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

County of Contra Costa
dba Contra Costa Health Plan

Contract Number: 04-36067

Audit Period: December 1, 2011
Through
November 30, 2012

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TABLE OF CONTENTS

I. INTRODUCTION 1

II. EXECUTIVE SUMMARY 2

III. SCOPE/AUDIT PROCEDURES 5

IV. COMPLIANCE AUDIT FINDINGS
Category 1 – Utilization Management 7
Category 2 – Continuity of Care 14
Category 3 – Availability and Accessibility 20
Category 4 – Member's Rights 27
Category 5 – Quality Management 30
Category 6 – Administrative and Organizational Capacity 37

I. INTRODUCTION

Contra Costa Health Plan (CCHP or the Plan) has been contracted with the State of California to provide health care services to Medi-Cal beneficiaries in Contra Costa County since 1984. CCHP is a county sponsored Health Maintenance Organization (HMO) and was the first federally qualified HMO in the country that is administered by a local government. The Plan was licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act on April 6, 1978. The Contra Costa County Board of Supervisors exercises oversight of the Plan through a Joint Conference Committee that consists of the Board of Supervisors and the Plan.

The State of California contracted with the County of Contra Costa as the Local Initiative under the two-plan model to provide managed care services to Medi-Cal beneficiaries under the provisions of Section 14087.3, Welfare and Institutions Code, in October 1996. CCHP received approval from the state to begin operations and commenced enrollment as the Local Initiative for Contra Costa County on February 1, 1997.

The Plan contracts with Community Provider Network (individual providers), Contra Costa Regional Medical Center (CCRMC), and Kaiser Permanente to provide or arrange comprehensive health care services. CCHP provides health care for public and private employee groups, private individuals, Medi-Cal and Medicare beneficiaries, and low-income county residents.

As of November 2012, CCHP had 94,595 Members of which 78,200 were Medi-Cal Members. The Plan also covers Contra Costa County employees (9,198), In-Home Support Services Homecare Workers (1,965), Private Commercial (152), Medicare (477), Healthy Families (4,549), Access for Infants and Mothers (AIM) (33), and Major Risk Medical Insurance Program (MRMIP) (21).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of December 1, 2011 through November 30, 2012. The on-site review was conducted from March 4, 2013 through March 15, 2013. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on July 18, 2013 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, Member's Rights, Quality Management (QI), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan did not perform essential UM activities as outlined in the Contract or its policies. The Plan only used informal observations by UM personnel to detect over-utilization, but did not use UM data to detect over-utilization and did not have a mechanism to detect under-utilization. The Plan did not produce reports showing trends, variations, or patterns.

The prior authorization (PA) appeal process requires appeals to be in writing, in violation of the Contract. The Plan's 45 working day time frame for appeal decisions is in conflict with the Contract. The Plan's delay in starting the 45-day requirement, pending receipt of additional information, is also in conflict with the Contract that specifically allows 14 additional days for necessary information.

The Plan did not adequately monitor entities with delegated responsibilities. It does not have the subcontracting, performance assessment, and corrective action planning processes in place to adequately monitor, assess, or evaluate delegated UM.

The referral tracking system did not track the time to process prior authorizations. Wait times for specialty care at CCRMC were in excess of the 15 business days specified in the Contract.

Category 2 – Continuity of Care

The Plan's compliance with identifying, monitoring, and coordinating health care services could not be determined due to its inability to locate records for 103 members. Performance of basic case management was not documented in the medical records reviewed. The Quality Council did not monitor care coordination or case management.

The Plan did not ensure care coordination between Primary Care Providers (PCP) and California Children's Services (CCS) for CCS Members. The Plan did not ensure care coordination between PCPs and the Regional Center for Early Intervention (EI) and Developmental Disabilities (DD) Members. The Plan did not monitor to ensure that CCS and EI Members received all medically necessary diagnostic, preventive, and treatment services through their PCP. The Plan's Policies and Procedures pertaining to roles, responsibilities, and functions are inconsistent with the Memorandum of Understanding (MOU).

Initial Health Assessments (IHA) were incomplete, not completed timely, or as outlined in the Plan's Policy. The Plan did not ensure that Providers made and documented reasonable attempts to contact new Members to schedule IHAs.

Category 3 – Availability and Accessibility

The Plan did not monitor wait times for telephone and office. CCRMC was utilized beyond its capacity and was unable to meet Timely Access standards. Members waiting to see a specialist at Regional Medical Center (RMC) Network were referred to Community Provider Networks (CPN) because of the long wait time at RMC.

The Plan did not monitor whether first prenatal visit for a pregnant Member was available within two weeks upon request.

The Plan's Advice Nurse Unit was not meeting time access standards. The Plan's emergency services claims and family planning claims were paid late. The Plan did not conduct monitoring of emergency rooms at contracted hospitals to ensure Members have access to a sufficient supply of medications in emergency situations.

Category 4 – Member's Rights

The Plan's grievance policies and flowchart did not include any monitoring by clinical staff to ensure non-clinical grievances were accurately classified. Resolution letters did not address all issues raised in the grievance and some responses were not clear and concise.

Grievances reflected quality of care issues due to difficulties accessing care but the Quality Committee did not take appropriate action to remedy any problems. The Plan did not follow-up with Providers having multiple uncommon grievances.

A Protected Health Information (PHI) breach was not reported to DHCS.

Category 5 – Quality Management

The Plan did not perform essential QM activities as outlined in the Contract or its policies. Quality Council minutes do not document an organized and continuous process of monitoring, evaluation, and action.

The Plan did not monitor access with a standard metric, such as third available appointment, and did not include UM and Member Satisfaction data during re-credentialing as is outlined in its Policy.

The Plan did not adequately monitor entities with delegated responsibilities. CCRMC did not conduct an evaluation of the effectiveness of its Quality Program. No annual QI evaluation of the PBM occurred during the audit period.

Medical records from multiple Provider sites were not consistently completed or maintained in accordance with the Contract, Plan Policies, or regulations.

The Plan is not in compliance with Informed Consent for sterilization procedures. Informed consent was not done within the required time frame or as outlined in the Plan's Policy.

Category 6 – Administrative and Organizational Capacity

The Plan identified deficiencies of delegated entities' Health Education Programs and performance but did not ensure implementation of the corrective action plan to comply with requirements.

Provider training was not conducted within ten days after a new provider was placed on active status.

The Plan failed to develop and implement its fraud and abuse program since the last audit and did not implement the prior audit CAP.

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 March 4, 2013 through March 15, 2013. 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:

Utilization Management – Category 1

Prior Authorization Requests: 32 medical and 13 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Notification of Prior Authorization Denial, Deferral, or Modification: 45 denial and modification letters were reviewed for written notification requirements.

