

Plan policy *2.70-1 Potential Inappropriate Care Issues (PICs)* (revised 7/21/2020) defines PICs as the term DHCS has identified as Potential QOC Issues (PQIs). The PICs require investigation to determine if an actual quality issue or opportunity for improvement exists. For PICs with potential or actual harm, the Plan requires the providers to submit CAPs to ensure needed improvements were made to improve QOC provided to members.

Finding: The Plan did not monitor, evaluate, identify, and take effective action to address needed improvements in QOC delivered by providers. The Plan did not ensure that a QOC problems are identified and corrected for all provider entities. The Plan did not properly investigate and ensure corrective action of PICs before closure.

In a verification study, four of five PICs reviewed showed incomplete evaluation and resolution of QOC issues. For these four PIC cases, the Plan approved CAPs that did not correct problems to improve QOC delivered by providers. Additionally, the Plan closed these PIC cases without the QI staff’s investigation of complete medical records resulting in a failure to identify and correct QOC problems for all provider entities. The Plan did not adhere to its policy.

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Without proper investigation, monitoring, and effective corrective action of PQI issues, Plan members might receive substandard medical care by these providers increasing risk of medical harm.

Recommendation: Revise and implement Plan policy to ensure the PIC process includes identification, evaluation, monitoring and taking corrective action to address, resolve, and improve QOC issues delivered by providers.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD AND ABUSE REPORTING
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6.2.1 Notification of Changes in Network Provider’s Circumstances

The Plan is required to provide prompt notification to DHCS when it receives information about a change in a network provider’s circumstances that may affect the provider’s eligibility to participate in the Medi-Cal MCP, including the termination of their provider agreement with the Plan in accordance with 42 CFR 438.608(a)(3). (*Contract, Exhibit E, Attachment 2 (26)(B)(4)*).

The Plan is also required to implement and maintain written policies and procedures that articulate a commitment to comply with all applicable requirements and standards under Contract, and all applicable federal and state requirements (*Contract, Exhibit E, Attachment 2 (26)(B)(1)(a)*).

Plan policy *4.39-P: Provider Termination (revision date 5/2021)* states “At least 60-days prior to the effective date of a voluntary provider network agreement termination, or immediately upon learning of the termination from the network provider, the Plan will provide DHCS with written notice of the termination”. This policy was not approved and implemented at the time of the audit.

Finding: The Plan did not notify DHCS of changes in network provider’s circumstances that affect the provider’s eligibility to participate in the Medi-Cal MCP, including the termination of their provider agreement with the Plan.

DHCS requested but did not receive any record of notification to DHCS when the Plan received information about changes in a network provider's circumstances that may affect the network provider's eligibility to participate in the Medi-Cal MCP, including the termination of their provider agreement with the Plan.

The Plan acknowledged during an interview that it did not notify DHCS when it received information about a change in a network provider's circumstances. This demonstrates a lack of Plan contractual oversight.

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Failure to promptly report changes in a network provider's circumstances could lead to negative member health care outcomes, and encourage Fraud, Waste, and Abuse (FWA).

Recommendation: Approve and implement policy and procedure to ensure prompt notification to DHCS of changes in network providers' circumstances.

6.2.2 Verification of Services Delivered

The Plan is required to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members, and the application of this verification process on a regular basis in accordance with 42 CFR 438.608(a)(3). (*Contract, Exhibit E, Attachment 2 (26)(B)(5)*).

The Plan is also required to implement and maintain written policies and procedures that articulate a commitment to comply with all applicable requirements and standards under Contract, and all applicable federal and state requirements (*Contract, Exhibit E, Attachment 2 (26)(B)(1)(a)*).

Finding: The Plan did not have policies and procedures to verify the services that have been represented to have been delivered were received by members.

The Plan acknowledged during the audit that it did not verify that services that have been represented as delivered by network providers were actually received by members. The Plan also confirmed it did not have policies and procedures to meet this requirement. This demonstrates a lack of Plan contractual oversight.

