DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SACRAMENTO SECTION

# REPORT ON THE MEDICAL AUDIT OF HEALTH PLAN OF SAN JOAQUIN FISCAL YEAR 2024-25

Contract Numbers: 04-35401 and 23-30224

Audit Period: August 1, 2023 — July 31, 2024

Dates of Audit: October 28, 2024 — November 8, 2024

Report Issued: April 9, 2025

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# I. INTRODUCTION

The Health Plan of San Joaquin (Plan) is a non-profit corporation headquartered in French Camp, California, and established in 1995. In 1996, the Plan received a 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 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 San Joaquin County Health Commission governs the Plan through a 13-member commission consisting of local government members, clinical, and non-clinical community representatives. In 2024, the Plan expanded to Alpine and El Dorado Counties as Mountain Valley Health Plan. In 2018, 2021, and 2024, the Plan was awarded the National Committee for Quality Assurance accreditation renewal.

Health care services are provided through contracts with independent medical groups and individual physicians (1,200 plus network providers and specialists). Health care services not provided directly by primary care physicians are arranged through contracts with other medical groups/physicians, allied health service suppliers, and hospitals. As of October 2024, the Plan had 415,161 Medi-Cal members. The Plan's Medi-Cal market share is about 80.7 percent in San Joaquin County, 69.6 percent in Stanislaus County, 21.8 percent in El Dorado County, and 13.6 percent in Alpine County.

# II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of August 1, 2023, through July 31, 2024. The audit was conducted from October 28, 2024, through November 8, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on March 19, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On April 3, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

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

The prior DHCS medical audit for the period of October 1, 2022, through July 31, 2023, was issued on April 9, 2024. This audit examined the Plan's compliance with the DHCS Contracts and assessed the implementation of the prior year 2023, Corrective Action Plan.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

## Category 1 – Utilization Management

The Plan is prohibited from imposing Prior Authorization (PA) requirements on preventive services and biomarker testing that is associated with a federal Food and Drug Administration (FDA) approved therapy for advanced or metastatic stage 3 or 4. The Plan incorrectly applied PA requirements to preventive services and cancer biomarker testing.

The Plan is required to respond to routine PA requests as expeditiously as the member's condition requires, but no longer than 5 working days from receipt of the information reasonably necessary and requested by the Plan to render a decision, and no longer than 14 calendar days from the Plan's receipt of the request.

The Plan is required to provide members with written notice of an adverse benefit determination using the appropriate DHCS developed, standardized Notice of Action (NOA) template and the NOA "Your Rights" template. The Plan did not send NOAs for adverse benefit determinations within the required timeframes.

The Plan is required to provide members with written notice of an adverse benefit determination using the appropriate DHCS developed, standardized NOA template and the NOA "Your Rights" template. The Plan must fully translate NOAs and Notice of Appeal Resolutions (NAR) in a member's required language. The Plan did not use the appropriate NOA template to inform members of PA denials.

The Plan is required to comply with all current and applicable provisions of the Medi-Cal Provider Manual. The Plan did not comply with all applicable provisions of the Medi-Cal Provider Manual in the Plan's decision making for coverage of pharmacy services.

## Category 2 – Case Management and Coordination of Care

There were no findings noted for this category during the audit period.

## Category 3 – Access and Availability of Care

The Plan is required to ensure members have access to family planning services through any available family planning provider, regardless of whether the provider is in or out of the network, without requiring PA. The Plan incorrectly applied PA requirements to family planning services.

## Category 4 – Member's Rights

There were no findings noted for this category during the audit period.

## Category 5 – Quality Management

There were no findings noted for this category during the audit period.

## Category 6 –Administrative and Organizational Capacity

There were no findings noted for this category during the audit period.

# III. SCOPE/AUDIT PROCEDURES

## SCOPE

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

## PROCEDURE

The DHCS conducted an audit of the Plan from October 28, 2024, through November 8, 2024, for the audit period of August 1, 2023, through July 31, 2024. The audit included a review of the Plan's Contracts with the DHCS, policies and procedures for providing services, 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 and staff.

The following verification studies were conducted:

## Category 1 – Utilization Management

Service Requests: A total of 25 medical service requests, including 9 for Seniors and Persons with Disabilities (SPD) members, were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeals Procedures: 15 PA appeals, including 6 for SPD members, were reviewed for appropriate and timely adjudication.

