MEDICAL REVIEW – NORTHERN SECTION I
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
dba
Central California Alliance for Health

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Through
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I. INTRODUCTION

The Santa Cruz-Monterey-Merced Managed Medical Care Commission is the governing board that oversees the Central California Alliance for Health (CCAH or the "Plan"). In 1993, the Santa Cruz County Board of Supervisors initially appointed the Commission to form a proposed countywide health plan. The Commission's Contract with the State of California was approved, and in January 1, 1996 the Plan became an exclusive county-wide Medicaid healthcare delivery system serving the healthcare needs of local Members.

As a County Organized Health System (COHS), the Plan serves 236,000 Members in the counties of Santa Cruz, Monterey, and Merced. The Plan's Members represent about 25% of the population in these counties.

The Plan contracts with a total of 4,760 providers in the geographical areas it serves, which forms its provider network. The Plan has two delegated entities that serve Medi-Cal Members, Beacon/College Health IPA (CHIPA) and Vision Services Plan (VSP). Beginning January 1, 2014, Beacon provided the expanded behavioral health benefits for Medi-Cal Managed Care Members. VSP provides routine vision services for Members.

As of April 2014, the Plan serves 236,000 Members: 234,500 Medi-Cal in Santa Cruz, Monterey, and Merced counties; 800 Healthy Kids in Santa Cruz County; 400 Alliance Care In-Home Supportive Services (IHSS) in Monterey County, and 300 Alliance Care Access for Infants and Mothers (AIM) in Monterey County.
II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of June 1, 2013 through May 31, 2014. The on-site review was conducted from September 8, 2014 through September 19, 2014. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on January 8, 2015 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 finding. The Plan submitted supplemental information after the Exit Conference which is reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability to Care, Members’ Rights, Quality Management (QI), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan does not ensure that Medi-Cal guidelines consistently take precedence over all other medical decision making guidelines. Pharmacy prior authorizations were not consistently decided within 24 hours or one business day.

The Plan’s Evidence of Coverage erroneously informs Medi-Cal Members that they must confirm that out of state emergency rooms (ERs) accept Medi-Cal before obtaining ER services and, if not, Members may be responsible for the bill. This language is not consistent with the Contract.

The Plan has an outdated policy that refers to the behavioral health benefit as a carve-out service, and cites non-existent grievance and appeals policies.

The Plan does not track nor does it ensure PCPs track open or unused referrals requiring prior authorization. The Plan delegates tracking of referrals requiring prior authorization to their completion to its Primary Care Providers (PCPs) but only evaluates this process during the every-three-year facility site reviews.

The Plan delegated Utilization Management to one of its entities prior to the Compliance Committee’s approval of the pre-delegation audit and without documented resolution of issues raised by other Plan departments.
Category 2 – Case Management and Coordination of Care

Requirements were not met as evidenced by: Providers interviewed were not aware that there were Complex Case Management Services. Policies and program descriptions did not contain language that described the contractually required services or roles of the multidisciplinary team.

The Plan did not fully execute a Memorandum of Understanding (MOU) with the local Regional Centers as required by Contract.

The Plan did not demonstrate effective monitoring of Initial Health Assessment (IHA) compliance with a valid methodology and did not ensure a continuous quality improvement approach to address the low compliance rate, prevent decline, and prepare for anticipated increases in enrollment.

Category 3 – Access and Availability of Care

The Plan did not ensure a continuous quality improvement approach to the analysis of its various access surveys. In addition, the Plan did not provide clear information to Members regarding the expected time to receive various appointments consistent with the Contract and Plan’s accessibility standards. Finally, the Plan did not ensure that providers who did not comply with its access standards submit corrective action plans as required by its policy.

The Plan did not have an effective monitoring process for after-hours calls. The Plan did not have a contract with a 24-hour Nurse Advice Line (NAL) but instead delegated this responsibility to providers; however, the self-reported access survey identified gaps in this service.

The Plan did not have policies and procedures to monitor access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. This is a repeat finding.

Category 4 – Members’ Rights

The Plan’s procedures did not include a routine review of all grievance cases by clinical staff to ensure that quality of care grievances are not overlooked. The Plan has non-clinical staff, without appropriate training, determine quality of service versus quality of care grievances.

The Plan inappropriately categorized many grievances as 24 hour complaints, which resulted in suboptimal investigations for numerous grievances. The Plan resolved the majority of these grievances by switching the Members’ primary care physician, but did not conduct investigation of the underlying issues.
The Plan prematurely closed quality of care grievances prior to medical director review and resolution of the potential quality issue investigation. The Plan sent factually inaccurate grievance resolution letters stating that cases had been reviewed by the grievance committee, prior to that review.

The Plan’s policies and procedures for the notification timeframe of Patient Health Information (PHI) disclosures did not comply with the current Contract. The Plan did not report a PHI disclosure according to this timeframe requirement.

**Category 5 – Quality Management**

The Plan did not conduct continuous quality improvement of access related issues, of the grievance process, and of compliance with Initial Health Assessment (IHA) completion, as follows; the Plan did not engage the Quality Improvement Committee (QIC) and Clinical Quality Improvement Committee (CQIC) in access related issues; the Plan did not ensure a thorough investigation of all grievances, including 24 hour complaints; and the Plan did not initiate active measures to address declining IHA completion rates in the face of increasing enrollment.

While the Plan routinely monitors the National Practitioner Data Bank and the Medical Board of California, they did not routinely review the Medi-Cal Suspended and Ineligible Provider List.

The Plan delegated Quality Improvement to one of its entities, prior to the Compliance Committee’s approval of the pre-delegation audit.

**Category 6 – Administrative and Organizational Capacity**

The Plan sent resolution letters to Members in advance of the CMO or Medical Director completing the PQI investigation.

The Plan did not preliminarily investigate and report to DHCS Suspected Fraud Waste and Abuse (FWA) cases within the required time frame. The Plan did not continuously ensure that suspended/ineligible providers were not contracted by the Plan. In addition, the Plan did not ensure that suspended/ineligible prescribers, whether contracted or not, were not able to order or prescribe services covered by the Medi-Cal program.
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 September 8, 2014 through September 19, 2014. 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 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: 22 medical and 22 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Notification of Prior Authorization Denial, Deferral, or Modification: 34 denial and modification letters were reviewed for written notification requirements.

Appeal Procedures: 16 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Coordination of Care: 45 records were included in a review of coordination of care between the Plan, PCP, Member, Specialty Providers, and other services.

Category 3 – Access and Availability of Care

Emergency Service Claims: 20 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 20 family planning claims were reviewed for appropriate and timely adjudication.
Category 4 – Members’ Rights

Grievance Procedures: 38 thirty-day grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. 146 twenty-four-hour grievances were also reviewed for appropriateness of resolution.

