

MEDICAL REVIEW – NORTH II SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Health Plan of San Joaquin

2021

Contract Number: 04-35401

Audit Period: July 1, 2019
Through
June 30, 2021

Dates of Audit: December 6, 2021
Through
December 17, 2021

Report Issued: July 29, 2022

TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	EXECUTIVE SUMMARY	2
III.	SCOPE/AUDIT PROCEDURES	5
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 – Utilization Management	7
	Category 2 – Case Management and Coordination of Care	9
	Category 4 – Member’s Rights	14
	Category 5 – Quality Management	16
	Category 6 – Administrative and Organizational Capacity	18

I. INTRODUCTION

The Health Plan of San Joaquin (Plan) is a non-profit corporation headquartered in French Camp, CA 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 2021 the Plan was awarded the National Committee for Quality Assurance accreditation renewal.

Health care services are provided through contracts with independent medical groups and individual physicians (350 plus primary care physicians). Health care services not provided directly by primary care physicians are arranged through contracts with other medical groups/physicians, allied health service suppliers, and 19 hospitals. The Plan has a network of over 710 physician specialists, five federally qualified health centers, and five rural health centers. As of December 2021, the Plan had 388,225 Medi-Cal members. The Plan's Medi-Cal market share is about 90.8 percent in San Joaquin County and 84.5 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 July 1, 2019 through June 30, 2021. The review was conducted from December 6, 2021 through December 17, 2021. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on June 1, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. On June 15, 2022, the Plan submitted a response. The result of our evaluation of the Plan's response are reflected in this report.

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

The prior DHCS medical audit (for the period of July 1, 2018 through June 30, 2019) was issued on November 7, 2019 and had no material findings. This year's audit examined documentation for Contract compliance.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 includes procedures and requirements for the Plan's UM program, prior authorization review and the appeal process.

The Plan is required to have a written record of appeals which must be reviewed periodically by the governing body of the Plan, the public policy body, and by an officer of the Plan or their designee. The review shall be thoroughly documented. The Plan did not document the review of their appeals system.

Category 2 – Case Management and Coordination of Care

Category 2 Continuity of Care (COC).

The Plan must notify the member 30 calendar days before the end of the COC period about the process that will occur to transition the member's care to an in-network provider. The Plan did not inform members 30 calendar days before the end of the COC period about the transition of the member's care to an in-network provider.

The Plan is required upon approval of a COC request to notify the member within seven calendar days. The Plan did not send notification letters to members within seven calendar days of the COC request.

The Plan is required to complete each COC request within 30, 15 or three calendar days depending on the condition/criteria for members care. The Plan did not complete COC requests within the required timeline.

The Plan is required to inform members of their COC protections and must include information about these protections in member information packets and handbooks. The Plan's member information packets, handbooks, and provider training materials did not include information on how to initiate a COC request.

The Plan must consider a COC request completed after a good faith effort to contact the provider and the provider is non-responsive after 30 calendar days. The Plan does not have a process that includes a good faith effort to contact the providers and allows for up to 30 calendar days for their response before denying COC requests.

Category 3 – Access and Availability of Care

No findings were noted for the audit period.

Category 4 – Member's Rights

Category 4 includes requirements to establish and maintain a grievance system.

The Plan is required to ensure that the written record of grievances is periodically reviewed by the governing body, the public policy body, and by an officer of the Plan or designee. The Plan did not ensure the periodic review of the written log by the Plan's board of directors, public policy body and the designated officer.

The Plan's grievance acknowledgement letters must include the date of receipt, and provide the name and telephone number of the Plan representative who may be contacted about the grievance. The Plan's acknowledgement letters did not contain the name of the person who was responsible for processing a member's grievance.

Category 5 – Quality Management

Category 5 includes requirements to maintain an effective quality improvement system.

The Plan is required to take effective action and have effective oversight to improve the quality of care delivered by all providers rendering services. The Plan did not provide effective oversight to improve deficient quality of care identified in Potential Quality Issue (PQI) complaints affecting member care.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to implement and maintain a compliance program to guard against fraud and abuse.

