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

Orange County Organized Health System dba CalOptima

Contract Number:	08-85214
Audit Period:	February 1, 2016 Through January 31, 2017
Report Issued:	November 16, 2017

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I. INTRODUCTION

The audit report represents the findings from the medical audit of CalOptima and their implementation of their County Organized Health System (COHS) managed care contract for Orange County with the State of California.

The Medical Review Branch conducted a full scope review of the requirements in CalOptima's Medi-Cal contract (No. 08-85214). The purpose of the review was to determine if the Plan was in compliance with the Medi-Cal contract and other applicable laws and regulations. Evaluation of the Plan's compliance with the contract and regulations in the areas of Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity was performed.

The Plan currently has several programs to provide medical care to its members residing in Orange County. As of February 2017, enrollment in these programs is as follows:

- **Medi-Cal**: 773,406 California's Medi-Cal recipients, since 1993
- **OneCare**: 1,281 Medicare/Medi-Cal recipients, since 2005
- **OneCare Connect**: 16,222 Medicare/Medi-Cal recipients, since 2015
- **PACE**: 194 Medicare and Medi-Cal recipients, since 2013

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 February 1, 2016 through January 31, 2017. The onsite review was conducted from February 6, 2017 through February 17, 2017. The audit consisted of document review, verification studies, and interviews with the Plan personnel.

An exit conference was held on August 30, 2017 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan did not submit supplemental information after the exit conference.

The audit evaluated six categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability of Care, Members' Rights, Quality Management (QI), and Administrative and Organizational Capacity. The summary of the findings by category is as follows:

Category 1 – Utilization Management

The contract requires the Plan to notify members of decisions to deny, modify or delay prior authorization requests for medical services and pharmaceuticals. This must be a written communication with language at understandable levels. This is to ensure the member's understanding of health plan covered services, processes, and ensure the member's ability to make informed health decisions. The language in several Notice of Action letters was not clear and understandable.

Category 2 – Case Management and Coordination of Care

The Plan is required to monitor and ensure the coordination of services and joint case management between its primary care providers, the California Children's Services (CCS) specialty providers, and local CCS programs. The Plan did not ensure the coordination of services and joint case management between its primary care providers, the CCS specialty providers, and local CCS programs to avoid delay in providing services to the members.

The contract states that the Plan and its healthcare networks shall ensure that contracted primary care provider (PCP) administer an Individual Health Education Behavioral Assessment to a member within 120 calendar days of enrollment as part of the Initial Health Assessment. A declination of services may be in the form of a signed statement by the member or the parent(s)/guardian of the member, or dated documentation of member's response to an in-person or telephone contact. Declination of services shall be noted in the member's medical record in a specific way. The Plan does not specify the requirements to the PCP for appropriately documenting Staying

Healthy Assessment (SHA) refusal by the member.

Category 3 – Access and Availability of Care

No findings.

Category 4 – Member's Rights

Contract requirements state that the Plan shall notify DHCS within 24-hours after the initial discovery, and shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer by electronic mail or facsimile, and by telephone. In addition, the Plan shall provide an interim written report of the investigation to the DHCS Privacy Officer, the DHCS Contract Manager, and the DHCS Information Security Officer within ten days after the initial discovery.

Upon initial discovery, the Plan did not notify DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer within the required timeframe. It also did not submit an interim written report of the investigation to the DHCS Privacy Officer, the DHCS Contract Manager, and the DHCS Information Security Officer within the required period. Due to a lapse of internal controls monitoring, the Plan did not report notifications of breach incidents and investigations of breaches in timely manner.

Category 5 – Quality Management

No findings.

Category 6 – Administrative and Organizational Capacity

In the prior year audit, the Plan did not report suspected fraud and abuse cases to DHCS within the required timeframe. As a result, the Plan's Special Investigations Unit (SIU) revised the SIU Desktop Procedure to reflect the enhancement of the investigative process to include a report versus referral process that will ensure that the results of the preliminary investigation are reported to the DHCS within the required ten (10) working day timeframe. The Supervisory Workload Report was developed to allow daily monitoring of the timeliness of the completion of the preliminary investigations by the SIU Supervisor.

