MEDICAL REVIEW BRANCH – ONTARIO
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

SENIOR CARE ACTION NETWORK HEALTH PLAN

Contract Number: **07-65712 A11**

Audit Period: March 1, 2016
Through
February 28, 2017

Report Issued: August 17, 2017

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I. INTRODUCTION

Senior Care Action Network (SCAN or the Plan) commenced operations in 1977 as a Multi-Purpose Senior Services Program. The Plan received its license as a Full Service Knox Keene California Health Plan from the California Department of Corporations in 1984. SCAN contracted with California Department of Health Care Services to provide health care services as a Dual Eligible Special Needs Plan in 1985.

Senior Care Action Network is a not-for-profit Medicare Advantage plan located in Long Beach, California. SCAN contracts with 28 medical groups, 32 hospitals, 3,337 primary care physicians (PCPs), and 5,642 specialists to provide a full range of Medicare Advantage product lines. SCAN has the only Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) contract in California and provides this product line to seniors in Riverside, San Bernardino, and Los Angeles counties.

The Plan administers its FIDE-SNP contract to dual eligible seniors who are entitled to both Medicare (Title XVIII) and medical assistance from a State Plan under Title XIX (Medi-Cal in California) where both Medicare and Medi-Cal services are administered through one plan. Dual eligible seniors voluntarily enroll both their Medicare and Medi-Cal coverage with SCAN and the Plan administers covered services for members by coordinating between Medicare and Medi-Cal.

As of February 28, 2017, SCAN has a total enrollment of 186,517 Medicare Advantage members, of which 13,402 enrolled as dual eligible members. SCAN does not participate in the commercial healthcare marketplace.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period March 1, 2016 through February 28, 2017. The on-site review was conducted from March 13, 2017 through March 24, 2017. The audit consisted of document review, verification studies, and interviews with Senior Care Action Network (SCAN or the Plan) personnel.

An Exit Conference was held on June 29, 2017 with the Plan. 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 Plan submitted supplemental information after the Exit Conference, which is reflected in this report.

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

The summary of the findings by category is as follows:

Category 1 – Utilization Management

The Plan did not include member's right to request a State Fair Hearing on the appeal resolution letters. The Plan submitted a revised appeal resolution template that included the appropriate wording, but did not submit actual documents to indicate implementation of the current revisions.

Category 2 – Case Management and Coordination of Care

The Plan does not have a methodology to monitor the completion of Initial Health Assessments (IHA). The Plan does not have an IHA monitoring method in place, but is currently in the process of establishing methods to capture and monitor complete and comprehensive IHAs.

Category 3 – Access and Availability of Care

The Plan did not properly ensure their medical groups maintained follow-up procedures for missed appointments. The Plan did not did not have an established method to monitor missed appointments by their medical groups.

The Plan did not have a process to ensure members obtained timely appointments with a specialist. Access standards for non-urgent specialist appointments should be within 15 business days of request.

Category 4 – Member's Rights

The Plan did not maintain effective oversight of physical and technical controls to safeguard protected health information (PHI). There was a lack of adequate controls regarding unauthorized access to PHI.

The Plan did not notify the DHCS Privacy Office within 24 hours from when security breach was first discovered.

Category 5 – Quality Management

The Plan did not ensure contracted nurse reviewers met California licensing standards and requirements. The Plan's contracted nurse reviewers hold licensure from various states throughout the United States, but not necessarily in California.

Category 6 – Administrative and Organizational Capacity

No findings noted during this audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

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

PROCEDURE

The on-site review of the Senior Care Action Network (SCAN) was conducted from March 13, 2017 through March 24, 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: Ten (10) medical and ten (10) pharmacy prior authorizations requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeals Process: Nine (9) prior authorization appeal requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment: Five (5) medical records were reviewed for completeness and timely completion.

Complex Case Management: Twelve (12) medical records were reviewed for evidence of continuous tracking and monitoring of members who received complex case management services.

Category 3 – Access and Availability of Care

Appointment Availability: Fifteen (15) contracted providers from the Provider's Directory were reviewed for accuracy, completeness, and appointment availability. The third next available appointment was used to measure access to care.

Emergency Service Claims: Nine (9) emergency service claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: Twenty (20) grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: One (1) case was reviewed for proper reporting of suspected and actual breaches to the appropriate entities within the required time frame.

Category 5 – Quality Management

New Provider Training: Ten (10) new contracted providers were reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: One (1) case was reviewed for proper reporting of suspected fraud and/or abuse to the appropriate entities within the required time frame.