The Plan is required to report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud has occurred by subcontractors, members, providers, or employees. The Plan is required to conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days. The Plan did not report all suspected fraud incidents to DHCS within ten working days of the date when they initially became aware of or received report.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

DHCS conducted an audit of the Plan from December 6, 2021 through December 17, 2021. The audit included a review of the Plan's Contract with DHCS, its policies and procedures for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. DHCS reviewed the Plan's documents and conducted interviews with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 37 medical and 31 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriateness of review.

Prior authorization appeal procedures: 43 prior authorization appeals (21 medical and 22 pharmacy) were reviewed for appropriateness and timeliness of decision-making.

Category 2 – Case Management and Coordination of Care

Complex Case Management (CCM): Eight medical records were reviewed for evidence of continuous tracking, monitoring, and coordination of resources for members who received CCM services.

Behavioral Health Treatment (BHT): 24 medical records were reviewed for coordination, completeness, and compliance with BHT provision requirements.

Continuity of Care: 12 member files were reviewed to confirm members received COC and fulfillment of requirements.

Category 3 – Access and Availability of Care

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

Non-Emergency Medical Transportation and Non-Medical Transportation (NEMT/NMT): 30 member records (15 NEMT and 15 NMT) were reviewed for completeness and compliance with the Contract.

Category 4 – Member’s Rights

Grievance System: 64 quality of service and 30 quality of care grievances were reviewed for timely resolution, response to complaint, and submission to the appropriate level for review.

Category 5 – Quality Management

Potential Quality of Care Issues: Six cases were reviewed for reporting, investigation, and remediation.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 12 fraud and abuse 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 (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

CATEGORY 1 - UTILIZATION MANAGEMENT

1.3

PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Appeals System Review

The Plan shall have in place a system in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph F.13 and 42 CFR 438.402-424. The Plan shall follow Grievance and Appeal requirements, and use all notice templates included in All Plan Letter (APL) 17-006. (*Contract A23, Exhibit A, Attachment 14(1)*)

An appeal by an enrollee or the enrollee's representative is considered a grievance. (*CCR, Title 28, Section 1300.68 (a)(1)*)

The Plan shall have a written record for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to section 1300.69, and by an officer of the plan or his designee. This review shall be thoroughly documented. (*CCR, Title 28, Section 1300.68 (b)(5)*)

The Plan must ensure that written record of appeals be reviewed periodically by the governing body of the Managed Care Plan (MCP), the public policy body and by an officer of the MCP or designee. The review shall be thoroughly documented. (*APL 17-006, Grievance and Appeal Oversight*)

The Plan policy, *QM65 Member Appeals* (effective 2/1/2019), requires the written record of grievances and appeals shall be reviewed periodically by the governing body of the Plan, the public policy body, and by an officer of the Plan or designee. The review shall be thoroughly documented.

Finding: The Plan did not document the review of their appeals system.

The Plan did not have documentation of the review of the written log by the governing body, public policy body and officer, or designee. The Plan did not document the oversight process as required by their policy QM65.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

A review of the Plan's governing body meeting minutes did not contain a review of the written log of grievance and appeals during the audit period. No public policy body minutes were submitted for review. The Plan did not document their review of the written record of appeals. During an interview, the Plan cited a shortage of staff as well as onboarding new staff, acknowledging they were out of compliance with APL 17-006.

Without documentation of the Plan's review of appeal logs, the governing board will lack the ability to understand the members' actual issues which can lead to missed quality improvement opportunities.

Recommendation: Ensure thorough documentation of periodic review of appeals by the governing body, public policy body, and officer or designee.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4 CONTINUITY OF CARE

2.4.1 Notification of End of the Continuity of Care Period

The Plan is required to comply with all existing final Policy Letters (PL) and All Plan Letters (APL) issued by Department of Health Services (DHS). (*Contract, Exhibit E, Attachment 2(1)(D)*)

The Plan must notify the member 30 calendar days before the end of the COC period about the process that will occur to transition the member's care to an in-network provider at the end of the COC period. (*APL 18-008, COC for Medi-Cal Members who Transition into Medi-Cal Managed Care (revised 07/10/2018)*)

The Plan's policy, *UM49 COC for Medi-Cal beneficiaries who transition into Medi-Cal Managed Care including Mental Health* (reviewed 04/2020), states that the Plan must notify the member 30 calendar days before the end of the COC period about the process that occurs to transition his or her care at the end of the COC period.

