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

REPORT ON THE MEDICAL AUDIT OF

Rady Children's Hospital – San Diego

Contract Number: 18-95314

Audit Period: September 1, 2019 Through August 31, 2020

Report Issued: January 4, 2021

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I. INTRODUCTION

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

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

The Plan established California Kids Care (CKC), an ACO-based model demonstration project, to provide comprehensive and coordinated care for children with certain eligible conditions that require long-term care and support. CKC provides care for children with the following five CCS-eligible conditions: Acute Lymphoblastic Leukemia, Cystic Fibrosis, Diabetes, Hemophilia, and Sickle Cell Disease.

CKC operations began on July 1, 2018, and members were enrolled on a voluntary basis starting August 1, 2018.

As of August 31, 2020, CKC serves 372 members.

II. EXECUTIVE SUMMARY

DHCS conducted an audit of the Plan from September 8, 2020 through September 11, 2020. This report presents the results of the DHCS limited scope medical audit for the audit period of September 1, 2019 through August 31, 2020.

An Exit Conference with the Plan was held on December 4, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in the report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

The audit consisted of document review, verification studies, and interviews with the Plan's personnel. The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit issued on February 4, 2020, for the audit period of September 1, 2018 through August 31, 2019 identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP closeout letter dated April 13, 2020, documented that DHCS closed all previous findings.

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

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

The Plan is required to provide written acknowledgment advising the member that the appeal has been received, the date of receipt, and the name, telephone number, and address of the representative who may be contacted about the appeal. In our verification study, the Plan's written acknowledgement letter excluded the name and address of the representative who may be contacted about the appeal.

The Plan is required to have fully translated member information, including Notice of Action letters, Grievance and Appeal Acknowledgement and Resolution letters. The audit team found that Notice of Appeal Resolution letters were not fully translated to the member's preferred language.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to provide an Initial Health Assessment (IHA) to new

members.

The Plan is required to cover and ensure the provision of an IHA to each new member within 120 days of enrollment, which consists of a comprehensive history and physical examination, preventive services, and an Individual Health Education Behavioral Assessment (IHEBA). Additionally, the Plan shall ensure that a completed IHA is contained in the member's medical record and is available during subsequent health visits. The Plan did not ensure the provision of a timely and complete IHA is documented in the member's medical records. The Plan lacks policies and procedures for reviewing medical records to track and monitor if members received, within stipulated timelines, an age-appropriate comprehensive history and physical examination that includes an IHEBA.

The Plan is required to make repeated attempts to contact a member and schedule an IHA. The Plan shall make at least three documented attempts that demonstrate the Plan's unsuccessful efforts to contact a member, which must include at least one telephone and one mail notification. The Plan did not contact members nor document its attempts to contact members to schedule an IHA within 120-calendar-days of enrollment.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding members' access to care and pharmaceutical services.

The Plan is required to maintain a procedure for triaging members' telephone calls, provide member services through sufficient assigned and knowledgeable staff, and to ensure that a physician or an appropriate licensed professional under his/her supervision is available for after-hours calls. The Plan did not monitor the system for telephone triage procedures and after-hours calls.

The Plan is required to ensure access to at least a 72-hour supply of a medically necessary, covered outpatient drug when the drug is prescribed in an emergency situation. Additionally, the Plan is required to have written policies and procedures describing how the Plan and/or the Plan's network hospitals will monitor compliance, including the methods used to ensure emergency room medication dispensing requirements are met. The Plan did not have a written policy and procedure in which network hospitals are made aware of emergency medication dispensing requirements.

Category 4 – Member's Rights

Category 4 includes requirements and procedures to establish and maintain a grievance system, and to protect members' rights by properly reporting suspected or actual breach or security incidents.

The Plan is required to have in place a system that shall track and monitor grievances received by the Plan, or any entity with delegated authority to receive or respond to grievances. The Plan did not maintain a grievance system that appropriately tracks and monitors grievances received.