Delegated Authorization Requests: A total of five medical service requests from Carelon were reviewed for consistent application of criteria, and appropriate and timely adjudication.

## Category 2 – Case Management and Coordination of Care

Health Risk Assessment (HRA) requirements: 20 cases were reviewed to confirm coordination of care and fulfillment of HRA requirements.

Initial Health Appointment (IHA): 20 cases were reviewed to confirm the performance and completeness of the IHA.

Continuity of Care (COC): 25 cases, including 10 for SPD members, were reviewed for timely processing of members' COC requests.

## Category 3 – Access and Availability of Care

Claims: 30 emergency services and 20 family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation (NEMT): 30 claims were reviewed to verify compliance with NEMT requirements.

Non-Medical Transportation (NMT): 30 claims were reviewed to verify compliance with NMT requirements.

## Category 4 – Member's Rights

Grievances: 59 standard grievances and 1 expedited grievance were reviewed for timely resolution, response to the complainant, and submission to the appropriate level for review. The 59 standard grievance cases included 34 Quality of Service (QOS) and 25 Quality of Care grievances.

## Category 5 – Quality Management

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

## Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 16 fraud and abuse cases were reviewed for appropriate reporting and processing.

# COMPLIANCE AUDIT FINDINGS

## Category 1 – Utilization Management

### 1.2 Prior Authorization Review and Requirements

#### 1.2.1 Review of Services Exempt from Prior Authorization

The Plan is prohibited from imposing PA requirements on preventive services. *(2024 Contract, Exhibit A, Attachment III, 2.3.1(H))*

The Plan is prohibited from imposing PA requirements on biomarker testing that is associated with a federal FDA approved therapy for advanced or metastatic stage 3 or 4 cancer. *(2024 Contract, Exhibit A, Attachment III, 5.3.7(Q))*

The Plan is required to accept requests for retrospective review authorization within a reasonably established time limit, not to exceed 365 calendar days from the date of service. The Plan must communicate decisions to the provider and to the member who received the services or to the member's authorized representative within 30 calendar days of the receipt of information that is reasonably necessary to make this determination. *(2024 Contract, Exhibit A, Attachment III, 2.3.2(D))*

The Plan's 2024 list of services requiring PA noted that PA requirement exemption applies to cancer biomarker associated with a federal FDA approved therapy for advanced or metastatic stage 3 or 4 cancer.

Plan policy, *UM01 Authorization and Referral Review* (revised 6/17/24), stated that the Plan does not require PA for preventive services. The policy also stated that the Plan accepts requests for retrospective review authorization.

**Finding:** The Plan incorrectly applied PA requirements to preventive services and cancer biomarker testing.

A verification study of 25 PA cases revealed 3 cases did not require PA, but were denied by the Plan as follows:

- The Plan denied two retrospective review requests for cancer biomarker testing, including a request for a member with advanced lung cancer and another request for a member with advanced ovarian cancer. The requests were denied for not meeting administrative eligibility criteria for retrospective review. However, since the requests were for cancer biomarker testing, which is

associated with a federal FDA approved therapy for advanced or metastatic stage 3 or 4 cancer, the Plan should not have imposed PA requirements.
- The Plan denied a retrospective review request for a herpes zoster vaccine for an immunocompromised member. The Advisory Committee on Immunization Practices (ACIP) recommends two zoster vaccine doses for the prevention of herpes zoster and related complications in immunodeficient, or immunosuppressed adults aged 19 years or older. ACIP recommended vaccines were listed as a preventive service in the Medi-Cal Provider Manual. Therefore, the Plan was not allowed to require PA for this service.

The Plan's policy for reviewing services exempt from PA requirements included contradictions contributing to contract non-compliance. The Plan's retrospective review protocol in policy UM01 did not exempt preventive services and cancer biomarker testing associated with a federal FDA approved therapy for advanced or metastatic stage 3 or 4 cancer, which can lead to incorrect denials of services that should be approved.

In an interview and a written narrative, the Plan stated that the current version of policy UM01 omitted a prior retrospective review procedure to exempt services that do not require PA. This omission occurred when the Plan revised policy UM01 on January 1, 2024, and June 17, 2024. As a result, the Plan incorrectly applied PA to preventive services and cancer biomarker testing.

