DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SACRAMENTO SECTION

REPORT ON THE MEDICAL AUDIT OF

# HEALTH PLAN OF SAN JOAQUIN

**2023**

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| Contract Number: | 04-35401 |
| Audit Period: | October 1, 2022<br>Through<br>July 31, 2023 |
| Dates of Audit: | October 30, 2023<br>Through<br>November 10, 2023 |
| Report Issued: | April 9, 2024 |

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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 its 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 an 11-member commission consisting of local government members, clinical, and non-clinical community representatives. In June 2018 and June 2021 the Plan was awarded the National Committee for Quality Assurance (NCQA) accreditation renewal.

Health care services are provided through contracts with independent medical groups and individual physicians (1,000 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 August 2023, the Plan had 457,053 Medi-Cal members. The Plan's Medi-Cal market share is about 89.4 percent in San Joaquin County and 70.8 percent in Stanislaus County.

# II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of October 1, 2022, through July 31, 2023. The audit was conducted from October 30, 2023, through November 10, 2023. The audit consisted of document review, verification studies, and interviews with Plan and Carelon (delegated entity) representatives.

An Exit Conference was held with the Plan on March 20, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On April 3, 2024, the Plan submitted a response to address the audit findings. The results of the DHCS evaluation of the Plan's response are reflected in this report.

The audit evaluated four categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Member's Rights, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period July 1, 2021, through September 30, 2022, was issued on May 30, 2023. This audit examined documentation for compliance and to determine to what extent the Plan had operationalized its Corrective Action Plan.

The summary of findings by category follows:

**Category 1 – Utilization Management**

The Plan is required to maintain a system that ensures accountability for delegated Quality Improvement (QI) activities. The Plan did not implement policies to include a behavioral health practitioner in the QI committee for oversight of the delegated behavioral health program.

The Plan is responsible to ensure that the UM program includes: The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports for review by the appropriate QIS staff. Integrated reports will be based on the review of the number and types of appeals, denials, deferrals, and modifications. The Plan did not ensure the delegate generated accurate integrated reports on its review of the number and types of appeals, denials, deferrals, and modifications for the Plan's QI/UM evaluation.

The Plan is required to collect and review delegates' ownership and control disclosure information. Plan delegates are required to provide written disclosure of information on ownership and control. The Plan did not collect and review ownership and control disclosures of its delegates.

**Category 2 – Case Management and Coordination of Care**

The Plan is required to complete individualized Care Management Plans (CMPs) for

members receiving Complex Case Management (CCM). The Plan did not complete CMPs for all members receiving CCM.

The Plan is required to include a comprehensive assessment of the member's condition in accordance with all NCQA requirements. The Plan did not conduct a medication review as part of the comprehensive assessment of CCM member conditions in accordance with NCQA guidelines.

**Category 4 – Member's Rights**

No findings were noted for the audit period.

**Category 6 – Administrative and Organizational Capacity**

The Plan is required to ensure prompt referral of any potential Fraud, Waste, or Abuse (FWA) that the Plan identifies to the DHCS, Audits and Investigation Intake Unit within ten working days. The Plan did not report all suspected fraud and abuse incidents to the DHCS within ten working days of the date the Plan first became aware of, or was on notice of, such activity.

# III. SCOPE/AUDIT PROCEDURES

## SCOPE

This audit was conducted by the DHCS Contract and Enrollment Review Division to ascertain that the medical services provided to Plan members complied with federal and state laws, Medi-Cal regulations and guidelines, and the state Contract.

## PROCEDURE

The audit was conducted from October 30, 2023, through November 10, 2023, for the audit period of October 1, 2022, through July 31, 2023. The audit included the review of the Plan's policies for providing services, the procedures used to implement the policies, and the verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan administrators, staff, and its delegated entity.

The following verification studies were conducted:

### Category 1 – Utilization Management

Prior Authorization (PA) Requests: 16 PA requests were reviewed for consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

### Category 2 – Case Management and Coordination of Care

Health Risk Assessment (HRA): 26 member files were reviewed to confirm coordination of care and fulfillment of HRA requirements.