The Plan is required to notify DHCS within 24 hours by email or fax, submit a “DHCS Privacy Incident Report” within 72 hours, and provide a complete report of the investigation within ten-working-days of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of protected health information (PHI) or personal information (PI), or potential loss of confidential data to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer. The Plan did not send a notification to DHCS regarding the discovery of suspected security incident within 24 hours. The Plan did not submit an updated “DHCS Privacy Incident Report” within 72 hours, and did not notify the DHCS Program Contract Manager and DHCS Information Security Officer. The Plan provided the complete report of the investigation to the DHCS Privacy Officer within ten-working-days. The complete report of the investigation was not provided to the DHCS Program Contract Manager and the DHCS Information Security Officer.

Category 5 – Quality Management

Category 5 includes requirements and procedures to monitor, evaluate, and take effective action to address needed improvements in quality of care delivered by providers.

The Plan is required to ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract, and to conduct training for all network providers within ten-working-days after the Plan places a newly contracted provider on active status. In our verification study, not all providers were trained within the contractual timeframe.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The review was conducted from September 8, 2020 through September 11, 2020. 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 the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 15 medical and 18 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Delegation of UM: Five medical prior authorizations were reviewed for appropriate adjudication.

Appeal Procedures: Two prior authorization appeals were reviewed for appropriate and timely adjudication. The Plan received only two appeals during the audit period.

Category 2 – Case Management and Coordination of Care

IHA: 11 medical records were reviewed for timeliness and completeness of the IHA requirements.

Category 4 – Member's Rights

Confidentiality Rights: One security incident was reviewed for processing and reporting requirements. The Plan received only one security incident during the audit period.

Category 5 – Quality Management

Provider Qualifications: 15 new provider training records were reviewed for timeliness of Medi-Cal Managed Care program training.

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

CATEGORY 1 – UTILIZATION MANAGEMENT

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Appeal Acknowledgement Letter

The Plan is required to ensure timely acknowledgement for each request for an appeal. The Plan shall provide written acknowledgment to the beneficiary that is dated and postmarked within five-calendar-days of receipt of the appeal. The acknowledgment letter shall advise the beneficiary that the appeal has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the appeal. *(Contract, Exhibit A, Attachment 14(1)(B) and All Plan Letter (APL) 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments)*

Finding: The Plan did not adhere to APL requirements and its policy as the Plan's written acknowledgement letter excluded the name and address of the representative who may be contacted about the appeal.

The Plan's policy CKC-161, *UM Appeals* (revised in June 2020), states that the Plan will provide a written acknowledgement to the member that is dated and postmarked within five-calendar-days of the receipt of the appeal. Notifications will follow applicable guidelines, including the name, address, and phone number for a representative who can provide information on the status of the appeal review.

During the audit period, the Plan received two appeals. For one of the appeals, the member appealed and received the acknowledgement letter within the contractual timeframe. However, the Plan did not adhere to APL requirements and its policy. The acknowledgement letter did not contain the name and address of the representative who may be contacted about the appeal.

The omission of the Plan's designated representative in the acknowledgement letter may not give members the opportunity to present any evidence and testimony, and/or make legal or factual arguments to support their appeal.

Recommendation: Adhere to APL requirements and that written acknowledgement letters advise the member that the appeal has been received, and shall include the date of receipt, as well as the name, telephone number, and address of the representative who may be contacted about the appeal.

1.3.2 Notice of Appeal Resolution

The Plan is required to have fully translated member information, including but not limited to the Member Services Guide, welcome packets, marketing information, and form letters, including Notice of Action letters, and Grievance and Appeal acknowledgement and resolution letters. The Plan shall provide translated written informing materials to all monolingual or limited English proficiency members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Plan's Service Area, and by the Plan in its Group Needs Assessment. *(Contract, Exhibit A, Attachment 9(14)(C)(2))*

Finding: The Plan did not fully translate the Notice of Appeal Resolution (NAR) letter to the member's preferred language.

The Plan's policy CKC-161, *UM Appeals* (revised in June 2020), states that the Plan will provide notices in identified threshold languages, and will translate notices into alternative formats as requested.

During the audit period, the Plan received two appeals. Review of a member's appeal showed that the member's preferred language is Spanish. After coming to a decision regarding the member's appeal, the Plan sent the member a NAR within 30-calendar-days to comply with the contractual timeframe requirements. However, the NAR was partially in English and Spanish. The Plan's reasons for its determination to uphold the decision for denial was not in the member's preferred language.

