

DHCS



California Department of
HealthCareServices

**Technical
Assistance
Guide**

for Medical Audits

Category 6 –
Administrative and Organizational
Capacity

Updated 10/25/18

TABLE OF CONTENTS

INTRODUCTION	3
GUIDANCE ON USING THE TECHNICAL ASSISTANCE GUIDE (TAG).....	3
CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY.....	5
6.1 Medical Director And Medical Decisions	5
6.2 Health Education.....	7
6.3 Fraud And Abuse	11

Introduction

In accordance with California Welfare and Institutions Code Section 14456, the Department of Health Care Services (DHCS) conducts medical audits of Medi-Cal managed care plans (MCPs) on an annual basis. Medical audits evaluate MCPs' compliance with the DHCS contractual requirements and applicable laws and regulations. DHCS' Managed Care Quality and Monitoring Division (MCQMD) is responsible for ensuring overall monitoring and oversight of MCPs. MCQMD designates the Medical Review Branch (MRB) of DHCS' Audits and Investigations Division (A&I) to perform the mandated audits. The audit scope encompasses the following six categories of review:

- Category 1 – Utilization Management
- Category 2 – Case Management and Coordination of Care
- Category 3 – Access and Availability
- Category 4 – Member's Rights
- Category 5 – Quality Improvement
- Category 6 – Administrative and Organizational Capacity

Guidance on Using the Technical Assistance Guide (TAG)

MCQMD and A&I have partnered together to create Technical Assistance Guides (TAG) for each category of review. The TAGs are designed to identify key elements that will be commonly evaluated to inform MCPs of the audit process and increase transparency. To this end, each TAG is broken down by subcategories and includes the following components, as applicable:

- **Contract Language:** This section identifies “key” contract provisions¹ that are the focus of review for each subcategory. While references to specific provisions may assist the MCP with narrowing the scope of review in preparation for the audit, it does not preclude the audit team from investigating the MCP's compliance with other contract requirements not explicitly named. MCPs are ultimately responsible for ensuring compliance with *all* provisions of the DHCS contract as well as any applicable All Plan Letters (APLs) and Plan Letters (PLs). The contract provisions included in the TAG are intended to serve as guidance only as well as a quick point of reference.

¹ The TAGs cite language from the general Two-Plan Boilerplate Contract. Each MCP should reference its own Plan-specific contract to confirm requirements.

- **Documentation Reviewed:** The items listed in this section reflect common *initial* documentation requests and not subsequent follow-up requests that may be warranted after initial review and interviews with the MCP. The initial documentation request includes, but is not limited to: policies and procedures, organizational charts, committee meeting minutes, monitoring reports, data logs, etc. While the documentation provides the audit team with a general overview of the operational structure and the team may glean insight regarding compliance with some contractual requirements, it is not all encompassing. Therefore, to ease the burden of further document requests made onsite, the MCP is advised to submit additional pre-onsite documentation for review (even if not explicitly requested) if the MCP believes that review of such information would assist the audit team with assessing compliance in any of the subcategories.
- **Verification Study (if applicable):** This section appears within a designated subcategory when a verification study (i.e., review of specific files such as grievances, prior authorizations, claims, etc.) may be used to assist with measuring compliance. The MCP is instructed to provide data in a prescribed format (i.e., spreadsheet containing all files for the audit review period). The log will assist the audit team with selection of specific files for onsite review. The audit team is neither precluded from conducting additional verification studies as needed nor expected to consistently conduct all verification studies listed in this TAG.
- **Examples of Best Practices:** This section details examples of best practices. The examples listed include strategies that some MCPs have implemented to either demonstrate compliance with a given standard or successfully remediate an identified deficiency. Every MCP and every audit is unique and best practices do not always transfer seamlessly. While the audit team does not audit to best practices, the burden is on the MCP to demonstrate that it is meeting its contractual obligations. To this end, examples of best practices emphasize the MCP's ability to produce *documented evidence* to substantiate that the MCP is in compliance with the contract requirements. When monitoring efforts reveal patterns of non-compliance, the MCP should similarly be able to produce documented evidence of barrier analysis and remedial actions enacted to substantiate efforts to bring the MCP into compliance.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.1	MEDICAL DIRECTOR AND MEDICAL DECISIONS		
CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES
<p><u>Exhibit A, Attachment 1 – ORGANIZATION AND ADMINISTRATION OF THE PLAN</u></p> <p>6. Medical Director: Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:</p> <p style="padding-left: 40px;">A. Ensuring that medical decisions are:</p> <p style="padding-left: 80px;">1) Rendered by qualified medical personnel...</p> <p>2-Plan Contract A.1.6</p>	<ul style="list-style-type: none"> -Policies and procedures -Governing Body/Utilization Management/Quality Improvement Minutes -Provider Contracts -Medical Director’s Curriculum -Plan’s Medical Director Position Statement -Organization charts displaying Chief Medical Officer/Medical Director’s relationships within the Plan -Internal monitoring reports 		<ul style="list-style-type: none"> -The Plan’s policies and procedures demonstrate alignment and consistency with the contractual requirements to maintain a full time physician as medical director. -The Plan’s policies and procedures include processes for license verification and re-verification of all new hires, promotions, and transfers. -The Plan’s policies and procedures include processes for conducting background checks of internal and external employees and applicants, to include verification of professional licensing and reviewed by Human Resources. -The Plan conducts internal monitoring (e.g. license verification tracking log) at a set frequency, which ensures Plan is tracking new hires and customer staff as it relates to license verifications. Logs may consist of names, license/certification, dates of issuance, expiration dates, re-verification dates, credential, and re-credential dates, etc. -The Plan ensures duty statements have been updated to include