Failure to verify that services represented by network providers were received by members can result in fraud, waste, or abuse.

Recommendation: Develop and implement policies and procedures to verify that services represented by network providers were indeed received by members.

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6.2.3 Notification to Program Integrity Unit of Suspended Providers

The Plan is required to notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. (*Contract, Exhibit E, Attachment 2 (26)(B)(8)*).

The Plan is also required to implement and maintain written policies and procedures that articulate a commitment to comply with all applicable requirements and standards under Contract, and all applicable federal and state requirements (*Contract, Exhibit E, Attachment 2 (26)(B)(1)(a)*).

Plan policy *14.04-P, Prevention, Detection, and Reporting Fraud, Waste, or Abuse (revised 2/01/2018)* states that the Plan will notify the Medi-Cal MCP/Program Integrity Unit within ten working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.

Finding: The Plan did not adhere to its policy to ensure notification to the Medi-Cal MCP/Program Integrity Unit within ten working days of removing a suspended, excluded, or terminated provider from its provider network.

The Plan has a list of terminated network providers. However, the Plan did not provide documents or evidence to confirm the terminated providers in the list had been reported to the Medi-Cal MCP/Program Integrity Unit.

During the interview, the Plan confirmed that it did not report suspended, excluded, or terminated providers to the Medi-Cal MCP/Program Integrity Unit after termination as required by the Contract. This demonstrates a lack of Plan contractual oversight.

Failure to notify the Medi-Cal MCP/Program Integrity Unit of excluded, suspended, or terminated provider can lead to fraud, waste, and/or patient harm by the suspended provider.

Recommendation: Implement policy and procedure to ensure the notification to the Medi-Cal MCP/Program Integrity Unit when a provider is excluded or suspended from participation in the Medicaid program.

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6.2.4 Fraud and Abuse Incident Investigation and Reporting to DHCS

The Plan shall meet requirements set forth in 42 CFR 438.608. The Plan shall report to the Contracting Officer (DHCS) all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, members, providers, or employees within ten working days of the date when Contractor first becomes aware of or is on notice of such activity. Contractor shall report investigation results within ten working days of conclusion of any fraud and/or abuse investigation. (*Contract, Exhibit E, Attachment 2, (26)(B)(7)*)

Plan policy *14.04-P, Prevention, Detection, and Reporting of Fraud, Waste, or Abuse (revised 2/01/2018)* stated that the Plan will report to the DHCS all cases of suspected fraud and/or abuse within 10 working days from the date that the Plan first becomes aware of or notices such activity.

Finding: The Plan did not report all cases of suspected fraud and/or abuse and forward results of investigations to the DHCS within ten working days of initial awareness of suspected fraud and/or abuse activity.

The Plan's FWA Committee met every one to two months during the audit period. The Plan submitted minutes for approximately 15 committee meetings. During these meetings, there were discussions regarding fraud, waste, abuse, and other issues for suspect providers.

The Plan maintained a detailed tracking log of providers actively monitored for potential fraud and/or abuse, quality issues, and potential patient harm. This tracking log was based on continuous review of prior authorization request activity. The Plan submitted the "*Tracking and Trending, 8/01/2019-7/31/2021*" document to the audit team. The FWA Committee meeting minutes and the tracking log indicated no referral of providers suspected for fraud and/or abuse to DHCS subsequent to August 29, 2019. We confirmed this lack of reporting with the DHCS Program Integrity Unit.

Following are examples of providers tracked for suspected fraud and/or abuse:

- Provider 1 requested numerous prior authorizations suspicious for fraud and/or abuse, lack of medical necessity, over-utilization of medical services, substandard QOC, and potential for patient harm. The FWA Committee minutes demonstrated awareness of potential fraud and/or abuse by this provider. A Plan UM Medical Director referred the provider to the Compliance Department for investigation and fraud and/or abuse reporting. Plan interview responses indicated knowledge of investigations into this provider by other outside entities. There was a detailed presentation by a UM Medical Director to the FWA

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Committee describing the potential fraud, abuse, and other concerns. These concerns were not reported to DHCS.