When the Plan requires PA for services that are exempt from PA requirements, such as cancer biomarker testing for members with advanced or metastatic cancers or preventive services, members may experience delays and limits in access to services. In addition, delays may lead to members not receiving the appropriate cancer treatment or suffering from preventable disease and may exacerbate health inequities.

**Recommendation:** Revise and implement policies and procedures to ensure that the Plan does not apply PA for services exempt from PA requirements.

### 1.2.2 Notice of Adverse Benefit Determinations

When the Plan makes an authorization decision, it must send an NOA, which is a notice of any action that impacts a member's ability to obtain covered services or other benefits the Plan is required to provide under the Contract. A NOA includes, but is not limited to, a Notice of Adverse Benefit Determination (NABD) for a requested health care service under Code of Federal Regulations (CFR), Title 42 sections

438.210(d) and 438.404. The Plan must approve, deny, or modify the request as follows:

- For standard authorization requests, the Plan must send the NOA within the shortest applicable timeframe that is appropriate for the nature of the member's condition, but no longer than 5 working days from the Plan's receipt of information reasonably necessary and requested by the Plan to make a determination, not to exceed 14 calendar days following the Plan's receipt of the request for service.
- For expedited authorization requests, the Plan must send the written NOA in a timeframe which is appropriate for the nature of the member's condition, but no longer than 72 hours from receipt of the authorization request.

*(2024 Contract, Exhibit A, Attachment III, 4.6.4)*

Standard and expedited authorization decisions may have an extension to the timeframes, up to 14 additional calendar days, if the member or the provider requests the extension or there is justification of a need for additional information and how the extension is in the member's interest. *(CFR, Title 42, section 438.210(d))*

The Plan's failure to render a decision and send a written NOA to the member within the required timeframes is considered a denial of the requested service and therefore constitutes an adverse benefit determination on the date that the Plan's timeframe for approval expires. *(2024 Contract, Exhibit A, Attachment III, 4.6.4)*

The Plan is required to notify members of a decision to deny, defer, or modify requests for PA by providing a NOA to members and/or their authorized representative, regarding any denial, deferral, or modification of a request for approval to provide a health care service. *(2024 Contract, Exhibit A, Attachment III, 5.1.5)*

Plan policy, *UM01 Authorization and Referral Review* (revised 4/16/24), stated that the timeframe for sending denial or modification NOA letters for routine PA requests is within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service (includes approval decisions), and for expedited PA requests, within 2 working days of making the decision, not to exceed three working days from the receipt of the request for service.

**Finding:** The Plan did not send NOAs for adverse benefit determinations within the required timeframes.

In a verification study, 4 of 25 PA requests revealed that the Plan did not send the NABD for denied service requests within the required timeframes. The Plan did not process the following delayed requests as denials once the required timeframe expired:

- The Plan received and processed an expedited PA request for surgery to treat bleeding inside the eye. The Plan failed to render a decision and send a written NOA to the member within the required 72-hour timeframe. In accordance with the Contract, if there was no 14-day extension request by the Plan, this is considered a denied request, and the Plan should have sent a written NABD. However, there was no documentation that the Plan requested a 14-day extension to the timeframe or that the Plan sent a NABD within 72 hours from receipt of the authorization request. Furthermore, a final decision for this expedited PA request was not made until 77 days after the request was received.
- The Plan received and processed three standard PA requests. The Plan failed to render a decision and send a written NOA to the member within the required 14-day timeframe. In accordance with the Contract, if there was no 14-day extension request by the Plan, this is considered a denied request, and the Plan should have sent a written NABD. However, there was no documentation that the Plan requested a 14-day extension to the timeframe or that the Plan sent a NABD within 14 days from receipt of the authorization request. Furthermore, the Plan did not send NABDs to members until 26-58 days after receiving the PA requests.

In all four PA requests from the verification study samples, the Plan did not follow policy UM01 and exceeded PA decision and notification timeframes due to the pending completion of Letters of Agreement (LOA) by out of network providers.

During an interview, the Plan did not explain why the delayed PA requests were not processed as denials once the required timeframe expired. The Plan explained that PAs were approved within the required timeframes, but due to the pending completion of LOAs by out of network providers, the provision of the approved services was delayed. The Plan acknowledged that there was a gap in procedures to address delayed PA requests.

