MEDICAL REVIEW – SOUTHERN SECTION III
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Rady Children's Hospital – San Diego

Contract Number:	18-95314
Audit Period:	September 1, 2018 Through August 31, 2019
Report Issued:	February 4, 2020

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I. INTRODUCTION

Rady Children's Hospital – San Diego (Plan) is a nonprofit, pediatric-care facility providing the largest source of comprehensive pediatric medical services in San Diego, Imperial, and southern Riverside counties. The Plan treats children from birth to 18 years old as well as adults with certain conditions for which specialized services are offered.

The Plan established an Accountable Care Organization (ACO) to manage treatment for children with significant medical needs. As an ACO, the Plan was chosen to participate in a pilot project with the Department of Health Care Services (DHCS) to provide whole-child care for the California Children's Services (CCS) program in San Diego. Additionally, the Plan was granted a limited waiver from Knox-Keene requirements.

The Plan established California Kids Care (CKC), an ACO based model demonstration project. CKC will provide care for children with the following five CCS-eligible conditions: Cystic Fibrosis, Sickle Cell, Diabetes, Acute Lymphoblastic Leukemia, and Hemophilia. The Plan began CKC's operations on July 1, 2018 and began enrolling members on a voluntary basis on August 1, 2018.

As of September 2019, the Plan served 350 members through the ACO based model demonstration project.

II. EXECUTIVE SUMMARY

DHCS conducted an onsite audit of the Plan from September 9, 2019 through September 11, 2019. This report presents the results of the DHCS full scope medical audit for the audit period of September 1, 2018 through August 31, 2019.

An Exit Conference was held on January 7, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in the report reflect the evaluation of all relevant information received prior and subsequent to the Exit Conference.

The audit consisted of document review, verification studies, and interviews with Plan personnel. 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, and Administrative and Organizational Capacity.

The audit period included the Plan's first year of operation in Medi-Cal Managed Care. The audit examined the Plan's compliance with its DHCS contract.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 includes procedures and requirements for the Plan's UM program, including delegation of UM, prior authorization review and the appeal process.

The Plan is required to send notices to members to ensure thorough, appropriate, and timely resolution of appeals. The Plan's appeal filing and member notification timeframes do not reflect applicable requirements stated in, *All Plan Letter (APL) 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments*.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements regarding CCS, Initial Health Assessment (IHA), Complex Case Management, Behavioral Health Treatment, Non-Medical Transportation and Non-Emergency Medical Transportation, and Continuity of Care.

The Plan did not conduct IHAs according to existing Plan policy, nor verify completion of IHA for new members during the audit period. Although the Plan's policy requires primary care physicians to perform an IHA on new members within 120 days of enrollment, the Plan's policy did not describe how the Plan would monitor the provision of IHA. The Plan stated that newly enrolled members completed IHAs from the member's established primary care providers prior to joining the Plan. However, the Plan did not verify IHA completion.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding member's access to care and pharmaceutical services and the adjudication of claims for emergency services and family planning services.

The Plan is required to have written policies and procedures to ensure the provision of drugs prescribed in emergency circumstances. The Plan did not have written policies and procedures outlining the provision of drugs prescribed in emergency situations and did not monitor for compliance.

Category 4 – Member's Rights

Category 4 includes requirements to protect members' rights by properly handling grievances and reporting of protected health information.

The Plan is required 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-working-days upon discovery of the breach or unauthorized use and disclosure. The Plan's policy does not include procedures for notifying all DHCS officers within ten-working-days of the complete Privacy Incident Report (PIR).

Category 5 – Quality Management

Category 5 includes requirements to deliver adequate quality of care to members and take effective action to address needed improvements in quality of care delivered by providers.

The Plan did not ensure provider training was conducted for newly contracted providers within the ten-working-days requirement.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to implement and maintain a health education system and compliance program.

The Plan did not have policies or procedures to report to DHCS the results of a preliminary investigation of: fraud or abuse, overpayments identified or recovered and specifying those due to potential fraud, changes affecting member or provider eligibility or to notify DHCS of the removal of a suspended, and excluded or terminated provider from its network.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the DHCS, Medical Review Branch to ascertain that the medical services provided to the Plan's members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State contract.