Category 6 – Administrative and Organizational Capacity

New Provider Training: 15 new provider training records were reviewed for 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: Central California Alliance for Health

AUDIT PERIOD: June 1, 2013 Through May 31, 2014

DATE OF AUDIT: September 8, 2014 Through September 19, 2014

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1 UTILIZATION MANAGEMENT PROGRAM

Utilization Management (UM) Program Requirements:
Contractor 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…. (as required by Contract)
COHS Contract A.5.1

There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
COHS Contract A.5.2.B

Under- and Over-Utilization:
Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services.
COHS Contract A.5.4

SUMMARY OF FINDINGS:

The Plan has developed and maintains a UM program with the necessary structure and qualified personnel to ensure appropriate processes are in place to review and approve the provision of Medically Necessary Covered Services. The Plan utilizes nationally recognized, peer reviewed criteria for medical decision making. It utilizes inter-rater reliability testing to ensure consistent application of criteria.

The Plan did not consistently apply medical decision making criteria in review of prior authorizations. An appeal from the audit period was overturned because the original physician reviewer had denied the service utilizing Milliman guidelines, though the physician recognized that the service was allowable by Medi-Cal guidelines. The decision was appropriately overturned on appeal, as Medi-Cal guidelines had been met. According to the Contract, the Plan must ensure that, "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 Medi-Cal Fee-For-Service" (Exhibit A, Attachment 10, 1). The Plan does not ensure that Medi-Cal guidelines consistently take precedence over all other medical decision making guidelines, so that Medi-Cal covered services are not denied. There is no policy which outlines how the various criteria are to be applied. When asked about the appeal case referenced above, Plan senior staff responded that criteria hierarchy is decided on a case by case basis.

Prior authorization is not required for certain services including ER and family planning services. However, the Plan’s EOC has incorrect language regarding the payment of ER services. The EOC implies that Medi-Cal members must first check that an out of state ER accepts Medi-Cal before obtaining ER services, and that the member might be responsible for the bill if the out of state ER does not accept Medi-Cal. This language is not consistent with the Contract (Exhibit A, Attachment 8;12) or California Health and Safety Code 1317.
RECOMMENDATIONS:

- Ensure Medi-Cal guidelines consistently take precedence over all other medical decision making guidelines so that Medi-Cal covered services are not denied.
- Modify language in the Member EOC to accurately reflect the Contract and statute regarding the payment of ER services.

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)

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

Notification of Prior Authorization Denial, Deferral, or Modification:
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

SUMMARY OF FINDINGS:

Although Policy #: 403-1103 Pharmacy Authorization Request Review Process states that pharmacy prior authorizations will be decided within 24 hours or one business day; in practice, the Plan extends pharmacy prior authorizations when additional information is required from the provider. This is in violation of the Contract and statute (W&I code 14185(a)), which require a 24 hour turnaround time on pharmacy prior authorizations. Ten of twenty two pharmacy prior authorizations reviewed were delayed greater than one business day.

The Plan has conflicting policies with regards to referrals for non-contracted providers. Policy #: 404-1310, Authorization Process for Referrals to Out of Service Area Providers, states that referrals to any In Service Area Provider, whether contracted or not, who is willing to see the member, do not require prior authorization; while Policy #: 404-1201, Authorization Request Process, states that services requiring authorization include all requests for referral to non-contracted providers and facilities, both in and out of area. Policy #: 404-1201 also refers to the behavioral health benefit as a carve-out service, and cites non-existent grievance and appeals policies.

A verification study of 22 medical and 22 pharmacy prior authorizations revealed one denied medical PA without a NOA (Notice of Action) letter sent to the member, and one denied medical PA with a delayed (8 business days after the decision) NOA letter to the member.
RECOMMENDATIONS:

- Adhere to contractual and statutory time frames with regards to pharmacy prior authorization turnaround time.
- Clarify policies and procedures regarding out of network and out of service area referrals.
- Update Policy #: 404-1201 to accurately reflect the behavioral health benefit, and the correct policies and procedures with regards to the grievance and appeals process.
- Ensure NOA letters are sent whenever a service is modified or denied and that such letters are sent promptly (no later than the 3rd business day after the action or determination).

1.3 REFERRAL TRACKING SYSTEM

Referral Tracking System:
Contractor is responsible to ensure that the UM program includes... An established system to track and monitor services requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified prior authorizations, and the timeliness of the determination. COHS Contract A.5.1.F

SUMMARY OF FINDINGS:

The Plan does not track nor does it ensure Primary Care Providers’ (PCP) track open or unused referrals requiring prior authorization. The Plan tracks only the timeliness of referral authorization approvals or denials. The Plan delegates the tracking of referrals requiring prior authorization to their completion, to its PCPs, as outlined in the Provider Manual and Policy #: 404-1313, PCP Responsibilities Including Case Management and Patient Centered Medical Homes, and Policy #: 404-1303, Referral Consultation Request Process. PCPs are required to maintain an up to date referral tracking log. The Plan reviews that log only at the every three year facility site review, or sooner, if that provider has an interim review; interim reviews are not, however, standard for all providers.

RECOMMENDATIONS:

- Develop and implement a process to track open or unused referrals requiring prior authorization.
- Monitor PCPs’ referral tracking process for referrals requiring prior authorization.
1.4 PRIOR AUTHORIZATION APPEAL PROCESS

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

SUMMARY OF FINDINGS:
As the Plan’s Policies and Procedures describe and the Contract mandates, one of the three medical directors must review each appeal of a modified or denied request for medical or pharmaceutical services. There were a total of 16 appeals during the audit period, all of which were reviewed. For one appeal there was no physician review of the appeal; the appeal was upheld by a nurse. Eleven denials were upheld and five were overturned. One acknowledgement letter was sent one day late, and in another appeal, the resolution letter was sent after 30 days without a Notice of Unresolved Complaint Letter sent to the Member.

RECOMMENDATIONS:

- Ensure all appeals are reviewed by a physician, as per Contractual requirements.
- Ensure all appeal acknowledgement letters are sent out within the required five day time frame.
- Ensure all appeal resolution letters are sent within the required 30 day time frame, and if not, that a Notice of Unresolved Complaint Letter is sent to the Member.
## DELEGATION OF UTILIZATION MANAGEMENT

**Delegated Utilization Management (UM) Activities:**
Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.

COHS Contract A.5.5

### SUMMARY OF FINDINGS:

The Plan has a delegation oversight process in place for the monitoring of UM by its two delegates, Beacon/College Health IPA (CHIPA) and Vision Services Plan (VSP). Pre-delegation and annual oversight audits are performed. However, Beacon/CHIPA began providing services to the Plan in January 2014; the Compliance Committee did not approve Beacon/CHIPA for delegation until the April 2014 meeting. Furthermore, there was no documentation that issues raised by various department subject matter experts, including UM, regarding the pre-delegation audit findings, had been addressed. Policy #: 404-1201, *Authorization Request Process*, states that delegation of UM is overseen by the Delegated Oversight Committee, though as of January 2014 this committee was absorbed into the Compliance Committee.