Finding: The Plan did not inform members 30 calendar days before the end of the COC period about the process that will occur to transition the member's care to an in-network provider.

During an interview, the Plan stated that members are not notified 30 days prior to the end of the COC period. The Plan stated that it recognized the deficiency.

Without a system in place to ensure that members are notified before the end of the COC period, and the process of transition into an in-network provider, members' care may be delayed or impacted.

Recommendation: Revise and implement policies and procedures to ensure that the Plan informs members, within 30 calendar days before the end of the COC period, about the process to transition members into in-network care.

2.4.2 Continuity of Care Approval Notification Letter

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

The Plan is required to comply with all existing final PLs and APLs issued by DHS.
(*Contract, Exhibit E, Attachment 2(1)(D)*)

Upon approval of a COC request, the Plan must notify the member of the following within seven calendar days (All Plan Letter 18-008, COC for Medi-Cal Members Who Transition into Medi-Cal Managed Care):

- The request approval.
- The duration of the COC arrangement.
- The process that will occur to transition the member's care at the end of the COC period.
- The member's right to choose a different provider from the MCP's provider network.

The Plan's policy, *UM49 COC for Medi-Cal beneficiaries who transition into Medi-Cal Managed Care including Mental Health* (reviewed 04/2020), includes the COC approval process and a COC approval letter template.

Finding: The Plan did not send notification letters to members within seven calendar days upon approval of COC request.

The Plan had a total of three COC cases during the audit period. In the verification study, two of three COC service requests were approved. However, the Plan did not send approval letters to notify these two members.

Although the Plan does not send notification letters subsequent to COC approvals, the Plan has an existing COC approval letter template that lacks the following necessary information:

- Duration of the COC arrangement.
- Transition process, and the member's rights to choose a different provider from the Plan's network.

If a member is not informed of the COC service request approval, it may delay or interrupt medically necessary services.

Recommendation: Revise and implement policies and procedures to ensure member notification of COC request approvals that will include information regarding the duration of the COC arrangement, transition process, and the member's rights to choose a different provider from the Plan's network.

2.4.3 Request Completion Timelines for Continuity of Care Services

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

The Plan is required to comply with all existing final PLs and APLs issued by DHS.
(*Contract, Exhibit E, Attachment 2(1)(D)*)

Each COC request must be completed within the following timelines:

- 30 calendar days from the date the MCP received the request;
- 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is risk of harm to the member. (*APL 18-008, COC for Medi-Cal Members who Transition into Medi-Cal Managed Care (revised 07/10/2018)*)

The Plan's policy, *UM49 COC for Medi-Cal beneficiaries who transition into Medi-Cal Managed Care including Mental Health* (reviewed 04/2020), states:

Each COC request must be completed within the following timelines:

- 30 calendar days from the date Plan receives the request;
- 15 calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is risk or harm to the member.

Finding: COC requests were not completed within the required timeline.

The Plan provided three COC cases for this verification study for the audit period. The verification study revealed that out of two approved cases one was approved 77 days after the member's request.

In the interview, the Plan stated that timelines for the completion of COC requests were not monitored. Instead the Plan monitors their attempts to reach the provider. According to the Plan staff, all the cases for COC services are treated as an out-of-network provider request which requires prior authorization while the COC criteria requires a provider to agree to accept the Plan's member for continued care.

All the direct requests from the members for COC services are sent from the customer services department to the provider network department for provider outreach. If the provider is not reached on the same day, the contracting staff will continue attempts to reach the provider within five working days. Attempts to reach the provider do not exceed three calendar days when there is potential harm to the member. After this process is completed, the provider network department staff requests that the provider submit a prior authorization request to the UM department to initiate a COC request. This process is not in compliance with APL 18-008.

If the Plan does not ensure that COC requests are completed in a timely manner member's care may be delayed or impacted.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

Recommendation: Ensure a timely and compliant process for processing COC requests.