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<p>7. Medical Director Changes Contractor shall report to DHCS any changes in the status of the medical director within 10 calendar days.</p> <p>2-Plan Contract A.1.7</p>	<ul style="list-style-type: none"> -Policies and procedures -Medical Director's Curriculum -Plan's Medical Director Position Statement -Organization charts displaying Chief Medical Officer/Medical Director's relationships within the Plan 		<p>requirements regarding education and/or training.</p> <ul style="list-style-type: none"> -The Plan's policies and procedures demonstrate alignment and consistency with the contractual requirements to notify DHCS of any changes in the status of the Medical Director within the timeframe (10 calendar days) requirements. -The Plan can verify appropriate evidence of notification (e.g. email correspondence, updated organizational charts displaying Chief Medical Officer/Medical Director's relationship within the Plan, curriculum vitae, etc.). -The Plan ensure all medical directors maintain appropriate licensing by developing a tracking log of license expiration dates that is monitored on a periodic basis (e.g. monthly, quarterly, annually, etc.).

6.2	HEALTH EDUCATION		
CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES
<p><u>Exhibit A, Attachment 10 – SCOPE OF SERVICES</u></p> <p>8. Services for All Members</p> <p>A. Health Education:</p> <ol style="list-style-type: none"> 1) Contractor shall implement and maintain a health education system that include programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members. 2) Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator. 3) Contractor shall provide health education programs and services at no charge to Members directly and/or through Subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Member population. 4) Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate 	<ul style="list-style-type: none"> -Policies and Procedures -Organizational Chart -Group Needs Assessment -Health Education Protocols -Health Education Materials -Provider Manual -Member Services Guide -Plan Website 		<ul style="list-style-type: none"> -The Plan's policies and procedures demonstrate alignment and consistency with provision of health education programs and services as required in the contract. -The Member Handbook/EOC/Plan Website clearly display Health Education classes that are offered at no cost and to which members they are offered. -The Plan's policies and procedures address the readability and suitability of written health education materials (e.g. linguistically appropriate, culturally appropriate, age and gender appropriate, written at a sixth grade reading level, etc.). -The Plan ensures a qualified full-time health educator provides administrative oversight of health education system.

6.2	HEALTH EDUCATION			
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<p>for Members and effective in achieving behavioral change for improved health.</p> <p>5) Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.</p> <p>6) Contractor shall maintain a health education system that provides educational interventions...</p> <p>7) Contractor shall ensure that Members receive point of service education as part of preventive and primary health care visits. Contractor shall provide education, training, and program resources to assist contracting medical providers in the delivery of health education services for Members.</p> <p>8) Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that</p>				

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CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES	
<p>are contracted to deliver health education services to ensure effectiveness.</p> <p>9) Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements....(as required by Contract)</p> <p>2-Plan Contract A.10.8.A</p>				
<p>Monitoring Performance of Contracted Health Education Providers</p> <p>8) Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to ensure effectiveness.</p>	<ul style="list-style-type: none"> -Policies and Procedures -Subcontracts/formal agreements -Health Education protocols -Health Education materials 		<ul style="list-style-type: none"> -The Plan's policies and procedures demonstrate alignment and consistency with the contractual requirements to monitor the performance of providers contracted to deliver health education services. -The Plan conducts internal monitoring (e.g. auditing) at a set frequency (e.g. quarterly, bi-annually, annually, etc.) to ensure the effectiveness of health education services. -The Plan's delegation agreements clearly specify all delegated functions and the responsibilities of 	

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<p>Health Categories and Topics in a Health Education System Contractor shall maintain a health education system that provides educational interventions addressing the following health categories and topics.</p> <p>b) Risk-reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and, parenting.</p>	<ul style="list-style-type: none"> -Policies and Procedures -Health Education materials -Member Service Guide -Plan Website 		<p>both the Plan and the delegated entity.</p> <p>-The Plan’s oversight methodology, as described in its policies and procedures, does not rely solely on desk-level reviews, but also includes review of actual practices (e.g. auditing) at set frequencies (e.g. quarterly, bi-annually, annually, etc.). When audit results demonstrate non-compliance, the Plan takes effective action and these efforts are clearly documented.</p> <p>-The Plan’s policies and procedures demonstrate alignment and consistency with provision of health education programs and services as required in the contract.</p> <p>-The Plan conducts periodic outreach (newsletters, fax blasts, site visits) to remind providers that health education interventions and programs are made available to members that address risk-reduction and healthy lifestyles.</p>