When the Plan does not process delayed PA requests as denials once the required timeframe expires, it may lead to the Plan not sending written NABDs to members or their authorized representative regarding any denial, deferral, or modification of a

PA request. This can cause delays in accessing medically necessary services and result in patient harm. Additionally, when the Plan does not send NOAs for delayed PA requests, providers and members may not receive the critical information necessary to exercise their appeal rights.

**Recommendation:** Revise and implement policies and procedures to ensure members are provided NOAs within the required timeframes.

### 1.2.3 Member Notice of Action Templates

The Plan is required to comply with all the DHCS guidance, including but not limited to APLs, Policy Letters (PL), the California Medicaid State Plan, and the Medi-Cal Provider Manual. *(2024 Contract, Exhibit E, 1.1.2)*

The Plan is required to provide members with written notification of an adverse benefit determination using the appropriate DHCS developed, standardized NOA template and the NOA "Your Rights" template. The Plan must fully translate NOAs and NARs in a member's required language. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, *UM07 Notice of Action for Delayed, Denied, Modified, or Terminated Services* (revised 8/16/24), stated that the Plan will provide members and providers with written notification for any adverse benefit determinations that clearly document and communicate the reasons for the decision so that members and providers receive sufficient information in easily understandable language to decide whether to appeal the decision.

**Finding:** The Plan did not use the appropriate NOA template to inform members of PA denials.

A verification study of 25 PA cases revealed that for 1 denied case for inpatient stay after ambulatory surgery, the Plan incorrectly sent a Spanish translated NOA notifying the member that the request was deferred. As a result, the Plan inaccurately notified the member that more time was needed to render a decision instead of informing the member that the request was denied.

During an interview and in a written response, the Plan stated that when a PA decision is rendered, Utilization Management staff generates the NOA letter by selecting a template that is translated when required. In this case, the member was provided the incorrect NOA due to mislabeling of the Spanish version of the Member Delay NOA template as a Member Deny NOA template in the Plan's system. Although

the Plan identified the mislabeling on June 12, 2024, and stated that the incorrect template was pulled down and replaced with the correct template, the Plan did not have a formal quality review process to ensure the correct labeling of translated NOAs were sent to members. Additionally, the Plan did not know how long the template was mislabeled within the system and was not able to provide the number of NOAs that were impacted prior to the discovery on June 12, 2024.

When the Plan does not use the appropriate NOA template to accurately inform members of PA decisions, members may not make appropriate decisions regarding their healthcare and may miss deadlines to exercise their appeal rights. Since this issue impacts members whose required language is not English, this issue may also contribute to health inequities.

**Recommendation:** Implement procedures to ensure members are provided with the appropriate NOA templates for PA denials.

### 1.3.1 Criteria for Pharmacy Coverage Services

The Plan is required to comply with all current and applicable provisions of the Medi-Cal Provider Manual. If the Medi-Cal Provider Manual conflicts with the Contract, APLs, and PLs, and/or any applicable federal or state laws, the Contract, the APL or PL, or the applicable law will control. *(2024 Contract, Exhibit E, 1.1.2(C))*

The Plan is required to ensure that covered services are provided to a member in an amount no less than what is offered to Medi-Cal members in Medi-Cal Fee-For-Service (FFS), as defined in the most current Medi-Cal Provider Manual and consistent with current, evidence based medical standards. *(2024 Contract, Exhibit A, Attachment III, 5.3.1(A))*

The Medi-Cal Provider Manual lists hyaluronan or derivative injections as covered physician-administered drugs. *(Medi-Cal Provider Manual, Part 2 - Injections: Drugs H Policy)*

Plan policy, *PH05 Prior Authorization* (revised 6/16/23), governs pharmacy reviews and stated that the Plan develops the PA criteria for physician administered drugs from information sources including published scientific literature, Facts and Comparison Formulary Services, and Micromedex. The policy does not include the Medi-Cal Provider Manual as a source of criteria.

**Finding:** The Plan did not comply with all applicable provisions of the Medi-Cal Provider Manual in decision making for coverage of pharmacy services.

