

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

Care 1st Health Plan

Contract Number: 09-86153

Audit Period: February 1, 2017
Through
January 31, 2018

Report Issued: June 12, 2018

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I. INTRODUCTION

Care 1st Health Plan, an affiliate of Blue Shield of California, is a Health Maintenance Organization engaged in providing Medi-Cal managed care services in San Diego County. Blue Shield is an independent member of the Blue Cross Blue Shield Association, nonprofit health plan, founded 75 years ago, and headquartered in San Francisco.

Care 1st Health Plan was founded in 1994 by a group comprised of providers, organized medical groups, and hospitals. Care 1st Health Plan has maintained a California full service health plan license under the Knox-Keene Act since 1995. In June 2005, the Department of Health Care Services granted the Geographic Managed Care contract to Care 1st Health Plan to provide health care services to Medi-Cal beneficiaries in San Diego County. In 2008, Care 1st Health Plan received a three-year Commendable Accreditation from the National Committee for Quality Assurance (NCQA) for its Medi-Cal line of business. For the audit period, Care 1st Health Plan continues with a NCQA accredited status.

As of March 29, 2018, Care 1st Health Plan's total enrollment for their Medi-Cal line of business was 85,097. Enrollment by product line was as follows:

- Medi-Cal 82,796
- Cal MediConnect 2,301

II. EXECUTIVE SUMMARY

This report presents the results of the Department of Health Care Services (DHCS) medical audit for the period of February 1, 2017 through January 31, 2018. The on-site review was conducted from February 26, 2018 through February 28, 2018. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held with the Plan on May 17, 2018. The Plan was allowed fifteen (15) calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report findings. 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), Case Management and Coordination of Care, Access and Availability of Care, Member Rights, Quality Management (QM), and Administrative and Organizational Capacity.

The prior DHCS medical audit issued July 6, 2017 (for the audit period of February 1, 2016 through January 31, 2017) identified deficiencies, which were addressed in a *corrective action plan* (CAP). The CAP closeout letter dated August 8, 2017, noted that DHCS closed all previous findings.

Historically, the Plan did not consistently have an internal monitoring system to detect potential fraud, waste, and abuse trends within the claims data system. The Plan's continuous postponement to implement data mining program efforts contributed to unsuccessful efforts to identify suspect claims, improper payments, or develop corrective action plans to respond to detected violations.

During the current audit period, the Plan implemented the recommendations from the prior years' audits. The Plan has a system to appropriately and accurately detect potential fraud, waste, and abuse trends within the claims data.

With the assistance of an outside consultant, the Plan implemented an internal monitoring system to detect potential fraud, waste, and abuse trends within the claims data. The Plan has also analyzed data for previous years of noncompliance. The Plan developed a policy and procedure for identifying, investigating and providing a prompt response against fraud and/or abuse. The Plan staff received extensive training on fraud and abuse issues.

This year's audit found the Plan did not ensure the provision of an Initial Health Assessment (IHA) to each new member within 120 calendar days of enrollment. According to the Plan's IHA Completion Report, the Plan enrolled 14,595 new members from February 2017 to September 2017 and 1,980 (14 percent) of these newly enrolled members received an IHA. The Plan describes its primary outreach method to members, the robo-call system, as antiquated and needs improvement. Additionally, the audit found moderate coordination between the Plan and its providers.

An initial health assessment decreases the risk that chronic conditions go undetected, which affects the member's health. The Plan's unsuccessful efforts to coordinate IHA outreach with providers contributed to low IHA completion rates.

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 February 26, 2018 through February 28, 2018. 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

Prior Authorization Requests: 20 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeal Procedures: 20 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment: 18 medical records were reviewed for completeness and timeliness.

Behavioral Health Treatment Services: 20 medical records were reviewed for evidence of coordination of care between the Plan and providers.

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.

Emergency Services and Family Planning Claims: 20 emergency service claims and 15 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 40 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level of review.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4

INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment (IHA):

Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with 22 CCR 53910.5(a)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

GMC Contract A.10.3.A; *Title 22 CCR Section 53910.5(a)(1) – Scope of Services*; See Provision 5 and 6, in part, below.

