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

Care 1st Partner Plan, LLC

Contract Number: 09-86153

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

Report Issued: July 6, 2017

TABLE OF CONTENTS

I. INTRODUCTION

Care 1st Partner Plan, LLC (Care 1st Health Plan), an affiliate of Blue Shield of California, is a Health Maintenance Organization engaged in providing Medi-Cal managed care services in San Diego County. Blue Shield is an independent member of the Blue Cross Blue Shield Association, nonprofit health plan, founded 75 years ago, and headquartered in San Francisco.

Care 1st Health Plan was founded in 1994 by a group comprised of providers, organized medical groups, and hospitals. Care 1st Health Plan has maintained a California full service health plan license under the Knox-Keene Act since 1995. In June 2005, Department of Health Care Services granted the Geographic Managed Care contract to Care 1st Health Plan to provide health care services to Medi-Cal beneficiaries in San Diego County. In 2008, Care 1st Health Plan received a three-year Commendable Accreditation from the National Committee for Quality Assurance (NCQA) for its Medi-Cal line of business. For the audit period, Care 1st Health Plan continues with a NCQA accredited status.

As of February 1, 2017, Care 1st Health Plan's total enrollment for their Medi-Cal line of business was 85,911. Enrollment by product line was as follows:

- Medi-Cal 83,393
- Cal MediConnect 2,518

II. EXECUTIVE SUMMARY

This report presents the results of the Department of Health Care Services (DHCS) medical audit for the period of February 1, 2016 through January 31, 2017. The on-site review was conducted from February 27, 2017 through March 2, 2017. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on May 30, 2017. The Plan was allowed fifteen (15) calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report findings. The Plan submitted supplemental information after the exit conference, which is reflected in this report.

The prior DHCS medical audit issued June 16, 2016 (for the audit period of January 1, 2015 through December 31, 2015) identified deficiencies, which were addressed in a *corrective action plan* (CAP). The CAP closeout letter dated December 1, 2016 noted that all previous findings were closed.

The following section presents previous audit deficient categories. This section includes the actions the Plan took to implement the CAP recommendations. The audit confirmed the Plan acted upon prior findings and revised its policies and procedures.

However, while the Plan addressed deficient categories in the corrective action process, the Plan has not fully implemented recommendations related to Administrative and Organizational Capacity. The area is highlighted as a repeat finding.

Category 1 – Utilization Management
The prior year audit found the Plan did not have a systematic method to process and monitor emergency room claims. The evaluation of criteria was inconsistent and did not adhere to established criteria. To correct the deficiencies, the Plan revised its procedure to include emergency room (ER) claims as part of its Inter-Rater Reliability (IRR) audit selection. Additionally, the Plan created a new process for the review of ER claims in a web portal platform called CareWebQI, clinical guideline system from MCG (formerly known as Milliman Care Guideline).

Furthermore, the Plan did not process California Children's Services (CCS) Notice of Action letters within the required timeframes. Additionally, the prior audit found a systemic issue with pharmaceutical prior authorizations. The pharmaceutical prior authorizations were delayed because of unresponsive requests from providers for medical records.

To address the deficiencies, the Plan revised its policy and procedures and created a new CCS authorization template.

The Plan began steps to improve its pharmaceutical prior authorization process in response to the prior year's audit. The Plan stated it would track and trend non-responsive physicians quarterly and outreach to non-responder physicians. A referral to Peer Review and Credentialing may result as a repeated lack of response after the initial outreach.

Although the Plan began to improve its process, the Plan acknowledged there is insufficient data to identify, track and trend the poorly responding physicians and was unable to provide any tracking reports.

In the prior year audit, the Plan's appeals policies and procedures did not clearly communicate to the Appeals and Grievance Coordinators, Contract requirements to ensure that a different person involved in the initial decision was not involved in the final decision. The Plan revised its policy language to align with Contract requirements. The appeals verification study in this audit revealed the person that made the final grievance solution was unassociated with the prior decision.

Category 2 – Case Management and Coordination of Care
The prior audit found the Plan failed to document three attempts to contact a member and schedule an Initial Health Assessment (IHA). Additionally, medical records reviewed did not have sufficient documentation to reflect a comprehensive office visit. Lastly, the Plan's method to monitor IHA completion was inadequate.

To address the prior year audit findings, the Plan updated its policy and procedures, revised its provider manual, and improved its IHA process. The Plan reviews medical records using its IHA Audit Tool, which includes adherence to the most current edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force and the most recent edition of the American Academy of Pediatrics. The Plan provides feedback to the independent practice associations; corrective action plans may be required to address noncompliance or other findings.

During the audit period, the Plan had a system to ensure a comprehensive IHA was completed within 120 calendar days and had procedures to monitor IHA completion.

