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

Health Plan of San Joaquin

Contract Number:	04-35401
Audit Period:	July 1, 2014 through June 30, 2015
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I. INTRODUCTION

The Health Plan of San Joaquin (The Plan) is a non-profit corporation headquartered in French Camp, CA and established in 1995. In 1996, The Plan received its Knox-Keene license and contracted with the State of California to provide health care services to Medi-Cal members in San Joaquin County.

On January 12, 1995, the State of California contracted with the San Joaquin County Board of Supervisors to serve as the Local Initiative under the 2-Plan Model, pursuant to the California Welfare and Institutions Code, Section 14087.31. On January 1, 2013, The Plan started to serve as the Stanislaus Local Initiative. The San Joaquin County Health Commission governs The Plan through an 11-member commission consisting of local government members, clinical, and non-clinical community representatives. In June 2015 HPSJ received NCQA accreditation.

Health care services are provided through contracts with independent medical groups and individual physicians (over 384 Primary Care Physicians). Health care services not provided directly by primary care physicians are arranged through contracts with other medical groups/physicians (over 1,200 network specialists), allied health service suppliers, and all local hospitals. The Plan has a tertiary network of over 3,700. As of March 2015, The Plan had over 300,000 Medi-Cal members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of July 1, 2014 through June 30, 2015. The on-site review was conducted from July 13, 2015 through July 24, 2015. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on February 23, 2016 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 Rights, Quality Management (QI), and Administrative and Organizational Capacity.

Category 1 – Utilization Management

- There is no systematic method of detecting underutilization of services or procedures.
- Complete appeal instructions were not routinely included in prior authorization files.
- The Plan does not track and trend specialist referrals.
- The Plan did not ensure continuous monitoring of delegated entities.

Category 2 – Case Management and Coordination of Care

- The Plan did not ensure the provision of all medically necessary covered services to the members until CCS eligibility is confirmed.
- The Plan did not fully execute the Memorandum of Understanding (MOU).
- The Plan did not implement a quality improvement strategy to address the low compliance rate of Initial Health Assessment (IHA).

Category 3 – Access and Availability of Care

- Plan did not have an efficient method for measuring compliance for initial prenatal appointments.
- Plan did not measure specialist appointment wait times in its annual access survey.
- Plan did not pay the correct amount of interest for emergency service claims paid over 45 working days.
- Plan has no policy for handling misdirected claims.

Category 4 – Member's Rights

- Medical Director did not review all levels of quality of care grievances.
- The Plan did not systematically analyze 24 hour grievance data for Quality Improvement.

- The Plan's process for reporting suspected privacy breaches allowed unauthorized PHI disclosures to circumvent DHCS reporting.

Category 5 – Quality Management

- Plan did not provide supporting documentation that interventions for grievance and PQI processes or under-utilization of services were communicated to the Board.
- The Plan did not ensure all providers were trained within ten working days.
- The Plan did not demonstrate accountability between the governing board and committees monitoring delegated entities.

Category 6 – Administrative and Organizational Capacity

- The Plan provided limited educational services and did not evaluate its education system.
- The Plan did not comply with Readability and Suitability Checklist standards for its education materials.

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 July 13, 2015 through July 24, 2015. 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: 45 medical and 27 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 23 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Coordination of Care: 3 records were included in a review of coordination of care between the Plan, PCP, Member, Specialty Providers, and other services.

California Children's Services: 3 medical records were reviewed for evidence of coordination of care between the Plan and CCS Providers.

Category 3 – Access and Availability of Care

Emergency Service Claims: 50 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 46 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 71 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

New Provider Training: 22 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 (CAF) ❖	
PLAN: Health Plan of San Joaquin	
AUDIT PERIOD: July 1, 2014 through June 30, 2015	DATE OF AUDIT: July 13, 2015 through July 24, 2015

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

Review of Utilization Data:
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:

1.1.1 **There is no systematic method of detecting underutilization of services or procedures.**

Contractor shall develop, implement, and continuously update and improve a UM program. Contract, Exhibit A, Attachment 4(1)

The Plan is required to have mechanisms within the Utilization Management Program (UM) to detect both under and overutilization. Contract, Exhibit A, Attachment 5(4)

The contract requires the Plan have a mechanism to detect over and underutilization of health care services. The Plan did not furnish evidence during the audit period that it had a system to detect underutilization beyond HEDIS measures which do not include all health care services e.g., pain management. This is a repeat finding.