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 contract.

PROCEDURE

The onsite audit of CalOptima was conducted from February 6, 2017 through February 17, 2017. The audit included a review of the Plan's contracts with 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 verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: Sixteen (16) medical and fourteen (14) pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review by the Plan.

Appeals Procedures: Four (4) appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): Ten (10) medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Individual Health Assessment (IHA): Twenty (20) medical records were reviewed for completeness and timely completion.

Complex Case Management (CCM): Five (5) medical records listed as CCM were reviewed for coordination of care.

Category 3 – Access and Availability of Care

Emergency Service Claims: Thirty-two (32) emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: Sixteen (16) family planning claims were reviewed for

appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: Thirty-one (31) grievances, six (6) expedited grievances and seven (7) exempt grievances were reviewed for timely resolution, response to complaint, and submission to the appropriate level for review.

Category 6 – Administrative and Organizational Capacity

New Provider Training: Fifteen (15) new provider training records were reviewed for appropriate and timely Medi-Cal Managed Care program training.

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

❖ COMPLIANCE AUDIT FINDINGS ❖	
PLAN: Orange County Organized Health System dba CalOptima	
AUDIT PERIOD: February 1, 2016 – January 31, 2017	DATE OF ONSITE AUDIT: February 6 – 17, 2017

CATEGORY 1 - UTILIZATION MANAGEMENT

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)
COHS Contract A.5.2.A, B, C, F, H, I

Exceptions to Prior Authorization:
Prior Authorization requirements are not applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
COHS Contract A.5.2.G

Timeframes for Medical Authorization
Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).
COHS Contract A.5.F

Routine authorizations: five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
COHS Contract A.5.H

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

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AUDIT PERIOD: February 1, 2016 – January 31, 2017	DATE OF ONSITE AUDIT: February 6 – 17, 2017

SUMMARY OF FINDINGS:

1.2.1 Notice of Action Letters

The contract requires the Plan to notify members of decisions to deny, modify or delay prior authorization requests for medical services and pharmaceuticals (Contract, Exhibit A, Attachment 13.8.A). The contract requires the Plan to provide members written communication with language at an understandable levels to ensure the members' understanding of the health plan covered services, processes, and ensure the member's ability to make informed health decisions, in accordance with CCR, Title 22, Section 53894 (Contract, Exhibit A, Attachment.13.4.C).

Medi-Cal Managed Care Division (MMCD) All Plan Letter 04-006 requires the Plan's Notice of Action letters to have a clear and concise explanation of the reasons for the Plan's decision. The details must contain a description of the criteria or guidelines used, including a citation of the specific regulations or Plan authorization procedures supporting the action and the clinical reasons for the decision regarding medical necessity.

Multiple examples of the medical and pharmacy prior authorizations and related Notice of Action letters were discussed with Plan personnel. The Plan has appropriate training, delegation oversight, monitoring, and control systems in place to assess these issues. The Plan has placed corrective action plans and taken other measures in an attempt at ongoing improvements. The Plan admits this has been an ongoing challenge to their control measures and monitoring systems, which continue to not be functioning as optimally as necessary.

A sample of sixteen (16) medical prior authorizations, fourteen (14) pharmacy prior authorizations, and related Notice of Action letters were reviewed. Multiple Notice of Action letters contained an insufficient explanation and/or contained language too complex for a member to understand. For example:

- "This request is denied because the information sent by your doctor was checked by CalOptima's doctor and does not meet criteria (rules). MCG 19th Edition, Echocardiography: A-0111 (AC) says you must have documentation of all of the following: Acute thrombeombolic event, (stroke) aortic dissection, (ballooning of the heart valve) ascending aortic aneurysm... electrophysiologic or ablative procedure…" The denial letter has an insufficient explanation, refers to source a member would not easily know, and is not at an appropriate reading level for member understanding.