PROCEDURE

The onsite review was conducted from September 9, 2019 through September 11, 2019. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Delegation of UM: The Plan delegates all prior authorization requests. Nine denied medical and ten denied pharmacy prior authorization cases from a delegate were reviewed. All prior authorization cases were evaluated for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeal Procedures: One medical prior authorization appeal was reviewed. The appeal was evaluated for appropriate and timely adjudication. The Plan received only one appeal during the audit period.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): 25 medical records were reviewed for completeness, timeliness, and evidence of coordination of care between the Plan and providers.

Behavioral Health Treatment Services: Six medical records were reviewed for coordination of care between the Plan and providers.

Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): 20 NMT services were reviewed for accuracy, completeness, and timeliness of transportation services provided. The Plan did not receive requests for NEMT services during the audit period.

Category 3 – Access and Availability of Care

Appointment Availability: 15 providers from the Plan's provider network were reviewed. The first available appointment was used to measure access to care.

Category 4 – Member's Rights

Grievance Procedures: One grievance was reviewed for timely resolution, response to complainant, and submission to the appropriate level of review. The Plan received only one grievance during the audit period.

Category 5 – Quality Management

Provider Qualifications: Ten new provider training records were reviewed for the timeliness of 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: Rady Children's Hospital – San Diego
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CATEGORY 1 – UTILIZATION MANAGEMENT

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Appeals Procedure

The Plan shall have a well-publicized appeals procedure for both providers and members. *(Contract, Exhibit A, Attachment 5(2)(F))*

Members have the right to file an appeal within 60-calendar-days from the date of the Notice of Action.

The Plan is required to send the member a written Notice of Action within two-business-days after the Plan makes an Adverse Benefit Determination. *(APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments)*

For appeals not resolved in favor of the member, the Plan must send a written Notice of Appeal Resolution within 30-calendar-days of the standard appeal.

For appeals resolved in favor of the member, the Plan must authorize or provide the disputed services promptly and as expeditiously as the member's condition requires, and no later than 72 hours from the date the determination was reversed.

Finding: Although the Plan has a well-publicized appeals procedure for both providers and members, the Plan's Provider Manual does not correspond with requirements in accordance with *APL 17-006*.

The timeframe requirement for filing an appeal is within 60-calendar-days from the date of the Notice of Action. However, the Provider Manual specifies that members may file a standard appeal verbally or in writing within 90-calendar-days of a denial of service or payment.

Although the Plan is required to send the member a written response within two-business-days after the Plan makes an Adverse Benefit Determination, the Provider Manual stated that the Plan will provide each member a written Notice of Action within ten days of the decision.

The Plan must send a Notice of Appeal Resolution within 30-calendar-days for a standard appeal. The Provider Manual stated that when the decision of an appeal is not

in favor of the member, meaning that the decision to deny, defer, or modify provision or payment of a service is upheld, the Plan will notify the member within 45-calendar-days from the date of the request for a standard appeal.

For appeals resolved in favor of the member, the Plan must authorize or provide the disputed services promptly and as expeditiously as the member's condition requires, and no later than 72 hours from the date the determination was reversed. However, the Provider Manual stated that the Plan will provide authorization no later than 45-calendar-days from the receipt of the request.

The Plan has not updated the Provider Manual to reflect its contractual obligations, which can affect the proceeding of appeals due to inconsistent information given to members and providers. Further, untimely appeal processes and decisions may prevent members from receiving the appropriate care needed.

Recommendation: Revise Provider Manual to indicate the correct appeal filing timeframes and member notifications in accordance with the Contract and APL 17-006 for providers to follow.

1.3.2 Oral Request for an Appeal

The Plan is required to ensure a member has 60-calendar-days from the date on the Notice of Action to file a request for an appeal either orally or in writing. Unless the member is requesting an expedited appeal, an oral request for an appeal should be followed by a written and signed appeal. *(Contract, Exhibit A, Attachment 14(5)(A))*

An oral appeal, excluding expedited appeals, shall be followed by a written and signed appeal. The date of the oral appeal establishes the filing date for the appeal. The Plan must request that the member's oral request for a standard appeal be followed by written confirmation in accordance with federal regulations. *(APL17-006)*

Finding: The Plan's policy and Provider Manual does not describe the requirement that an oral appeal, excluding expedited appeal, must be followed by a written and signed appeal.

