CONTRACT AND ENROLLMENT REVIEW DIVISION
SANTA ANA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Health Plan of San Joaquin

2022

Contract Number:	04-35401
Audit Period:	July 1, 2021 Through September 30, 2022
Dates of Audit:	October 10, 2022 Through October 21, 2022
Report Issued:	May 30, 2023

TABLE OF CONTENTS

I. INTRODUCTION 1

II. EXECUTIVE SUMMARY 2

III. SCOPE/AUDIT PROCEDURES 4

IV. COMPLIANCE AUDIT FINDINGS
Category 1 – Utilization Management……..... 6
Category 2 – Case Management and Coordination of Care……. 8
Category 3 – Access and Availability of Care ……..…..11
Category 4 – Member's Rights ……....17

I. INTRODUCTION

The Health Plan of San Joaquin (Plan) is a non-profit corporation headquartered in French Camp, CA, and established in 1995. The Plan provides medical managed care services to Medi-Cal members and is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act in San Joaquin County.

On January 12, 1995, the Plan served as the Local Initiative under the Two-Plan Model, pursuant to the California Welfare and Institutions Code, Section 14087.31. On January 1, 2013, the Plan began to serve as the Stanislaus Local Initiative. The Plan is governed by an 11 member public commission appointed by the San Joaquin County Board of Supervisors.

The Plan's provider network consists of approximately 345 primary care providers. As of October 2022, the Plan had approximately 418,882 Medi-Cal members, 257,306 members in San Joaquin County and 161,576 members in Stanislaus County.

II. EXECUTIVE SUMMARY

This report presents the findings of the Department of Health Care Services (DHCS) medical audit for the period of July 1, 2021 through September 30, 2022. The review was conducted from October 10, 2022 through October 21, 2022. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on May 4, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the audit report findings. No additional information was submitted after the Exit Conference on
May 4, 2023.

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

The prior DHCS medical audit, for the audit period of July 1, 2019 through June 30, 2021 was issued on June 1, 2022. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized its Corrective Action Plan (CAP).

The summary of the findings by category is as follows:

Category 1 – Utilization Management

The Plan must comply with all current and applicable provisions of the Medi-Cal Provider Manual, unless the Medi-Cal Provider Manual conflicts with this Contract, All Plan Letters (APL), and/or any applicable federal or state laws, regulations, in which case the specific terms of this Contract, the APL, or the applicable law will apply. The Plan did not use the appropriate coverage criteria to deny medical service requests.

Category 2 – Case Management and Coordination of Care

The Plan must ensure that their network providers provide oral or written anticipatory guidance to the parents or guardians of a child at each Periodic Health Assessment (PHA), starting at six months of age and continuing until 72 months of age. The Plan did not ensure the provision of oral or written blood lead anticipatory guidance to the parent(s) or guardian(s) of a child member at each PHA starting at six months of age and continuing until 72 months.

The Plan must ensure that their network providers order or perform Blood Lead Screening (BLS) tests on all child members at 12 months and 24 months of age. The Plan did not ensure the provision of a BLS tests to members at 12 months to 72 months of age.

Category 3 – Access and Availability of Care

The Plan must communicate, enforce, and monitor providers' compliance with access standards. The Plan did not ensure that corrective actions were implemented for providers who did not comply with appointment wait time standards.

The Plan must develop, implement, and maintain a procedure to monitor waiting times for telephone calls. The Plan did not monitor the wait times for providers to answer and return calls to members.

The Plan must develop, implement, and maintain a procedure to monitor waiting times in network providers' offices. The Plan did not have a policy and procedure to monitor providers' compliance with wait times in the providers' offices for scheduled appointments.

The Plan must use a DHCS-approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members. The Plan did not ensure the use of a DHCS-approved PCS form, complete with required information, to determine the appropriate level of service for Medi-Cal members.

The Plan must comply with statewide Medi-Cal Free-For-Service (FFS) enrollment standards and federal enrollment standards when verifying enrollment of providers through a state-level enrollment pathway or developing a provider enrollment pathway. The Plan did not ensure that its Non-Emergency Medical Transportation (NEMT) providers are enrolled in the Medi-Cal program.

Category 4 – Member's Rights

The Plan must establish and maintain written procedures for submitting, processing, and resolving all grievances. The Plan did not ensure full grievance resolution prior to sending resolution letters.

Category 5 – Quality Management

No findings were noted for the audit period.