Continuity of Care (COC): Six member files were reviewed to confirm COC and fulfillment of requirements.

### Category 4 – Member's Rights

Confidentiality Rights: 15 Health Insurance Portability and Accountability Act breach and security incidents were reviewed for processing and timeliness requirements.

### Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: 18 cases were reviewed for appropriate reporting and processing within the required timeframes.

A description of the findings for each category is contained in the following report.

| ❖ COMPLIANCE AUDIT FINDINGS ❖ |
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| **PLAN:** Health Plan of San Joaquin |
| **AUDIT PERIOD: October 1, 2022, through July 31, 2023**<br>**DATES OF AUDIT: October 30, 2023, through November 10, 2023** |

## CATEGORY 1 – UTILIZATION MANAGEMENT

| 1.5 | DELEGATION OF UTILIZATION MANAGEMENT |
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### 1.5.1 Behavioral Health Program Oversight

The Plan is required to maintain a system to ensure accountability for delegated QI activities that, includes the continuous monitoring, evaluation, and approval of the delegated functions. *(Contract, Exhibit A, Attachment 4(6)(B)(2))*

Plan policy, *CMP 31 Oversight of HPSJ Delegated Administrative Functions* (revised 05/05/2023), stated that the Plan shall establish a Delegation Agreement with any organization to which it delegates the authority to carry out a function that the Plan would otherwise perform. The Plan shall remain accountable for all delegated activities, even if the Plan delegates all or part of these activities. The policy delineated behavioral health services as delegated functions that required Plan oversight.

Plan policy, *QM 38 Quality Improvement and Health Equity Committee (QIHEC)* (revised 04/19/2023), designated the QIHEC as the Plan's oversight body and stated that the committee membership shall include behavioral health practitioners, behavioral health county partners, and other non-clinical behavioral health providers as part of its QIS.

The delegation agreement between the Plan and its delegate required the Plan to have a behavioral health practitioner involved in the QIS to oversee behavioral health aspects of the program.

**Finding**: The Plan did not implement its policies to include a behavioral health practitioner in its QIHEC for oversight of the delegated behavioral health program.

Review of the QIHEC meeting minutes did not demonstrate that the Plan had a behavioral health practitioner participating as a committee member.

In an interview, the Plan confirmed that its QIHEC did not have a designated behavioral health practitioner who continuously monitored and evaluated the delegated UM functions such as behavioral health services. The Plan stated its Quality Management/Utilization Management committee used to have a county health physician who served in an oversight role, but the physician left the position due to higher demand for his services at the County.

When the Plan does not ensure a behavioral health practitioner is involved in the behavioral health program, it may lead to a lack of delegate oversight and may have an adverse impact on the delivery of medically necessary services.

**Recommendation**: Revise and implement the Plan's policies and procedures to include a behavioral health practitioner in the Plan's QIHEC to ensure oversight and accountability of the delegated behavioral health program.

### 1.5.2 Integration of Utilization Management Reports

The Plan is responsible to ensure that the UM program includes: The integration of UM activities into the QIS, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. *(Contract, Exhibit A, Attachment 5(1)(G))*

The Plan is required to maintain a system to ensure accountability for delegated QI activities that includes the continuous monitoring, evaluation, and approval of the delegated functions *(Contract, Exhibit A, Attachment 4 (6)(B)(2))*.

Regardless of the relationship the Plan has with a delegate, whether direct or indirect through additional layers of contracting or delegation, the Plan has the ultimate responsibility for adhering to, and fully complying with, all terms and conditions of its contract with the DHCS. (*All Plan Letter* (*APL) 23-006, Delegation and Subcontractor Network Certification)*

Plan policy, *CMP 31 Oversight of HPSJ Delegated Administrative* Functions *(revised 10/01/2023)*, stated that the Plan shall continually assess network providers' and contractors' ability to perform delegated functions. The Plan shall assess through initial reviews, ongoing monitoring, annual performance audits, analysis of data, and utilization of benchmarks, by desktop review and/or by on-site review. The policy did not address oversight to ensure the delivery of quality medical care and appropriateness of medical decision making.