### RECOMMENDATIONS:

- Ensure Compliance Committee approval is obtained prior to delegation of UM activities.
- Ensure all issues on the pre-delegation audit for a delegated entity are resolved prior to approving delegation.
- Update Policy #: 404-1201 to accurately reflect that UM delegation is overseen by the Compliance Committee.
## CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

### 2.1 CASE MANAGEMENT AND COORDINATION OF CARE: WITHIN AND OUT-OF-PLAN

**Case Management and Coordination of Services:**
Contractor shall ensure contracted providers provide basic comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor’s provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.

**COHS Contract A.11.1**

**Out-of-Plan Case Management and Coordination of Services:**
Contractor shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services...

**COHS Contract A.11.6**

### SUMMARY OF FINDINGS:

**Basic Case Management:**

According to the Contract, Basic Case Management (BCM) services are provided by the Primary Care Provider (PCP) in collaboration with the Plan and include: Initial Health Assessment (IHA), Initial Health Education Behavioral Assessment (IHEBA), identification of appropriate providers and facilities to meet Member care needs, and coordination of carved out and linked services.

**Initial Health Assessment:** Requirement not met. See findings in 2.4 Initial Health Assessment.

**Identification of Providers and Facilities to Meet Member Care Needs**

The Contract requires the Plan to identify appropriate providers and facilities to meet the Member’s care needs. Onsite interviews were conducted with PCPs who reported several specialty providers and services within and outside the network were difficult to access and often Members waited months to receive appointments. Specialty providers and services for mental health and chronic pain management were cited by PCPs as difficult to access. Difficulties accessing orthopedists, neurologists, allergists, and dermatologists were also described and some providers expressed concern that Members would be at risk for adverse outcomes related to a delay in treatment. Similarly, the Plan’s provider satisfaction survey results for 2013 found that PCPs cite the need for increased access to orthopedics, mental health, ENT, dermatology, neurology, and in Santa Cruz County, in particular, pain management services were cited.

The Plan did not demonstrate a strong quality improvement approach to well-documented and continuous problems with access to care thereby failing to ensure the availability of appropriate providers and services to meet members’ care needs. Requirement not met. See findings in 5.1 Quality and 3.1 Access.

**Coordination of Carved-Out and Linked Services:** Requirement not met. See findings in 2.3 EI/DD.
Complex Case Management

According to the Contract, Complex Case Management services are provided by the PCP in collaboration with the Plan and include, at a minimum, the following: Basic Case Management services, management of acute or chronic illness, emotional and social support needs by a multidisciplinary team, intense coordination of resources to ensure member regains optimal health or improved functionality, development of care plans specific to individual needs, and updating of plans annually.

The Plan’s Policy#: 405-1113, Care Management Complex Case Management, defines Complex Case Management as the “systematic coordination and assessment of care and services provided to members by a multidisciplinary team for Members…who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.”

A program description of the Plan’s Complex Case Management Services was found in the 2014 Provider Manual. According to this Manual, the case management team (RNs, LVNs, and social workers), facilitates care for Members who “have very complex health issues and need assistance in managing their lives”. The March 2014 Provider Newsletter contained a description of the Complex Case Management Program as well but both the Manual and Newsletters lacked language that indicated the program provided contractually required services to include emotional and social support from a multidisciplinary team with management of acute or chronic illness, intense coordination of resources to ensure member regains optimal health or improved functionality, and individualized care plans prepared by the team with the involvement of the PCP and Member.

Although the Contract requires that PCPs provide Complex Case Management, the role of PCP was not clearly and consistently referenced in the Plan’s policies or Provider Manual with regard to these services. The Plan’s Policy #: 404-1313, Primary Care Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home, did not clarify the role of PCP in the provision of Complex Case Management. The Plan’s Policy #: 405-1113, Care Management Complex Case Management, stated that the PCP provides Basic Case Management while the Plan’s Care Management Department provides Complex Case Management. The Plan’s Policy #: 405-1113 noted that the Basic Care Management services provided by PCPs were “different than Complex case management services.” This policy further stated that the multidisciplinary team is comprised of nurses, social workers, health educators, dietitians, pharmacists, care coordinators, and “medical directors” but Primary Care Providers were not listed as members of the team. Similarly, the Plan’s Provider Manual states the members of the multidisciplinary team include “RNs, LVNs, and social workers” and does not mention the role of PCP as a member of that team.

Policy #: 405-1113 states that Members whose care needs are high risk or complex will be identified as eligible for CCM services based on predictive modeling or claims analysis, hospital emergency department and readmission data, or the Member and PCP may request services. Member enrollment in Complex Case Management during the audit year was examined. The Plan’s written report of referrals to Complex Case Management showed there were 47 Members referred from three counties during the first four months since the program’s inception. The Plan provided narratives of the reasons for referral into Complex Case Management. Less than half of the referrals were consistent with the Plan’s criteria for Member participation in the program or the contractual requirement for services. Many of these referrals appeared related to Basic Case Management. For example, several were referral requests for speech therapy for children and 13 were generated by an administrative representative from a clinic where the pain management provider was on a leave of absence, creating a gap in services for those Members who were referred for “help with pain management care with other clinic providers”. Few referrals were generated by PCPs and none were identified through predictive modeling, claims analysis, or readmission data.
Multiple providers were interviewed in the Plan’s three counties of operation and the majority reported little or no knowledge of the Plan’s Complex Case Management services however each agreed it was possible to readily identify Members whose care needs were complex and who might benefit from emotional and social support, help managing acute and chronic illness, and intense coordination of resources from a multidisciplinary team. The provider knowledge deficit about Complex Case Management was most acute in Merced County and the referral log for the program showed that only three Member referrals from the list of 47 were generated in that county.

**Requirements were not met as evidenced by**

- Providers interviewed were not aware that there were Complex Case Management Services
- Policies & program descriptions did not contain language that described the contractually required services.
- Policies and program descriptions did not clarify the roles of the multidisciplinary team.

**RECOMMENDATIONS:**

- Ensure Primary Care Providers are educated regarding Complex Case Management services available for Members, the role of PCP, and how these services are accessed.
- Ensure policies and procedures describe contractually required Complex Case Management services and the roles of multidisciplinary participants.
### EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

#### Services for Persons with Developmental Disabilities:

A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

B. Contractor shall provide all screening, preventive, Medically Necessary, and therapeutic Covered Services to Members with developmental disabilities. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall monitor and coordinate all medical services and Medically Necessary Outpatient Mental Health Services with the Regional Center staff, including identification of all appropriate services, which need to be provided to the Member.

C. Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered under this Contract. Contractor shall implement and maintain systems to identify Members with developmental disabilities that may meet the requirements for participation in this waiver and refer these Members to the HCBS waiver program administered by the State Department of Developmental Services (DDS). If DDS concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled in the plan. Contractor shall continue to provide all Medically Necessary Covered Services.

D. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, Provision 2 for the coordination of services for Members with developmental disabilities.