The Plan did not adhere to Contract requirements. In order to comply with contractual timeframe requirements, the Plan's NAR was not fully translated in the member's preferred language. During the interview, the Plan stated vendor translation services caused delays. The delay will result in the Plan exceeding the contractual timeframe for sending out the NAR letter within the 30-day timeframe.

The Plan's failure to translate the resolution of the member's appeal does not address the linguistic and cultural needs of its members. The Plan may cause a barrier for the members to be able to fully participate in the Grievance and Appeal System due to the member's limited English proficiency.

Recommendation: Adhere to Contract requirements and that the NARs are fully translated in the member's preferred language.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Rady Children's Hospital – San Diego
AUDIT PERIOD: September 1, 2019 through August 31, 2020 **DATE OF AUDIT:** September 8, 2020 through September 11, 2020

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Monitoring of Completed IHA

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

The Plan shall ensure that member's completed IHA is contained in the member's medical record and available during subsequent health visits. *(Contract, Exhibit A, Attachment 10(3)(G))*

Plan policies CKC-107, *Child Health and Disability Prevention* (revised in June 2020), and CKC-112, *Individual Health Education Behavioral Assessment* (revised in June 2020), tasks Primary Care Physicians (PCPs) to complete an IHA, that includes the IHEBA, on all new members within 120 days of enrollment with the Plan. The IHA must include requirements to assess and document a comprehensive history and physical examination, maintain immunization records, and conduct age-appropriate screenings such as Blood Lead Level (BLL) tests. The Plan's procedure includes sending a notification to the assigned PCP of a newly enrolled member within ten days of eligibility notification. The notification includes instructions on the IHA requirements and the member's demographic information.

Finding: The Plan did not ensure the provision of a timely and complete IHA that is documented in the member's medical records. The Plan lacks policies and procedures for reviewing medical records to track and monitor if members received, within stipulated timelines, an age-appropriate comprehensive history and physical examination that includes an IHEBA.

To address the deficiency from the prior year's audit finding, the Plan revised the policy CKC-112, *Individual Health Education Behavioral Assessment* (revised in June 2020), to include a section on monitoring. The Plan will track IHA completion by individual members every 30-60 days, including documentation of IHAs that may have been completed during the member's health plan assignment. If IHAs are not completed, the Plan will conduct outreach to the assigned PCP three times to gather information on the reason for non-completion and/or to provide education or training to ensure IHAs are

completed. The Plan developed the *IHA Tracking Grid* to identify pending or incomplete IHAs. Using this grid, the Plan documents each outreach attempt to remind PCPs to follow up and complete IHAs. However, there is no mention of the Plan's method to review medical records to ensure that PCPs perform and document a timely and complete IHA that includes the IHEBA.

The Plan's policy CKC-107, *Child Health and Disability Prevention* (revised in June 2020), describes that the Plan conducts routine medical record audit processes. Medical records in the PCP's office may be subject to review/audit by the Plan for compliance with the IHA requirements and ongoing periodic screening assessment and preventive health care requirements. In addition, quality of records and services provided will be measured annually by completing designated Healthcare Effectiveness Data and Information Set requirements for pediatric and adolescent preventive care. Although there is a policy for monitoring IHA completion through medical record audits, the Plan did not provide documentation of a review tool, report, and analysis showing implementation of its process for routine medical record or quality of records review.

A complete IHA consists of a comprehensive history and physical examination, an age-appropriate IHEBA, and must be completed within 120-calendar-days following the date of enrollment or within American Academy of Pediatrics (AAP) periodicity timelines. Findings from the verification study revealed that five of 11 member medical records did not contain a complete IHA:

- Two medical records lacked a comprehensive documentation of preventive immunization and BLL screening.
- One medical record showed a non-timely IHA completion and lacked documentation of an age-appropriate IHEBA.
- One medical record showed a non-timely completion of the IHA.
- One medical record lacked documentation of an age-appropriate IHEBA.