Category 3 – Access and Availability of Care
Plans are required to develop and implement procedures to monitor waiting times in providers' offices. The prior year audit finding determined the Plan did not have a mechanism in place to monitor compliance. As a result, the Plan developed and implemented a pilot study to monitor compliance with wait time in provider's offices. In August 2016, the Plan selected one primary care provider to participate in the pilot study.

In addition, the Plan developed a survey tool intended for the member to record appointment and arrival times, time seen by the provider, and appointment end time. The Plan will continue to monitor for patterns of non-compliance and determine any need for future corrective actions. The Plan will continue to increase provider awareness, education, and monitor compliance through member grievances and satisfaction surveys.

The prior year audit found, the Plan did not have policies or procedures to define appointment wait time standards to ensure the first prenatal visit for a pregnant member will be available within two weeks upon request. The Plan did not monitor compliance to ensure the first prenatal visit for a pregnant member will be available within two weeks upon request. To address prior year findings, the Plan revised its policies to meet required

appointment wait time standards. In addition, the Plan conducted a survey to measure provider compliance with the first prenatal visit standard. The survey addressed availability of the first prenatal visit to ensure members are offered appointments within the required time frames. Furthermore, to educate the contracted provider network and ensure compliance, the Plan furnished access to care appointment standard posters that required a signed attestation as proof of receipt.

The Plan fully implemented the recommendations from the prior audit with regard to the provider directory. Since the last audit, the Plan updated its online provider directory, which now includes specialty providers.

The prior year audit found the Plan did not provide accurate and clear written explanations to support reduced reimbursement to high-level emergency department claims. As a result, the Plan's Physician Reviewer now reviews high-level emergency department claims for appropriateness using approved clinical guidelines from MCG (formerly known as Milliman Care Guidelines). The verification study confirmed the Plan documents a clear explanation to support the lower level reimbursement.

The prior year audit found the Plan did not effectively monitor compliance to ensure member access to at least a 72-hour supply of covered outpatient drugs in an emergency situation.

To address the prior year audit finding, the Plan implemented an audit process to assess compliance with the 72-hour supply. Semi-annually, the Pharmacy Department will conduct an audit of emergency department (ED) claims for each contracted hospital to identify relevant prescription activity within 48 hours of the ED visit.

Category 6 – Administrative and Organizational Capacity
The prior year finding specified the Plan did not establish language for notification requirements of suspended providers in its Anti-Fraud and Abuse Program policies. The Plan revised its policies to report the termination of suspended, excluded, or terminated providers within 10 state working days to the Medi-Cal Managed Care Program/Program Integrity Unit. The policy includes a procedure to confirm that the provider is no longer receiving payments in connection with the Medicaid program.

The Plan did not have an internal monitoring system to detect potential fraud, waste, and abuse (FWA) trends within the claims data for the entire audit period. Continuous postponement to implement data mining program efforts contributed to unsuccessful efforts to identify suspect claims or improper payments, or develop any corrective action plans to respond to detected violations. The Plan has failed to implement a provision to monitor and identify FWA trends within the claims system in two consecutive DHCS medical audits. **This is a repeat finding**.

A description of the findings are contained in the following report.

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 on-site review was conducted from February 27, 2017 through March 2, 2017. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those 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: 34 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

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

Category 2 – Case Management and Coordination of Care
Complex Case Management: 5 medical records were reviewed for evidence of coordination of care between the Plan and providers.

California Children's Services (CCS): 5 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Initial Health Assessment: 21 medical records were reviewed for completeness and timeliness.

Category 3 – Access and Availability of Care
Appointment Availability: 12 providers from the Plan's Provider Network were reviewed. The third next available appointment was used to measure access to care.

Emergency Services and Family Planning Claims: 15 emergency service claims and 15 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights
Grievance Procedures: 35 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level of review.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2 FRAUD AND ABUSE

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

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
2) Contractor shall provide effective training and education for the compliance officer and all employees.
3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity….
5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs….

GMC Contract E.2.25.B

SUMMARY OF FINDINGS:

6.2.1 Provision to monitor and identify fraud, waste, and abuse trends within the claims system

The Plan shall make a provision for internal monitoring and auditing. [Contract, Exhibit E, Attachment 2 (25)(B)(3)]

The Plan did not have an internal monitoring system to detect potential fraud, waste, and abuse (FWA) trends within the claims data for the entire audit period. **This is a repeat finding.**

The Plan has not had a provision to monitor FWA since it terminated its contract with a vendor on March 1, 2015. The vendor provided data mining and investigation services to identify possible FWA trends within the claims processing system. The Plan signed a contract with a new vendor. The agreed upon services between the Plan and the vendor include developing a system to data mine the claims system edits to identify potential FWA trends. The Plan stated it expected a "go-live" with the data mining system late in the first quarter 2016.