**COHS Contract A.11.11**

#### Early Intervention Services:

Contractor shall develop and implement systems to identify children under three (3) years of age who may be eligible to receive services from the Early Start Program and refer them to the local Early Start Program. Contractor shall collaborate with the local Regional Center or local Early Start Program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start Program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start Program, with Primary Care Provider participation.

**COHS Contract A.11.12**

### SUMMARY OF FINDINGS:

The Contract requires the Plan to execute a Memorandum of Understanding (MOU) with local Regional Centers for coordination of services provided by this program. The Plan has MOUs with two Regional Centers; San Andreas Regional Center/Early Start (SARC/ES) and Central Valley Regional Center (CVRC). Both MOUs required annual review and revision as needed. Both MOUs also required meetings on a semi-annual (CVRC) or annual (SARC/ES) basis with agendas and meeting minutes to be submitted to the state. However, the Plan did not review the MOUs according to these requirements. These MOUs were last updated in August 2009.

According to the MOUs, The Plans Health Services Director, or designated liaison, will meet with the Regional Centers for coordination of services to members semi-annually and annually to resolve operational, administrative, and policy issues and ensure ongoing communication. The Plan provided emails showing two meetings were scheduled in March 2013 and November 2013 between the Plan and SARC. The Plan could not provide agendas or meeting minutes documenting meetings and communication between the Plan's liaison and the Regional Center staff actually occurred on a semi-annual or annual basis.
The requirement for the execution of the MOU with the local Regional Center for Services for Persons with Developmental Disabilities (DD) was not met.

**RECOMMENDATION:**

Ensure MOUs between the Plan and the Regional Centers are fully executed.
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.10.6

SUMMARY OF FINDINGS:
The Contract requires the Plan to ensure each Member receives an Initial Health Assessment (IHA) consisting of a comprehensive history, physical and mental status examination, identified diagnoses, and a plan of care within 120 days of enrollment. The IHA content must conform with requirements established by Title 22 CCR Section 53910.5(a)(1). According to the Plan’s Policy #:401-1511, Initial Health Assessment, the requirement for IHA was monitored through Facility Site Reviews (FSR) and quarterly IHA Compliance Reports. The Plan’s monitoring activities were examined through review of IHA Compliance Reports, Clinical Quality Improvement (CQI) meeting minutes, and interviews with Plan staff and PCPs.

IHA Compliance Reports: The IHA Compliance reporting was conducted quarterly during 2013 and monthly during 2014. According to the Plan’s methodology statement, the intent of the IHA Compliance Report was to quantify the newly enrolled members who received an IHA within 120 days of their enrollment. Compliance rates were calculated based on claims data submitted for encounters in primary care.

According to methodology statements in the IHA Compliance Reports, the Plan used 46 billing service/procedure codes in 2013 to determine IHA compliance. Not all of the 46 codes accepted by the Plan describe the complexity or time element required for a comprehensive initial health assessment (CPT® 2013 Professional Edition). For example, Evaluation and Management (E/M) Code 99211 does not represent a visit that encompasses a comprehensive initial health assessment. This code is used for a visit that typically lasts five minutes, involves a problem of minimal severity, and does not require a history. Similarly, E/M Codes 99201 and 99212 represent visits that typically last ten minutes and the histories and exams are problem-focused. Problem-focused histories include the chief complaint and a brief history of the present illness or problem. Problem-focused exams are those with limited examination of the affected body area or organ system.
An IHA, by contractual definition, consists of a comprehensive history, physical and mental health examination, a behavioral assessment, and diagnoses. The IHA is comprehensive enough to enable the PCP to assess and manage the member’s acute, chronic, and preventive health needs and to develop a plan of care.

In the 1st quarter of 2014, the methodology for monitoring IHA compliance was revised but billed service/procedure codes insufficient to describe an IHA visit remained on the new list of 27 qualifying codes. For example, E/M Code 99213 is an established patient code used for a visit that typically lasts 15 minutes and involves a limited examination of an affected body area or organ system.

In the revised IHA compliance methodology, the Plan continued to define IHA encounters using a select set of CPT codes without confirming that the select codes correlated with the actual performance of an IHA. Without this confirmation, the subsequent calculated IHA rates represent conjecture. The lack of a validated methodology to calculate and track IHA performance prevented the Plan from monitoring compliance and from detecting or correcting patterns or instances of noncompliance.

Continuous Quality Improvement:

The Plan’s efforts to address the low compliance rate, prevent its decline, and prepare for anticipated increases in enrollment were examined through interviews with Plan staff and through review of documents including the CQIW, CQIC, and QIC meeting minutes for the audit period.

While the Plan was able to demonstrate it routinely informed Members and providers of the IHA requirement through the use of ongoing trainings for providers, outreach to new Members, newsletters, and policies, its continuous quality improvement with regard to an at-risk and declining compliance rate was not evident in its CQIW, CQIC, and QIC minutes or in the compliance outcomes during the audit period (see Section 5.1).

The contractual requirement to ensure that each member receives an IHA within 120 days of enrollment was not met as evidenced by:

- The Plan was unable to demonstrate its monitoring through the use of valid methodology.
- The Plan was unable to demonstrate continuous quality improvement in the context of the evolving decline in IHA compliance amid anticipated rising enrollment.

RECOMMENDATIONS:

- Ensure IHA completion monitoring is based on valid methodology to measure compliance.
- See Section 5.1 for recommendations regarding Continuous Quality Improvement.
**COMPLIANCE AUDIT FINDINGS**

PLAN: Central California Alliance for Health

AUDIT PERIOD: June 1, 2013 Through May 31, 2014

DATE OF AUDIT: September 8, 2014 Through September 19, 2014

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**CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE**

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<table>
<thead>
<tr>
<th>3.1</th>
<th>APPOINTMENT PROCEDURES AND WAITING TIMES</th>
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</table>
| **Appointment Procedures:** | Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children’s preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.  
COHS Contract A.9.3.A  
Members must be offered appointments within the following timeframes:  
   c) Non-urgent primary care appointments – within ten (10) business days of request;  
COHS Contract A.9.3.A.2  
**Prenatal Care:**  
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within 10 business days upon request.  
COHS Contract A.9.3.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 Subprovision A, Appointments, above.  
COHS Contract A.9.3.C |

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**SUMMARY OF FINDINGS:**

Policy #: 300-8030, *Monitoring Network Compliance with Accessibility Standards*, describes the Plan’s process to ensure Member’s access to care. The Plan subcontracted the conduct of the Plan’s Annual Accessibility and Appointment Availability Survey, the Member Access Satisfaction Survey, and the CAPHS Survey.

The Accessibility and Appointment Availability survey is a self-reported survey. For example, the survey simply inquired of providers how long they think the waiting time is to see a doctor at the providers’ offices or the time it took providers to answer or return telephone calls from Members; the survey did not determine how long such waiting times actually took. The Plan did not verify the results of the access survey with follow-up phone calls or secret shopper calls.

In addition, the Plan did not conduct 3rd Next Available Appointment verification to determine the time to obtain various types of appointments.