**Finding**: The Plan did not ensure its delegate generated accurate integrated reports in the review of the number and types of appeals, denials, deferrals, and modifications for the Plan's QI/UM evaluation.

A verification study review of the Plan's delegated entity revealed that 27 of 38 services for eight members were incorrectly reported in its Applied Behavioral Analysis Prior Authorization Log. All 38 services were documented as "modified" determinations. However, only 11 services were modified, 25 were approved, and 2 were denied.

Although the policy stated that the Plan would continually assess delegated functions,

the policy did not address the process to ensure the delivery of quality medical care and appropriateness of medical decision making. As part of its oversight process, the Plan conducted a delegate annual review; however, the annual review did not verify the accuracy of integrated reports for modified or denied pre-service and concurrent review service determinations.

During an interview, the Plan stated that oversight of clinical decision making was performed in the delegate's annual audit. However, the annual audit did not identify accuracy of the reporting for authorization determinations.

When the Plan does not ensure accurate data collection of prior authorizations, it may lead to potential underutilization of medically necessary services, which can prevent members from receiving adequate treatment.

**Recommendation**: Revise and implement policies and procedures to ensure the Plan and its delegates generate accurate integrated reports on its review of the number and types of appeals, denials, deferrals, and modifications for the Plan's QI/UM evaluation.

### 1.5.3 Collection and Review of Delegate Ownership and Control

The Plan is required to collect and reviewsubcontractors' ownership and control disclosure information as set forth in Code of Federal Regulations, Title 42, section 455.104. Subcontractors are required to provide written disclosure of information on subcontractors' ownership and control. The review of ownership and control disclosures applies to subcontractors contracting with the Plan. The Plan must make the subcontractors' ownership and control disclosure information available, and upon request, this information is subject to audit by DHCS. *(APL 17-004, Delegation and Subcontractor Network Certification)*

Plan policy, *CMP 31 Oversight of HPSJ Delegated Functions (revised 10/01/2023),* stated that upon contracting and annually thereafter, network providers and contractors shall provide a written disclosure of the information on ownership and control. This information includes, but it is not limited to, date of birth and social security number for each person with ownership or control interest and each managing employee.

**Finding**: The Plan did not collect and review ownership and control disclosures for its delegate.

Although the Plan's policy CMP 31 stated that an annual review of the ownership would be conducted, the Plan did not implement its policy to ensure ownership documentation was collected and reviewed during the audit period. The Plan did not demonstrate implementation of procedures to ensure ownership documentation was collected and reviewed annually. The Plan stated in an interview that it requested the delegate's

ownership and control disclosure documentation. However, the auditor noted that the request was made after the audit period. Additionally, the submitted ownership and control disclosure form was unsigned, undated, and did not include the addresses of the directors.

When the Plan does not ensure collection and review of delegates' ownership and control disclosures, it may lead to the provision of medical services facilitated by an ineligible delegate and may result in potential FWA.

**Recommendation**: Revise and implement policies and procedures to ensure collection and review of the ownership and control disclosures fordelegate.

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| CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE |
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| 2.1 | BASIC CASE MANAGEMENT |
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### 2.1.1 Complex Care Management Plans

The Plan's CCM program must include comprehensive assessment of the member's condition; determination of available benefits and resources; development and implementation of a CMP with performance goals, monitoring and follow-up. *(Contract, Exhibit A, Amendment 39, Attachment 22(7)(B)(1)(c))*

The Plan must ensure that the CCM Care Manager completes a CMP for all members receiving CCM. The CMP must:

a. Address a member's health and social needs, including needs due to Social Drivers of Health.
b. Be reviewed and updated at least annually, upon a change in member's condition or level of care, or upon request of the member.
c. Be in an electronic format, a part of the member's medical record, and document all of the member's services and treating providers.
d. Be developed using a person-centered planning process that includes identifying, educating, and training the member's parents, family members, legal guardians, Authorized Representatives , caregivers, or authorized support persons, as needed; and
e. Include referrals to community-based social services and other resources even if they are not Covered Services under this Contract.
*(Contract, Exhibit A, Amendment 39, Attachment 22(7)(B)(1)(c))*