Category 6 – Administrative and Organizational Capacity

No findings were noted for the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division, conducted this audit to ascertain whether the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and the State Contracts.

PROCEDURE

The review was conducted from October 10, 2022 through October 21, 2022. The audit included a review of the Plan's Contracts with DHCS, its 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 the Plan's administrators, staff, and the delegated entities.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization (PA) Requests: 28 PA requests were reviewed, which included 18 standard and ten urgent requests for consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

PA Appeals: 28 medical PA appeals were reviewed, which included 11 urgent and 17 standard appeals for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Blood Lead Anticipatory Guidance: 14 blood lead anticipatory guidance samples were reviewed to verify if the guidance on blood lead was provided at each PHA starting at six months of age.

BLS Tests: 14 BLS test samples were reviewed to verify if the guidance on blood lead was provided at each PHA starting at six months of age.

Category 3 – Access and Availability of Care

NEMT and PCS Forms**:** 30 NEMT service samples were reviewed for completion and Medi-Cal enrollment.

NEMT Medi-Cal Enrollment: 17 NEMT service samples were reviewed for Medi-Cal enrollment.

Category 4 – Member's Rights

Call-Inquiry: 11 call-inquiry cases were reviewed to verify the grievance classification and investigation process.

Exempt Grievances: 15 exempt grievance cases were reviewed to verify the classification, reporting timeframes, and investigation process.

Quality of Service (QOS) Grievances: 15 QOS grievance cases were reviewed for timeliness, investigation process, and appropriate resolution.

Quality of Care (QOC) Grievances: 15 QOC standard grievances and one QOC expedited grievances were reviewed for processing, clear and timely response, and appropriate level of review.

Category 5 – Quality Management

Potential Quality Issues (PQI): Ten PQI cases were reviewed for appropriate evaluation and effective action taken to address needed improvements.

Category 6 – Administrative and Organizational Capacity

Overpayment Reporting: 12 overpayment recovery cases were reviewed for timely reporting to DHCS and annual reporting of total overpayment recoveries to DHCS.

Encounter Data: Five encounter data cases were reviewed for the existence and the accuracy of the medical records information that will be submitted by Plan.

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, 2021 through September 30, 2022 **DATE OF AUDIT: October 10, 2022 through October 21, 2022**

CATEGORY 1 – UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION

1.2.1 Prior Authorization Medical Coverage Criteria

The Plan shall comply with all current and applicable provisions of the Medi-Cal Provider Manual, unless the Medi-Cal Provider Manual conflicts with this Contract, APL, and/or any applicable federal or state laws, regulations, in which case the specific terms of this Contract, the APL, or the applicable law will apply. *(Contract Exhibit E, Attachment 2(1)(E))*

The Plan is required to have new coverage requirements for biomarker testing for applicable members diagnosed with cancer, advanced or metastatic stage three or four cancer, effective July 1, 2022. (*APL 22-010 Cancer Biomarker Testing dated June 22, 2022)*

The Plan may not categorically exclude health care services related to gender transition on the basis that it excludes these services for all members. For individuals under 21 years of age, a service is "medically necessary" if the service corrects or ameliorates defects and physical and mental illnesses and conditions. *(APL 20-018 Ensuring Transgender Access to Services dated October 26, 2020)*

Plan Policy *UM 01 Authorization and Referral Review* (revised 11/2021*)* stated that Medical Review Criteria (also known as UM Criteria and Medical Necessity Criteria) are used to evaluate all requests. The Plan makes UM decisions that are based only on the appropriateness of care and service and the existence of coverage.

Plan Policy *UM 06 Medical Review Criteria* (revised date 11/2021) stated that the Plan's quality and UM committee has approved the State of California's manual of Medi-Cal Provider Manual Criteria shall serve as the primary reference for benefit coverage.

Plan Policy *UM 48 Requirements for Coverage of Early and Periodic Screening, Diagnostic and Treatment (EPSDT)Services for Medi-Cal Beneficiaries* (revised date 07/2020) stated that the EPSDT benefit is designed to ensure that eligible children receive comprehensive screening, diagnostic, treatment, and preventative health care services for children under age 21.

Finding: The Plan did not use the appropriate coverage criteria to deny medical service requests.

In a verification study of 28 PA requests, 18 standard PA requests demonstrated that coverage criteria were misapplied to five standard PA requests and were denied inappropriately.