Appeal Procedures: 6 prior authorization appeals were reviewed for appropriate and timely adjudication.

Continuity of Care – Category 2

California Children's Services (CCS): 13 medical records were reviewed for evidence of coordination of care between the Plan and CCS Providers.

Early Intervention Services and Developmental Disabilities: 6 medical records were reviewed for evidence of coordination of care between the Plan and Regional Centers. Some of the records requested were not available.

Individual Health Assessment: 48 medical records were reviewed for completeness and timely completion.

Availability and Accessibility – Category 3

Emergency Service Claims: 17 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 17 family planning claims were reviewed for appropriate and timely adjudication.

Member's Rights – Category 4

Grievance Procedures: 39 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Quality Management – Category 5

Medical Records: 48 medical records were reviewed for completeness.

Informed Consent: 13 informed consent records were reviewed for completeness and sufficient consideration time. Some of the records requested were not available.

Administrative and Organizational Capacity – Category 6

New Provider Training: 7 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.

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM

Utilization Management (UM) Program Requirements:
Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. …(as required by Contract)
2-Plan 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.
2-Plan Contract A.5.2.C

Under- and Over-Utilization:
Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.
2-Plan Contract A.5.4

SUMMARY OF FINDINGS:

The Contract requires a UM Program that ensures appropriate processes are used to review and approve Medically Necessary services. The Plan's Program Description states that Plan personnel aggregate, analyze and report utilization trends. Plan personnel are to identify trends and variations in service utilization by providers. The UM Program Description states that the Plan monitors ambulatory data, ED Visits, referral patterns and UM related HEDIS data. The Program Description states that the UM Manager's responsibilities include:

> "Identifying trends and variations in service utilization by providers. Preparing and presenting data analysis, complex reports, and findings related to utilization activities."

The only monitoring the Plan could demonstrate were bed day utilization by network and product line, visits per 1,000 enrollees and ED visits. These are reported to the Quality Council. The Plan did not produce reports showing trends, variations, patterns; they did not have documentation of complex reports or data analysis.

Policy #: UM15.008, Under/Overutilization, states that the Plan monitors under- and over-utilization by:

1. Trending outpatient and inpatient days, including patterns of readmission and similar diagnosis
2. Monitoring frequency of procedures, imaging studies, laboratory tests, or ancillary services
3. Reviewing level of care activities

The plan does not perform trending or analysis of referral patterns, encounter data, hospital admissions by diagnosis or frequency of procedures, imaging studies, laboratory tests, or ancillary services.

The Plan's UM Manager stated that over-utilization is detected informally, and not through regular data analysis. UM personnel take note of services that seem to be in requested in high or increasing volume, and then notify the Medical Director, who may decide to take action. The Plan cited a program for frequent ER users as an example of using data to manage over-utilization. An examination of this program did not show that the Plan had used data to

demonstrate that inappropriate ED usage represented a high priority area of over-utilization. It had arbitrarily chosen to focus on Members with five or more apparently unwarranted ED visits. The Plan's management was limited to educational mailings, and possible assignment of individual Members to case management. This program is more properly characterized as an isolated case finding and education program than as a set of mechanisms within UM to detect over-utilization of health care services.

The UM Director stated that there is no mechanism to detect potential under-utilization and could not recall any examples of suspected under-utilization at the plan. The UM department does not perform any analysis of HEDIS data looking for under-utilization.

The Plan's UM Program states that the Medical Director:

- Monitors and evaluates UM activities, including the review of issues involving access, under-utilization, over-utilization, continuity and coordination of care, as well as a systems review for continuous quality improvement. This information may be used to identify specific member issues, or to identify systemic quality of care issues.
- Determines whether a problem identified during the UM process requires a corrective action plan, formulates a plan of action to correct the deficiency, and measures outcome. The results of these evaluations & review are reported to the QC.

The UM Director could not recall any formal process of issue identification, barrier analysis, action and re-measurement within the UM department. She stated that there is no application of Quality Improvement within the UM Department; QI is an activity conducted solely within the QI Department. When informed of this statement during the interview, the Medical Director did not disagree.

The Plan attempts to ensure consistency in the implementation of guidelines by measuring inter-rater reliability, but the evaluation tool measures completion dates, and asks nurses to speculate on medical director decision-making. It does not focus on guideline interpretation by nurses. The inter-rater reliability testing process detects no opportunities for improvement.

Policy #: UM15.008, Under/Overutilization, states that the Plan tracks access to care. The Contract specifies specialist appointment access standards of "within 15 business days". The Plan does monitor access to specialty care at CCRMC, and refers members who have been waiting, depending on specialty, for 45 days or longer to community specialists. The Plan documented 1,023 such community referrals during the audit period. When asked if there had been any attempt to refer patients prior to the 45 day waiting period, the UM Manager stated she had no authorization to do so.

RECOMMENDATIONS:

- Perform trending and analysis of UM data in accordance with the UM Program Description and the Plan's Policies and Procedures.
- Implement a data driven mechanism to detect over-utilization across the continuum of care.
- Implement a mechanism to detect under-utilization.
- Use recognized QI tools and techniques to continuously measure and improve its processes.
- Ensure consistency in the application of guidelines by measuring consistency of potentially variable aspects of the UM nurses' work processes and by looking for opportunities for improvement.
- Be proactive in its efforts to ensure that all authorized specialty services are rendered in a timely manner and that Members are not subjected to excessive wait times before being seen by a qualified specialty Provider.

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)
2-Plan Contract A.5.2.A, B, D, F, H, and I.

Exceptions to Prior Authorization:
Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
2-Plan 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, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.
2-Plan Contract A.13.8.A

SUMMARY OF FINDINGS:

The Plan's Policy *#: UM15.015a, Timeliness of Utilization Review Decision and Communication,* does not include the requirement that extensions of time frames for routine authorizations are allowable only when in the Member's interest. Members must either request such extensions or the Contractor must justify the extension; it cannot simply be agreed to by the Member in the absence of such justification or request.

The Plan's policy of a 5-day turnaround time for routine Pharmacy PA requests is not in compliance with the Contract or Welfare and Institutions Code 14185.

Both routine Medical Service PA determinations and routine Pharmacy PA determinations frequently exceed required time frames, without notification to Providers and Members of a need for an extension or the justification of such extensions as being in the Member's interest.

RECOMMENDATIONS:

- The Plan's policy should clearly state that extensions of time frames for routine authorizations must be in the Member's interest. Members must either request extensions of time frames or Plan must provide justification for the extension.
- The Plan's Policy should state a 24-hour time frame for routine Pharmacy PA determinations.
- Adhere to required time frames.
- Notify Members and Providers when there is a need to extend time frames for authorizations.
- Produce previously available statistics on turnaround time using the Plan's current software.