Plan policy, *CM71 Complex Case Management (effective 08/11/2023),* delineated the components of a comprehensive assessment and individualized care plan, but did not note the provision of the components for all members receiving CCM. The policy did not state that the Plan would complete a CMP for all members receiving CCM or that the CMP was person-centered with input from the member, the member's family, the provider, and interdisciplinary team.

**Finding**: The Plan did not complete CMPs for all members receiving CCM.

A verification study revealed that seven of seven eligible CCM member files did not contain a care management plan. All seven member files did not contain evidence of an individualized care plan with primary care physician or family member input.

The Plan confirmed in an interview that care management staff did not create a care

plan or provide CCM services until the member gave consent. The Plan attributed the lack of access to complete medical records for the failure to complete CMPs for members. The Plan stated that they only had access to the CCM referrals.

When the Plan does not complete CMPs for all members receiving CCM, it may lead to harmful consequences such as worsening symptoms, disease complications, and increased healthcare costs.

**Recommendation**: Revise policies and implement procedures to ensure that CCM services are provided to all eligible members through an opt-out CCM program approach.

### 2.1.2 National Committee for Quality Assurance Complex Case Management Requirements

The Plan is required to operate and administer CCM in accordance with all NCQA CCM standards and requirements and coordinate services for high and medium-rising risk members through the Plan's CCM approach. The Plan is required to maintain policies and procedures that, at a minimum, include a comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a CMP with performance goals, monitoring and follow up. *(Contract Exhibit A, Amendment 39, Attachment 22 (7)(B)(1)(b))*

NCQA guidelines require the Plan's CCM procedures to include documentation of clinical history which should include medication review. *(National Committee for Quality Assurance, Appendix 2, QI 8: Complex Case Management, Element G: Case Management Process (2))*

Plan policy, *CM66 Health Risk Assessments Case Management and Disease Management (revised 06/02/2023),* stated that the Plan shall follow all NCQA guidelines. The policy requires a discharge case manager to perform medication reconciliation for patients changing levels of care. However, it did not address a review of member medications for the outpatient CCM program.

**Finding**: The Plan did not maintain procedures to ensure a comprehensive assessment of the members' condition in accordance with NCQA guidelines.

A verification study revealed that seven of seven CCM member files did not include a review of medications. Although the Plan's policy stated that it will follow NCQA guidelines, the Plan did not have an established process to ensure a review of medication was included as part of its comprehensive assessment of the member's conditions.

During an interview, the Plan acknowledged that staff did not review medications as part of the comprehensive review. The Plan attributed the lack of access to complete medical records as the reason for failure to complete medication reviews for members receiving CCM. The Plan stated that they only had access to the CCM referrals.

When the Plan does not ensure a comprehensive assessment of the members' condition in accordance with NCQA guidelines, it may have an adverse impact on member health and lead to increased healthcare costs.

**Recommendation**: Revise and implement policies and procedures to ensure a comprehensive review of member conditions in accordance with NCQA guidelines.

| ❖ COMPLIANCE AUDIT FINDINGS ❖ |
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| CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY |
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| 6.2 | FRAUD AND ABUSE |
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### 6.2.1 Fraud, Waste, or Abuse Reporting to DHCS

The Plan is required to ensure prompt referral of any potential FWA that the Plan identifies to the DHCS, Audits and Investigation Intake Unit. 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 (26)(B)(7))*

Plan policy, *CMP05 Fraud Waste and Abuse (revised 03/04/2021),* stated that the Plan must report to DHCS, the California Department of Justice, and any other applicable regulatory agencies, all cases of suspected and/or credible FWA when there is reason to believe an incident has occurred. Incidents of suspected and/or credible FWA will be reported within ten working days of the reported incident.