In an interview, the Plan stated that it does not conduct medical record reviews to ascertain that PCPs perform and document timely and complete IHAs. The Plan expressed that inaccurate contact information and the COVID-19 pandemic potentially affected timely completion of IHAs. Medi-Cal members tend to be transitory and often did not provide the Plan with updated addresses and telephone information. Despite reassurances from their PCPs, members may have opted to delay IHA completion in fear of contracting COVID-19.

Failure to conduct timely and complete IHAs can result in poor health outcomes related to delayed or missed assessment of medical care needs, identification of health risks, preventive health screens, and prescription of prompt treatment or referrals for coordination of care.

Recommendation: Revise and implement policies and procedures to include a system to review and ensure that timely and comprehensive IHAs are performed and documented in the member's medical records.

2.1.2 Provision of IHA

The Plan shall make repeated attempts, if necessary, to contact a member and schedule an IHA. The Plan shall make at least three documented attempts that demonstrate the Plan's unsuccessful efforts to contact a member and schedule an IHA. Contact methods must include at least one telephone and one mail notification. The Plan must document all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed. *(Contract, Exhibit A, Attachment 10(3)(H))*

For members under the age of 18 months, the Plan shall ensure the provision of an IHA within 120-calendar-days following the date of enrollment or within periodicity timelines established by the AAP for ages two and younger, whichever is less. *(Contract, Exhibit A, Attachment 10(3)(B))*

For member 18 months of age and older upon enrollment, the Plan is responsible for ensuring an IHA is performed within 120-calendar-days of enrollment. *(Contract, Exhibit A, Attachment 10(3)(C))*

Finding: The Plan did not contact members nor document its repeated attempts to contact members to schedule an IHA within 120-calendar-days of enrollment.

Plan's policies CKC-107, *Child Health and Disability Prevention* (revised in June 2020), and CKC-112, *Individual Health Education Behavioral Assessment* (revised in June 2020), state that PCP's are responsible for documenting in the member's medical record all contacts or attempted contacts, in letters and/or telephone calls, with the member. It is also the PCP's responsibility to make a minimum of two attempts to schedule an IHA for newly enrolled members. The Plan developed the *IHA Tracking Grid* that documents the Plan's outreach attempts to inform PCPs of members with incomplete IHAs. If IHAs are not completed, the Plan will outreach to the assigned PCP three times to gather information on the reason for non-completion, provide education or training if needed, assist with appropriate contact information for the member, or offer assistance to ensure IHAs are completed. However, policies and procedures do not describe the Plan's method to review medical records or other documentation systems to track and monitor if PCPs document their attempts to contact members and schedule an IHA.

In the verification study, all 11 medical records did not contain documentation of PCP attempts, by telephone or mail, to contact members to schedule an IHA.

During the interview, the Plan explained that it developed and initiated the use of an *IHA Tracking Grid* that documents the Plan's outreach attempts to PCPs offices for follow-up of incomplete IHAs. However, medical record documentation of PCP-to-member outreach attempts are not tracked by the Plan as part of its IHA completion assessment.

Failure to contact members and schedule an IHA can lead to members not receiving necessary medical care due to delays or a lack of identification of health risks, medical treatment, or referrals for coordination of care.

Recommendation: Revise policies and develop procedures to track and monitor whether medical records or other tracking systems document at least three attempts to schedule an IHA by communicating with members by telephone and mail notification.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.2	URGENT CARE AND EMERGENCY CARE / TELEPHONE PROCEDURES AND AFTER-HOURS CALLS / SPECIALISTS AND SPECIALTY SERVICES

3.2.1 Telephone Triage Procedures

The Plan shall require providers to maintain a procedure for triaging members' telephone calls, providing telephone medical advice (if it is made available), and accessing telephone interpreters. *(Contract, Exhibit A, Attachment 9(3)(D))*

The Plan shall maintain the capability to provide member services to Medi-Cal members or potential members through sufficient assigned and knowledgeable staff. *(Contract, Exhibit A, Attachment 13(2)(A))*

At a minimum, the Plan shall ensure that a physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls. *(Contract, Exhibit A, Attachment 9(3)(E))*

Finding: The Plan did not monitor telephone triage procedures of providers nor if after-hour telephone triage lines were answered by appropriate licensed professionals.