- "In order for TPN Electrolytes 35 mEq-20 mEq-5 mEq/20 mL intravenous solution to be considered, requires you have impairment of the digestive tract preventing nutrients from being absorbed by your body or you are peri-operative." The denial letter language is too complex for a member to understand easily and clearly.

Without clear and accurate Notice of Action letters, members and providers may not easily understand the reason for Plan actions/decisions and/or what additional information may be needed to secure approval of potentially necessary services and/or medications. Complex, inaccurate, and/or insufficient language in letters may cause added confusion and distress instead of enhancing members understanding and planning.

RECOMMENDATION:

1.2.1 Implement effective monitoring and controlling systems of the prior authorization process to ensure completeness and clear/concise language in Notice of Action letters to members as stipulated in the contract.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.2	CALIFORNIA CHILDREN'S SERVICES

California Children's Services (CCS):
Upon diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:
   1) Ensure that Contractor's providers perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS eligible medical condition.
   2) Assure that Contracting Providers understand that CCS reimburses only CCS paneled providers and CCS-approved hospitals within Contractor's network; and only from the date of referral.
   3) Enable initial referrals of Member's with CCS eligible conditions to be made to the local CCS program by telephone, same-day mail or FAX, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.
   4) Ensure that Contractor continues to provide all Medically Necessary Covered Services for the Member's CCS eligible condition until CCS eligibility is confirmed.
   5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are unrelated to the CCS eligible condition and shall monitor and ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program.
   6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program…for the coordination of CCS services to Members.

COHS Contract A.11.10.A, B

SUMMARY OF FINDINGS:

2.2.1Coordination of services and joint case management between its primary care providers, the California Children Services specialty providers, and the local California Children Services program

The Plan shall monitor and ensure the coordination of services and joint case management between its primary care providers, the California Children Services specialty providers, and the local California Children Services (CCS) program (Contract, Exhibit A, Attachment 11.10.A(5)).

Samples of medical records for CCS eligible members were reviewed in a verification study. The study revealed that in some instances, members had different primary care providers listed on the Plan's member list from their Medical Home on the Service Authorization Request. Medical Home is defined as team-based approach. The clinic or the primary care providers coordinates all medical care with the rest of the team, usually consisting of the member, family, primary physician and specialists who all work towards the common goal of the member's good health.

An interview with the medical director of California Children's Services (CCS), CCS updates the member's information annually, but if the information submitted by the Plan is not updated or revised, the Service Authorization Request will not be updated. Interviews with Plan personnel stated that the updated list of members with changes are submitted to California Children's Services as needed. The Plan does not verify that the updated information of member's primary care provider is documented on the Service Authorization Request. The Plan agreed to implement a system to ensure a smooth process for better coordination and case management of the member.

If a member's primary care provider documented in the Plan's system is different from the medical home in the Service Authorization Request, it can cause potential problems in collaboration for joint case management and communications in reaching the intended provider. The confusion can negatively affect team communication, referrals, and create system barriers to needed services.

RECOMMENDATION:

2.2.1 Develop monitoring to ensure consistency in the identification of the listed primary care provider and the Plan's listed medical home team for efficient coordination of services and case management of the members.

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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 Section 53851 (b)(1) and Section 53910.5(a)(1) to each new Member within 120 days of enrollment.
COHS Contract A.10.3.A

Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA…..(as required by Contract)
COHS Contract A.10.3.E

Provision of IHAs for Members under Age 21:

1) For Members under the age of 18 months, Contractor shall ensure the provision of an IHA within 120 calendar days following the date of enrollment or within the most recent periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger, whichever is less.
2) 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.

COHS Contract A.10.5

Services for Adults Twenty-One (21) Years of Age and Older:
Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
COHS Contract A.10.7

SUMMARY OF FINDINGS:

2.4.1Individual Health Education Behavioral Assessment documentation

The Plan shall ensure that all new members complete the Individual Health Education Behavioral Assessment within 120 calendar days of enrollment as part of the initial health assessment and that all existing members complete the Health Education Behavioral Assessment at their next non-acute care visit (Contract, Exhibit A, Attachment 10.7.A.9). The Plan must provide training on Health Education Behavioral Assessment contract & documentation requirements, to all contracted providers, and subcontractors (MMCD Policy Letter 13-001).