For example:

- The Plan denied genetic testing for a three-year-old male member with a history of gross motor delay. However, this testing service is a covered benefit under the Medi-Cal section for early periodic developmental screening and testing.
- The Plan denied reproductive evaluation services for a 12-year-old transgender member. However, this service is a covered benefit under APL 20-018.
- The Plan denied genetic biomarker testing on August 8, 2022 for a 74-year-old female with metastatic (4B) vulvar cancer. However, this testing service is a covered benefit under APL 22-010, dated June 22, 2022.

During the interview, the Plan stated that it gives training and emails notifications about updated medical criteria to medical reviewers. However, reviewers did not follow the Plan policy UM 01 to consider Medi-Cal and updated APLs criteria. The Plan confirmed that new registered nurses denied the covered benefits incorrectly. However, the current Inter-Rater-Reliability monitoring process to determine whether reviewers correctly adjudicate PA are done on hypothetical cases only. There was no real time monitoring of actual PA cases to capture adjudication errors.

The Plan's inappropriate denial of covered benefits could lead to poor health outcomes and diminished QOC for members.

Recommendation: Implement policies and procedures to ensure UM reviewers use the appropriate criteria to make medical coverage decisions.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Plan of San Joaquin
AUDIT PERIOD: July 1, 2021 through September 30, 2022 **DATE OF AUDIT: October 10, 2022 through October 21, 2022**

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	BLOOD LEAD SCREENING

2.1.1 Anticipatory Guidance for Lead Exposure and Lead Poisoning

The Plan shall cover and ensure the provision of BLS tests to Members in accordance with APL 20-016. *(Contract 04-35401, Exhibit A, Attachment 10(5)(D)(1))*

The Plan is required to ensure their network providers give oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. The parent or guardian must be provided this anticipatory guidance at each PHA, starting at six months of age and continuing until 72 months. *(APL 20-016, BLS of Young Children)*

The Plan's Policy and Procedure, *QM66, BLS of Young Children* (Review/Revision Date: 08/22), stated that the Plan's Primary Care Providers (PCPs) must provide oral or written anticipatory guidance to the parent or guardian of a child member at each PHA starting at six months to 72 months of age. The Plan will select a random sample to perform spot check audits to determine whether: anticipatory guidance, lead testing, and caregiver refusal are documented.

The Plan's Policy and Procedure, *QM22, Initial Health Assessments (IHAs)* (Review/Revision Date: 10/20), stated that, through its Facility Site Review/Medical Record Review (FSR/MRR), the Plan ascertains the completion of an IHA that includes the performance of preventive care such as blood lead screenings and the provision of BLS anticipatory guidance.

Finding: The Plan did not ensure the provision of oral or written blood lead anticipatory guidance to the parent(s) or guardian(s) of a child member at each PHA starting at six months of age and continuing until 72 months.

In a verification study, six of 14 member records did not document oral or written anticipatory guidance provided to the parent(s) or guardian(s) of a child member at each PHA starting at six months of age and continuing until 72 months.

During the interview, the Plan explained that through its FSR/MRR process, it reviews for documentation of the provision of BLS anticipatory guidance. However, the Plan

acknowledged that it does not report FSR/MRR trends regarding BLS anticipatory guidance to the QM/UM Committee.

Not providing BLS anticipatory guidance education to parent(s) or guardian(s) may lead to poor health outcomes in pediatric members.

Recommendation: Revise and implement policies and procedures to ensure the provision of anticipatory guidance concerning childhood lead poisoning and lead exposure to members' parents/guardians at each PHA starting at six months to 72 months of age.

2.1.2 Provision of Blood Lead Screening of Young Children

The Plan shall cover and ensure the provision of BLS tests to Members in accordance with APL 20-016. *(Contract 04-35401, Exhibit A, Attachment 10(5)(D)(1))*

The Plan is required to provide BLS tests to all child members at 12 months and 24 months of age, and when the network provider performing a PHA becomes aware that a child member who is 12 to 72 months of age has no documented evidence of a BLS test taken. *(APL 20-016, BLS of Young Children)*

The Plan's Policy and Procedure, *QM66, BLS of Young Children* (Review/Revision Date: 08/22), stated that the plan's PCPs must order and perform BLS tests on all child members at ages specified in APL 20-016, 12 months to 72 months of age. This policy states that the Plan tracks, trends, and conducts BLS spot audit checks but there is no procedure to perform a CAP for providers who did not meet BLS requirements.

Finding: The Plan did not ensure the provision of a BLS tests to members at 12 months to 72 months of age.