The Plan's policy CKC-053, *Access Standards* (revised in June 2020), establishes triage and screening services provided to members by telephone 24 hours per day, seven days per week and monitoring processes for telephone triage procedures. In addition, the member waiting time from a member's initial call to the time a practitioner speaks to the member may not exceed 30 minutes. The Plan is to ensure that a physician or an appropriate licensed medical professional under their supervision is available for after-hours calls. Furthermore, the Plan's Provider Services Director is responsible for conducting the triage survey to ascertain compliance with the timely access standards.

During the interview, Plan's staff stated that it is engaged in providing medical call center services to the provider network, obtainable by duly licensed registered nurses, on a 24-hour basis. In addition, the Plan's registered nurses follow the nationally accepted Schmitt-Thompson physician-authored telephone triage guidelines. However, the Plan did not provide utilization reports containing call management statistics and service details for the audit period. Furthermore, the Plan did not provide a survey of 24/7 telephone triage services as stated in its policy.

In addition, the Plan did not monitor whether 24/7 telephone triage lines used by medical groups were answered by appropriate licensed professionals.

The lack of monitoring standards and compliance with its telephone exchange to ensure accessibility for members and the availability to provide timely access may negate the Plan the opportunity to initiate interventions to improve performance, and in return, may jeopardize the member's health.

Recommendation: Develop and implement procedures to monitor telephone triage maintained by providers, and that appropriate licensed professionals are available for after-hour calls through a 24/7 telephone triage line used by the Plan and its delegated medical groups.

3.4 ACCESS TO PHARMACEUTICAL SERVICES

3.4.1 Plan Network Hospitals

The Plan shall ensure access to at least a 72-hour supply of a medically necessary, covered outpatient drug when the drug is prescribed in an emergency situation. The Plan shall meet this requirement by doing all of the following:

Having written policies and procedures, including, if applicable, written policies and procedures of the Plan's network hospitals' policies and procedures related to emergency medication dispensing, which describe the methods that are used to ensure that the emergency room medication dispensing requirements are met, including, if applicable, specific language in network hospital subcontracts. Written policies and procedures must describe how the Plan and/or the Plan's network hospitals will monitor compliance with the requirements. Compliance monitoring does not require verification of receipt of medications for each and every emergency room visit made by members which does not result in hospitalization. *(Contract, Exhibit A, Attachment 10(7)(G)(3)(a))*

Finding: The Plan did not have a procedure in which every network hospital is made aware of emergency medication dispensing requirement.

To address the deficiency from the prior year's audit finding, the Plan developed policy CKC-154, *72 Hour Emergency Prescriptions*. The policy outlines the procedures the Plan will follow to ensure that emergency room medication dispensing requirements will be met. It includes a section regarding the 72-hour supply of medically necessary

covered outpatient drugs when the drug is prescribed in an emergency situation, as well as the Plan's monitoring of electronic health records in Epic Systems for members seen and discharged from the emergency room.

The policy, however, does not describe the method in which network hospitals will ensure that the emergency room medication dispensing requirements will be met. The Plan's facility services agreement for network hospitals had no written stipulation of the procedure related to emergency medication dispensing.

The Plan does not have a procedure in which every network hospital is made aware of emergency medication dispensing requirement. A written policy or stipulation in the Plan's agreement with network hospitals does not include the network hospital's responsibility of ensuring that members have access to at least a 72-hour supply of a medically necessary covered outpatient drug in an emergency situation.

Network hospitals may not be entirely informed of the requirement of ensuring that Plan members have access to at least a 72-hour supply of medically necessary drugs. The absence of a written stipulation within the Plan's agreement with network hospitals regarding emergency medication dispensing for Plan members can become an access barrier for medically necessary pharmaceutical services in an emergency situation.

This is a repeat of prior year finding 3.4.1 – Monitoring of the Provision of Drugs Prescribed in Emergency Situations.

