

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**

2021

Contract Number: 18-95314

Audit Period: September 1, 2020
Through
June 30, 2021

Report Issued: October 20, 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) 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. An audit was conducted in accordance with Welfare and Institutions Code, section 14456.

As of July 31, 2021, CKC served 385 members.

II. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS Medical Review Branch 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 review was conducted from August 23, 2021 through August 27, 2021. 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 Plan Administration and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: Five medical and five pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members.

Appeals Procedures: One prior authorization appeal was reviewed for appropriate and timely adjudication. The Plan received only one appeal during the audit period.

Category 2 – Initial Health Assessment

Initial Health Assessment (IHA): Due to the All Plan Letter (APL) 20-004, *Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19*, there was no sample selected for review. During the interview, one medical record was reviewed for timeliness and completeness of the IHA requirements. The audit also tested the Plan's procedures to track IHA outreach attempts.

Category 4 – Member's Rights

Grievance Procedures: One grievance was reviewed for timely resolution, response to complainant, and submission to the appropriate level of review. The Plan only received one standard grievance during the audit period.

Category 5 – Quality Management

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

III. EXECUTIVE SUMMARY

DHCS conducted an audit of the Plan from August 23, 2021 through August 27, 2021. This reports presents the results of the DHCS limited scope medical audit for the period of September 1, 2020 through June 30, 2021. The audit focused on the prior audit findings and consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was offered on October 11, 2021. The Plan declined to hold an Exit Conference, as there were no areas of noncompliance found in this review.

The audit evaluated five categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member Rights, and Quality Management.

Implementation of Prior Year Audit Recommendations

The prior DHCS medical audit identified deficiencies for the period of September 1, 2019 through August 31, 2020. The Plan addressed the deficiencies in a Corrective Action Plan (CAP). The CAP closeout letter dated June 4, 2021 noted that all previous findings were closed.

The following sections below presents the prior audit findings and the corrective actions the Plan implemented to resolve those deficiencies.

Category 1 – Utilization Management

Appeal Acknowledgement Letter

The prior year audit found that the Plan did not adhere to APL 17-006, *Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments*, 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 implemented the recommendation from the prior year audit by updating its appeals acknowledgement letter. The Plan’s revised acknowledgement letter contained the name of the designated individual and the phone number for the member to contact with any questions or concerns.

Notice of Appeal Resolution

The prior year audit also found the Plan did not fully translate the Notice of Appeal Resolution (NAR) letter to the member’s preferred language.

To correct this deficiency, the Plan updated its Standard Operating Procedures (SOP), *CKC UM Appeal SOP 01.2021* (revised January 2021). The procedures include

translation of the paragraph containing the member's information and decision in the NAR letter, prior to mailing the letter to the member.

The Plan has a small and specific population of members who have complex and chronic medical conditions. The Plan stated that efforts by the CKC Care Navigation Team contributed to a lack of member appeals following the Plan's implementation of corrective actions. Comprised of registered nurses, the Plan's CKC Care Navigation Team contacted and coordinated care for a small and specific population of members with complex and chronic medical conditions.

Category 2 – Case Management and Coordination of Care

Monitoring of Completed Initial Health Assessment

In the 2019 DHCS medical audit, the Plan lacked 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 Individual Health Education Behavioral Assessment (IHEBA). The 2020 DHCS medical audit found that the Plan revised policy CKC-112, *Individual Health Education Behavioral Assessment* (revised in June 2020) and developed the *IHA Tracking Grid* to identify pending or incomplete IHA. However, there was no mention of the Plan's method to review medical records to ensure that practitioners performed and documented a timely and complete IHA that includes the IHEBA.

During the audit period, the Plan implemented the recommendations from the prior years' audit. The Plan conducted provider training to further educate the providers on the IHA requirements and documentation.