2.4.4 Members and Provider's Education for Initiation of Continuity of Care Service Requests

The Plan is required to comply with all existing final PLs and APLs issued by DHS. (*Contract, Exhibit E, Attachment 2(1)(D)*)

The Plan must inform members of their COC protections and must include information about these protections in member information packets and handbooks. This information must include how the member and provider initiate a COC request with the Plan. (*APL 18-008, COC for Medi-Cal Members who Transition into Medi-Cal Managed Care (revised 07/10/2018)*)

The Plan's policy, *UM49 COC for Medi-Cal beneficiaries who transition into Medi-Cal Managed Care including Mental Health* (reviewed 04/2020), includes information required by APL for member and Provider Outreach and Education.

Finding: Members' information packets, handbooks, and providers' training materials did not include information on how to initiate a COC request with the Plan.

The Plan's welcome package for the members and the Member Handbook, did not inform members about how to initiate COC a request with the Plan. The Plan's online provider training material that is shared with the providers upon onboarding to the Plan did not contain information about how a provider can initiate a COC request with the Plan.

During the interview, Plan staff stated that due to a shortage of staff and lack of leadership during the audit period, the Plan could not address these issues. Without a system in place to ensure that members and providers are informed about how to initiate COC services, members' medically necessary services can be delayed and or impacted.

Recommendation: Revise information package for the members, and provider training material to ensure that members and providers are informed about how to initiate the process for receiving COC with the Plan.

2.4.5 Continuity of Care Service Requests

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

The Plan is required to comply with all existing final PLs and APLs issued by DHS.
(*Contract, Exhibit E, Attachment 2(1)(D)*)

A COC request is considered completed when:

- The Plan notifies the member that the request has been approved;
- The Plan and the out-of-network Medi-Cal Fee For Service (FFS) provider are unable to agree to a rate;
- The Plan has documented quality of care issues with the Medi-Cal FFS provider; or
- The Plan makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days. (*APL 18-008, COC for Medi-Cal Members who Transition into Medi-Cal Managed Care (revised 07/10/2018)*)

The Plan's policy, *UM49 COC for Medi-Cal beneficiaries who transition into Medi-Cal Managed Care including Mental Health (reviewed 04/2020)*, states that if the Plan and the out of network provider are unable to reach an agreement because they cannot agree to a rate, or the Plan has documented quality of care issues with the provider, the Plan will offer the member an in-network alternative. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the COC process, the member maintains the right to file a grievance.

Finding: The Plan does not have a process to ensure a good faith effort to contact the providers and allow for up to 30 calendar days for their response before denying COC requests.

During the interview, the Plan's staff stated, that if the provider is not reached on the same day of the request, the Provider Network Department staff will continue attempts to reach the provider within five working days. If the provider is not responsive after five days, the case will be denied. This process is not in compliant with APL requirements.

Not allowing providers 30 calendar days to respond before denying COC requests may impact or delay member care.

Recommendation: Revise and implement policies and procedures to ensure that the COC process includes a good faith effort to contact the providers and allows for up to 30 calendar days for their response before denying COC requests.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

CATEGORY 4 – MEMBER’S RIGHTS

4.1	GRIEVANCE SYSTEM
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4.1.1 Grievance System Review

The Plan is required to implement and maintain procedures to monitor the member’s grievance system and the expedited review of grievances required under CCR, Title 28, sections 1300.68 and 1300.68.01 and CCR, Title 22, section 53858. (*Contract, Exhibit A, Attachment 14(2)*)

The written record of grievances shall be reviewed periodically by the governing body of the Plan, the public policy body created pursuant to section 1300.69, and by an officer of the Plan or their designee. The review shall be thoroughly documented. (*CCR, Title 28, section 1300.68 (b)(5)*)

Finding: The Plan did not ensure the periodic review of the written log by the Plan’s board of directors, public policy body and the designated officer.

The Plan has not updated its grievance policies and procedures to reflect the CCR, Title 22, section 53858 requirement. During the interview, the Plan stated, that their governing body reviewed grievance trends and patterns but not the whole grievance logs on a quarterly basis.

The Plan’s governing body, public policy body and the designated officer or designee did not document and attest to a review of the written record of grievances. The lack of review could affect the Plan’s ability to make timely interventions to remedy problems identified and provide quality of care and services to its members.