1.3	REFERRAL TRACKING SYSTEM

Referral Tracking System:
Contractor is responsible to ensure that the UM program includes: … An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.
2-Plan Contract A.5.1.F

SUMMARY OF FINDINGS:

The Plan does track inpatient bed days and Emergency Department (ED) visits. It does not track procedure rates or ancillary services. Since the implementation of the EPIC system, it no longer tracks process times for PA.

The Plan's system follows up on urgent authorized specialty services, a sample of routine authorizations, and specialty services in areas with known access issues. The Plan stated that referral tracking revealed that timely access remained a problem in multiple specialties at CCRMC. A total of 1,023 referrals to CCRMC specialists exceeded wait times of 45 days and were redirected to community specialists, but only after the member had waited at least that long.

RECOMMENDATIONS:

- Track procedures and ancillary services.
- Monitor process times for PA as was done prior to implementation of the Epic ccLink system.
- Continue to monitor access for authorized specialty visits and continue to address or require action plans until the problem of timely access in multiple specialties at CCRMC is resolved.

1.4	PRIOR AUTHORIZATION APPEAL PROCESS

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

SUMMARY OF FINDINGS:

The Plan reported only six appeals. The Plan's appeals procedure is well publicized. Although the Plan's policy and procedure allow verbal appeals, in practice the Plan requires appeals to be in writing, in violation of the Contract. The Member Handbook and Evidence of Coverage (EOC) also state that an appeal must be in writing. The Plan's 45 working day time frame for notice of decisions on Member Appeals conflicts with the Contract (Exhibit A, Attachment 14, (5)(B). The Plan's delay in starting the 45-day requirement, pending receipt of additional information, is in conflict with the Contract that specifically allows 14 additional days for necessary information. The Plan did not meet the 45-day requirement in two of six appeals. One of six appeal decisions did not adhere to the Plan's medical guidelines.

RECOMMENDATIONS:

- Allow oral or telephonic filing of an appeal and reflect this in the Member Handbook and EOC.
- Revise policies and operations regarding time frames to adhere to the Contract: 45 days for resolution, with a maximum of 14 additional days if there is a need for additional information, and the delay is in the Member's interest.
- Follow guidelines in denial decisions and subsequent appeals.
- Characterize all activities that dispute a Plan decision to deny, delay, or modify a requested service as appeals.

1.5	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.
2-Plan Contract A.5.5

SUMMARY OF FINDINGS:

The Plan is not performing activities that demonstrate accountability for delegated UM responsibilities. There are deficiencies in subcontracts with delegated entities, in the performance of oversight evaluations, and with corrective actions for deficiencies identified in oversight evaluations.

The Contract requires that subcontracts of delegated entities include responsibilities, specific delegated functions and activities; oversight monitoring and evaluation processes (and subcontractor's agreement to such processes); quarterly reporting of findings and resulting quality improvement activities and remedies for obligations not met.

Although the Plan has contracts with Kaiser and CCRMC, they do not contain specific UM responsibilities, oversight and monitoring, or reporting requirements. The only remedy is a termination of the entire contract for a material breach of the contract. Material breach is explicitly defined in the CCRMC contract; failure to perform delegated UM activities is not listed as a material term.

Annual delegation oversight evaluations are conducted of the Kaiser network. A repeated finding was a deficiency in timeliness of UM decision making. This was not addressed after previous oversight evaluations, and was not addressed with a corrective action plan after this evaluation, despite it being a repeat finding. The Plan did not implement activities to detect over- and under-utilization at Kaiser, and the oversight evaluation did not address over- and under-utilization.

Delegation evaluations are not conducted annually at CCRMC. **This is a repeat finding.** Although an oversight evaluation occurred during DHCS' Audit period, it is the only one that has taken place in the last two years. Deficiencies identified in CCRMC's performance of delegated activities included:

- Lack of informing Providers on how to obtain copies of guidelines
- Lack of inter-rater reliability testing
- No after-hours access to UM staff
- No delineation of authority for decision making
- No statement for timeliness of urgent and non-urgent decisions disseminated to practitioners and employees who make UM Decisions
- Lack of adherence to timelines for non-urgent denials
- No process for the evaluation of new technology

No corrective action plan was produced. The Plan has not implemented activities to detect over- and under-utilization at CCRMC, and the oversight evaluation does not address over- and under-utilization.

Although the Plan's Medical Director maintains that UM activities are delegated to the PBM, no evaluation of the PBM occurred during the audit period. **This is a repeat finding**.

RECOMMENDATIONS:

- The Plan should have formal, mutually agreed upon, delegation agreements with entities to which it delegates. These should include a description of the delegated activities, the specific delegated functions of the delegated entity and the Plan, the oversight monitoring and evaluation processes, reporting requirements, and the remedies/actions available to the Plan.
- The Plan should either monitor delegated UM for over- and under-utilization, or its evaluation tools for UM should include activities related to the detection of under- and over-utilization.
- Repeated findings on oversight evaluations of the Kaiser network should result in a corrective action plan.
- Annual oversight evaluations should be conducted on CCRMC and the Plan's PBM.
- Deficiencies noted in Kaiser's and CCRMC's most recent oversight evaluations should result in the development of a corrective action plan.

CATEGORY 2 - CONTINUITY OF CARE

2.1	COORDINATION OF CARE: WITHIN AND OUT-OF-PLAN

Case Management and Coordination of Services:
Contractor shall ensure the provision of 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.
2-Plan 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…
2-Plan Contract A.11.5

SUMMARY OF FINDINGS:

Medical records reviewed did not document that PCPs performed basic case management as defined in the Plan's *Policy #: QM14.704* and as instructed by the Plan. Records reviewed did not contain reference to basic case management and did not consistently implement the procedures described in the Plan's Policies. The Contract states that the Plan 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." The Plan did not provide 103 of 238 medical records requested; as a result, the Plan's compliance with identifying, monitoring, and coordinating health care services was not validated.

A review of the minutes from Quality Council Meetings did not validate that the Plan monitors care coordination and basic case management through its quarterly, semi-annual, annual, and triennial quality assurance processes.

RECOMMENDATIONS:

- Develop and implement a policy for out-of-network coordination of care.
- Develop and implement an effective monitoring system to ensure that case management services are provided.
- Develop and implement a records management system that would ensure that Member records can be located.