A verification study revealed that for 2 of 15 appeal cases, the Plan initially denied requests for hyaluronan derivative injections with documentation stating that there were no specific review criteria to approve the physician administered drugs. Although the Medi-Cal Provider Manual delineated criteria for hyaluronan derivative injections, the Plan did not document referencing the Medi-Cal Provider Manual for the initial denial of the requests and the subsequent review of the denial appeals.

During an interview, the Plan acknowledged a gap in policy PH05. The Plan stated that policy PH05 was updated on August 30, 2024, to address the gap so that the Medi-Cal Provider Manual criteria are explicitly specified. However, the effectiveness of the updated policy could not be validated since the correction occurred after the audit period. The Plan stated that staff normally check the Medi-Cal Provider Manual guideline hierarchy to ensure that the Plan's guidelines are not more stringent than Medi-Cal guidelines. However, the Plan confirmed that the process did not occur in the pharmacy cases.

When the Plan does not include the Medi-Cal Provider Manual criteria in deciding the medical necessity of requested services, this can lead to incorrect denials or delays in obtaining covered and medically necessary services and may result in member harm.

**Recommendation:** Revise and implement policies and procedures to ensure the Plan complies with all applicable provisions of the Medi-Cal Provider Manual in the Plan's decision making for coverage of pharmacy services.

# COMPLIANCE AUDIT FINDINGS

## Category 3 – Access and Availability of Care

### 3.6 Emergency Services and Family Planning Claims

#### 3.6.1 Prior Authorization Requirements for Family Planning Services

The Plan is required to ensure members have access to family planning services through any available family planning provider regardless of whether the provider is in or out of the network, without requiring PA. *(2024 Contract, Exhibit A, Attachment III, 5.2.8(A)(1))*

Plan policy, *CLMS13 Reimbursement of Services* (revised 5/2/24), stated that the Plan is required to reimburse complete family planning claims within 45 working days of receipt of the claim, unless the Plan contests the claim. However, the policy did not specify that PA is not required for family planning services.

**Finding:** The Plan incorrectly applied PA requirements to family planning services.

A verification study revealed that the Plan did not pay 5 of 19 family planning services claims due to PA requirements for services. All five denied claims included a note stating that services billed required authorization.

During an interview and in a written response, the Plan confirmed that the issue occurred during a code update process. The update caused the electronic health system to apply PA requirements to family planning codes. The Plan did not identify the claim update error due to a lack of staff oversight. Additionally, staff denied claims for lack of PA without reviewing diagnosis or Current Procedural Terminology code exceptions, resulting in claim denial errors.

When the Plan incorrectly applies PA requirements to family planning claims, it may discourage providers from participating with the Plan and adversely impact members' access to family planning services.

**Recommendation:** Revise and implement policies and procedures to ensure PA requirements are not applied to family planning claims.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SACRAMENTO SECTION

# REPORT ON THE MEDICAL AUDIT OF HEALTH PLAN OF SAN JOAQUIN FISCAL YEAR 2024-25

Contract Numbers: 03-75801 and 23-30256

Contract Type: State Supported Services

Audit Period: August 1, 2023 — July 31, 2024

Dates of Audit: October 28, 2024 — November 8, 2024

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# I. INTRODUCTION

This report presents the results of the audit of the Health Plan of San Joaquin (Plan) compliance and implementation of the State Supported Services Contract numbers 03-75801 and 23-30256 with the State of California. The State Supported Services Contracts covers abortion services with the Plan.

The audit covered the period of August 1, 2023, through July 31, 2024. The audit was conducted from October 28, 2024, through November 8, 2024, which consisted of a document review and verification study with the Plan's administration and staff.

An Exit Conference with the Plan was held on March 19, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On April 3, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

# COMPLIANCE AUDIT FINDINGS

## State Supported Services

The Plan's policies and procedures, Provider Manual, and Member Handbook indicate that Medi-Cal members may obtain an abortion from any qualified provider without obtaining a referral or prior authorization. A qualified provider of abortion services is the member's primary care physician, an obstetrician/gynecologist, certified nurse midwife, nurse practitioner, physician assistant, family planning clinic, or a Federally Qualified Health Center.

A verification study of 20 State Supported Services claims was conducted to determine appropriate process and timely adjudication of claims. There were no material findings noted during the audit period.

**Recommendation:** None.