RECOMMENDATIONS:

1.1.1 Develop and implement UM program mechanisms to detect and track underutilization of health care 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)
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

Timeframes for Medical Authorization
Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto.
2-Plan Contract A.5.3.F

Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
2-Plan Contract A.5.2.H

Denial, Deferral, or Modification of Prior Authorization Requests:
Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, 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:

1.2.1 **Complete appeal instructions were not routinely included in prior authorization files.**

Contractor shall provide for a written notification to the Member and the Member's representative on a standardized form informing the Member of… The Member's right to, and method of obtaining, a State Fair Hearing to contest the denial, deferral, or modification action and the decision the Contractor has made. Contract, Exhibit A Attachment 13(8)(D)(1)

Members may request an Independent Medical Review (IMR) regarding the NOA from the Department of Managed Health Care (DMHC). An IMR may not be requested if a State Fair Hearing has already been requested for that NOA. Contract, Exhibit A Attachment 14(4)(B)(2)

Instructions for obtaining State Fair Hearing or Independent Medical Review were not present in 9 of 18 medical Prior Authorizations denials and 1 of 7 pharmacy Prior Authorization denials.

RECOMMENDATIONS:

1.2.1 Ensure that complete appeal instructions are included in the NOA letter.

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:

1.3.1 **The Plan does not track and trend specialist referrals.**

The Plan is required to have an established specialty referral system to track and monitor referrals requiring prior authorization through the Plan. Contract, Exhibit A, Attachment 5(1)(F).

The Plan did not provide evidence that it tracks and trends referrals or appointments. The Plan stated during an interview that it uses claims to track utilized referrals. However, this method results in incomplete information for Quality Improvement and Utilization Management purposes as it does not track when the referral was made or account for open and unused referrals. This is a repeat finding.

RECOMMENDATIONS:

1.3.1 Develop and implement a referral tracking system.

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 Contract, Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.
2-Plan Contract A.5.5

SUMMARY OF FINDINGS:

1.5.1 **The Plan did not ensure continuous monitoring of delegated entities**.

Plan is accountable for all quality improvement functions and responsibilities that are delegated to subcontractors…at least quarterly. Contract, Exhibit A, Attachment 4(6)(A)(3)

Contractor shall maintain a system to ensure accountability for delegated quality improvement activities that at a minimum…includes the continuous monitoring, evaluation and approval of the delegated functions. Contract, Exhibit A, Attachment 4(6)(B)(3)

Oversight reports were not obtained in a timely basis. The Quality of Care (QOC) meeting minutes noted that delegated entities did not provide the required oversight reports.

RECOMMENDATIONS:

1.5.1 Ensure continuous monitoring and oversight of delegated entities through timely receipt of oversight reports.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

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:

2.2.1 **The Plan did not ensure the provision of all medically necessary covered services to the members until CCS eligibility is confirmed.**

The Plan has a total of 28 days to render a decision on routine authorizations. Contract, Exhibit A, Attachment 5(3)(G)

According to the Plan's Policy and Procedure UM 41 "CCS prior authorization review process flow chart", prior authorization is "deferred" to CCS if it is identified as being potentially eligible for CCS services. During interviews with Providers, Providers reported delays in getting their requests approved due to the potential that the care might be covered under the CCS program. A report from the Plan shows over 90 deferred prior authorizations greater than 30 days, thus indicating delays in service.

RECOMMENDATIONS:

2.2.1 A) Ensure continued provision of all medically necessary covered services to the member until CCS eligibility is confirmed.

B) Ensure all medically necessary authorizations are approved within the required time frame.

C) Ensure policy reflects contractual requirements.

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:

2.3.1 **The Plan did not fully execute the Memorandum of Understanding (MOU).**

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Contract, Exhibit A, Attachment 12, Provision 2, for the coordination of services for Members with developmental disabilities. Contract, Exhibit A, Attachment 11(10)(E).

The MOU between the Regional Center and The Plan states that both parties will maintain processes that identify recipients (members) who have joint eligibility to coordinate services. April 22, 2015 meeting minutes with the area Regional Center states “The Regional Center does not have a way in their system to identify the type of insurance the consumer has.” The Regional Center also stated during interviews that the Department of Developmental Services database used for tracking members in the Early Intervention Developmental Disabilities (EI/DD) program did not capture the name of the health plan nor the PCP. This caused an inadequate exchange of medical information between the parties. Consequently, the referring PCP and the Plan do not receive documentation that the member has been receiving services from the Regional Center indicating a lack of coordination of care. The requirement for the execution of the MOU with the local Regional Center for coordination of care and services for Persons with Developmental Disabilities (DD) was not met.