2.2	CALIFORNIA CHILDREN'S SERVICES (CCS)

California Children's Services (CCS):
Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program….(as required by Contract)

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program…for the coordination of CCS services to Members.
2-Plan Contract A.11.9.A, B

SUMMARY OF FINDINGS:

Per *Policy #: UM15.038, Coordinating Care with Specialized Programs,* the Plan will identify, monitor, and coordinate health care services available to eligible Members under specialized funding programs. The Plan did not track and monitor the coordination of care for Members receiving California Children's Services (CCS). The Plan did not ensure Members participating in CCS received all medically necessary diagnostic and preventive services and treatments through their Primary Care Providers.

According to the MOU, the Plan will meet with CCS annually to "review the effectiveness" of the CCHP provisions of the MOU and the Plan's UM Nurse and Provider Liaison will meet with CCS quarterly for the same purpose. The CCS MOU states the Plan's Medical Director and Executive Director will participate at least annually as will the CCS Medical Director and Administrator. No evidence that these meetings occurred was provided by the Plan and the MOU was not revised or updated when the Plan updated its policies. The Plan's UM staff reported formal meetings with CCS did not occur. CCHP and CCS did not track, trend, and report program performance to Quality Council. Roles, responsibilities, and procedures as outlined in the MOU between the Plan and CCS were not always consistent with the Plan's policies and procedures or with the processes described by the Plan's Case Management and Utilization Management staff during on-site interviews.
A verification study revealed the following:

a. In a sample of 13 records of Members cared for under the CCS program, 8 lacked evidence of a complete and comprehensive initial health assessment.
b. Documentation of physical examinations and medical and social histories was often incomplete and/or illegible. Blood lead screenings, tuberculosis risk assessments, developmental assessments, and anthropometric measurements were not consistently found in each child's chart.

RECOMMENDATIONS:

- Revise the MOU for consistency with the Plan's Policies and Procedures pertaining to roles, responsibilities, and functions.
- Develop and implement a monitoring system to ensure Members enrolled in California Children's Services are receiving all medically necessary diagnostic, preventive and treatment services through their Primary Care Providers.
- Develop and implement a monitoring system for Members receiving California Children's Services to ensure their care is coordinated between the Plan, Primary Care Providers, and CCS.

2.3	EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

Services for Persons with Developmental Disabilities:
Contractor shall develop and implement procedures for the identification of 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 participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers…for the coordination of services for Members with developmental disabilities.
2-Plan Contract A.11.10.A, C, E

Early Intervention Services:
Contractor shall develop and implement systems to identify children 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.
2-Plan Contract A.11.11

SUMMARY OF FINDINGS:

Per *Policy #: UM15.038, Coordinating Care with Specialized Programs,* the Plan will identify, monitor, and coordinate health care services available to eligible Members under specialized funding programs. The Plan did not track and monitor the coordination of care for Members receiving Early Intervention Services and Services for Persons with Developmental Disabilities. The Plan did not ensure Members participating in the Early Start Program received all medically necessary diagnostic and preventive services and treatments through their Primary Care Providers.

According to the Plan's *Memorandum of Understanding (MOU) with Regional Center of the East Bay (RCEB),* a CCHP liaison will meet with RCEB staff at least annually to coordinate care for Members, and will review and update the *MOU* quarterly. The annual or quarterly meetings between the Plan and RCEB did not take place. The Plan provided two sign-in sheets from meetings titled, "Autism Updates" held in August 2012 and February 2013 but did not provide an agenda for either to indicate the meetings met the intent and requirement outlined in the MOU. The Plan had no direct communication with RCEB to ensure coordination of care between the Plan, the Primary Care Providers, and RCEB. **This is a repeat finding.**

Verification study revealed the following:

a. 5 of 13 medical records for Members identified by the Plan to be receiving EI/DD services were missing. The Plan's assigned Primary Care Providers had no record of the Members being seen at their site.

b. 6 EI/DD Member's medical records reviewed showed the following:

- Coordination of care between the Plan, Primary Care Providers, and RCEB was not documented in six records.
- Necessary diagnostic and preventive services such as developmental screening, vision, hearing, nutrition and dental assessment, and tuberculosis screening were not documented in two records.

RECOMMENDATIONS:

- Develop and implement a monitoring system to ensure Members enrolled EI are receiving all medically necessary diagnostic, preventive and treatment services through their Primary Care Providers.
- Develop and implement a monitoring system for Members receiving EI/DD services to ensure care coordination between the Plan, PCPs, and RCEB.
- Ensure program collaboration between the Plan and RCEB as outlined in the MOU.

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) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.
2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21
For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

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.
2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
   a) blood pressure,
   b) height and weight,
   c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
   d) clinical breast examination for women over 40,
   e) mammogram for women age 50 and over,
   f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
   g) chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
   h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
   i) health education behavioral risk assessment.

2-Plan Contract A.10.6

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.
2-Plan Contract A.10.3.D

SUMMARY OF FINDINGS:

Per *Policy #: QM14.701, Preventive Services/ Initial Health Assessment,* the Plan must complete Initial Health Assessments (IHA) within 60 days of enrollment for new Members less than 18 months of age, and within 120 days for new Members 18 months of age and older.

The Plan's *Provider Manual* has reference to IHA completion, but no specific guidelines are given to Providers to ensure that all the measures are completely documented at the time of the first visit or within the required time frames after membership is established or within the time required.

Post-exit, the Plan provided 1) a policy indicating that they monitor phone calls placed by Plan staff to families and members as reminders to schedule IHAs, 2) statistics regarding calls placed to families and members regarding reminders to schedule IHAs, and 3) a sample letter that is sent to families and members regarding IHAs. Evidence that the Plan monitors the requirement for comprehensive and timely completion of IHA by PCPs was not provided.

The Plan did not monitor Provider completion of the required IHAs for new Members per regulation and the Contract. IHAs were not completed within the required time frames and were incomplete, lacking comprehensive clinical information needed to assess and diagnose acute and chronic illnesses. **This is a repeat finding.**

Verification study revealed the following:

48 Member's records were reviewed for compliance with IHA requirements. In 32 of 48 medical records the IHAs were incomplete and/or were not completed within the required time frame.

RECOMMENDATIONS:

- Develop and implement a system to monitor Providers for completion of comprehensive IHAs within the required time frames.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

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.
2-Plan Contract A.9.3.A

Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.
2-Plan Contract A.9.3.B

Monitoring of 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…
2-Plan Contract A.9.3.C

SUMMARY OF FINDINGS:

The *Timely Access Summary Report 2012 [Draft]* prepared by CCHP Quality Director stated that CCRMC was being utilized beyond its capacity and was unable to meet Timely Access standards. The Plan reported many of the Providers' panels were in excess of the community standard and the Plan determined it was inadvisable to direct more Plan Members to this network until Provider capacity increased. However, the Plan maintained that Health Services leadership is challenged with controlling the costs associated with directing Members to more costly networks in order to ensure that the County has the funds to enable it to continue to provide necessary services.