In a verification study, five of 14 member records did not document blood lead test orders or results.

In an interview, the Plan monitors for the performance of BLS by conducting an annual spot check audit, as mentioned in Policy and Procedure, *QM66.* Additionally, in a written response, the Plan indicated that it conducts quarterly monitoring and reporting of BLS tests. The Plan's quarterly monitoring showed a downward trend in the provision of BLS with the possible cause related to the barriers and challenges of the COVID pandemic.

Although the Plan's Information Technology (IT) Department gathers the BLS testing data for analysis and reporting findings to the QM Department, the Plan acknowledged that it does not have a process to implement corrective actions for non-compliant providers who did not adhere to BLS requirements.

Not providing BLS tests in a timely matter may lead to undetected blood lead poisoning in pediatric members.

Recommendation: Revise and implement policies and procedures to ensure the provision of a BLS tests to members at 12 months to 72 months of age.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING OF WAIT TIMES

3.1.1 Compliance with Appointment Wait Time Standards

The Plan shall establish acceptable accessibility standards in accordance with California Code of Regulations (CCR), Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. *(Exhibit A, Attachment 9 (3)(C))*

The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access, which includes but is not limited to taking all necessary and appropriate action to identify the causes underlying identified timely access deficiencies and to bring its network into compliance. *(CCR, Title 28, section 1300.67.2.2 (d)(3))*

The Plan Policy PRO028 *Monitoring Appointment Access: Annual Department of Managed Health Care (DMHC) Timely Access Survey* (revised date 03/2021) stated that the Plan conducts the DMHC Timely Access Survey on an annual basis. The Provider Access Reporting Committee will review the results of the annual Provider Appointment Availability Survey (PAAS). Actions to deficiencies include notification to the provider of deficient access; further provider education and monitoring; resurvey of provider access; unmet access expectations that could result in implementing a CAP with an end date to be compliant with the deficiency.

Finding: The Plan did not ensure that corrective actions were implemented for providers who did not comply with appointment wait time standards.

In a verification study of samples from the 2020 and 2021 PAAS for 21 non-compliant providers, the Plan could not substantiate or provide any documentation that the Plan had communicated and enforced any corrective actions for the non-compliant providers.

During the interview, the Plan stated that providers with low scores per the PAAS survey were contacted via phone calls to discuss the survey results. However, the Plan could not substantiate through documentation that this outreach was conducted. Additionally, the Plan confirmed that no CAPs were developed or implemented during the audit period.

Without ensuring implementation of corrective actions for non-compliant providers, these providers will remain non-compliant, resulting in members not receiving timely care access, potentially leading to member harm.

Recommendation: Ensure corrective actions are implemented for providers who did not comply with appointment wait time standards.

3.1.2 Telephone Wait Times

The Plan shall establish acceptable accessibility standards in accordance with 28 CCR, section 1300.67.2.1. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times for telephone calls (to answer and return). *(Contract, Exhibit A, Attachment, 9(3)(C))*

Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, including, but not limited to, waiting time and appointments*. (CCR* Title 28, section *1300.67.2, (f) Accessibility of Services.)*

The Plan Policy PRO028 *Monitoring Appointment Access: Annual DMHC Timely Access Survey* (revised date 03/2021) stated that access 24 hours a day, seven days a week, to talk to a qualified health professional to decide if the health problem is urgent. Call back must occur within 30 minutes. Member Services' wait times are not to exceed ten minutes during normal business hours.

Finding: The Plan did not monitor the wait times for providers to answer and return calls to members.

During the interview, the Plan stated that it uses the grievance data to evaluate telephone wait times. However, the Plan confirmed that telephone wait time grievances identified during the audit period did not reach a level to require provider monitoring.

The Plan also stated during the interview that it evaluates data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to monitor telephone wait times. The Plan acknowledged that its monitoring processes lack the ability to identify non-compliant providers.

The Plan cannot communicate and enforce compliance with telephone wait time standards if its monitoring process lacks the ability to identify non-compliant providers. Non-compliance with telephone wait time standards may result in delayed access to medically necessary services.

Recommendation: Develop and implement policies and procedures to monitor the wait times for providers to answer and return calls to members.

3.1.3 Provider Office Wait Times

The Plan shall establish acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2.1. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times in network providers' offices. *(Contract, Exhibit A, Attachment 9(3)(C))*

The Plan is required to have a documented system for monitoring and evaluating the accessibility of care, including a system for addressing problems that develop, including, but not limited to, waiting time and appointments. (*CCR, Title 28, section 1300.67.2 (f)*)

Finding: The Plan did not have a policy and procedure to monitor providers' compliance with wait times in the providers' offices for scheduled appointments.