RECOMMENDATIONS:

2.3.1 Ensure the MOU is 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, Sections 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 120 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:

2.4.1 **The Plan did not implement a quality improvement strategy to address the low compliance rate of Initial Health Assessment (IHA).**

The Plan is accountable to cover and ensure the provision of an IHA in conformance with Title 22 CCR section 53851 (b)(1) and 53910.5 (a)(1) to each new member within 120 calendar days of enrollment. Contract, Exhibit A, Attachment 10(3)(A)

The Plan must have procedures for the promotion of IHA completion via mechanisms such as quality improvement strategies and training providers (MMCD Policy Letter No.08-003 Initial Comprehensive Health Assessment).

The Plan's IHA data documented a completion rate of 9.95% during the audit period showing low compliance rate. The lack of timely IHAs was also noted in the Plan's 3/18/15 QM/UM Meeting Minutes, however, no further actions were recommended. In addition, there was no discussion of IHA compliance rate in the Plan's Quality Improvement Work-plan or its San Joaquin County Health Commission meetings minutes. Based on the submitted documentation there is no evidence to demonstrate quality improvement on IHA completion.

RECOMMENDATIONS:

2.4.1 Develop and implement quality improvement strategies to address low IHA compliance rate.

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

Members must be offered appointments within the following timeframes:
3) Non-urgent primary care appointments – within ten (10) business days of request;
4) Appointment with a specialist – within 15 business days of request;
2-Plan Contract A.9.4.B

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:

3.1.1 **Plan did not have an efficient method for measuring compliance for initial prenatal appointments.**

The plan is required to "ensure that the first prenatal visit for a pregnant member will be available within 2 week upon request." Contract, Exhibit A, Attachment 9(3)(B)

According to the review of Plan Policy QM 04 and based on the interview with Plan staff, the Plan measures compliance for initial prenatal appointment availability through its Appointment Availability Report. However, based on the review of the report, there was no evidence that initial prenatal appointment wait time was surveyed. This is a repeat finding.

3.1.2 **Plan did not measure specialist appointment wait times in its annual access survey.**

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2… and monitor providers' compliance with these standards. Contract, Exhibit A, Attachment 9(4)

The plan did not measure access timeliness standards for specialist providers on its 2015 Appointment Availability Report.

RECOMMENDATIONS:

3.1.1 Ensure availability of First Prenatal Visit within 2 weeks upon request.

3.1.2 Ensure the monitoring of timeliness access standards for specialist providers.

3.5	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims):
Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the plan.
2-Plan Contract A.8.13.A

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

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
2-Plan Contract A.8.13.D

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). 3
2-Plan Contract A.8.13.E

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

Family Planning (Claims):
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:

3.5.1 **Plan did not pay the correct amount of interest for emergency service claims paid over 45 working days.**

Late payment on a complete claim for emergency services and care, which is neither contested nor denied, shall automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late. CCR, Title 28, §1300.71(i)(1)

According to review of the Plan's out-of-network emergency services claims data, 162 late payment claim lines paid interest. Of those 162 claim lines, 147 paid interest less than $15. According to the review of the verification study of out-of-network emergency services claims, 3 of 3 claims that did pay interest paid under $15 of interest. The plan is required to pay a minimum of $15 dollars per claim line for late emergency services claims.

3.5.2 **Plan has no policy for handling misdirected claims.**

For a provider claim involving emergency service and care, the plan shall forward the claim to the appropriate capitated provider within ten (10) working days of receipt of the claim that was incorrectly sent to the plan. CCR, Title 28, §1300.71(b)(2)(A)

The plan's employee guide "Edit 201" has the instructions for handling misdirected claims but does not require analysts to forward them within ten working days. However, the Plan has not developed a formal policy to forward misdirected claims to the appropriate provider within 10 working days.

RECOMMENDATIONS:

3.5.1 Pay the correct amount of interest on emergency claims that take longer than 45 days to pay.

3.5.2 Develop policy that requires the Plan to forward misdirected claims to appropriate provider within ten working days of receipt.