The Plan did not monitor office and telephone wait times and call return times as outlined by the Plan's prior audit Corrective Action Plan process. The Plan did not monitor whether first prenatal visit for a pregnant Member was available within two weeks upon request. **This is a repeat finding.**

The Plan conducted appointment availability surveys over telephone with 54 Providers (15 PCPs, 30 Specialists, 2 Ancillary and 7 Mental Health). Providers were asked three questions and the expected response was either "Yes" or "No". The Plan was unable to successfully conduct the survey with one specialist. A total of 52 out of 53 responded yes to all three questions. The survey was self-reported and the Plan did not conduct any studies to verify the accuracy of the answers. Exhibit A, Attachment 9 of the Contract requires the Plan to develop, implement, and maintain a procedure to monitor waiting times in Providers' offices and time to obtain various types of appointments.

Members were not offered appointments with a specialist within the 15 day time frame as required by the Contract, Exhibit A, Attachment 9 and the Plan's *Policy #: QM14.101*. Members waiting to see a specialist at Regional Medical Center (RMC) Network were referred to CPN because of the long wait time at RMC. Utilization Management (UM) Director stated during the April 26, 2012 Quality Council Meeting that the Plan redirected 378 new specialty care referrals to the CPN during the first four months of 2012 in order to decrease the wait list and wait times in the RMC Network. However, the specialties for the 378 referrals were not mentioned. The UM Director stated planned actions include redirecting RMC Network Members to CPN to decrease wait list and wait times.

RECOMMENDATIONS:

- Monitor waiting times for telephone and office and whether the first prenatal visit for a pregnant Member is available within two weeks upon request.
- Implement actions when deficiencies to access standards are detected.

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.
2-Plan Contract A.9.3.D

Contractor shall maintain the capability to provide Member services to Medi-Cal Members or potential members through sufficient assigned and knowledgeable staff
2-Plan 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 will be available for after-hours calls.
2-Plan Contract A.9.3.E

SUMMARY OF FINDINGS:

Policy #: AN17.004.1, Answer Time Standards, states the Advice Nurse Unit should maintain an average speed of answer by a live person of 60 seconds or less and an average abandonment rate of 5% or less. The Plan was not meeting this standard. The Plan's average speed to answer was 188 seconds and 165 seconds in the 1st Quarter and 2nd Quarter of 2012 respectively. The Plan's abandonment rate was 14% and 12% in the 1st Quarter and 2nd Quarter of 2012 respectively. The short-term goal for abandonment rate is 15%, the mid-term goal is 10%, and the long-term goal is 5%.

RECOMMENDATION:

Improve call waiting times to comply with telephone answering time access standards outlined in policies and procedures.

3.5	EMERGENCY SERVICE PROVIDERS (CLAIMS)

Emergency Service Providers (Claims):
Contractor shall pay for emergency services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge….
2-Plan Contract A.8.13.C

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D).
2-Plan Contract A.8.13.E

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section…Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.
2-Plan Contract A.8.5

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.
2-Plan Contract A.9.7.A

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).
CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

There were significant increases in late payment of emergency services claims during the audit period. The Plan attributed this problem to the IT system change from QICLink to the new CCLink system (EPIC). In addition, the Plan was still adjusting to increased membership due the addition of the County's SPD (Seniors and Persons with Disabilities) population. These two events created a significant stress and overload on CCHP's systems and resources.

The Plan's *Policy #: CLM 4.007, Claims Determination Timeliness,* states the mandated time frame for Medi-Cal claims is 95% within 45 days. This policy does not comply with Exhibit A, Attachment 8.5 of the Contract that states the Plan shall pay 90% of all clean claims within 30 days of the date of receipt and 99% of all clean claims within 90 days. The Plan still does not track clean claim rates for compliance with the Contract. **This is a repeat finding.**

A sample of 17 claims was reviewed.

- 9 of 17 claims were paid late with interest.
- 1 of 17 claims was sent to the Plan in error. This claim was held for 62 day before it was forwarded to the Plan's delegated entity. California Code of Regulations (CCR), Title 28, section 1300.71(b)(2) requires the Plan to forward misdirected claims to the appropriate capitated provider within ten working days.

RECOMMENDATIONS:

- Ensure that ER claims are paid timely as required by the Contract.
- Ensure that ER claims for Members covered by the Plan's delegated entities are forwarded in a timely manner.
- Revise *Policy #: CLM 4.007, Claims Determination Timeliness,* to comply with the Contract.
- Monitor clean claims payment and improve timely payment processing to comply with the Contract to pay 90% of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims within 90 days.

3.6	FAMILY PLANNING (PAYMENTS)

Family Planning: (Payment):
Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate….(as required by Contract)
2-Plan Contract A.8.9

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section…Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.
2-Plan Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).
CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

A review of 17 family planning claims for accurate and timely payment was conducted; 9 claims were from QicLink system and 8 claims were from EPIC (ccLink) system. 14 out of 17 claims were paid beyond 45 working days after the date of receipt of the complete claim by the Plan or the Plan's capitated Provider, unless the complete claim or portion thereof was contested or denied.

The Plan's *Policy #: CLM 4.007, Claims Determination Timeliness,* states the mandated time frame for Medi-Cal claims is 95% within 45 days. This policy does not comply with Exhibit A, Attachment 8.5 of the Contract that states the Plan shall pay 90% of all clean claims within 30 days of the date of receipt and 99% of all clean claims within 90 days. The Plan still does not track clean claim rates for compliance with the Contract. **This is a repeat finding.**

RECOMMENDATIONS:

- Ensure that family planning claims are paid timely as required by the Contract.
- Revise *Policy #: CLM 4.007, Claims Determination Timeliness,* to comply with the Contract.
- Monitor clean claims payment and improve timely payment processing to comply with the Contract to pay 90% of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims within 90 days.

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...

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.
2-Plan Contract A.10.8.G.1

SUMMARY OF FINDINGS:

The Plan's *Policy #: PM6.010, Pharmacy Management,* states the Plan will review the policy and procedure of the emergency room at contracted hospitals to monitor if Members have access to a sufficient supply of medications in emergency situations to last until the Member can reasonably expected to have a prescription filled. If warranted the Plan will randomly select and review Emergency Department claims to determine if prescribed medications were dispensed in sufficient quantities. However, the Plan did not conduct monitoring of emergency rooms at contracted hospitals to ensure Members have access to a sufficient supply of medications in emergency situations. **This is a repeat finding.**

The Plan did not implement the Corrective Action Plan (CAP) from the previous audit to address Emergency Department monitoring. The Plan's CAP stated a report using a random sample of patients discharged from the Emergency Room would be run from an annual report to determine if an emergency supply of medications should have been dispensed. The Plan was to monitor whether the medications were dispensed from Emergency Department when prescribed. An analysis of this report would be given to the Plan's Medical Director by the Pharmacy Director, and the Director of Compliance would ensure that clinical staff involved follows this procedure annually. The Pharmacy Director stated the Annual Report described in the CAP had not been done.