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

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.4	PRIOR AUTHORIZATION APPEAL PROCESS
Appeal Procedures: There shall be a well-publicized appeals procedure for both providers and patients. **DHCS SCAN Contract A.5.2.D**	

SUMMARY OF FINDINGS:

1.4.1 **Notification of Member's right to request a State Fair Hearing**

The Contract requires the Plan to "implement and maintain an appeal process as described below to resolve member appeals. Contractor must provide a member notice, as expeditiously as the member's health condition requires, within 45 days from the day Contractor receives the appeal. A member notice, at a minimum, must include the result and date of the appeal resolution. For decisions not wholly in the member's favor, Contractor, at a minimum' must include: 1) Member's right to request a State Fair Hearing; 2) How to request a State Fair Hearing; 3) Right to continue to receive benefits pending a State Fair Hearing…" (Contract, Exhibit A, Attachment 14 Member Grievance System, Section 5(B), Member Appeal Process)

The Plan did not include member's right to request a State Fair Hearing on the appeal resolution letters. Prior to February 1, 2017, the Plan did not have written policies and procedures to address the inclusion of member's State Fair Hearing rights on appeal resolution letters. In addition, verification study confirmed that appeal resolution letters reviewed during the audit period did not include State Fair Hearing notification.

During the interview, the Plan affirmed there was an oversight of the contractual requirements regarding notification of member's rights to a State-Fair Hearing, and therefore implemented Policy and Procedure (GA-0034) on February 1, 2017 that contained the required contract language. The Plan submitted template appeal resolution letters updated as of February 24, 2017, that included member's State Fair Hearing rights. The Plan did not submit actual resolution letters that would indicate the implementation of the current revisions during our audit period.

Incomplete member's rights information contained on appeal resolution letters could result in missed opportunities to reverse inappropriate denials, which may potentially cause delay in the delivery of medically needed services.

RECOMMENDATION:

1.4.1 Maintain a process that ensures appeal resolution letter notifications include member State Fair Hearing rights.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4	INITIAL HEALTH ASSESSMENT

Initial Health Assessment:

A. 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) to each new Member within timelines stipulated in provision 4 below.

B. Contractor shall ensure that the IHA includes a health education behavioral assessment using an age appropriate DHCS approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and health education behavioral assessment.

C. Contractor shall ensure that Members' completed IHA and health education behavioral assessment tool are contained in the Members' medical record and available during subsequent preventive health visits.

D. Contractor shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement.

DHCS SCAN Contract A.10.3.A, B, and D; See Provision 4 below:

Contract A.10, Provision 4:

A. IHAs

Contractor shall cover and ensure that an IHA is performed within 120 days of enrollment.

Contractor shall ensure that the performance of the initial and annual complete history and physical exam includes, but is not limited to:

1) Blood pressure.
2) Height and weight.
3) Total serum cholesterol measurement.
4) Clinical breast examination.
5) Mammogram for women age 50 and over concluding at age 75 unless pathology has been identified.
6) Pap smear on all women determined to be sexually active, regular screening may be discontinued after age
65 on those participants who have had regular screening with consistent normal results.
7) Chlamydia screen for all sexually active females who are determined to be at high-risk for chlamydia
infection using the most current CDC guidelines.
8) All Members will receive TB testing upon enrollment and annual screening will be part of the annual history
and physical.
9) Health education behavioral risk assessment.

References Cited:

Title 22, CCR Section 53851(b)(1) – Scope of Services

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SUMMARY OF FINDINGS:

2.4.1 **IHA monitoring procedures**

The Contract requires the Plan to "cover and ensure the provision of an Initial Health Assessment (IHA) (complete history and physical examination) in conformance with Title 22, CCR, Section 53851(b)(1) to each new Member …" (*Contract, Exhibit A, Attachment 10 (3) (A)*).

In addition, the Plan is required to have "written procedures for monitoring IHA completion within the required timeframes" (MMCD Policy Letter 08-003).

The Plan does not have a methodology to monitor the completion of Initial Health Assessments (IHA). According to the Plan's Provider Operation Manual, "PCPs must conduct an IHA for Members, within 90 days of the effective date of enrollment." However, the Plan does not have written procedures to monitor and ensure IHA completion within the required timeframe.

During the onsite interview, the Plan acknowledged they do not have a method in place to monitor IHA completion, but currently are in the process of establishing methods to capture and monitor completed comprehensive IHA.

Without a valid monitoring methodology, the Plan cannot ensure the completion of comprehensive IHAs, which may cause potential delay in appropriate treatments, interventions, and care of the member.