Policy #: 300-8030 requires that the rate of compliance, as determined by the annual accessibility survey, be reported to Access Initiative and Clinical Quality Improvement Committee. The Access Initiative meeting minutes indicated that they received a presentation of the survey results. The Clinical Quality Improvement Committee (CQIC) meeting minutes were examined, but review of the rate of compliance, as determined by the survey results, was not documented.
The CQIC or QIC meeting minutes did not indicate that the results of these surveys (Annual Accessibility and Appointment Availability Survey, the Member Access Satisfaction Survey, and the CAPHS Survey) were compared and evaluated.

The Member Services Guide provided conflicting information regarding the expected time to receive various appointments and is not consistent with the Plan’s accessibility Standards indicated in Policy #: 401-1509, Accessibility. For example, the Member Services Guide advises Members to make routine, non-urgent appointment three to six weeks in advance. However, the Contract and the Plan’s accessibility standards require routine, non-urgent appointments to be available within ten business days.

Policy #: 300-8030, Monitoring Network Compliance with Accessibility Standards, requires that “the Access Initiative shall investigate and implement corrective action, including taking all necessary and appropriate actions to identify the cause of the identified timely access deficiencies and steps to bring the network into compliance.” The Plan sent letters to providers who had access deficiencies identified for two consecutive years. The letters did not request corrective action plans. The Contract requires that “Contractor shall communicate, enforce, and monitor providers’ compliance with these [accessibility] standards.”

RECOMMENDATIONS:

- Ensure Clinical Quality Improvement Committee (CQIC) reviews, compares and evaluates the results of the access-related surveys.
- Ensure Member Services Guide provides clear information regarding the expected time to receive various appointments that are consistent with the Contract and Plan’s accessibility standards.
- Ensure providers who did not comply with the access standards submit corrective action plans as required by the Plan’s policy and the Contract.
### 3.3 TELEPHONE PROCEDURES / AFTER HOURS CALLS

**Telephone Procedures:**
Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.
COHS Contract A.9.3.D

Contractor shall maintain the level of knowledgeable and trained staff sufficient to provide Covered Services to Members and all other services covered under this Contract.
COHS Contract A.13.2.A

**After Hours Calls:**
At a minimum, Contractor shall ensure that a Physician or an appropriate licensed professional under his/her supervision is available for after-hours calls.
COHS Contract A.9.3.F

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**SUMMARY OF FINDINGS:**

The Plan arranges for the provision of telephone triage and after-hours calls through the Plan’s Primary Care network. Plan Policy #: 401-1514, *In-Office Telephone Triage*, defines telephone triage as “…the system for managing telephone callers during and after office hours”. This policy states that “All PCP sites maintain procedures for staff answering telephones which detail triage instructions for specific presenting signs and symptoms including medical emergencies. Compliance with this policy is monitored during (the every three years) Facility Site Review.”

The Plan does not effectively monitor providers’ telephone triaging or after-hours call availability. The Plan subcontracted the conduct of the Plan’s Annual Accessibility and Appointment Availability Survey. This survey asked, using language that is very similar to CCR, Title 28, section 1300.67.2.2(c)(8)(B)(1): “Does your practice provide a telephone appointment triage or screening services, such as an answering machines or answering services”. Twenty-five percent of providers responded no to this question.

The Contract and CCR, Title 28, 1300.67.2.2 (c) (8) (B) (2) requires that “A plan that arranges for the provision of triage or screening services through contracted primary care and mental health care providers who are unable to meet the time-elapsed standards established in paragraph (8)(A) shall also provide or arrange for the provision of plan-contracted or operated triage or screening services, which shall, at a minimum, be made available to enrollees affected by that portion of the plan's network.”

However, the plan does not contract with a 24 hours Nurse Advice Line, nor offer 24 hours per day, seven day per week telephone triaging/screening services to the Members who are affected by the 25% of PCPs who responded they do not provide these services.

**RECOMMENDATION:**

Develop and implement policies and procedures to effectively monitor and ensure appropriately licensed professionals are available for triaging/screening Members’ telephone and after-hours calls.
### COMPLIANCE AUDIT FINDINGS

**PLAN:** Central California Alliance for Health

**AUDIT PERIOD:** June 1, 2013 Through May 31, 2014

**DATE OF AUDIT:** September 8, 2014 Through September 19, 2014

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#### 3.7 ACCESS TO PHARMACEUTICAL SERVICES

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

Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours. Contractor shall develop and implement effective drug utilization reviews and treatment outcomes systems to optimize the quality of pharmacy services.

Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. Contractor shall meet this requirement by doing all of the following: … (as required by Contract).

COHS Contract A.10.8.F.1

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#### SUMMARY OF FINDINGS:

The Plan utilizes a Pharmacy Benefit Manager (PBM) for claims processing, payment, and pharmacy network administration. In addition, credentialing of pharmacy providers is delegated to the PBM. The Pharmacy and Therapeutics Committee maintains the drug formulary, reviews policies that guide use of drugs, and performs quality assurance activities related to drug utilization.

The Plan contracts with only three 24-hour pharmacies: two in Monterey County, one in Santa Cruz County, and none in Merced County. As such, the Plan relies on, and has policies and procedures requiring emergency departments to provide a sufficient quantity of medication in an emergency situation, until Members can reasonably be expected to have a prescription filled.

The Plan does not have policies and procedures in place to monitor and ensure that emergency drugs are actually provided to Members as required by Contract. The Plan did not completely or consistently determine emergency department compliance with these requirements throughout the audit period. During the interview, Plan personnel stated and showed documentation that during the first half of 2013 the monitoring of ER drugs was done by tracking four diagnoses codes of selected patients who went to the ER and reviewing them to ensure these patients received a 72 hour supply of medication. In late September 2013 Policy #: 403-1126, *Pharmaceutical Services Access*, was amended to only require contracted area hospitals with emergency departments to annually submit a copy of their current policies and procedures regarding the dispensing of medications to patients in emergency situations and attest that Plan Members have access to sufficient drugs in emergency situations. This annual attestation does not actively monitor the dispensing of medication to members in emergency situations, as per Contract requirements. **This is a repeat finding.**

#### RECOMMENDATION:

Develop and implement policies and procedures to ensure the monitoring of and access to a 72-hour supply of covered outpatient medications in emergency situations.
CATEGORIE 4 – MEMBERS’ RIGHTS

4.1 GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance system in accordance with Title 28 CCR Section 1300.68 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph D.13, and 42 CFR 438.420(a)(b) and (c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member’s health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

COHS Contract A.14.1
Contractor shall implement and maintain procedures…to monitor the Member’s Grievance system and the expedited review of grievances required under Title 28 CCR Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858…. (as required by Contract)

COHS Contract A.14.2
Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

COHS Contract A.14.3.A

SUMMARY OF FINDINGS:
The Plan has a grievance process as outlined in contractual and statutory requirements. However, the Plan allows non-clinical Member Services Representatives (MSRs) the discretion to decide what qualifies as a 24-hour grievance (exempt from written notification to the Member) and what qualifies as a 30-day grievance. The only oversight of this process is conducted by non-clinical grievance coordinators. These same staff members are also responsible for differentiating between quality of care (QOC) and quality of service (QOS) grievances. The only oversight of this process occurs at the monthly Staff Grievance Review Committee meetings. However, not all grievance cases are reviewed individually at this meeting. The cases are reviewed one to several months after original receipt by the Plan, and after resolution.