RECOMMENDATIONS:

- Monitor Emergency Departments at contracted hospitals to ensure Members have access to a sufficient supply of medications in emergency situations to last until the Member can reasonably be expected to have a prescription filled.
- Implement procedures outlined in prior audit CAP.

CATEGORY 4 – MEMBER'S 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 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan 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)
2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting 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).
2-Plan Contract A.14.3.A

SUMMARY OF FINDINGS:

Grievances were forwarded to the designated Member Services Representative (MSR) in Member Services, a non-clinical position. The MSR categorized the grievance as either clinical or non-clinical and forwarded it to the appropriate person for review and response. Quality of Service (non-clinical) grievances were handled by Member Services while Quality of Care (clinical) grievances were handled by the Quality Management (QM) R.N. Either the MSR or the QM R.N. responded with a resolution letter. The Plan fully delegated grievance and appeal handling to Kaiser. The Plan received quarterly reports and audits Kaiser annually.

The Plan stated during the interview that the QM R.N. reviewed all grievances for proper classification between clinical and non-clinical grievances. However, the Plan's policies, procedures, and flowchart did not include monitoring by clinical staff to ensure non-clinical grievances were accurately classified. Three grievances reviewed did not show clinical staff review as stated by the Plan.

QM Director reported during the Quality Council meeting that there was an increase in volume and communication issues continue to be the most frequent category. Follow up actions include continue to review for trends, changes, and cases involving Providers with earlier issues. However, there was no mention of any other trends or review and analysis to quality assurance committee to take appropriate action to remedy any problems.

File review of 39 grievances found:

- 5 of 39 grievances had a quality of care issues due to difficulty accessing care. CCRMC Members had long wait times and could not get responses from their doctors. In a response to a grievance, a Provider stated that the appointment slots at CCRMC were too short to address all of a patient's issues. A Member waited more than six months for colposcopy and needed to file a grievance to receive an outside referral.
- 3 of 39 grievances had inadequate resolution letters where not all issues were addressed, had inadequate response to issues raised, or were not clear and concise. CCR, Title 28, section 1300.68(d)(3) and *Policy #: MS 8.001*
- 2 of 39 grievances were on the same Provider. One grievance alleged that non-sterilized tools (speculum) were used. The Plan accepted the Provider's statement without a site visit for verification. The Provider stated he always uses clean tools on each patient. A second grievance filed by a different Member because she was denied an OB/GYN appointment due to her obesity and the office didn't have the proper instrument. The Plan did not address the issue of multiple uncommon grievances with the Provider.

A review of *Policy #: MS 8.001, Handling of Complaints and Grievances*, found minor errors. Contra Costa County Regional Medical Center and Health Centers were incorrectly included in the Non-Delegated Providers section. The last sentence of the first paragraph of Partially Delegated Providers contains an incomplete sentence.

RECOMMENDATIONS:

- Provide review and analysis to quality assurance committee to take appropriate action to remedy any problems.
- Follow-up with Providers with multiple uncommon grievances.
- Ensure clinical monitoring of grievance classification by MSR.
- Ensure resolution letters address all issues raised in the grievance and the response is clear and concise.
- Correct errors in *Policy #: MS 8.001, Handling of Complaints and Grievances*.

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.

2-Plan Contract A.13.1.B

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:
Contractor agrees:

B. 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…..

H. Notification of Breach—During the term of this Agreement:
   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…
   2). Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer…

I. Notice of Privacy Practices. To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit…

2-Plan Contract G.3.B, H, and I

SUMMARY OF FINDINGS:

The Plan is under the Contra Costa Health Services (CCHS) umbrella for compliance with HIPAA and Privacy requirements and adopts all CCHS HIPAA and Privacy policies and procedures. During grievance file review, a grievance was reviewed about a CCRMC nurse who committed a Protected Health Information (PHI) breach. This grievance was processed through the grievance procedure, but the Plan's Compliance Officer (who is responsible for reporting HIPAA breaches to DHCS) was not informed of this breach and DHCS was not notified.

RECOMMENDATION:

Ensure timely DHCS notification of all PHI breaches as required by the Contract.

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.
2-Plan Contract A.4.1

SUMMARY OF FINDINGS:

While the Plan has evidence of QI efforts, including formal processes of measurement, the Quality Council minutes do not document an organized and continuous process of monitoring, evaluation, and action.

The Kaiser representative attended one of ten Quality Council meetings during the audit period.

RECOMMENDATIONS:

- Implement an organized, data driven process of Quality Improvement and have it reflected in the Quality Council Minutes. Document the flow of monitoring, identification of root causes, barriers, and prioritized actions from meeting to meeting.
- Document actions in areas of importance to the Plan as resulting in improvement in repeat analysis and action planning.
- Improve Kaiser representation on the Quality Council.

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 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

Provider Participation:
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

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…
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:

The Plan has corrected a finding in the 2010 audit.

The Plan has not carried out and documented all the features of credentialing and re-credentialing as outlined in *Policy #: CR 11.002, Practitioner Re-credentialing Process. S*ection *(g) Performance Monitoring* indicates that results of UM review and Member Satisfaction shall be included in the Peer Review. UM and Member Satisfaction were not found in review of the Peer Review and Credentialing Committee minutes.

RECOMMENDATION:

Perform re-credentialing activities and document all the features as required by *Policy #: CR 11.002, Practitioner Re-credentialing Process.*

5.3	QUALITY IMPROVEMENT PROGRAM DESCRIPTION AND STRUCTURE

Written Description: Contractor shall implement and maintain a written description of its QIS [Quality Improvement System]…(as required by Contract)

2-Plan Contract A.4.7.A-I

Accountability: Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted physicians and contracted providers in the process of QIS development and performance review. Participation of non-contracting providers is discretionary.
2-Plan Contract A.4.2

Governing Body*:* Contractor shall implement and maintain policies that specify the responsibilities of the governing…(as required by Contract)
2-Plan Contract A.4.3.A-D

Provider Participation: Contractor shall ensure that contracting physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.

2-Plan Contract A.4.5

SUMMARY OF FINDINGS:

The Plan maintains a written description of a Quality Improvement System that includes the elements of accountability, responsibilities of the Governing Body, and the participation of Plan Providers, as outlined in the Contract.

There is no regular standardized measurement of appointment availability. It is planned for CCRMC in the coming year.

RECOMMENDATION:

Monitor access with a standard metric, such as third available appointment.