The Plan's policy, *CKC-161, UM Appeals,* only stated that appeals may be filed by a member, a provider acting on behalf of a member, or an authorized representative and may be filed either orally or in writing. Appeals, whether standard or expedited, may be filed by method of mail, phone, or fax. Interview with Plan staff reiterated that the Plan's procedure did not include requiring a written and signed appeal following an oral request for an appeal.

The Plan informs providers and members of its appeal procedures through the publicized Provider Manual and Member Handbook. However, the Plan's Provider Manual does not state that an oral appeal must be followed by a written and signed appeal.

Without a written and signed appeal, the members' request may be miscommunicated, which may cause a delay in care.

Recommendation: Revise and implement Plan policy and Provider Manual to reflect the Plan's contractual obligation to request a written and signed confirmation following an oral request for an appeal.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Initial Health Assessment

The Plan must cover and ensure the provision of an IHA to each new member within 120 days of enrollment. An IHA consists of a comprehensive history and physical examination, preventive services, and an Individual Health Education Behavioral Assessment. *(Contract, Exhibit A, Attachment 10(3) and Policy Letter 08-003 Initial Comprehensive Health Assessment)*

Finding: The Plan did not conduct IHAs according to existing Plan policy nor verify completion of IHA for new members. Although the Plan's policy *CKC-112, Individual Health Education Behavioral Assessment,* requires primary care physicians to perform an IHA on new members within 120 days of enrollment, the Plan's policy did not describe how the Plan would monitor the provision of IHA. The Plan stated that newly enrolled members had established primary care physicians, or appropriate specialists, who have completed the IHA prior to the member's effective date of enrollment with the Plan. However, the Plan did not verify IHA completion.

Without ensuring and monitoring the provision of an IHA, the Plan is unable to assess member's current acute, chronic, and preventive health needs that require coordination with appropriate community resources or agencies.

Recommendation: Implement Plan policies and procedures to monitor and ensure members receive a complete IHA within 120 days of enrollment.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.4 ACCESS TO PHARMACEUTICAL SERVICES

3.4.1 Monitoring of the Provision of Drugs Prescribed in Emergency Situations

The Plan is required to ensure access to at least a 72-hour supply of a medically necessary, covered outpatient drug when the drug is prescribed in an emergency situation. The Plan shall have written policies and procedures related to emergency medication dispensing, which describe the methods that are used to ensure that the emergency room medication dispensing requirements are met. Written policies and procedures must describe how the Plan will monitor compliance with the requirements. *(Contract, Exhibit A, Attachment 10(7)(G)(3))*

Finding: The Plan did not have written policies and procedures outlining the provision of drugs prescribed in emergencies or how the Plan will monitor compliance with the emergency room medication dispensing requirements.

In an interview, the Plan stated that it does not have policies and procedures related to emergency medication dispensing. The Plan delegates this responsibility to the Pharmacy Benefit Manager (PBM). The audit team obtained the service agreement between the Plan and the PBM along with the PBM's policies outlining emergency medication dispensing.

The PBM's policy *#480-PD-1100*, *Prior Authorization Process*, stated that upon receipt of a prior authorization request in an emergency situation, the PBM provides for the dispensing of a 72-hour supply of the covered outpatient drug. However, the policy does not describe the methods used to ensure that emergency medications are dispensed and the monitoring system to ensure requirements are met.

The DHCS Pharmaceutical Services and Prescription Drugs Questionnaire, completed by the Plan's Pharmacy Director, stated that the Plan did not ensure that members were provided an emergency provision of prescribed drugs because it is out of the scope given the size of the Plan.

The Plan's responsibility is to ensure compliance with contract requirements in regards to a 72-hour supply of medically necessary covered outpatient drug when the drug is prescribed in an emergency situation. Failure to monitor emergency prescriptions can lead to members not receiving medically necessary drugs in a timely manner, which can result in adverse effects on members' health.

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Recommendation: Develop and implement Plan policies and procedures to ensure access to a 72-hour supply of medically necessary prescriptions in an emergency situation and develop how the Plan will monitor compliance with the requirements.