In interviews, the Plan confirmed that it lacked policies or procedures to monitor in-office wait times. The Plan explained that it uses both grievance data and CAHPS survey findings to capture and evaluate in-office wait times. The Plan acknowledged that its monitoring processes lack the ability to identify non-compliant providers.

The Plan cannot communicate and enforce compliance with in-office wait time standards if its monitoring process lacks the ability to identify non-compliant providers. Non-compliance with in-office wait time standards may result in delayed access to medically necessary services.

Recommendation: Develop and implement policies and procedures to monitor providers' compliance with in-office wait times.

3.2	NON-EMERGENCY MEDICAL TRANSPORTATION

3.2.1 Physician Certification Statement

The Plan shall cover NEMT services required by Members to access Medi-Cal services, as provided for in Title 22 CCR Section 51323, subject to the Plan's PCS form being completed by the Member's Provider. *(Contract, Exhibit A, Attachment 10 (8)(H)(2))*

The Plan must use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. The Plan must ensure that all NEMT PCS forms must include, at a minimum: function limitations justification, dates of service needed, mode of transportation needed, and certification statement. The Plan must have a mechanism to capture and submit data from the PCS form to DHCS. *(APL 17-010*, *Non-Emergency Medical and Non-Medical Transportation Services)*

The Plan's Policy and Procedure, *UM55 Emergency Transportation, NEMT and Related Expenses* (reviewed 08/2022), stated that the Plan will ensure a copy of a DHCS approved PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider.

Finding: The Plan did not ensure the use of a DHCS-approved PCS form, complete with required information, to determine the appropriate level of service for Medi-Cal members.

A verification study revealed that 14 of 30 NEMT trips showed non-compliance with NEMT requirements.

- Four member records did not have corresponding PCS forms.
- Ten member records that had PCS forms, and these forms were incomplete, e.g., missing functional limitations justification, dates of service needed, and/or mode of transportation needed.

During the interview, the Plan indicated that the UM team reviews the provider PCS forms for completeness to ensure there are no missing components and then a final review of the completed PCS forms is conducted by a registered nurse. However, the Plan could not provide documentation of such reviews for each of the ten incomplete PCS forms upon request.

Incomplete PCS forms may impair the provision of appropriate transportation services to members.

Recommendation: Revise and implement policies and procedures to ensure that the Plan obtains and completes PCS forms for NEMT services.

3.2.2 Medi-Cal Enrollment of NEMT Providers

The Medi-Cal managed care program and the Plan must comply with statewide Medi-Cal FFS enrollment standards and federal enrollment standards when verifying enrollment of providers through a state-level enrollment pathway or developing a provider enrollment pathway. *(APL 19-004, Provider Credentialing and Re-credentialing and Screening and Enrollment)*

The Plan's Policy and Procedure, *UM55 Emergency Transportation, NEMT and Related Expenses* (reviewed 08/2022), stated that the Plan will ensure compliance with all federal and state requirements related to transportation services.

The Plan's Policy and Procedure, *QM23*, *Credentialing and Re-credentialing of Practitioners* (revised date 06/2022), state providers need to meet statewide Medi-Cal FFS enrollment standards. In accordance with its contracting policy, the Plan will inform their network providers, as well as any providers seeking to enroll with an Managed Care Health Plan (MCP), of the differences between the MCP's and DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

Finding: The Plan did not ensure that its NEMT providers are enrolled in the Medi-Cal program.

The Plan's Policy and Procedure, *QM23*, *Credentialing and Re-credentialing of Practitioners* (revised date 06/2022), described the Plan's requirement that providers need to meet statewide Medi-Cal FFS enrollment standards. This policy does not describe a process to verify whether providers, such as NEMT providers, are enrolled through a state-level enrollment pathway or developing a provider enrollment pathway.

The verification study showed that four of 17 providers were not enrolled in the Medi-Cal program. Enrollment with Medi-Cal was verified through the Provider Application and Validation for Enrollment system.

In a written statement, the Plan stated that on a monthly basis their IT Department compares the providers in the Plan's system with the Medi-Cal provider enrollment database from DHCS. However, in an interview the Plan acknowledged that its IT Department is currently going through system configuration which does not allow the Plan to identify any NEMT providers who are not enrolled in the Medi-Cal program.