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, that 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.

2-Plan Contract A.4.6

SUMMARY OF FINDINGS:

Although the Plan has contracts with Kaiser and CCRMC, there are no formal delegation agreements. Delegation evaluations are not conducted annually at CCRMC. **This is a repeat finding.** Although an oversight evaluation occurred during DHCS' Audit period, it is the only one that has taken place in the last two years.
Deficiencies were identified in CCRMC's performance of delegated activities. A repeat finding of the Plan was that CCRMC is not conducting an evaluation of the effectiveness of its Quality Program. CCRMC also does not have standards in place for availability or access to practitioners, and does not measure performance. UM data regarding redirected referrals and grievances about access highlight the impact of this deficiency.

No annual QI evaluation of the PBM occurred during the audit period. **This is a repeat finding.**

RECOMMENDATIONS:

- Implement an effective QI program for all services regardless of the number of contracting and subcontracting layers between the Plan and the Provider.
- Execute formal, mutually agreed upon, delegation agreements with entities to which it delegates. Include a description of the delegated activities, the specific delegated functions of the delegated entity and the Plan, the oversight monitoring and evaluation processes, reporting requirements, and the remedies and actions available to the Plan.
- Perform annual delegation evaluations once a year at CCRMC. Monitor Corrective Actions for effectiveness.
- Ensure that CCRMC's QI Program adequately addresses access and availability to practitioners and uses all existing data to verify that Members are not subjected to barriers to access of care.
- Conduct Annual QI oversight evaluations at the PBM.

5.5	MEDICAL RECORDS

Medical Records

A. General Requirement
Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861 and MMCD Policy Letter 02-02.

B. Medical Records
Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:
1) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.
2) To ensure that medical records are protected and confidential in accordance with all Federal and State law.
3) For the release of information and obtaining consent for treatment.
4) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

C. On-Site Medical Records
Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

D. Member Medical Record
Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes:
1) Member identification on each page; personal/biographical data in the record.
2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
3) All entries dated and author identified; for Member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
4) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.
5) Allergies and adverse reactions are prominently noted in the record.
6) All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.
7) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.
8) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
9) For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.
10) Health education behavioral assessment and referrals to health education services.

2-Plan Contract A.4.13.A, B, C, D

SUMMARY OF FINDINGS:

135 of 238 requested medical records were obtained. There were 103 records the Plan was unable to locate and PCPs were unable to identify as current patients.

Forty-eight medical records from multiple Provider sites were reviewed and findings showed medical records were not consistently completed and maintained in accordance with the provisions of the Contract, CCHP Policies and Procedures, and CCR, Title 22, section 5386 especially with regard to:

- *Lists of current, ongoing medications identifying the drug name, strength, dosage, route, and frequency, as well as discontinued medications.*
- *Legal medical documentation standards for signatories, dates, legibility, and error correction.*
- *Subjective complaints, objective findings, and the plan for diagnosis and treatment.*
- *Problem lists for ongoing conditions.*
- *Complete records of immunizations.*
- *Tuberculosis risk screenings.*
- *Provider notation following abnormal results, consultations, referrals, and specialist visits.*
- *Documentation of Durable Power of Attorney for Health Care.*

In summary, policies and procedures for medical records management and documentation processes were not consistently implemented.

RECOMMENDATION:

Develop and implement monitoring system to ensure that medical records are consistently completed and maintained in accordance with the provisions of the Contract, CCHP Policies and Procedures, and CCR, Title 22 section 53861.

5.6	INFORMED CONSENT

Informed Consent
Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes: …All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.
2-Plan Contract A.4.13.D.6

Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3.
2-Plan Contract A.9.9.A.1

SUMMARY OF FINDINGS:

The Plan's *Policy #: QM14.602, Consent for Sterilization Procedures,* requires that informed consent for sterilization be signed by the Member at least 30 days before the procedure is performed. The Provider performing the sterilization must sign the consent form on the day of the procedure to certify that Member had voluntarily requested to be sterilized and fully understand the nature and consequences of the procedure. This policy was consistent with CCR, Title 22, sections 51305.1 and 51305.3 regarding the required time frames for sterilization procedures.

The verification study showed the Plan is not in compliance with regulatory and the Contract for Informed Consent procedures. A Member was not given adequate time to reconsider and reverse the decision to be sterilized and the medical record did not contain documentation that would indicate an emergency condition existed. For some Members, the rendering Provider did not sign the sterilization consent form on the day of the procedure as outlined by the *CCHP Policy #: QM14.602, Consent for Sterilization Procedures.*

RECOMMENDATION:

Develop and implement system to ensure that all Informed Consents are done according to CCR, Title 22, sections 51305.1, 51305.3, and CCHP *Policy #: QM14.602, Consent for Sterilization Procedures***.**

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3	HEALTH EDUCATION PROGRAM

Health Education:

1) Contractor shall implement and maintain a health education system that include programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members.
2) Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator.
3) Contractor shall provide health education programs and services at no charge to Members directly and/or through Subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Member population.
4) Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health.
5) Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.
6) Contractor shall maintain a health education system that provides educational interventions...
7) Contractor shall ensure that Members receive point of service education as part of preventive and primary health care visits. Contractor shall provide education, training, and program resources to assist contracting medical providers in the delivery of health education services for Members.
8) Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to ensure effectiveness.
9) Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements….(as required by Contract)

2-Plan Contract A.10.8.A

SUMMARY OF FINDINGS:

The Plan's Health Education Specialist conducts annual audits of the delegated entities' Health Education Program and performance. CCRMC received a 50% score in health education performance which has been a continuing problem in prior annual audits. CCRMC was cited for its continued failure to take corrective action to comply with the following requirements:

- Provide specific educational offerings in both English and Spanish to 3 regions in the County.
- Provide Member participation data in educational offerings.
- Make available and post in Health Centers and website a list of classes and resources.
- Provide a contact person responsible for overseeing CCRMC Health Education Department and empowered to improve its services.

CCRMC's failure to provide adequate health education services renders the Plan out of compliance with the Contract health education requirements. The impact of this deficiency is further highlighted by the fact that over 50% of the Plan's Medi-Cal Members are served by CCRMC and not receiving adequate health education services. The Plan did not ensure CCRMC performed corrective action to resolve this deficiency. As mentioned in the Section 5.4, Delegation of QI Activities, the Plan does not have a delegation agreement with CCRMC. Without a delegation agreement to define performance requirements, the Plan lacks the ability by which to hold CCRMC accountable.

RECOMMENDATION:

Ensure CCRMC performs corrective action to comply with Health Education Program requirements.