RECOMMENDATION:

2.4.1 Develop and implement a methodology to monitor and ensure the completion of comprehensive IHAs within the required timeframe.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

Appointments:
Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
DHCS SCAN Contract A.9.3.A

Members must be offered appointments within the following timeframes:

3) Non-urgent primary care appointments – within ten (10) business days of request;
4) Appointment with a specialist – within 15 business days of request;
5) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

DHCS SCAN Contract A.9.4.B

Waiting Times:
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in subparagraph A. Appointments, above.
DHCS SCAN Contract A.9.3.C; See Appointments above, Contract A.9.3.A

SUMMARY OF FINDINGS:

3.1.1 **Follow up appointment procedures**

The Contract requires the Plan to “implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments”. Additionally, the contract requires the Plan to “communicate, enforce, and monitor providers’ compliance with these standards” (*Contract, Exhibit A, Attachment 9(3)*).

The Plan did not ensure their medical groups maintained follow-up procedures for missed appointments. During the interview, the Plan stated the process of ensuring access to care compliance is an activity delegated to contracted medical groups. According to the Plan’s Provider Operation Manual, providers must maintain procedures for follow-up on missed appointments. The Plan submitted policy and procedure QM-AC-01 “Access to Care Standards” from a contracted medical group; however, review of the policy revealed procedures for follow-up on missed appointments were not contained.

During the interview, the Plan also stated that audits are conducted annually to ensure contracted medical groups have a process in place that meets access to care requirements. Review of the audit tool utilized to perform their annual audits confirmed that criteria for medical groups to maintain a procedure for follow-up on missed appointments was not incorporated.

There was a lack of delegation oversight; the Plan did not have an established method to monitor medical groups' missed appointment procedures.

Lack of follow-up procedures for missed appointments could lead to delays in members' receiving medical treatment and result in negative health outcomes.

3.1.2 **Timely appointments with specialists**

The Plan is required to "ensure the provision of acceptable accessibility standards in accordance with Title 28, CCR, section 1300.67.2.2 and as specified below. The Plan "shall communicate, enforce, and monitor providers' compliance with these standards" (*Contract, Exhibit A, Attachment 9*). In addition, the Plan is required to "ensure that Members are offered appointments with a specialist within 15 business days of request" (*Contract, Exhibit A, Attachment 9(4)(B)(4)*).

The Plan did not have a process in place to ensure members obtained appointments with a specialist within 15 business days of request. Review of the Plan's Provider Operational Manual, revealed that accessibility standards for an appointment with a specialist was not addressed. The Plan's 2016 Appointment Availability Survey revealed appointments with specialists were obtained within 30 business days of request, not the required 15 business days. In addition, review of grievances confirmed that a dual eligible member did not receive an appointment with a specialist within the required 15 business days of request.

During an interview, the Plan stated that Medicare standards of 30 business days of request were used to monitor specialist appointments. The Plan also submitted the following statement that "SCAN acknowledges that the Access Standard outlined for non-urgent appointments with specialist physicians for DHCS are within 15 business days of the request. SCAN will present the proposed access standard change to the appropriate quality committees for review and approval, after which the appropriate activities will take place to ensure compliance".

Not having a process to ensure members receive timely appointments with a specialist could delay necessary medical treatment and potentially cause harm to the members' health and wellbeing.

RECOMMENDATIONS:

3.1.1 Implement and maintain procedures to ensure follow-up on missed appointments.

3.1.2 Develop and maintain a process to ensure members obtain appointments with a specialist within 15 business days of request.

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CATEGORY 4 – MEMBER'S RIGHTS

4.3	CONFIDENTIALITY RIGHTS

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

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

DHCS SCAN Contract A.13.1.B

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities
Responsibilities of Contractor:
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.
DHCS SCAN Contract G.3.B.

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Notification of Breach:
(1) Discovery of Breach. To notify DHCS **immediately by telephone call plus e-mail or fax** upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or **within 24 hours by e-mail or fax** of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract, or potential loss of confidential data affecting this Contract. Notification shall be provided to the DHCS Long-Term Care Division (LTCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, notification shall be provided by calling the DHCS ITSD Help Desk. Contractor shall take:
a) Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating
environment; and
b) Any action pertaining to such unauthorized disclosure required by applicable federal and State laws and regulations.
(2) Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within five working days of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer of:
a) What data elements were involved and the extent of the data involved in the breach.
b) A description of the unauthorized persons known or reasonably believed to have improperly used or
disclosed PHI or confidential data.
c) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or
utilized.
d) A description of the probable causes of the improper use or disclosure.
e) Whether Civil Code sections 1798.29 or 1798.82 or any other federal or state laws requiring individual
notifications or breaches are triggered.
DHCS SCAN Contract G.3.H.