Twenty-four hour grievances were frequently resolved with a switch of primary care provider (PCP) and the complaint closed with no further investigation into the underlying issue. Although the complaint may have been resolved in the member’s view, the switch to a new PCP did not explore or resolve the underlying issue that prompted the call. This resulted in several complaints, such as those related to long wait times, potential violations of personal health information, or lack of necessary translator services, which were not thoroughly investigated. Thus, an opportunity for continuous quality improvement was lost by the Plan (see section 5.1). Per the DHCS Grievance Questionnaire filled out by the Plan, Grievance Coordinators review each complaint within 24 hours to determine whether the case can be immediately resolved and is exempt (i.e., a 24-hour complaint), or if “the case requires investigation and resolution as a non-exempt 30-day case”. Title 28, 1300.68 section 8 states that, “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”. Twenty-four-hour grievances are exempt from a written acknowledgment and response, not from a complete investigation and resolution of the underlying complaint. The Plan recognized that the 24-hour/30-day grievance ratio was too high, and a concerted effort was made to correct this system weakness during the second half of the audit period.
MSRs do not have the training to assess those grievances that require further investigation beyond 24 hours, and do not have the training to differentiate Quality of Service (QOS) from Quality of Care (QOC); nor do the grievance coordinators. There is no consistent clinical oversight of that process, which can result in overlooking potential QOC cases, particularly with the 24-hour grievances. Several of the 146 (all of the 24-hour complaints for the audit period) 24-hour grievances reviewed should have had more action taken than just a PCP switch, and would have been more appropriately categorized as 30-day grievances. For instance, one 24-hour grievance involved a member complaining about difficulty obtaining her seizure medication; she claimed she had several seizures as a result. The last line of the narrative in the Alliance Care Tracking (ACT) system was “member still doesn’t have her medication”; this should have been an immediate referral to the grievance team as a quality of care 30-day grievance with physician review. Although this case was eventually referred as a PQI, the grievance occurred on July 1, 2013 (date member stated that she didn’t have her medication) and the PQI was not opened until August 15, 2013. Additionally, there was no apparent resolution documented for many of the 24-hour grievances. There were cases where the member stated they would like to pursue a complaint, yet it remained a 24-hour grievance with no documentation that the option of a 30-day grievance was offered. Per Plan personnel, MSRs do not routinely offer members the option of filing a 30-day grievance when they call to complain. In the event that the Plan conducted further inquiry or made referrals associated with a 24 hour grievance, the documentation wasn’t adequate to support that investigation.

The QOC grievance investigation is accomplished through the PQI investigation in the quality department. Once a potential QOC grievance is referred to QI and accepted as a case, it is reviewed by an RN and physician, who investigate and resolve the case. While this occurs, a resolution letter is often mailed to the member. In twelve 30-day grievances, the grievance resolution letter was mailed within a few days of receipt of the grievance, yet the PQI investigation had just been initiated. Furthermore, the PQI investigation was completed prior to the 30 day window for resolution in many of those 12 cases. In addition, those 12 grievance resolution letters stated that the “Grievance Review Committee reviewed your complaint”; yet that review occurred after the letter was sent, as documented in the ACT system. Thus, the resolution letter was factually inaccurate, and did not represent a resolution as the PQI investigation had just begun. Furthermore, these potential quality of care complaints did not have physician review prior to the resolution letter being sent to the member. As per the Contract, the Medical Director’s responsibilities shall include the resolving of grievances related to medical quality of care (Exhibit A, Attachment 1, 6, E).

RECOMMENDATIONS:

- Ensure all 24-hour and 30-day grievances receive routine review by clinical staff to ensure that quality of care grievances are not overlooked.
- Provide specific training to member services staff and grievance coordinators on how to identify quality of care grievances.
- Ensure grievances requiring a full investigation are not inappropriately classified as 24-hour complaints by providing training to member services staff and conducting oversight of the grievance intake process.
- Amend practices to ensure quality of care grievance cases are not closed prematurely before the resolution of the potential quality issue and ensure that grievance resolution letters are accurate.
- Amend practices to ensure quality of care grievance resolution letters are not mailed prior to review of the grievance by a Medical Director.
**CONFIDENTIALITY RIGHTS**

**Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:**

**A. Responsibilities of Business Associate.**

2. **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, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316….(as required by Contract)

**J. 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.** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated “DHCS Privacy Incident Report” containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer;

3. **Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure….

**SUMMARY OF FINDINGS:**

The Plan’s HIPAA Compliance Program is under the Plan’s Compliance Program. The Plan’s Chief Operating Officer (COO) is designated as the Plan’s Compliance Officer. The Plan has a Privacy Officer and Security Officer that are both charged with HIPAA Compliance.

Policy #: 100-2005, *HIPAA Privacy and Security Committee*, describes the role of the HIPAA Committee to discuss the Plan’s policies and reports from the HIPAA Privacy Officer regarding any incidents and/or breaches that may have occurred. The HIPAA Committee was subsequently consolidated into the larger Compliance Committee where the reports of HIPAA are submitted.
Policy #: 100-2028, Security Breach, enumerates the Plan’s procedures to investigate and implement corrective actions for any violation of HIPAA requirements. This policy requires that “suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI and/or any actual suspected use of disclosure of PHI…” be notified to DHCS and DHCS Contracting Officer within twenty-four (24) hours during a work week. However, the amended contract as of January 1, 2014 (Contract No. 08-85216 Amendment No. 17) now requires, (1) an immediate notice to DHCS for discovery of any (electronic media or in any other media) breach or unauthorized disclosure of PHI and (2), a notice within 24 hours for suspected security incident or suspected disclosure of PHI.

Two unauthorized disclosures of PHI involved misdirected Remittance Advices (RAs) sent to incorrect providers. Both cases were reported to the DHCS Privacy Officer and MMCD Contract Manager more than 24 hours after they were first discovered. Neither one was reported to the DHCS Information Security Officer (ISO) as required by contract. One of the two cases, discovered on April 1, 2014 and is a known unauthorized PHI access by an incorrect provider, is subject to the amended Contract requirement of immediate notice to DHCS because it occurred after the effective date of this amendment and both were hard copy.