6.4	PROVIDER TRAINING

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

SUMMARY OF FINDINGS:

After a Provider is credentialed, contracted, and placed on the active status list, a congratulations letter is sent to welcome and request the Provider to contact the Plan's Provider Relations Liaison within ten days to schedule orientation training. If the Plan is not contacted by the Provider, Provider Relations Liaison follows up to schedule the training. The Plan tracks and follows up on new Provider training for all newly credentialed Providers. The Plan obtains a signed form from the Provider upon completion of the training or acknowledgment of receipt of training materials. The congratulations letters, however, were often sent past the ten working days from active status date. A sample review of seven Providers found that for five of these Providers, the training was not conducted within ten working days after being placed on active status.

RECOMMENDATION:

Ensure new Provider training is conducted within ten working days after the Plan places the Provider on active status as required by the Contract.

6.5	FRAUD AND ABUSE

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

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

2-Plan Contract E.2.26.B

SUMMARY OF FINDINGS:

The prior audit report recommended the Plan develop and implement policies and procedures to undertake a more proactive fraud and abuse detection and intervention program. The Plan's Corrective Action Plan (CAP) proposed that its Information Technology (IT) Department would research this issue and create a tool to detect fraud and abuse. In MMCD's Medical Audit Close-Out Report dated February 3, 2011, MMCD stated that the Plan's CAP was not corrected because "the Plan is still in the process of developing a proactive fraud and abuse detection and intervention program." This work has not been completed. The Plan stated it engaged a subcontractor mid-2012 for claims review and monitoring, but the subcontractor's work has been postponed.

Policy #: ADMN 1.006 stated "The Anti-Fraud Unit/Compliance-Fraud Subcommittee will meet twice a month and no less than quarterly to review the program and make recommendations for improvements to assure the success of the program in preventing, detecting, investigating, and reporting fraud…." While the Benefits Interpretation Manual (BIM)/Compliance Fraud Sub-Committee (CFS) usually met twice a month, the focus of the meeting was for BIM only. During the audit period, there was no CFS discussion to review the Fraud and Abuse program or make recommendations for improvement other than to report suspected or actual fraud or abuse cases. The issues and delays of the claims review and monitoring subcontractor's work were never discussed in CFS meetings based on meeting minutes. The BIM/CFS Minutes reflect very similar meeting content found in the prior audit.

The Plan did not implement its policies and procedures to undertake a more proactive fraud and abuse program and did not implement the prior audit CAP. **This is a repeat finding.**

RECOMMENDATION:

Implement its policies and procedures to undertake a more proactive fraud and abuse detection and intervention program.

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

County of Contra Costa
dba Contra Costa Health Plan

Contract Number:	03-75796 State Supported Services
Audit Period:	December 1, 2011 Through November 30, 2012
Report Issued:	August 16, 2013

TABLE OF CONTENTS

INTRODUCTION1

I. COMPLIANCE AUDIT FINDINGS.....2

INTRODUCTION

Audit Findings of County of Contra Costa dba Contra Costa Health Plan (CCHP)
This report presents the audit findings of County of Contra Costa dba Contra Costa Health Plan's (CCHP) State Supported Services contract No. 03-75796. The State Supported Services contract covers contracted abortion services with CCHP.

The onsite audit was conducted from March 4th through March 15th, 2013. The audit period is December 1, 2011 through November 30, 2012 and consisted of document review of materials supplied by the Plan and interview conducted onsite.

An Exit Conference was held on July 18, 2013 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. No additional information was submitted following the Exit Conference.

COMPLIANCE AUDIT FINDINGS

SUBCAT. #	REQ. #	REVIEW REQUIREMENT
1	***OTHER CONTRACT REQUIREMENTS***	

SUMMARY OF FINDINGS:

The Contract requires that abortion services be available to Members without prior authorization from any Medi-Cal Provider in or out of the Plan's network. Prior audit findings required changes to the Provider Manual and *Policy #: UM15.003, Policy for Prior Authorization* to remove implications of any restrictions or prior authorization for abortion services. The Plan made corrections to the Provider Manual, but numerous policies and procedures continue to contain language that place limitations or conditions to receive abortion services. **This is a repeat finding.**

The following policies and Plan literature contain restrictive access language with regard to abortion services:

- *Policy #: UM15.003, Prior Authorization*—Attachment A to this policy is a chart and under the 3rd column entitled "TABs", this chart shows that for Medi-Cal, a Member may "Use any RMC [Regional Medical Center] or CPN [Community Provider Network] provider". This limits Member choices to contracted Providers only. There is no mention that the Member may select any Medi-Cal Provider in or out of network.
- *Policy #: UM15.003, Prior Authorization*—Under the "TABs" column, Medi-Cal Members may use "Kaiser/Kaiser contracted only" Providers with "No referral" and No auth". Again, there is no mention that the Member may select any Kaiser Provider or any Medi-Cal Provider in or out of the Kaiser or CCHP network.
- *Policy #: CLM 4.503, Abortion Services,* states that Medi-Cal (RMC/CPN): Can go to any RMC/CPN provider without authorization. Arrangements are required for non-plan providers.
- *Policy #: CLM 4.503, Abortion Services,* states that Medi-Cal (Kaiser): "Can only go to Kaiser or Kaiser-contracted provider."
- *Policy #: CLM 4.573, Sensitive Services: HIV, Family Planning & Sexually Transmitted Disease.* The Sensitive Services Grid contained in this policy still state that for RMC or CPN providers "Arrangements required for non-plan providers" Further, for CCHP Kaiser, Members are limited to using Kaiser/Kaiser contracted Providers only.
- The Kaiser CCHP Member Handbook, page 55, states "We cover abortions at no charge when we arrange for the services. Your PCP does not have to authorize these services."

The Plan stated that while the policy language may be interpreted as limited access to abortions services in reality Members have open access, in and out of network, to any Medi-Cal Provider as stated in the Plan's Evidence of Coverage. However, for Plan Members receiving services from Kaiser, the Member is restricted to Kaiser contracted Providers only. In addition, the Plan's subcontract with Kaiser does not address the Contract requirements for abortion services.

RECOMMENDATIONS:

- Revise policies and procedures to remove language that implies any restriction for Member self-referral to any Medi-Cal Provider for abortion services or that prior authorization or referral is required.
- Revise Kaiser CCHP Member Handbook to inform Members that abortion services may be obtained from any Medi-Cal Provider and are not restricted to Kaiser Providers, Kaiser contracted Providers, or CCHP contracted Providers.
- Monitor Kaiser's access to abortion services to ensure Kaiser implements and allows the Member's right to use out-of-Kaiser network Medi-Cal Providers for abortion services.
- Ensure Kaiser's contract requires that Members are allowed to self-refer to any Medi-Cal Provider outside the Kaiser or CCHP network without prior authorization.