- Provider 2 requested prior authorizations for many high-cost durable medical equipment (DME) and custom-made DME items, with many considered as medically unnecessary and suspicious for fraud and/or abuse. A Plan UM Medical Director referred his concerns to Plan management and subsequently documented a discussion with management regarding ongoing fraud and/or abuse concerns. Plan management concurred that the concerns might be fraud and/or abuse but these concerns were not reported to DHCS.
- Provider 3 requested numerous prior authorizations suspicious for fraud and/or abuse, lack of medical necessity, and aberrant practice patterns. A Plan UM Medical Director escalated the potential fraud and/or abuse and other issues to Plan management. An outside provider of the same specialty as Provider three performed medical record reviews and determined that 50 percent of requested services lacked medical necessity. Subsequently, the UM Medical Director sent an email to Plan management describing ongoing concerns of fraud and/or abuse along with other concerns described above. However, no actions were taken against this provider and these concerns were not reported to DHCS.

Plan policy 14.04, *Prevention, Detection, and Reporting of FWA* was aligned with fraud and/or abuse reporting requirements contained within the Contract. The Plan did not adhere to its FWA policy and Contract requirements for fraud and/or abuse incident investigation and reporting to DHCS.

When suspected fraud and/or abuse activity by providers is not investigated and reported to DHCS, there is risk of medical harm to members from unnecessary procedures and risk of substandard quality of medical care. Undeterred provider fraud and/or abuse, over-utilization, and inappropriate utilization of medical services leads to significant financial losses by the Plan and the Medi-Cal program, diverting financial and medical resources from the members who need it most.

Recommendation: Implement the existing Plan policy to ensure adherence to the Contract and ensure that incidents of suspected fraud and/or abuse is investigated and reported to DHCS within ten working days of awareness of such activity.

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

REPORT ON THE MEDICAL AUDIT OF

KERN HEALTH SYSTEMS
dba
KERN FAMILY HEALTH CARE

2021

Contract Number: 03-75798
State Supported Services

Audit Period: August 1, 2019
Through
July 31, 2021

Report Issued: February 7, 2022

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I. INTRODUCTION

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

The audit period was August 1, 2019 through July 31, 2021. The onsite audit was conducted from September 13, 2021 through September 24, 2021.

An Exit Conference with the Plan was held on January 10, 2022. There were no deficiencies found.

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STATE SUPPORTED SERVICES

SUMMARY OF FINDINGS:

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Coding System Codes 59840 through 59857 and Health Care Finance Administration Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract. *(Contract, Exhibit A, (1))*

The Plan provides Medi-Cal members' timely access to abortion services from any qualified contracting or non-contracting provider without prior authorization unless inpatient hospitalization is requested to perform the abortion. Minors do not need consent or referral to access pregnancy termination services. According to the Plan's *Policy 3.21-P, Family Planning Services and Abortion*, the Plan maintains procedures to ensure confidentiality and access to sensitive services for all members including minors in a timely manner and without prior authorization requirements.

Policy #3.21-P: Family Planning Services and Abortion states, "Prior authorization for abortion services is not required unless inpatient hospitalization for the performance of the abortion has been requested. Plan members are educated regarding abortion policies and procedures through new member entry, the member handbook, and member newsletters. Abortion services include access to Mifepristone (RU486) in accordance with the FDA approved treatment regimen. Plan members are advised that they may go to the provider of their choice for abortion services; however, some hospitals and other providers may refuse to provide abortion services. A physician or other health care provider is not mandated to preform abortion services. The Plan shall not tolerate retaliation in any form to a physician or other provider of health care services for objecting to perform abortion services. The Plan will assist with the redirection of members who are refused abortion services by a provider."

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

RECOMMENDATION: None