If not enrolled in the Medi-Cal program, transportation providers may not meet state licensing and safety requirements resulting in members receiving inadequate or unsafe transportation.

Recommendation: Develop and implement policies and procedures to monitor and ensure that new and existing NEMT providers meet the Medi-Cal enrollment requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Plan of San Joaquin
AUDIT PERIOD: July 1, 2021 through September 30, 2022 **DATE OF AUDIT: October 10, 2022 through October 21, 2022**

CATEGORY 4 – MEMBER'S RIGHTS

4.1	**GRIEVANCE SYSTEM**

4.1.1 Grievance Resolution

The Plan is required to implement and maintain a Member Grievance System in accordance with the CCR, Title 22, section 53858, and Title 28, section 1300.68. *(Contract, Exhibit A, Attachment 14(2))*

The Plan is required to establish and maintain written procedures for submittal, processing, and resolution of all grievances. *(CCR, Title 22, section 53858(a))*

The Plan shall continue to comply with the State's established time frame of 30 calendar days for grievance resolution. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated in state regulations. (*APL 21-011 Grievance and Appeal Requirements, Notice and Your Rights templates*)

Plan Policy *GRV02 Grievance Procedures* (revised 01/2021) stated that failure of the provider to provide a timely response may result in the grievance being closed in the member's favor. In addition, all the grievances are reviewed and closed with the severity level and point values and that a proposed Resolution to the grievance and the rights information will be sent.

Finding: The Plan did not ensure full grievance resolution prior to sending resolution letters.

In a verification study, seven of 15 standard QOC grievances revealed that members were sent resolution letters prior to full resolution of grievances.

For example:

- An elderly member complained that a vendor delivered an unassembled cane. The resolution letter did not indicate how the grievance was resolved.
- The son of a member (father) complained that a provider did not review the laboratory results with the member. The resolution letter did not address how the member would get the laboratory results.

- A member with oral cancer who has lost part of his tongue complained that a provider did not review his medical chart and obtain vitals during the visits. The Plan did not indicate how it resolved the grievance but indicated the Plan would track and trend the provider.

During the interview, the Plan indicated that they focus on closing the grievances within the 30-day requirement without necessarily resolving them during the grievance process. Plan Policy GRV02 did not require the complete resolution of member grievances.

In addition, the Plan provided presentation slides of how individual grievance oversight was performed in accordance with Plan Policy GRV02. The checklist review did not ensure member QOC grievances were completely resolved.

Inadequate grievance investigation and resolution could delay care and medically necessary services for members and potentially lead to member harm or medical care of diminished quality.

Recommendation: Develop and implement policy and procedures to ensure that all grievances are fully investigated and resolved prior to closing them.

CONTRACT AND ENROLLMENT REVIEW DIVISION
SANTA ANA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

HEALTH PLAN OF SAN JOAQUIN
2022

Contract Number:	03-75801 State Supported Services
Audit Period:	July 1, 2021 Through September 30, 2022
Dates of Audit:	October 10, 2022 Through October 21, 2022
Report Issued:	May 30, 2023

TABLE OF CONTENTS

I. INTRODUCTION 1

II. COMPLIANCE AUDIT FINDINGS 2

I. INTRODUCTION

The report presents the audit findings of the contract compliance audit of the Health Plan of San Joaquin (Plan), and its implementation of the State Supported Services Contract No. 03-75801 with the State of California. The State Supported Services Contract covers abortion services for the Plan.

The audit was conducted from October 10, 2022 through October 21, 2022 and covered the review period from July 1, 2021 through September 30, 2022. The audit consisted of a document review of materials provided by the Plan and interviews with Plan staff.

An Exit Conference with the Plan was held on May 4, 2023. There were no deficiencies found.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2021 through September 30, 2022
DATE OF AUDIT: October 10, 2022 through October 21, 2022

STATE SUPPORTED SERVICES

The Plan's policies and procedures, provider manual, and member handbook were reviewed for the provision of State Supported Services.

A member may self-refer to any in-network or out-of-network provider for an abortion. Members may go to any provider of their choice for abortion services, at any time, for any reason, regardless of network affiliation, and a person of any age can receive an abortion without parental consent or prior authorization.

A verification study of 25 state-supported service claims was conducted to determine appropriate and timely adjudication. There were no compliance issues or deficiencies identified in the verification study.

Recommendation: None