Recommendation: Develop and implement a process to ensure the periodic review of the grievance record by the Plan’s governing body, public policy body, and by an officer of the Plan or their designee.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

4.1.2 Acknowledgement Letters

The Plan is required to implement and maintain a Member Grievance System in accordance with CCR, Title 28, section 1300.68 and 1300.68.01, CCR, Title 22, section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c). (*Contract, Exhibit A, Attachment 14(1)*)

The Plan is required to respond to grievances with a written acknowledgment within five calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance. (*CCR, Title 28, section 1300.68 (d)(1)*)

The Plan's policy, *GRV02 Grievance Procedures* (revised 10/1/2021), requires the Plan to include the contact information of the representative responsible for processing the grievance to be included in the acknowledgement letters sent to the member.

Finding: The Plan's acknowledgement letters did not contain the name of the person who was responsible for processing a member's grievance request.

The Plan's grievance policy does not specify to provide the name of the person responsible for a grievance in the acknowledgement letters. This policy is not consistent with the contract requirement and regulation.

Not identifying a contact person inhibits the member from contacting the right person regarding their grievance, and may impact their ability to obtain information and make decisions.

Recommendation: Revise and implement the grievance policy and procedures to ensure inclusion of the name of the person to contact about the grievance in the acknowledgement letter.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

CATEGORY 5 – QUALITY MANAGEMENT

5.1 QUALITY IMPROVEMENT SYSTEM

5.1.1 Quality Improvement System Oversight

The Plan is required to implement an effective quality improvement system in accordance with the standards in CCR, Title 28, section 1300.70. The Plan shall have effective oversight to improve the quality of care delivered by all providers rendering services on its behalf, in any setting. (*Contract A10, Exhibit A, Attachment 4(2)*)

The Plan's policy, QM13 *Chief Medical Officer (CMO)/Medical Director Role and Responsibility to the Quality Improvement Program* (revision 12/2020), states that the CMO is responsible for the oversight of the Plan's Medical Directors and ensuring that the medical care provided meets acceptable medical care standards.

The Plan's *Quality Management & Improvement Program Description 2019-2020* internal guide (Health Commission approved 08/28/2019), stated that the Plan's CMO has the ultimate responsibility of oversight for the Quality Management Program. And oversees activities of medical management for safe and effective health care services in conjunction with the Medical Director.

Finding: The Plan did not provide effective oversight to improve deficient quality of care identified in PQI complaints affecting member care.

PQI Verification Study Case examples

- A Medical Director reviewed a provider with a complaint of inappropriate phone triage of a suicidal member. The Plan documented in the case review that this was the second similar incident in the same month affecting this provider. The Medical Director closed the PQI without a complete resolution because the member was no longer with the Plan.
- A general surgeon Medical Director did not review all the available documentation involving the obstetrical care of a member with a retained foreign body after a hysterectomy. There was no documentation by the Medical Director that all the available medical records were reviewed. The case was closed without a recommendation and sent to peer review. A Medical Director with obstetric specialty care only commented in peer review committee on the surgical complication of retained foreign body but did not review the entire medical quality

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

of care of this member including post-delivery care and the identification of a prolapsed uterus and management. There was no review by the obstetric Medical Director on the provider's surgical skills of performing a hysterectomy which required transfusion of two units of packed red blood cells to the member during the procedure, which is not standard of care. The obstetric Medical Director did not comment about the medical necessity of a non-emergent hysterectomy and why other less invasive management options were not documented as being provided to the member.

- A Medical Director failed to review the entire PQI case involving a member that fell at a skilled nursing facility with an eight hour delay in receiving medical care. The Medical Director during the interview stated that the documentation by the Plan's concurrent review nurse assessment of the fall implied that the fall was due in part to a language barrier at the facility and was not reviewed by the Medical Director. This led to a lower severity scoring and minimal intervention by the Plan.
- A Medical Director reviewed a PQI involving a pain clinic. During the interview, the Medical Director stated that a full assessment of the available medical records of this member was not reviewed entirely so the overall quality of care and medical necessity of repeated spinal procedures or medical management was not adjudicated. Only the documentation involving the procedure with a complication was reviewed but the overall quality of care delivered to the member was not reviewed.

During the interview, the CMO stated that they did not routinely review the Medical Directors' adjudications of PQIs involving the quality of care complaints by members. The CMO did not ensure that members' quality of care concerns were adjudicated completely.