Medi-Cal Managed Care Division (MMCD) All Plan Letter 13-017, states that the Individual Health Education Behavioral Assessment is a required component of the Initial Comprehensive Health Assessment. DHCS provided specific requirements and guidance regarding the use of

the Individual Health Education Behavioral Assessment in MMCD Policy Letter 13-001, "Requirements for the Staying Healthy Assessment/Individual Health Education Behavioral Assessment". The Plan must ensure that they administer an Individual Health Education Behavioral Assessment to all new beneficiaries within the first 120 days of enrollment. The Policy Letter outlines the specific requirements to document when a member refuses to complete a Staying Healthy Assessment questionnaire and keeping the Staying Healthy Assessment refusal in the member's medical record.

Plan Policy GG.1203, Individual Health Education Behavioral Assessments states a primary care provider shall inform a member of the right to refuse to answer any Staying Healthy Assessment questions and the right to refuse to complete the Staying Healthy Assessment. The policy also states that the primary care provider must document a member's refusal to complete the Staying Healthy Assessment on the appropriate age-specific form and include it in the member's confidential medical record. However, this policy does not specify the requirements for appropriately documenting Staying Healthy Assessment refusal by the member as required by MMCD Policy Letter 13-001.
Plan Policy EE.1103, Provider Education and Training does not mention the Plan's Policy GG.1203 and MMCD Policy Letter 13-001 which are both specific to Individual Health Education Behavioral Assessment/Staying Healthy Assessment documentation.

A verification study consisted of the review of thirty-five (35) medical records. Eighteen (18) medical records lacked the required Individual Health Education Behavioral Assessment documentation. Thirteen (13) of these records did not document the reasons the Individual Health Education Behavioral Assessment portion was missing. During an interview, the Plan personnel acknowledged that the provision of Individual Health Education Behavioral Assessment documentation by their providers continues to be a challenge.

The Plan did not outline specific steps on how providers should appropriately document the Individual Health Education Behavioral Assessment in its policy, the Plan's Provider Manual, Provider Education, and Training Policy, as required by MMCD Policy Letter 13-001. Specifically outlining the steps with Individual Health Education Behavioral Assessment documentation can clarify the ambiguous policy statements and processes. The Individual Health Education Behavioral Assessment is an important tool for physicians to review risk factors and behaviors with member specific to the appropriate age group, gender or similar classifications. The Individual Health Education Behavioral Assessment may prevent acute and chronic diseases through health education and follow-up clinic visits.

RECOMMENDATION:

2.4.1 Ensure policies, systems, training that direct, and support compliance with the Initial Health Assessment requirement to include provisions of Individual Health Education Behavioral Assessment documentation by the primary care providers.

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CATEGORY 4 – MEMBER'S RIGHTS

4.3	CONFIDENTIALITY RIGHTS

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

B. Responsibilities of Contractor.

1. 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. Contractor shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities. Contractor will provide DHCS with information concerning such safeguards as DHCS may reasonably request as per 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316….(as required by Contract)

H. Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS.** (1) To notify DHCS immediately by telephone call plus email or fax upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate….

2. **Investigation and Investigation Report.** Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within ten (10) working days of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer of what data elements were involved and the extent of the data involved in the breach. A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized. A description of the probable causes of the improper use or disclosure. Whether Civil Code sections 1798.29 or 1798.82 or any other Federal or State laws requiring individual notifications of breaches are triggered.

COHS Contract G.III.B, H

SUMMARY OF FINDINGS:

4.3.1Breach Incident Reporting Time Frames

The Plan is required to notify DHCS of a discovery of a breach within twenty-four (24) hours by email or fax of any suspected security incident, intrusion or unauthorized access to the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer (Contract, Exhibit G.H.1 and MMCD All Plan Letter 09-014).