CATEGORY 4 – MEMBER'S RIGHTS

4.3	CONFIDENTIALITY RIGHTS

4.3.1 Privacy Incident Report

The Plan is required 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-working-days of the discovery of the breach, unauthorized use, or disclosure. The report shall be submitted on the PIR form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, the HIPAA regulations and/or state law. The PIR shall also include a full, detailed Corrective Action Plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. *(Contract, Exhibit G.III.J)*

Finding: The Plan did not submit complete PIR reports to all three required DHCS officers within ten-working-days of the discovery of the breach, unauthorized use, or disclosure.

The Plan's policy, *CKC-181, Security Breach: Notification to DHCS*, stated Plan's procedure include notifying DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer immediately by a telephone call plus email or fax within 24 hours upon the discovery of a breach. The Plan will then investigate such security incident, breach, unauthorized access, use or disclosure of Protected Health Information (PHI), or Personal Information (PI) and submit an updated PIR to all three required DHCS officers within 72 hours of the discovery. The Plan's policy *CKC-181* does not include Plan's procedures for notifying DHCS within ten-working-days of the complete PIR.

During the audit period, the Plan did not discover any potential breaches. Therefore, the audit team did not conduct a verification study to determine if the Plan submits potential breaches in a timely fashion.

The Plan's responsibility is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed, and to comply with the HITECH Act and HIPAA regulations. Failure to comply with contract requirements may result in untimely member notification when a potential PHI or PI

breach has occurred. In addition, the Plan may be subject to sanctions and/or penalties under the HITECH Act and HIPAA regulations.

Recommendation: Ensure the Plan implements policies and procedures to submit complete PIRs to the appropriate DHCS officers within ten-working-days of the discovery of the breach.

CATEGORY 5 – QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

5.2.1 Newly Contracted Provider Training

The Plan is required to 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. The Plan is required to conduct training, which shall include methods for sharing information between providers within ten-working-days after the Plan places a new contracted provider on active status. *(Contract, Exhibit A, Attachment 7(5)(A))*

Finding: The Plan did not ensure provider training was conducted within ten-working-days.

The verification study demonstrated ten newly contracted providers did not receive training within the ten-working-day requirement. The audit team conducted a verification study to ensure all network providers received training in regards to the Medi-Cal Managed Care program. During the audit period, the Plan contracted 62 new providers. The audit team randomly selected ten providers to review. None of the selected providers received the required Medi-Cal Managed Care program training. Further, the Plan lacked documentation to support provider training was conducted within ten days after the Plan placed a newly contracted provider on active status.

The Plan's policy, *CKC-020, Credentialing and Recredentialing*, does not stipulate the contractual obligation to educate all contracted providers with regard to the Plan's policies and procedures relating to the delivery of health care services and Plan administration within ten-working-days after the Plan has placed a newly contracted provider on active status.

The Plan's failure to ensure compliance with newly contracted provider training could result in an inconsistent process throughout the provider network to apply Plan standards, approved policies and procedures, established criteria, applicable state and federal laws, and the requirements of the Plan's Medi-Cal Contract with the State.

Recommendation: Develop and implement effective Plan policies and procedures to ensure that newly contracted providers receive training within the ten-working-day requirement.

6.2	Fraud and Abuse

6.2.1 Fraud and Abuse Reporting

The Plan shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten-working-days of the date the Plan first becomes aware of, or is on notice of, such activity. *(Contract, Exhibit E, Attachment 2(25))*

The Plan must promptly report to DHCS all overpayments identified or recovered, specifying which overpayments are due to potential fraud.

The Plan must notify DHCS when the Plan receives information about changes in member's circumstances that may affect the member's eligibility. The Plan must also notify DHCS when Plan receives information about changes in network provider's circumstances that may affect the network provider's eligibility to participate in the Medi-Cal Managed Care program, including the termination of their provider agreement with the Plan.

The Plan must notify the Medi-Cal Managed Care program/Program Integrity Unit within ten-state-working-days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.

Finding: The Plan did not notify DHCS of potential fraud, waste, or abuse, and overpayments identified or recovered, specifying which overpayments are due to potential fraud. Further, the Plan did not notify DHCS of information the Plan received in regards to changes in members or network providers' eligibility to participate. Lastly, the Plan did not notify DHCS of the removal of a suspended, excluded, or terminated provider from its provider network and confirm the provider is no longer receiving payments in connection with the Medicaid program.