Contract A.10, Provision 5.A (Provision of IHA for Members under Age 21):

- 1) For Members under the age of 18 months, Contractor shall ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger, whichever is less.
- 2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

Contract A.10, Provision 6.A (Services for Adults - Age 21 and older)

- A. Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

Contractor shall ensure that the performance of the initial comprehensive history and physical exam for adults includes, but is not limited to:

- 1) A comprehensive history including, but not limited to, mental and physical systems, and social and past medical history.
- 2) Status of currently recommended preventive services.
- 3) Comprehensive physical and cognitive exam sufficient to assess and diagnose acute and chronic conditions.
- 4) Diagnoses and plan of care including follow-up activities.

Contractor is responsible for assuring that arrangements are made for follow-up services and plan of care that reflect the findings and risk factors determined during the IHA.

Contractor shall ensure that Member's completed IHA is contained in the Member's Medical Record and available during subsequent health visits.

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2.4

INITIAL HEALTH ASSESSMENT

Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA.

- 1) Contractor shall make at least three documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA. Contact methods must include at least one telephone and one mail notification.
- 2) Contractor must document all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed.

GMC Contract A.10.3.E

Individual Health Education Behavioral Assessment (IHEBA):

Contractor shall ensure that the IHA includes the IHEBA as described in Exhibit A, Attachment 10, Provision 8, Subprovision A.

GMC Contract A.10.3.B; See also Contract A.10, Provision 8.A.9 below.

Contract A.10, Provision 8.A.9

Contractor shall ensure that all new Members complete the IHEBA within 120 calendar days of enrollment as part of the initial health assessment and that all existing Members complete the IHEBA at their next non-acute care visit, but no later than their next scheduled health screening exam.

SUMMARY OF FINDINGS:

2.4.1 Initial Health Assessment

The Plan shall cover and ensure the provision of an Initial Health Assessment (IHA) to each new member within 120 calendar days of enrollment and have procedures in place to monitor its completion. [Contract, Exhibit A, Attachment 10, 3(A)].

The Plan did not ensure the provision of an IHA to each new member within 120 calendar days of enrollment. According to the Plan's IHA Performance Report, the Plan enrolled 14,595 new members from February 2017 through September 2017. Of the 14,595 new members, 1,980 (14 percent) members completed an IHA.

The audit team reviewed the Plan's website, policies and procedures, committee minutes, work plan, outreach and IHA data reports, and other relevant Plan documents. The audit team's analysis of the Plan's IHA Completion Report was the same as the Plan's results.

A verification study was conducted to verify the Plan's compliance with IHA. The study included provider site visits, medical record reviews, and interviews with

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provider and Plan staff. The audit team's verification study found barriers to IHAs being completed within 120 days.

The Plan relies primarily on phone outreach to inform members of the IHA provision. IHA outreach includes attempts to contact new members with the goal to schedule an appointment with a provider to have an IHA completed within 120 days of enrollment. The Plan documents the number of attempts to reach the member and the outcome. According to the Plan's IHA Outreach Report, 11,287 members were referred to IHA outreach from February 2017 through September 2017. Of the 11,287 members, 947 had a disconnected/invalid number, 372 declined, and 152 were not reached. The report indicated 9,364 members were reached and given a reminder to schedule and 446 (4 percent) had an appointment arranged.

The outcome of IHA outreach is reported to the Medical Services Committee (MSC). The Plan has identified challenges with their primary outreach method. The MSC minutes indicated data support has not been consistently available, causing delays and not meeting IHA timeframes. The Plan referred to the robo-call system as being antiquated, with plans to replace and improve the system. During the Plan interviews, Plan staff stated it has considered adding communication modalities, such as text, and has added more resources to specifically aid in IHA outreach efforts. The Plan also stated that some Federally Qualified Health Centers' scheduling systems can be accessed and more will be added to improve new member IHA completion rates.

Besides phone outreach, the Plan informs members about the importance of having an IHA completed and encourages members to schedule an appointment through mailings, such as the Member Handbook and by letter, and through the Plan's website. In addition, the Plan sends providers a list of new members and letters requesting to reach out to new members. The Plan expects providers to document the number of outreach attempts and analyze the data found. Providers are also encouraged to access the Plan's provider web portal for new members. During the Plan interviews, Plan staff stated follow-up is not done to verify whether providers reached out to new members. Without effective follow-up with providers, the Plan is unable to identify barriers the providers experience.