The Plan is also required to investigate the security incident, breach, or unauthorized use or disclosure of PHI or confidential data within ten (10) working days of the discovery and to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer (Contract, Exhibit G.H.2).

DHCS selected twenty (20) HIPAA cases for review and noted the following:

- The Plan did not notify DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer regarding the discovery of a breach within the required 24-hour timeframe in seventeen (17) cases. Four (4) cases were submitted within 10 days and thirteen (13) cases were submitted between 30 to 40 working days.

- The Plan did not notify DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer regarding the investigation of a breach within the required timeframe of ten working days in fifteen (15) cases. Thirteen (13) cases were submitted between 30 to 40 days after the discovery and two (2) cases were submitted between 10 to 20 days after the discovery.

The Plan did not report notifications of breach incidents and investigations of breaches in timely manner. Plan personnel acknowledged these findings during the onsite interview. The Plan indicated the deficiencies cited were due to a lapse of internal monitoring and control systems. Meeting these timeframes is paramount to minimizing the exposure of members' personal health information.

In May 2016, the Plan implemented new measures for improvement and internal monitoring in their reporting system. This included hiring new staff to ensure that the HIPAA cases are processed and reported to DHCS in timely manner. The Plan also provided extensive training to new staff with an emphasis in meeting required timeframes.

RECOMMENDATION:

4.3.1 Improve monitoring systems to ensure the notification of breaches or security incidents and subsequent investigations are submitted within the required timeframe.

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

Orange County Organized Health System dba CalOptima

Contract Number: 08-85221
State Supported Services

Audit Period: February 1, 2016
Through
January 31, 2017

Report Issued: November 16, 2017

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INTRODUCTION

The audit report presents the findings of the contract compliance audit of Orange County Organized Health System dba CalOptima and its implementation of the State Supported Services contract No. 08-85221 with the State of California. The State Supported Services contract covers abortion services for CalOptima.

The onsite audit of the Plan was conducted from February 6, 2017 through February 17, 2017. The audit covered the review period from February 1, 2016 through January 31, 2017 and consisted of a document review of materials provided by the Plan.

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AUDIT PERIOD: February 1, 2016 - January 31, 2017	DATE OF ONSITE AUDIT: February 6 – 17, 2017

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion – Services to be Performed: *Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:* *Current Procedural Coding System Codes*: 59840 through 59857* *HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336* **These codes are subject to change upon the Department of Health Care Services' (DHCS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.* *State Supported Services Contract Exhibit A.4*

SUMMARY OF FINDINGS:

The Plan Policy GG.1508, Authorization and Processing Referrals, states that elective abortion services must be provided and does not require prior authorization to ensure that a qualified provider treats a Member. A Member requesting an elective abortion can access information about qualified Medi-Cal practitioners by calling the Plan's Customer Service Department or the Member's Health Network Member services department.

The Member Handbook informs Members that family planning services to prevent or delay pregnancy, pregnancy prevention, and abortion services are available. These services do not require prior authorization and do not need guardian or parent consent. In addition, the handbook states that these services are available to adults and adolescents. All Members have the right to confidentiality when obtaining these services. Members have the right to receive family planning services and choose a doctor or clinic outside the Plan network. Authorization from their Primary Care Physician is not needed. Members can call their health network or the Plan's Customer Service Department if they have questions or need help finding a qualified Medi-Cal provider.

The Provider Manual informs Providers that abortion services are under the categories of care, which require no prior authorization to render services. The manual references Plan Policy GG. 1118, Family Planning Services, Out-of-Network, that states Members may access family planning services on a self-referral basis to any qualified family planning practitioner, including an out-of-network practitioner, without prior authorization.

According to Plan personnel, the claims department maintains an updated list of claim codes for abortion services. The Plan reviews the code list yearly, as well as when new codes are established. The Plan monitors weekly reports to ensure that out-of-network providers are properly reimbursed. The Plan has guidelines to provide instructions for the billing of abortion services for participating Providers and for claims processors when paying or denying a claim with updated billing codes. The Plan is in compliance with the Contractual requirements.