The Plan also updated policy CKC-112, *Individual Health Education Behavioral Assessment (IHEBA)* (revised January 2021), to reflect the new chart review process and applicable oversight reporting. The chart review process utilizes the *IHA Tracking Grid*, which was developed in the prior audit to check for all of the components within an IHA including IHEBA.

Provision of IHA

Additionally, the prior year audit found the Plan did not contact members nor document its repeated attempts to contact members to schedule an IHA within 120-calendar-days of enrollment.

As part of the CAP, the Plan updated policy CKC-112, *Individual Health Education Behavioral Assessment (IHEBA)* (revised January 2021), to include the procedures for conducting member outreach attempts within 120-calendar-days of enrollment.

The Plan implements various outreach methods for IHA completion. The Plan stated that it contacts providers of the newly assigned members, within ten days of the eligibility notification, to educate them of the IHA requirements and to provide them with the members' demographic information. The Plan also sends the member packet that

contains a welcome letter informing members on how to schedule an IHA. The Plan revised its welcome letter to include an emphasis on the importance of completing an IHA. The Plan's CKC Care Navigation Team also made attempts to educate and schedule IHAs during the onboarding calls with the members. The Plan tracked the members' IHA completion on a monthly basis. If the Plan found an IHA was not completed, then the Plan contacted the members via follow-up phone calls and/or through the Plan's member portal, no less than three times. The Plan tracked all of the outreach attempts in the updated IHA spreadsheet tracking grid and reported the findings to the Plan's Joint Quality Team, Delegation Oversight, and Quality of Care committees.

While APL 20-004, *Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19*, allowed for plans to defer the completion of the IHA until the end of the public health emergency, the Plan was able to demonstrate a complete and comprehensive IHA was performed during the audit period.

Category 3 – Access and Availability of Care

Telephone Triage Procedures

The prior year audit found that the Plan did not monitor provider telephone triage procedures nor did it monitor whether the after-hours telephone triage lines were answered by appropriate licensed professionals.

The Plan updated policy CKC-067, *After-Hours Phone Coverage* (revised February 2021), to include a procedure that allows families to reach licensed professional providers and their specialist 24 hours a day, seven days a week by contacting the Plan's operators directly.

The Plan tracked staff assignments and provided the specialty providers' monthly on-call schedules as evidence that members have access to licensed professional staff for after-hours assistance.

The Plan also began to utilize its CKC after-hours phone coverage survey, an audit tool developed in the prior audit, to monitor the specialty providers/licensed professionals taking the after hour calls. The annual survey tested for compliance in areas such as timeliness and accessibility to a provider in urgent situations.

Due to the complexity of the members' diseases, the Plan stated that the specialists preferred and opted to directly address the members' health concerns instead of asking members to utilize the Plan's nurse triage services. Although the specialists communicated their preference for members to contact them directly, the Plan continued to develop policies and procedures to give members the option of contacting the Plan's nurse triage services whether in cases when specialists cannot be reached or in situations when members prefer to speak with the triage nurse.

Plan Network Hospitals

The prior year audit found the Plan did not have a procedure in which every network hospital is made aware of the emergency medication dispensing requirement. The Plan updated policy CKC-154, *72-hour Emergency Prescription* (revised February 2021), to include a notification letter to be sent to all Plan network hospitals on an annual basis. The letter contained information regarding the 72-hour supply of medically necessary covered outpatient drugs.

The Plan's Care Navigation Team monitored members that had been seen and discharged from the emergency department. The Plan followed up with members by phone to ensure that they had received their 72-hour supply of medication. If the member had not received their prescription, the Plan would make arrangements for the member to obtain their medication and subsequently send a notification letter to the network hospital that did not comply with the requirement. During the audit period, the Plan found that all of their members received a 72-hour supply of medication after being discharged from the emergency room.

Category 4 – Member's Rights

Tracking and Monitoring Grievance

The prior year audit found 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 captured all expressions of dissatisfaction and appropriately classified or categorized the grievances received.