RECOMMENDATIONS:

- Ensure all cases, regardless of media type, involving unauthorized PHI disclosures discovered as of January 1, 2014 are reported to DHCS immediately.
- Ensure notifications of all cases involving unauthorized PHI disclosures are reported to the DHCS Information Security Officer and within the required timeframes of the amended Contract.
- Update Policy #: 100-2028, Security Breach, to be consistent with the amended Contract.
- Update Policy #: 100-2005, HIPAA Privacy and Security Committee, to refer to the Compliance Committee which has recently absorbed the HIPAA Privacy and Security Committee.
## CATEGORY 5 – QUALITY MANAGEMENT

### 5.1 QUALITY IMPROVEMENT SYSTEM

**General Requirements:**
Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

**COHS Contract A.4.1**

**SUMMARY OF FINDINGS:**

CCAH’s quality improvement program exists to monitor, evaluate and modify practices, as recommended by the Quality Performance Improvement Program (QPIP), and is staffed by qualified personnel. The Clinical Quality Improvement Committee (CQIC) is charged with implementation of the QI program, with the Quality Improvement Committee (QIC) providing direction and oversight. The CQIC met three times during the audit period, and the QIC twice.

The Plan did not exhibit continuous quality improvement with regards to persistent access issues. Numerous access issues were noted in various areas of the Plan. The 2013 Provider Satisfaction Survey revealed that only 38.5% of the responding providers felt that the Alliance had adequate numbers of high quality specialists to whom they could refer. Call center trending reports, as discussed in the Access Initiative minutes, repeatedly identified access as an issue for both PCPs and specialists. Several access related grievances in the 24 hour grievance log related to PCP access. There was no documented investigation or follow-up of those grievances. The resolution of the issue was for the beneficiary to switch to a different PCP. Despite these access issues noted in various areas, the issues were not discussed or documented as discussed, in the CQIC or QIC during the audit period. Finally, the Plan noted that its Providers scored highly on the timely access survey which the Meyers Group conducted in 2013. This, however, was a self-reported survey in which the Plan did not verify the results with follow up phone calls or secret shopper calls to Providers’ offices.

The Plan demonstrated a lack of continuous quality improvement by not actively addressing the continuing trend of IHA completion non-compliance. The compliance rate for IHA completion sharply declined for Q1 2014 and the beginning of Q2 2014, due to significant but expected enrollment increases. The Plan’s efforts to address the low rate of compliance and prevent decline included the development of an IHA workgroup and contracting with a vendor to implement outreach to new Members (“Care Calls”); however, rates continued to decline throughout 2013 and, more significantly, in 2014. Subsequently, the workgroup did not document active initiatives to improve the IHA compliance rate or prevent further decline, but only discussed a plan to address the issue. In April 2014, when the IHA compliance rate was down to approximately 4%, the workgroup reported to the CQIC that they were “in the process of identifying how to incentivize new members to seek care with providers to complete their IHA”; however, no such incentives were identified, and the compliance rate continued to fall through May 2014.

The Plan also demonstrated a lack of continuous quality improvement with regards to the grievance process. Numerous 24 hour grievances required a more thorough investigation than simply a switch of the member’s primary care provider. Frequently, there was no evidence of referral to another department, e.g. provider services, or any other follow-up which left the underlying initiating issue unaddressed.
RECOMMENDATIONS:

- Ensure the QPIP identifies and acts on opportunities to improve care and services including but not limited to continuous quality improvement of access related issues, the grievance process and Initial Health Assessment (IHA) compliance, as outlined below:
  
  - Implement engagement of the quality improvement committee and clinical quality improvement committee in access related issues.
  - Initiate active measures to address declining rates of IHA completion.
  - Ensure a thorough investigation of all grievances, including 24 hour complaints.
5.2 PROVIDER QUALIFICATIONS

**Credentialing and Re-credentialing:**
Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD, Credentialing and Recredentialing Policy Letter, MMCD Policy Letter 02-03. 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.

COHS Contract A.4.12

**Provider Qualifications:**
All providers of Covered Services, including physicians and specialists, must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered and have a valid National Provider Identifier (NPI) number.

COHS Contract A.4.12.A

**Delegated Credentialing:**
Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6. Delegation of Quality Improvement Activities…

COHS Contract A.4.12.C

**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.


**Medi-Cal and Medicare Provider Status:**
The Contractor will verify that their subcontracted providers, including physicians and specialists, have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider list. Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list, cannot participate in the Contractor’s provider network.

COHS Contract A.4.12.F

**SUMMARY OF FINDINGS:**
The Plan’s Policies and Procedures outline the process by which the Peer Review Credentialing Committee (PRCC) credentials and re-credentials providers and allied health professionals. There is an internal process which delineates the ongoing reviews of existing providers, between credentialing cycles. While the Plan routinely monitors the National Practitioner Data Bank and the Medical Board of California, they did not routinely review the Medi-Cal Suspended and Ineligible Provider List.

**RECOMMENDATION:**
Develop a policy and practice to check the Medi-Cal Suspended and Ineligible Provider List to routinely verify that Providers have not been suspended, and are eligible to participate in Medi-Cal, as per Contract requirements (Exhibit A, Attachment 4;12; E).
### 5.4 DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

**Delegation of Quality Improvement Activities:**

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum:

1. Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
2. Contractor’s oversight, monitoring, and evaluation processes and subcontractor’s agreement to such processes.
3. Contractor’s reporting requirements and approval processes. The agreement shall include subcontractor’s responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
4. Contractor’s actions/remedies if subcontractor’s obligations are not met.

B. Contractor shall maintain a system to ensure accountability for delegated Quality Improvement activities, at a minimum:

1. Evaluates subcontractor’s ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
2. Ensures subcontractor meets standards set forth by the Contractor and DHCS.
3. Includes the continuous monitoring, evaluation and approval of the delegated functions.

COHS Contract A.4.6

### SUMMARY OF FINDINGS:

The Plan has a delegation oversight process in place for the monitoring of QI by its two delegates, Beacon/College Heath IPA (CHIPA) and Vision Services Plan (VSP). Pre-delegation and annual oversight audits are performed. However, Beacon/CHIPA began providing services to the Plan in January 2014; the Compliance Committee did not approve Beacon/CHIPA for delegation until the April 2014 meeting. Policy #: 401-1101, *Quality and Performance Improvement Program*, states that delegation of QI is overseen by the Delegated Oversight Committee, though as of January 2014 this committee was absorbed into the Compliance committee.