During the interview, the Plan stated the vendor encountered obstacles with the Plan's claims data that resulted in a continuous cycle to extend the "go-live" date. The Plan stated the vendor's software system caused the delay, not the Plan's data elements. The Plan's FWA management states it maintains

communication contemporaneously with the vendor for consult and/or guidance. The vendor responds quickly to address software challenges or any unforeseen events.

The Plan reports it is working diligently to implement a comprehensive internal program to prevent and detect FWA. Nevertheless, the Plan was unable to provide claims data monitoring reports to detect possible fraud, waste, and abuse. As a result, the audit found that the Plan did not monitor and identify fraud, waste, and abuse trends within the claims system. Continuous postponement to implement data mining programs also contributed to unsuccessful efforts to identify suspect claims or improper payments, or develop any corrective action plans to respond to detected violations. In this regard, the Plan did not consider risks to the program's ability to collect the data and did not include a contingency plan.

The Plan acknowledged that currently and during the entire audit period, the Plan did not meet its contractual obligations to prevent, detect, and investigate fraud and abuse in claims data. Methods to uncover patterns and relationships in claims activity that are potentially fraudulent are absent. Insufficient planning and no consideration for unexpected obstacles or risk of delays in reaching full implementation of the system affected the Plan's ability to ensure compliance.

Since March 2015, the Plan was at risk, by lacking an incentive to identify and recover improper payments. The Plan did not implement a provision to monitor and identify FWA trends within the claims system in two consecutive DHCS medical audits. The Plan relied solely on the outside vendor to meet compliance requirements and did not perform internal monitoring nor self-audits during the audit period to deter fraud, waste and abuse.

In the Plan's response to the audit findings, the Plan submitted its proposed action to enhance its FWA monitoring. The Plan's action included new procedures and data mining efforts implemented subsequent to the audit period. Although the Plan intends to take future corrective action, the Plan failed to identify and assess risk or detect noncompliance through claims data reviews for the past two consecutive DHCS medical audits.

RECOMMENDATION:

6.2.1 Implement an internal monitoring system within the claims processing system and proactively explore ways to deter fraud, waste, and abuse.

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

Care 1st Partner Plan, LLC

Contract Number: 09-86154
State Supported Services

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

Report Issued: July 6, 2017

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the audit findings of Care 1st Partner Plan, LLC (Care 1st Health Plan) State Supported Services contract No. 09-86154. The State Supported Services contract covers contracted abortion services with Care 1st Partner Plan, LLC.

The on-site audit was conducted from February 27, 2017 through March 2, 2017. The audit period is February 1, 2016 through January 31, 2017 and consisted of document review of material supplied by the Plan and interviews conducted on-site.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Care 1st Partner Plan, LLC	
AUDIT PERIOD: February 1, 2016 through January 31, 2017	DATE OF AUDIT: February 27, 2017 through March 2, 2017

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion
Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes*: 59840 through 59857
HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*
State Supported Services Contract Exhibit A.1

A. Family Planning

Members have the right to access family planning services through any family planning provider without Prior Authorization. Contractor shall inform its Members in writing of their right to access any qualified family planning provider without Prior Authorization in its Member Services Guide.

GMC Contract A.9.9.A

SUMMARY OF FINDINGS:

The Plan's Policy 10.2.35, *Abortion Services*, states that members can access abortion services in- or out-of-network without prior authorization. The Plan defines abortion services as a "sensitive service" and ensures confidentiality and accessibility to its members. Inpatient hospitalization for the performance of an abortion does require prior authorization under the same criteria as other medical procedures in accordance with California Code of Regulations (CCR), Title 22, Section 51327.

The prior year's audit found the Plan failed to include language in the Member Handbook/Evidence of Coverage (EOC) to inform members of the right to access sensitive services through a contracted or non-contracted provider. The Plan addressed the finding and revised the Member Handbook to include language as it pertains to members' rights to access abortion services through any family planning provider.

The Plan covers both surgical abortions Current Procedural Terminology CPT-4 codes 59840 through 59857; Healthcare Common Procedure Coding (HCPCS) codes A4649-U1(X1516) and A4649-U2 (X1518); and medical abortions HCPCS codes S0199 (Z0336), S0190 Mifepristone 200 mg RU-486 (X7724) and S0191 Misoprostol 200 mcg (X7726).

In addition to the Member Handbook, members can also contact the Member Service Call Center for assistance with abortion services. The Plan informs providers of the members' rights to sensitive services without prior authorization in the Provider manual, which can be found on the website.

The Plan's claims payment system contains all of the required pregnancy termination billing codes. The Plan's vendor, Calibrated Health Network, adjudicates the claims in the Plan's system without prior authorization.

The audit found the Plan complies with the contractual requirements.