6.3		FRAUD AND ABUSE		
CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES	
<p><u>Exhibit E, Attachment 2 – PROGRAM TERMS AND CONDITIONS</u></p> <p>26. Fraud and Abuse Reporting</p> <p>B. Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse....</p> <p>1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.</p> <p>2-Plan Contract E.2.26.B</p>	<ul style="list-style-type: none"> -Policies and procedures -Plan's logs of fraud and abuse incidents -Compliance Committee meeting minutes -Reports to Governing Body/Management -Provider Manual -Member Services Guide -Delegation agreements -Delegation reports -Delegation audits -Delegation oversight 		<ul style="list-style-type: none"> -The Plan's policies and procedures demonstrate alignment and consistency with requirements to identity investigate and take appropriate corrective action against fraud and/or abuse in the provision of health care services. -The Plan's policies and procedures demonstrate alignment and consistency with contractual requirements to designate a Compliance Officer and Compliance Committee to oversee the Fraud and Abuse Program and are accountable to senior management. -The Plan conducts initial and ongoing training for its Compliance Officer and all appropriate staff addressing fraud, waste and abuse reporting requirements and how and what to report. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g. desktop procedures, PowerPoint presentations, etc.) which are consistent with contractual requirements, etc. -The Plan performs data analysis in order to monitor, detect, and prevent potential fraud, waste and/or abuse. 	

6.3	FRAUD AND ABUSE		
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			<p>-The Plan's delegation agreements clearly specify all delegated functions and the responsibilities of both the Plan and the delegated entity.</p> <p>-The Plan's delegation agreements clearly specify oversight and monitoring activities including reporting requirements by the delegate at set frequencies (e.g. monthly, quarterly and annually, etc.).</p> <p>-The Plan's delegation agreements clearly specify actions the Plan will take if the delegate does not fulfill its obligations (e.g. implementation of CAPs, de-delegation, increased reporting/auditing, etc.).</p> <p>-The Plan provides evidence that a pre-delegation assessment of the delegate's ability to perform all delegated responsibilities was conducted prior to delegation. Documentation supports that all outstanding concerns/questions have been resolved prior to delegation.</p> <p>-The Plan provides evidence that the delegate submits all reports at the specified frequencies indicated in the delegation agreement. The</p>

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			<p>Plan is readily able to produce all reports.</p> <ul style="list-style-type: none"> -The Plan is able to provide documentation through the Delegation Oversight Committee meeting minutes that reports submitted by the delegate are regularly reviewed, analyzed, and discussed. -The Plan conducts audits of the delegate at set intervals as indicated by the delegation agreement and there is documented discussion of audit results in the Delegation Oversight Committee meeting minutes. When audit results demonstrate non-compliance, the Plan takes effective action and these efforts are clearly documented. The Plan conducts re-measurement activities as necessary to monitor progress.
<p>4) Fraud and Abuse Reporting Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall</p>	<ul style="list-style-type: none"> -Policies and procedures -Plan's logs of fraud and abuse incidents -Compliance Committee meeting minutes -Reports to Governing 		<ul style="list-style-type: none"> -The Plan's policies and procedures demonstrate alignment and consistency with the preliminary investigation and reporting requirements. -The Plan's policies and procedures clearly demonstrates compliance with requirement to report all

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<p>conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity....</p>	<p>Body/Management -Provider Manual -Member Services Guide</p>		<p>suspected fraud, waste and abuse cases to DHCS within 10 working days from the date the Plan first becomes aware of the suspected activity.</p> <ul style="list-style-type: none"> -The Member Service Guide/EOC and Provider Manual clearly display the reporting requirement to report all suspected fraud, waste and abuse cases to DHCS within the required timeframe. -The Plan ensure all suspected fraud, waste and abuse cases are reported on the required MC609 form and includes all supporting documentation. -The Plan establishes desktop procedures that will ensure the results of preliminary investigations are reported to DHCS within the required timeframe. -The Plan conducts internal monitoring (e.g. work load reports, tracking logs that allow for daily, monthly monitoring of timeliness of the completion of preliminary investigations and ensure timely reporting.

6.3	FRAUD AND ABUSE		
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<p>5) Tracking Suspended Providers Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 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.</p>	<ul style="list-style-type: none"> -Policies and procedures -Plan's logs of fraud and abuse incidents -Compliance Committee meeting minutes -Reports to Governing Body/Management -Provider Manual -Member Services Guide 		<ul style="list-style-type: none"> -The Plan's policies and procedures demonstrate alignment and consistency with requirements to track and notify DHCS of suspended, excluded, or ineligible providers. -The Plan has processes in place that ensures the Plan reports to DHCS within 10 business days the removal of a suspended, excluded, or ineligible provider from its network. -The Plan has processes in place to ensure that providers suspended, excluded, or ineligible no longer receive payments in connection with the Medi-Cal program. -The Plan conducts initial and ongoing training for Compliance staff. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g. desktop procedures, PowerPoint presentation, etc.) which address the monitoring, tracking and reporting requirements.