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, Contract, 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:

4.1.1 **Medical Director did not review all levels of quality of care grievances.**

Grievances related to medical quality of care issues shall be referred to the Contractor's medical director. Contract, Exhibit A, Attachment 14(2)(E)

Plan staff stated in an interview that quality of care issues of lesser severity (Potential Quality Issue level 0 and 1) are not routinely reviewed by a medical director. They are instead reviewed by QM nurses.

(Example 1) Grievance file # 44 – A pulmonary embolus was misdiagnosed twice. Plan did not provide documentation that CMO reviewed this case.

(Example 2) Grievance file #46— gynecologic surgery with adverse outcome was escalated to a Potential Quality Issue, but there were no CMO or MD notes included in the resolution file.

4.1.2 **The Plan did not systematically analyze 24 hour grievance data for Quality Improvement.**

Contractor shall implement and maintain procedures for systematic aggregation and analysis of grievance data. Contract, Exhibit A, Attachment 14(2)(C)

Plan did not provide reports or other documentation to show it analyzed 24 hour grievance data. The Plan stated in an interview that it does not aggregate and analyze 24 hour grievance data.

RECOMMENDATIONS:

4.1.1 Ensure medical director reviews all medical quality of care issues.

4.1.2 Ensure aggregation and analysis of 24 hour grievances for quality improvement.

4.3	CONFIDENTIALITY RIGHTS

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

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:
Business Associate agrees:

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. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

2-Plan Contract G.III.C.2.

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.

2-Plan Contract G.III.J

SUMMARY OF FINDINGS:

4.3.1 **The Plan's process for reporting suspected privacy breaches allowed unauthorized PHI disclosures to circumvent DHCS reporting.**

The Plan must "notify 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 to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract, or potential loss of confidential data affecting this Contract." Contract, Exhibit G (3)(H)(1)

Prior to any notification, the Plan utilizes a Privacy Incident Report to determine if a breach or a security incident is reportable to DHCS. This decision process allowed some incidents or breaches with unauthorized PHI disclosures to bypass DHCS notification if certain conditions were met.

RECOMMENDATIONS:

4.3.1 Report all breaches and security incidents to DHCS within the required time frames.

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

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:

5.1.1 **No supporting documentation that interventions for grievance and PQI processes were communicated to the Board.**

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. Contract, Exhibit A, Attachment 4(1)

Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following… Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made. Contract, Exhibit A, Attachment 4(3)(C)

Per review of the board minutes, there was no evidence that process improvements were communicated to the Board.

5.1.2 **Plan did not provide documentation of interventions or follow-up actions for under-utilization of**

services to the Board.

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…in the process of QIS development and performance review. Contract, Exhibit A, Attachment 4(2)

Review of QM/UM Committee minutes identified two underutilized services: asthma medication and Initial Health Assessment. There was no documentation that interventions or follow-up activities for these two services were communicated from the QM/UM Committee to the governing body.

RECOMMENDATIONS:

5.1.1 Ensure the board receives documentation of interventions for the grievance and PQI process from QM/UM.

5.1.2 Ensure the board receives and reviews documentation of interventions for underutilization of services.

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

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

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

Delegated Credentialing:
Contractor may delegate credentialing and 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:

5.2.1 **The Plan did not ensure all providers were trained within ten working days.**

Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program… 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 within ten (10) working days after the Contractor places a newly contracted provider on active status. Contract, Exhibit A, Attachment 7(5)

Per the Plan's Policy PRO 20, the provider will sign with their full signature to document their presence at the training.

Based on the interview, provider training was not scheduled for allied providers. The verification study demonstrated that 10 of 22 providers were trained beyond 10 working days after active status was obtained. Eighteen of twenty two records showed the office staff signed for the receipt of training instead of the actual provider. Full physician signatures were not collected for all training sessions. Webinar training was offered, but provider attendance was not validated. The documentation submitted did not validate that the provider was present during the training. This is a repeat finding.

RECOMMENDATION:

5.2.1 A) Ensure Plan conducts training for all newly credentialed providers within 10 working days on active status.

B) Ensure documentation with the full signatures of the providers trained.

5.3	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.

SUMMARY OF FINDINGS:

5.3.1 **The plan did not demonstrate accountability between the governing board and committees monitoring delegated entities.**

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… in the process of QIS development and performance review. Contract, Exhibit A, Attachment 4(2)

Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following: Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made. Contract, Exhibit A, Attachment 4(3)(C)&(D).