Recommendation: Revise policy and establish a method outlining how network hospitals will ensure that 72-hour supply of medically necessary covered outpatient drugs will be provided to members.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Tracking and Monitoring Grievances

The Plan shall have in place a system in accordance with California Code of Regulations (CCR), Title 28, section 1300.68 (except Subdivision 1300.68(g)). *(Contract, Exhibit A, Attachment 14(1))*

The Plan's grievance system shall track and monitor grievances received by the Plan, or any entity with delegated authority to receive or respond to grievances. *(CCR, Title 28, section 1300.68(e))*

Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgement and response. The Plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of resolution, and the Plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the Plan. *(APL 17-006)*

Finding: The Plan did not maintain an appropriate and adequate system that tracks and monitors grievances received by the Plan. The Plan did not have a grievance system that captures all expressions of dissatisfaction and a grievance system that appropriately classifies or categorizes grievances received.

The Plan's policy CKC-159, *Grievances* (revised in June 2020), defines a grievance as an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. An inquiry is also defined by the Plan as a request for information that does not include an expression of dissatisfaction. Furthermore, the Plan defines a complaint as a grievance. If the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered as a grievance.

Furthermore, the Plan's policy states that grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day are logged in the call logging system as a complaint. The Customer

Service Manager reviews the complaint calls on a daily basis. The Plan also reviews the complaint calls on a monthly basis for potential escalation to a formal grievance, referral to the Plan's management for necessary action, or referral to the Quality Committee for review regarding quality of care provided.

During the audit period, the Plan stated that there were no grievances received. Upon review of the Plan's *Member Call Log*, the Plan received a call from a member's parent expressing dissatisfaction. The Plan clarified that the complaint was resolved within 24 hours and provided supporting documentation, which showed that the Plan staff affirmed with the member that the issue was indeed addressed and resolved during the call. However, the Plan's *Exempt Grievance Log* did not contain this communication. The call was improperly categorized as merely an inquiry and not as an exempt grievance. As a result, the *Member Call Log* contained both inquiries and complaints or grievances.

An appropriate and adequate grievance system was not maintained. The Plan did not have a grievance system that captures all expressions of dissatisfaction and a grievance system that appropriately classifies or categorizes grievances received. There was no review or analysis performed on the complaint calls, in contrast to the procedures that the Plan stated in its policy. During the interview, the Plan recognized the error in incorrectly categorizing the complaint.

Maintenance of a proper grievance system that captures and properly categorizes all expressions of dissatisfaction is necessary for tracking and trending. This would allow the Plan to resolve complaints or grievances received appropriately, and to develop further interventions or corrective actions.

Recommendation: Maintain a grievance system that appropriately tracks and monitors grievances received.

4.3	CONFIDENTIALITY RIGHTS

4.3.1 Breaches and Security Incidents

The Plan is required to notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, or potential loss of confidential data. Notice shall be provided to the DHCS Program Contract Manager, Privacy Officer, and Information Security Officer. *(Contract, Exhibit G(3)(J)(1))*

The Plan is required to immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, the Plan must submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, Privacy Officer, and Information Security Officer. *(Contract, Exhibit G(3)(J)(2))*

The Plan is required to provide a complete report of the investigation to the DHCS Program Contract Manager, Privacy Officer, and Information Security Officer within ten-working-days of the discovery of the breach or unauthorized use or disclosure. *(Contract, Exhibit G(3)(J)(3))*

Finding: The Plan did not notify DHCS regarding the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, or potential loss of confidential data within 24 hours, nor did the Plan submit the "DHCS Privacy Incident Report" within 72 hours of discovery. Lastly, the Plan provided the complete "DHCS Privacy Incident Report" to the DHCS Privacy Officer within ten-working-days of discovery, but not to the Program Contract Manager and Information Security Officer.

The Plan's policy CPM 11-100, *Privacy Breach Reporting* (last approved in January 2020), defines a breach as the acquisition, access, use or disclosure of patient information which violates the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule or other applicable laws or regulations and compromises the security or privacy of the patient information. It is the Plan's policy that any privacy-related event will be communicated and the Plan will notify the DHCS Program Contract Manager, Privacy Officer, and Information Security Officer immediately upon discovery of a breach or suspected breach involving a member's PHI or PI. Such notification shall be by telephone with a follow up fax or email within 24 hours upon the discovery of a breach.