The Plan's policies and procedures lack contractual language of any reporting to DHCS authorities. According to the Plan's policy, *CPM 12-20, Compliance Review, Resolution and Non-Retaliation Policy,* the Plan's Chief Compliance and Privacy Officer shall document and log all reported compliance incidents and assess whether issues require a review by the Compliance Department. However, the policy does not mention the notification to DHCS.

When the audit team inquired about notification of potential fraud and abuse to DHCS during the interview, the Plan's Compliance Officer explained Plan policies and procedures only include reporting at the county level. The Plan's Compliance Officer clarified the Plan notifies DHCS and other external parties of providers who are no longer qualified to participate or have been terminated. However, the Plan's policies and procedures do not reflect this contractual requirement. The Plan did not identify any suspended/excluded providers during the audit period.

The Plan did not encounter any potential fraud and/or abuse incidents during the audit period. Therefore, the audit team was unable to perform a verification study to determine appropriate reporting and processing.

The Plan's responsibility is to guard against fraud and abuse by reporting all cases of suspected fraud and abuse, including overpayments due to potential fraud, and changes in member or provider eligibility within the required timeframes. Failure to report timely to DHCS may compromise the integrity of the Plan and the Medi-Cal Program.

Recommendation: Develop and implement Plan policies and procedures to ensure DHCS is notified of any potential fraud and abuse; overpayments; changes in member or provider eligibility to participate; and removal of suspended, excluded, or terminated providers from the Plan's provider network.

MEDICAL REVIEW – SOUTHERN SECTION III
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Rady Children's Hospital – San Diego

Contract Number: 18-95367
State Supported Services

Audit Period: September 1, 2018
Through
August 31, 2019

Report Issued: February 4, 2020

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I. **INTRODUCTION**

This report presents the audit findings of Rady Children's Hospital – San Diego (Plan) State Supported Services Contract No. 18-95367. The State Supported Services contract covers contracted abortion services with the Plan.

The onsite audit was conducted from September 9, 2019 through September 11, 2019. The audit period is September 1, 2018 through August 31, 2019, and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

An Exit Conference with the Plan was held on January 7, 2020.

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SSS.1 Access to Abortion Services

The contract requires the Plan to provide or arrange to provide, to eligible members State Supported Services, which include the Current Procedural Terminology (CPT) codes 59840 through 59857 and Healthcare Common Procedure Coding System (HCPCS) codes A4649, S0190, S0191, and S0199. (*State Supported Services Contract Exhibit A.1*)

Finding: The Plan's policy, *CKC-078, Payment Methodology for Family Planning and Sensitive Services Rendered to a CKC Member,* stated that elective abortions, including CPT codes 59840, 59841, 59850-59852, and 59855-59857, do not require prior authorization. However, the Plan's policy did not include the HCPCS codes A4649, S0190, S0191, and S0199.

The Plan's policy does not list the complete codes required to be provided or arranged to be provided, to eligible members for State Supported Services. The Plan's claims systems also did not identify the complete list of codes as auto-adjudicated. The non-inclusion of requirements pursuant to the Contract in the Plan's policy could lead to denial of claims and services, and delays in receiving care for eligible members.

Recommendation: Revise and implement Plan policy and claims system to reflect the Contract requirements to include HCPCS codes A4649, S0190, S0191, and S0199.

SSS.2 Medical Justification or Prior Authorization

The Plan is required to provide outpatient abortion services without medical justification or prior authorization, and eligible members may go to any provider of their choice regardless of network affiliation. *(All Plan Letter 15-020 Abortion Services)*

Finding: The Plan's Provider Manual stated that the Plan may only provide pregnancy termination in the following situations: (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the member in danger of death unless a pregnancy termination is performed. During the interview, Plan staff mentioned that this is not its policy. The Plan's policy, *CKC-078, Payment Methodology for Family Planning and Sensitive Services Rendered to a CKC Member,* stated members may self-refer to a qualified family planning provider, contracted or non-contracted, without prior authorization for sensitive services, including abortion.

The Provider Manual does not reflect the Plan’s policy and procedure regarding the provision of State Supported Services. Misinformation in the Provider Manual may lead to members not receiving covered services.

Recommendation: Revise the Provider Manual to ensure contractual compliance when providing outpatient abortion services without medical justification or prior authorization, regardless of network affiliation.