In review of QIUM meeting minutes, the governing body did not receive written progress reports from the QI Committee on a routine basis to ensure continuous monitoring of delegated entities. The Plan's "The Governing Body" meeting minutes documented only one instance of delegation oversight during the audit period on January 28, 2015.

RECOMMENDATIONS:

5.3.1 Ensure the Governing Body routinely receives and follows up on written progress reports from the Quality Improvement Committee regarding its delegated entities.

6.2	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:

6.2.1 **The plan provided limited educational services.**

Contractor shall implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all members. Contract, Exhibit A, Attachment 10(8)(A)(1)

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. Contract, Exhibit A, Attachment 10(8)(A)(3)

The plan stated during interviews that it directs members to community education events and it does not have its own education classes, nor does it have formal agreements with outside companies to provide educational classes or events.

6.2.2 **The plan did not conduct evaluation of its education system.**

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. Contract, Exhibit A, Attachment 10(8)(A)(8)

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. Contract, Exhibit A, Attachment 10(8)(A)(9)

Plan staff stated in the interview that the plan did not collect sign-in sheets or member feedback from these community health education programs to compile metrics of participation and sustained behavioral change for improved health. The plan is unable to effectively evaluate the classes to ensure the efficacy without documentation of participation and feedback, and is unable to choose the content of the classes based on member needs.

Plan staff also stated during an interview that there was no Health Education Committee during the audit period. Review of QI/UM and Community Affairs Committee minutes revealed a limited discussion and analysis of the health education system or of the collection of data related to the health education system.

Plan Policy HE01 says an annual education workplan is developed by the health educator that outlines specific education goals to be accomplished during the year. However, the annual workplan was not completed during the audit period.

6.2.3 **The plan did not comply with Readability and Suitability Checklist standards for its education materials.**

All written health education materials developed, adapted, purchased…must comply with requirements set forth in this letter… Plans can approve written member health education materials as long as…materials are assessed and approved using the enclosed Readability and Suitability Checklist and all required elements or items have been met… Approval process must be completed by a qualified health educator/health education specialist. Health Education materials which are developed, adapted, or obtained from outside sources must be field tested. All Plan Letter (APL) 11-018

The plan did not comply with Readability and Suitability Checklist (RSC) standards for its education materials. The plan provided one RSC to audit team and it was signed by the medical director instead of a qualified health education specialist as required by APL 11-018. In addition, the field testing requirement was not marked as completed and the material did not meet field testing exemption requirements specified on page five of APL 11-018.

RECOMMENDATION:

6.2.1 Develop and monitor health education programs, functions, and services.

6.2.2 Ensure the periodic review the health education system for the appropriate allocation of health education resources.

6.2.3 Ensure Readability and Suitability Checklists, including field testing, are completed and signed off by a full-time health educator for each plan approved written education material.

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

Health Plan of San Joaquin

Contract Number:	03-75801 State Supported Services
Audit Period:	July 1, 2014 through June 30, 2015
Report Issued:	March 23, 2016

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INTRODUCTION

This report presents the audit findings of The Health Plan of San Joaquin (The Plan) State Supported Services Contract No. 03-75801. The State Supported Services contract covers contracted abortion services with The Plan.

The onsite audit was conducted from July 13, 2015 through July 24, 2015. The audit period is July 1, 2014 through June 30, 2015 and consisted of document review of materials supplied by The Plan and interviews conducted onsite.

An Exit Conference was held on February 23, 2016 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 (CAF) ❖	
PLAN: Health Plan of San Joaquin	
AUDIT PERIOD: July 1, 2014 through June 30, 2015	DATE OF AUDIT: July 13, 2015 through July 24, 2015

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

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

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

SUMMARY OF FINDINGS:

SSS.1 **Plan inaccurately states on its EOC and policies that children above the age of 12 can receive abortion services without parental consent.**

A pregnant minor could obtain, without parental consent, the full range of medical care relating to her pregnancy that a pregnant adult lawfully could obtain. (American Academy of Pediatrics v. Lungren)

On page 27 of its Explanation of Coverage and on page 1 of Policy HPA06, the plan states that children above the age of 12 can receive an abortion without parental consent. It should state that a person of any age can receive an abortion without parental consent.

RECOMMENDATIONS:

SSS.1 Amend language in Explanation of Coverage, policies, and any other document to reflect that members under 18 do not need parental or guardian consent.