Furthermore, the policy states that the Plan will submit an updated "DHCS Privacy Incident Report" to DHCS Program Contract Manager, Privacy Officer, and Information Security Officer within 72 hours of the discovery of the event providing additional information and corrective actions taken since the initial report.

Lastly, the Plan's policy states that a completed "DHCS Privacy Incident Report" will be submitted to the DHCS Program Contract Manager, Privacy Officer, and Information Security Officer within ten-working-days after discovery of the incident. This report shall include an assessment of all known factors relevant to the determination of whether a breach occurred under applicable provisions of HIPAA, Health Information Technology for Economic and Clinical Health Act and state law, as well as a full, detailed CAP,

including measures that were taken to halt and/or contain the improper use or disclosure.

The verification study sampled one case to determine compliance with contractual timeframes of reporting any breach or suspected security incident to DHCS. The incident was due to a misdirected mailing of a prescription medication to the incorrect member. This was the only case that occurred during the audit period. Findings from the verification study revealed the following:

- The Plan did not notify the DHCS Program Contract Manager, Privacy Officer, and Information Security Officer within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, or potential loss of confidential data.
- The Plan submitted an updated "DHCS Privacy Incident Report" to the DHCS Privacy Officer five days after the discovery. The Plan did not notify the Program Contract Manager and Information Security Officer, and did not provide the "DHCS Privacy Incident Report" within 72 hours of discovery.
- The Plan only provided a complete report of the investigation to the DHCS Privacy Officer within ten-working-days of discovery, but not to the Program Contract Manager and Information Security Officer. The complete report was not provided to all three DHCS officers.

During the interview, the Plan stated that DHCS found the incident to be a non-breach. However, this was subsequent to the review and investigation of the case. Nonetheless, the Plan is required to notify DHCS within 24 hours and submit a DHCS Privacy Incident Report within 72 hours prior to the determination of whether the case is a suspected security incident or an actual breach.

Prompt reporting of any breach or suspected security incident is important in order to prevent and mitigate the access, use, or disclosure of confidential information by an unauthorized person. Reporting in a timely manner allows DHCS to be informed of the nature of the events and to understand the severity of the incidents to determine the proper mitigation and corrective actions necessary.

Recommendation: Adhere to contractual requirements and established procedures to notify the DHCS Program Contract Manager, Privacy Officer, and Information Security Officer within 24 hours by email or fax for any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI. Additionally, implement a system to investigate any security incident, breach, or unauthorized access, use or disclosure of PHI, PI, or confidential data, and submit an initial "DHCS Privacy Incident Report" within 72 hours of discovery and a complete report of investigation within ten-working-days of discovery to the DHCS Program Contract Manager, Privacy Officer, and Information

Security Officer.

CATEGORY 5 – QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

5.2.1 New Provider Training

The Plan shall ensure that all providers receive training regarding the Medi-Cal Managed Care Program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations. The Plan shall conduct training for all network providers within ten-working-days after the Plan places a newly contracted provider on active status. *(Contract, Exhibit A, Attachment 7(5)(A))*

Finding: The Plan did not train new providers within the contractual timeframe.

As part of the CAP from the prior year's audit, the Plan revised its policy CKC-020, *Credentialing and Recredentialing*, which describes a procedure for all new providers to receive training materials concurrent with the credentialing and onboarding process. The Plan is to track and monitor signed attestations of provider training to ensure providers have received the required training. However, the Plan did not ensure all new network providers returned a signed attestation and/or sustained compliance to meet standards set forth by the Contract. The lack of signed attestations does not demonstrate that new network providers received training regarding the Medi-Cal Managed Care Program.

The Plan's policy CKC-020, *Credentialing and Recredentialing* (revised in June 2020), states that the Plan will train and educate its providers on the Medi-Cal Managed Care Plan's policies and procedures, relating to the delivery of health care services and Plan administration, concurrent with the credentialing and onboarding process. This training is not to exceed ten-working-days of placing a newly contracted provider on active status. Furthermore, the Plan will track and monitor signed attestations to ensure providers have received the required training.