### RECOMMENDATIONS:

- Ensure Compliance Committee approval is obtained prior to delegation of QI activities.
- Update Policy #: 401-1101 to accurately reflect that QI delegation is overseen by the Compliance Committee.
COMPLIANCE AUDIT FINDINGS

PLAN: Central California Alliance for Health

AUDIT PERIOD: June 1, 2013 Through May 31, 2014

DATE OF AUDIT: September 8, 2014 Through September 19, 2014

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

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<th>6.1</th>
<th>MEDICAL DIRECTOR</th>
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<td><strong>Medical Director:</strong> Contractor shall maintain a full time Physician as Medical Director whose responsibilities shall include, but not be limited to, the following:</td>
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<tr>
<td>A. Ensuring that medical decisions are:</td>
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<td>1) Rendered by qualified medical personnel.</td>
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<td>2) Are not unduly influenced by fiscal or administrative management considerations.</td>
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<td>B. Ensuring that the medical care provided meets the standards for acceptable medical care.</td>
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<td>C. Ensuring that medical protocols and Standards of Conduct for plan medical personnel are followed.</td>
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<td>D. Developing and implementing medical policy.</td>
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<td>E. Resolve grievances related to medical quality of care. For purposes of this provision, the resolution of grievances related to medical quality of care may be by the Medical Director's physician designee.</td>
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<td>F. Have a role in the implementation of Quality Improvement activities.</td>
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<td>G. Actively participate in the functioning of the Contractor’s grievance procedures as specified in Exhibit A, Attachment 14, Member Grievance System.</td>
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COHS Contract A.1.6

SUMMARY OF FINDINGS:

The Contract states that the responsibilities of the Medical Director shall include, “Resolve grievances related to medical quality of care. For purposes of this provision, the resolution of grievances related to medical quality of care may be by the Medical Director’s physician designee.” However, in 12 of 38 non-exempt grievance investigations involving potential quality of care issues, the Plan sent the member a resolution letter in advance of the CMO (Chief Medical Officer) or Medical Director completing the PQI investigation. Therefore, CMO or Medical Directors did not participate in the resolution of these potential quality of care grievances, which were resolved in advance of the complete PQI investigation.

RECOMMENDATION:

Amend Plan practice so that potential quality of care grievances are not resolved (sent resolution letters) prior to the completion of the PQI investigation and CMO or Medical Director involvement (see section 4.1, as well).
6.4 PROVIDER TRAINING

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all Primary Care 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. Contractor shall conduct training for all providers no later than 10 (ten) working days after the Contractor places a newly contracted provider on active status and shall complete the training within 30 calendar days of placing on active status.... COHS Contract A.7.5

SUMMARY OF FINDINGS:

Policy #: 300-6030, New Primary Care Provider Training, indicated that all newly contracted Primary Care Physicians (PCP) shall be trained “no later than ten (10) working days after the PCP’s Active Status Date, and complete the training within thirty (30) calendar days of the PCP’s Active Status Date.” In addition to requiring PCP’s to be trained regarding the Medi-Cal Managed Care Program requirements, services, policies and procedures; the contract requires all providers to be trained on all Member rights specified in Exhibit A, Attachment 13, including the right to actively participate in health care decisions, according to the above timeframe requirements. The Plan does not have a policy to conduct training for newly contracted non-PCP providers.

The results of the verification study showed that seven out of 15 providers did not receive new provider training. For the eight remaining providers who received new provider training, one began training after the ten working days requirement. The seven untrained providers were not PCPs.

The requirement to conduct training of all newly contracted providers no later than ten working days after active status and completion within 30 calendar days was not met.

RECOMMENDATION:

Update Plan policy and ensure training for all new providers begins within ten working days after the active status date and is completed within 30 calendar days as required by the Contract.
6.5 FRAUD AND ABUSE

Fraud and Abuse Reporting

B. 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. These requirements shall be met through the following:

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 ten (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 Title 42 CFR Section 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. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal website (www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig/hhs.gov). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) State 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.

COHS Contract E.2.27.B

SUMMARY OF FINDINGS:

The Plan’s Compliance Plan provides the organizational structure and processes of the Plan’s Fraud Waste and Abuse Program (FWAP) which is a component of the Plan’s Compliance Program.

The Special Investigation Unit (SIU) conducts the operational functions of the FWAP. Per Policy #: 100-3001, Fraud, Waste and Abuse Prevention Program, the SIU reviews the allegations or supporting evidence of potential or suspected Fraud Waste and Abuse (FWA) cases, known to the Plan as the Matter Under Investigation (MUIs), and makes recommendations to the Fraud Waste and Abuse Prevention Committee (FWAPC). Plan personnel clarified that the SIU consists of the Compliance Director, Compliance Manager, Program Integrity Supervisor, and Program Integrity Specialists. This is in contrast to Policy #: 100-3001, which indicates that the SIU is comprised of management staff and/or representatives from other departments. In addition, the FWAPC, which is mentioned in Policy #: 100-3001, has been consolidated into the Compliance Committee.

The Plan did not conduct, complete, and report to DHCS, preliminary investigations of suspected fraud and/or abuse within ten (10) working days of first becoming aware of, or was on notice of, such activity. Plan departments, such as claims or UM among others, typically refer potential or suspected FWA cases to the SIU which are listed in the MUIs Log. Two potential fraud cases in the MUIs Log included the following: one was referred by the claims department for billing “irregularities”, the other by the UM department for “anomalous” utilization patterns for trigger point injections claims. The Plan subcontracted with another entity to conduct the medical records reviews for these claims, which were completed several months after these potential FWA cases were initially identified and referred to the SIU.
The Plan classified these two potential FWA cases as “suspected” upon the completion date of the medical records review, reported such cases to MMCD’s Program Integrity Unit (PIU) a few days after and assumed it had met the ten working days reporting requirement. However, there is no evidence that the Plan conducted any preliminary investigations and reported them to DHCS ten working days after the billing “irregularities” or “anomalous” utilization patterns were first identified by the Plan’s respective departments.

The Plan did not continuously ensure providers listed on Medi-Cal’s Suspended and Ineligible list were not in the Plan’s provider network as required by its Policy # 300-4090, Ongoing Monitoring of Provider Credentials and Issues. During the audit, the Plan confirmed that although historically it checked the Medi-Cal Suspended and Ineligible list as part of this process, due to a misunderstanding by staff it only reviewed monthly the Federal OIG-LEIE excluded provider database and not the Medi-Cal Ineligible and Suspended list. Staff assumed that Medi-Cal suspended providers are also listed in the Federal OIG list. The Plan stated that Medi-Cal Ineligible and Suspended list has been included as part of its monthly Process as of September 16, 2014.

California Code Regulations, Title 22, 51303(k) states, in part, that “Services prescribed or ordered by a provider suspended from participation in the Medi-Cal program shall not be covered by the program while the suspension is in effect...” The Plan demonstrated that for pharmaceutical claims, their contracted Pharmacy Benefits Manager’s billing system checks to ensure that no prescriptions are ordered by a sanctioned or suspended prescriber per the State and Federal lists. However, the Plan could not demonstrate similar safeguards for other prescribed items, e.g., allied items such as durable medical equipment or medical supplies.

RECOMMENDATIONS:

- Update Policy 100-3001, Fraud, Waste and Abuse Prevention Program, to include the new staff composition of the Special Investigation Unit (SIU) and the integration of the FWAPC into the Compliance Committee.
- Ensure suspected FWA cases are preliminarily investigated and reported to DHCS within “ten (10) working days of the date Contractor first becomes aware of, or is on notice of, such activity,” as required by Contract.
- Continuously ensure no providers listed in the Medi-Cal Suspended and Ineligible list are employed or contracted by the Plan.
- Ensure all services ordered or prescribed by a sanctioned or suspended provider per the State and Federal lists are not covered by the Medi-Cal program.