A lack of oversight of the Plan's PQI process led to quality of care complaints against providers to be closed prematurely and inadequately reviewed. The Plan missed opportunities to intervene or further investigate providers with suspected poor quality of care. This affects members, leaving them with potential exposure to providers with unaddressed quality of care concerns.

Recommendation: Ensure effective oversight to improve deficient quality of care identified in PQI complaints.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2 FRAUD AND ABUSE

6.2.1 Suspected Fraud and Abuse Reporting to DHCS

Contractor shall meet the requirements set forth in CFR, Title 42, section 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. 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 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 Contractor first becomes aware of, or is on notice of, such activity. (*Contract A10, Exhibit E, Attachment 2(26)(B)(4)*)

The Plan's policy, *CMP05 Fraud, Waste and Abuse (FWA) Policies and Procedures* (revised 03/04/2021), states that "HPSJ must report to DHCS, the California Department of Justice (DOJ) and any other applicable regulatory agencies, all cases of suspected and/or credible FWA when there is reason to believe an incident has occurred. These 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 incidents to DHCS within ten working days of the date when they initially became aware of or received report.

Verification Study Case examples

- Incident one was related to a pain management provider. In 2019, California DOJ, launched an investigation on the pain management provider for fraudulent billing and potential patient harm. The Plan attended a DOJ quarterly meeting and obtained some detailed information about the pain management provider. The Plan provided DOJ the pain management provider's claim data. The Plan became aware that the pain management provider had some issues prior to the DOJ investigation, and started reviewing and monitoring the provider's drug utilization patterns and how many patients the pain management provider's rendering providers treated per day. Despite the Plan being aware of FWA issues with this provider for the audit period, the Plan did not submit an MC 609 form and report the incidents to DHCS.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Joaquin

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DATE OF AUDIT: December 6, 2021 through December 17, 2021

- Incident two was related to a diagnostics provider. On 6/11/2019, a whistleblower reached out to the Plan and reported several fraudulent activities against the provider such as up coding, providing services that were not medically necessary, and professional misconduct in genetic testing. The Plan did an investigation on the provider and reported it to DOJ. However, the Plan did not report these incidents related to the provider to DHCS.

The Plan's fraud and abuse policies and procedures were in alignment with the Contract requirements. However, the Plan did not implement its own policy and procedure to report the suspected fraud and abuse incidents within ten working days of awareness of such incidents.

Not reporting incidents to DHCS could lead to provider fraud and abuse, financial losses to the Medi-Cal program, and in some instances may lead to patient harm.

Recommendation: Ensure implementation of the Plan's policy to report suspected fraud and abuse incidents to DHCS within ten working days of becoming aware of such incidents.

MEDICAL REVIEW – NORTH II SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Health Plan of San Joaquin
2021

Contract Number: 03-75801
State Supported Services

Audit Period: July 1, 2019
Through
June 30, 2021

Dates of Audit: December 6, 2021
Through
December 17, 2021

Report Issued: July 29, 2022

TABLE OF CONTENTS

I. INTRODUCTION1

II. COMPLIANCE AUDIT FINDINGS2

I. INTRODUCTION

This report presents audit results for Health Plan of San Joaquin (Plan) State Supported Services Contract No. 03-75801. The State Supported Services Contract covers contracted abortion services with the Plan.

The audit was conducted from December 6, 2021 through December 17, 2021. The audit period was July 1, 2019 through June 30, 2021 and consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on June 1, 2022. There were no deficiencies found.

❖ **COMPLIANCE AUDIT FINDINGS (CAF)** ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2019 through June 30, 2021

DATE OF AUDIT: December 6, 2021 through December 17, 2021

STATE SUPPORTED SERVICES

The Plan's policies and procedures, Provider Manual, and Member Handbook were reviewed for the provision of State Supported Services.

The Plan had policies and procedures in place to provide abortion services to members. Members are informed of these services through the Member Handbook. Providers are informed of their responsibility to provide abortion services without prior authorization through the Plan's Provider Manual.

A verification study of 14 State Supported Service claims was conducted to determine appropriate and timely adjudication of claims. There were no systemic compliance issues identified in the verification study.

There were no deficiencies identified in this audit.

Recommendation: None