References Cited:

45 CFR Section 164.308 – Administrative Safeguards
45 CFR Section 164.310 – Physical Safeguards
45 CFR Section 164.312 – Technical Requirements
45 CFR Section 164.316 – Policies and Procedures and Documentation Requirements

SUMMARY OF FINDINGS:

4.3.1 **Personal Health Information (PHI) safeguards**

The Contract requires the Plan to implement and maintain policies and procedures to ensure members' information confidentiality rights (Contract, Exhibit A, Attachment 13(1)(B)). In addition, the Plan is required to maintain administrative, physical, and technical safeguards that reasonably and appropriately protect members' confidentiality rights (Contract, Exhibit G, Attachment 3(B)).

Although the Plan had policies and procedures to prevent PHI from intentionally or unintentionally being used or disclosed, the Plan did not maintain effective oversight of physical and technical controls to safeguard protected health information (PHI). During the audit period, the Plan reported to DHCS unauthorized access to PHI. In response to the privacy incident, the Plan implemented system security changes such as, strengthened password requirements, new technical safeguards, and additional training of staff. In addition, the Plan implemented new policy and procedure MIS-0756 "Information Access Management and Control Policy" that clearly address administrative, physical, and technical safeguards to further ensure protection of PHI held within the Plan's systems.

Without maintaining effective oversight of physical and technical controls, the Plan cannot ensure the protection and confidentiality of PHI. This can result in an increase to member vulnerability and threat of fraudulent activity.

4.3.2 **Timely notification of security breach**

The Contract requires the Plan to notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach security of PHI. In addition, the Plan is required to notify DHCS Long-Term Care Division (LTCD) Contracting Officer, DHCS Privacy Officer, and the DHCS Information Security Officer within 24 hours of discovery of breach and within 5 working days report investigation of breach (Contract, Exhibit G (H)(1)).

The Plan's Policy and Procedure CRP-0075 "Management of Suspected Privacy Breaches of Personal Health Information and Personal Identifiable Information", states that notification to DHCS of Breaches involving Medi-Medi beneficiaries shall be made in accordance with the terms and conditions of any in-force DHCS contracts. The Plan did not report discovery of security breach to DHCS in a timely manner. During the audit period, the Plan learned of a security breach and launched an investigation that confirmed member information was obtained without authorization.

The Plan stated they were initially unaware of the security breach and did not notify the DHCS Privacy Office within 24 hours from the date of discovery.

Without ensuring timely reporting of security breaches, the Plan cannot effectively prevent unauthorized use of PHI.

RECOMMENDATIONS:

4.3.1 Monitor and ensure staff adhere to the new policies, procedures, and safeguards to protect member PHI.

4.3.2 Improve the notification process to DHCS to ensure security breaches are reported to the proper authorities in a timely manner.

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CATEGORY 5 – QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

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

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

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

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

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

SUMMARY OF FINDINGS:

5.2.1 California Registered Nurse (RN) License Requirements

The Plan is required to "ensure that the UM program includes Qualified staff …" (Contract, Exhibit A, Attachment 5(1)(A)). In addition, the Plan must comply with all standards, requirements and responsibilities stipulated and agreed to in the Contract between the Plan and the Department of Health Care Services (DHCS) including administration and staffing (CCR, Title 22, section 53840 (b)(c)). The contract defines a nurse as a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN) (Contract, Exhibit E, Attachment 1(5)).

Business and Professions Code 2732 stipulates, no person shall engage in the practice of nursing, as defined in Section 2725, without holding a license which is in active status issued under this chapter except otherwise provided in this act. As required and mandated by the California Board of Registered Nursing, a nurse must have a California registered license to practice nursing in direct and indirect patient care settings (Business & Professions Code 2725 (b)).

The Plan did not ensure contracted nurses who preview appeals met California licensing standards and requirements. During the interview, the Plan stated they have a contract with an outside staffing organization to provide U.S. licensed nurse reviewers who work remotely outside of the United States. According to the staffing contract, nurses will review, investigate and render final appeal decisions and recommendations on the appeal case assigned. Review of appeal nurse qualifications revealed 15 nurse reviewers do not have a California registered license.

During the onsite interview, the Plan acknowledged that contracted appeal reviewers hold nursing licensure from various states throughout the United States, but not necessarily in

California. In addition, review of the Plan's contracted staff credential status list confirmed 15 appeal review nurses do not hold California registered nursing licensure.

Without ensuring nurses meet licensing standards and requirements to practice in California, the Plan cannot confirm qualified professionals are properly performing tasks and providing care for California members.

RECOMMENDATION:

5.2.1 Develop and implement procedures to ensure that staff, including contractors, are qualified to practice in California according to contract requirements, California Code of Regulations, Business and Professions Code, and licensing boards including but not limited to the California Board of Registered Nursing.