Through the review of Plan documents and the verification study, the audit team found the Plan had a system for IHA outreach, however providers either had a separate system or no system in place. Coordination between the Plan and the provider is an integral part of connecting with new members to establish rapport and ensure the provision of an IHA.

During provider onsite visits, providers expressed concerns that the Plan did not provide sufficient training on IHA requirements, guidance on outreach expectations,

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and communication of the Plan's monitoring efforts. The providers shared that there were barriers with attempting to schedule an IHA by not always having member contact information available when new member lists were received. Coordinating outreach efforts between the Plan and the provider will impact the overall provision of IHA for new members. The Plan acknowledged there is an opportunity for improvement in coordinating with providers on member outreach.

The Plan's minimal outreach efforts with providers regarding IHA completion is evident in the Plan's IHA Completion Report. The report indicated 14 percent of members had a completed IHA during February 2017 to December 2017. The Plan has shown improvement from the 2017 DHCS audit, in which six percent of new members completed an IHA. However, IHA completion rates for new members continue to remain low placing members at increased health risk by not obtaining a completed IHA within 120 days. The Plan's unsuccessful efforts to coordinate IHA outreach with providers contributed to low IHA completion rates. This has prevented members from establishing and obtaining necessary health care within a timely manner, which has the potential to lead to poor health outcomes, such as a decline in health status, worsened health condition, or preventive health recommendations not being met.

In the Plan's response to the audit findings, the Plan identified future strategies to improve current IHA processes. The Plan's strategies include enhanced provider communication, provider training, and additional resources for member outreach. Although the Plan intends to take future corrective action, the Plan's new member IHA completion remained low during the audit period.

RECOMMENDATION:

- 2.4.1** Ensure members schedule and complete an IHA within 120 days, as required by the contract.

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AUDITS AND INVESTIGATIONS
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Care 1st Health Plan

Contract Number: 09-86154
State Supported Services

Audit Period: February 1, 2017
Through
January 31, 2018

Report Issued: June 12, 2018

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I. INTRODUCTION

This report presents the audit findings of Care 1st Health Plan State Supported Services contract No. 09-86154. The State Supported Services contract covers contracted abortion services with Care 1st Health Plan.

The on-site audit was conducted from February 26, 2018 through February 28, 2018. The audit period is February 1, 2017 through January 31, 2018 and consisted of document review of material supplied by the Plan and interviews conducted on-site.

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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

A. Family Planning

Members have the right to access family planning services through any family planning provider without Prior Authorization. Contractor shall inform its Members in writing of their right to access any qualified family planning provider without Prior Authorization in its Member Services Guide.

GMC Contract A.9.9.A

SUMMARY OF FINDINGS:

The Plan's Policy 10.2.35, *Abortion Services*, states that members can access abortion services in- or out-of-network without prior authorization. The Plan defines abortion services as a "sensitive service" and ensures confidentiality and accessibility to its members. Inpatient hospitalization for the performance of an abortion does require prior authorization under the same criteria as other medical procedures in accordance with California Code of Regulations (CCR), Title 22, section 51327.

The Plan covers both surgical abortions Current Procedural Terminology CPT-4 codes 59840 through 59857; Healthcare Common Procedure Coding (HCPCS) codes A4649-U1(X1516) and A4649-U2 (X1518); and medical abortions HCPCS codes S0199 (Z0336), S0190 Mifepristone 200 mg RU-486 (X7724) and S0191 Misoprostol 200 mcg (X7726).

In addition to the Member Handbook, members can also contact the Member Service Call Center for assistance with abortion services. The Plan informs providers of the members' rights to sensitive services without prior authorization in the Provider manual, which can be found on the website.

The Plan's claims payment system contains all of the required pregnancy termination billing codes. The Plan's vendor, Calibrated Health Network, adjudicates the claims in the Plan's system without prior authorization.

The Claims Department experience turnover of staff during the audit period. However, the audit team did not find any evidence to show the turnover had a negative impact on the state supported services. No claims or access issues related to state supported services were found in the grievance universe.

The audit found no discrepancies in the State Supported Services section.