To correct the deficiency, the Plan revised its SOP, *CKC Grievance Processing* (revised February 2021), to track and monitor all grievances received. The Plan will collect all expressions of dissatisfaction and log it in the Plan's tracking system. Subsequently, this information will be utilized by the Plan to gather grievance data for requested DHCS reporting requirements.

During the audit period, the Plan also trained its customer service staff using the revised SOP and developed a new workflow chart, which contained grievance definitions, timeframes, and procedures. The Plan stated that most of their grievances are received from the Plan's care navigators. These clinicians reviewed the grievances for proper categorization.

As previously mentioned, the Plan has a small and specific population of members. The actions taken by the nurse care navigator staff support member needs, provide proactive intervention for high risk cases, and care navigation for chronic conditions. The Plan did not have any member grievances after the implementation of the corrective actions.

Breaches and Security Incidents

The prior year audit found the Plan did not notify DHCS regarding the discovery of suspected security incidents, intrusion or unauthorized access, use or disclosure of

protected health information or personal information, 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 DHCS Program Contract Manager and DHCS Information Security Officer.

To address this prior audit finding, the Plan modified its policy CPM 11-100, *Privacy Breach Reporting* (approved March 2021), to provide additional direction in health plan reporting. The policy contains timelines and the appropriate contact information when reporting any potential breach or security incident to DHCS.

The Plan utilized an online safety reporting system to document suspected and/or confirmed incidents. While no breaches were reported during the audit period, the Plan’s Compliance Department had a calendaring system in place to ensure that the Plan meets its reporting deadlines.

Category 5 – Quality Management

New Provider Training

In 2019, the DHCS audit found the Plan did not provide training to new providers within the contractual timeframe. The 2020 DHCS audit found that while the Plan revised its policy CKC-020, *Credentialing and Recredentialing* (revised June 2020), the Plan did not ensure all new network providers returned a signed attestation to confirm receipt of the new provider training.

In the current audit, the audit team found the Plan developed a new provider training workflow to capture and monitor all of the new provider training attestations. The process included the identification of staff responsibilities, monitoring and reporting of the completed and missing attestations to the Plan committees.

The Plan also created a tracking grid to document the receipt of the attestations and the outreach attempts made for missing attestations. The Plan developed a monthly report, based on the tracking grid, and reported the outcomes to multiple committees.

A verification study of the new provider training confirmed the effectiveness of the Plan’s CAP. The Plan implemented the recommendations from the prior audits as all new providers had received training within ten-working-days after being placed on active status during the audit period.

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DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

**Rady Children's Hospital –
San Diego**

2021

Contract Number: 18-95367
State Supported Services

Audit Period: September 1, 2020
Through
June 30, 2021

Report Issued: October 20, 2021

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II. COMPLIANCE AUDIT FINDINGS2

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, 2020 through June 30, 2021. The review was conducted from August 23, 2021 through August 27, 2021, which consisted of a document review of materials provided by the Plan and interviews with the Plan's administration and staff.

An Exit Conference with the Plan was offered on October 11, 2021. The Plan declined to hold an Exit Conference, as there were no areas of noncompliance found in this review.

An audit was conducted in accordance with Welfare and Institutions Code, section 14456.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Rady Children’s Hospital – San Diego

AUDIT PERIOD: September 1, 2020 through June 30, 2021

DATE OF AUDIT: August 23, 2021 through August 27, 2021

STATE SUPPORTED SERVICES

The Plan must 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, and Z0336. (*State Supported Services Contract, Exhibit A(1)*)

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 services” 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.

The Plan’s Member Handbook/Evidence of Coverage informs members of their rights to access abortion services, and abortion-related procedures without prior authorization and through a physician or clinic of members’ choice under strict confidentiality. The Plan informs providers about abortion services through the Provider Manual. Both documents are available on the Plan’s website.

The audit found no discrepancies in this section.

RECOMMENDATION(S): None