**Finding:** The Plan did not report all suspected fraud and abuse incidents to DHCS within ten working days of the date the Plan first became aware of, or was on notice of, such activity.

A verification study revealed that 6 of 18 FWA cases exceeded ten working days. The Plan reported the cases between 12 to 64 days after the date it initially became aware of the suspected FWA.

The Plan's FWA reporting process consisted of a preliminary and full investigation of reported allegations. Although the Plan's policy stated that all suspected and credible cases of FWA were to be submitted to DHCS within ten business days, the Plan did not follow policy and did not timely report the results of their preliminary investigations to DHCS.

During an interview, the Plan stated that suspected fraud was only reported to DHCS when enough credible evidence had been obtained from a preliminary investigation. Additionally, the Plan stated that it calculated the ten-day reporting requirement using the "date created", which was after the Plan created a lead and when the potential FWA became a case. As a result, cases submitted to DHCS did not include all potential fraud.

Failure to timely report all identified cases of potential FWA to the DHCS, can limit the ability to track, analyze, and respond to the incidents to mitigate the impact to members, providers, the Plan, and the Medi-Cal program.

**Recommendation**: Implement procedures to ensure prompt reporting of all potential FWA within ten working days of when the Plan first becomes aware of, or is on notice of, the activity.

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REPORT ON THE MEDICAL AUDIT OF

# HEALTH PLAN OF SAN JOAQUIN

**2023**

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|---|---|
| Contract Number: | 03-75801<br>State Supported Services |
| Audit Period: | October 1, 2022<br>Through<br>July 31, 2023 |
| Dates of Audit: | October 30, 2023<br>Through<br>November 10, 2023 |
| Report Issued: | April 9, 2024 |

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# I. INTRODUCTION

The report presents the audit findings of the contract compliance audit of the Health Plan of San Joaquin (Plan), and its implementation of the State Supported Services Contract Number 03-75801 with the State of California. The State Supported Services Contract covers abortion services for the Plan.

The audit was conducted from October 30, 2023, through November 10, 2023 and covered the review period from October 1, 2022, through July 31, 2023. The audit consisted of a document review of materials provided by the Plan and interviews with Plan staff. Twenty-five State Supported Services claims were reviewed for appropriate and timely adjudication.

An Exit Conference with the Plan was held on March 20, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The findings in the report reflect the evaluation of all relevant information received prior and subsequent to the Exit Conference.

## ❖ COMPLIANCE AUDIT FINDINGS ❖

**PLAN:** Health Plan of San Joaquin

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## STATE SUPPORTED SERVICES

### SSS.1 Misdirected Claims

The Plan is required to maintain a sufficient claims processing system with the capability to comply with applicable state and federal law, regulations, and Contract requirements. *(Contract, Exhibit A, Attachment 8(5) (C))*

The Plan is required to forward all misdirected claims to the appropriate capitated provider within ten working days of receipt. *(California Code of Regulations, Title 28, section 1300.71(b)(2))*

Plan policy *CLMS12, Misdirected Claims (revised 12/01/2021),* stated the Plan is required to forward misdirected claims to the appropriate payer or delegated provider within ten business days of receipt of the claim.

**Finding:** The Plan did not forward misdirected claims within ten working days of receipt.

A verification study revealed that the Plan did not forward three of five misdirected state supported services claims to the appropriate capitated provider within ten working days of receipt. For all three claims, the Plan notified providers that the claims should be directed to the responsible delegated entity. However, the misdirected claims were forwarded between 16 to 18 days after the date of receipt.

The Plan did not follow its policy which required misdirected claims to be forwarded to their delegated entity within ten working days. The Plan stated in an interview that a gap within the IT processing system was identified during the onsite audit. The Plan noted that during the audit period there were specific queues within the IT system that would at times cause misdirected claims to be forwarded after the tenth business day.

When the Plan does not forward misdirected claims timely, providers may not be reimbursed for services rendered and may be discouraged from treating members.

**Recommendation:** Implement procedures to ensure forwarding of misdirected claims within ten working days.