During the interview, Plan staff reported issues with the process to track signed attestations and recognized the inadequate maintenance of records regarding new provider training. The Plan acknowledged the necessity to assess the appropriateness of the current tracking mechanism and the obligation to operate in full compliance with the Contract. Remediation efforts are in discussion at internal committees such as the Joint Quality Team to revise procedural issues and the development of a Work Group to address the current situation and ensure all new providers receive training regarding the

Medi-Cal Managed Care Program.

The verification study of 15 provider training samples found the following deficiencies:

- Five new providers did not have signed attestation forms to confirm the completion of provider training.
- Four new providers received training between 111 to 249 working-days, which were past the required ten-working-day timeframe of obtaining active status with the Plan.
- Four new providers had signed attestations on file as required by the Plan's policy. However, there was no information on the date establishing the active status.

Without new provider training, the Plan cannot ensure providers operate in full compliance with the Contract and all applicable federal, state, and local regulations to meet program requirements.

This is a repeat of prior year finding 5.2.1 – Newly Contracted Provider Training.

Recommendation: Revise and implement policies and procedures to ensure providers receive new provider training within ten-working-days after being placed on active status.

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

REPORT ON THE MEDICAL AUDIT OF

Rady Children's Hospital – San Diego

Contract Number:	18-95367 State Supported Services
Audit Period:	September 1, 2019 Through August 31, 2020
Report Issued:	January 4, 2021

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I. INTRODUCTION

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

The audit period is from September 1, 2019, through August 31, 2020. The review was conducted from September 8, 2020, through September 11, 2020, which consisted of document review of materials provided by the Plan and interviews with the Plan's administration and staff.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Rady Children's Hospital – San Diego

AUDIT PERIOD: September 1, 2019 through August 31, 2020
DATE OF AUDIT: September 8, 2020 through September 11, 2020

STATE SUPPORTED SERVICES

The Plan agrees to provide, or arrange to provide, to eligible members State Supported Services, which include the Current Procedural Terminology (CPT) codes 59840 through 59857 and Healthcare Common Procedure Coding System (HCPCS) codes X1516, X1518, X7724, X7726, Z0336. *(State Supported Services Contract Exhibit A(1))*

The prior year audit found that the Plan's policy CKC-078, *Payment Methodology for Family Planning and Sensitive Services Rendered to a CKC Member*, did not include the HCPCS codes A4649, S0190, S0191, and S0199. The Plan's policy did not list the complete codes required to be provided, or arranged to be provided, to eligible members for State Supported Services. The Plan's claims systems also did not identify the complete list of codes as auto-adjudicated. Lastly, the Plan's Provider Manual did not reflect the Plan's policy and procedure regarding the provision of State Supported Services.

In accordance with the Corrective Action Plan, the Plan updated its policy to include HCPCS codes A4649, S0190, S0191, and S0199. Review of the Plan's latest revised policy June 2020, confirmed that the Plan corrected its policy to include the complete list of codes, including CPT codes 59840 through 59857 and HPCPS codes A4649, S0190, S0191, and S0199. Furthermore, review of the Plan's auto-adjudication process verified that the required codes were added within the Plan's system. Lastly, the Plan revised its Provider Manual to align with policy CKC-078. Review of the Provider Manual confirmed that the information was corrected in regards to the provision of State Supported Services.

The Plan's policy CKC-078, *Payment Methodology for Family Planning and Sensitive Services Rendered to a CKC Member*, 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 assures that confidentiality and accessibility are maintained. In addition, the policy states that the Plan reimburses a non-contracted provider at 100 percent of the current Medi-Cal Fee Schedule for covered services rendered to a Plan member.

The Plan's abortion billing code sheet includes CPT codes 59840 through 59857 and HCPCS codes A4649-U1, A4649-U2, S0190, S0191, and S0199 as billable pregnancy termination services as required by the Contract.

Members are informed that abortion and abortion-related procedures are covered and do not require a referral from the primary care provider through the Member Handbook/Evidence of Coverage. The Plan informs providers about abortion services through the Provider Manual, which is available to providers on the Plan's website.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Rady Children's Hospital – San Diego

AUDIT PERIOD: September 1, 2019 through August 31, 2020
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The audit found no discrepancies in this section.

Recommendation: None.