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

REPORT ON THE MEDICAL AUDIT OF

Contra Costa Health Plan

Contract Number: 04-36067

Audit Period: May 1, 2019
Through
April 30, 2020

Report Issued: December 21, 2020

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I. INTRODUCTION

Since 1984, Contra Costa Health Plan (Plan) has contracted with the State of California to provide health care services to Medi-Cal beneficiaries in Contra Costa County. The Plan is a county sponsored Health Maintenance Organization. The Plan is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act. The Contra Costa County Board of Supervisors exercises oversight of the Plan through a Joint Conference Committee.

In October 1996, the State of California contracted with the County of Contra Costa as the Local Initiative under the two-plan model to provide managed care services to Medi-Cal beneficiaries under the provisions of Welfare and Institutions Code, section 14087.3. The Plan received approval from the State to begin operations and commenced enrollment as the Local Initiative for Contra Costa County on February 1, 1997.

The Plan contracts with individual network providers, Contra Costa Regional Medical Center, and Kaiser Permanente to provide or arrange comprehensive health care services. The Plan provides health care for public and private employee groups, private individuals, Medi-Cal and Medicare beneficiaries, and low-income county residents.

As of April 30, 2020, the Plan had 180,550 members of which 172,356 were Medi-Cal including 14,630 Seniors and Persons with Disabilities (SPD) members. The Plan also covers county employees (5,742), commercial (2,240), and uninsured recipients (212).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of May 1, 2019 through April 30, 2020. The onsite review was conducted from August 17, 2020 through August 28, 2020. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on November 19, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, 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 June 1, 2018 through March 31, 2019 was issued on September 19, 2019. This audit examined documentation for compliance and to determine to what extent the Plan has implemented in regards to their Corrective Action Plan.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

Category 1 covers procedures and requirements for the Plan's Utilization Management (UM) program, including delegation of UM, prior authorization review and the appeal process.

The Plan is required to ensure that there is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. The Plan is required to ensure decisions for concurrent review shall be made within five working days or less. Decisions for routine authorizations shall be made within five working days but no longer than 14 calendar days from the receipt of the request. The decision may be deferred and extended an additional 14 calendar days only when it is in the member's best interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. Decisions for retrospective review shall be made within 30 calendar days.

The Plan used incorrect criteria to deny medical service requests. The Plan did not process routine, concurrent, and retrospective service requests within required time frames.

The Plan must inform the member of the limited time available to present evidence in person and in writing, sufficiently in advance of the resolution timeframe for expedited appeals. The Plan did not inform members of the limited time available to present evidence or testimony in person or in writing sufficiently in advance of the appeal resolution for expedited appeals.

If the Plan delegates UM functions, the Plan and the delegated entity are required to include specific delegated functions and activities of the Plan and delegate in their subcontract. The Plan did not include UM responsibilities and specific delegated functions and activities in the subcontract.

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities that at a minimum ensures subcontractor meets standards set forth by the Plan and DHCS. The Plan did not ensure that a delegate used appropriate processes to review and approve the provision of medically necessary covered services.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to provide Initial Health Assessments (IHAs) to new members, Health Risk Assessments (HRA) for SPD and the provision of mental health and substance abuse services.

The Plan is required to use a risk stratification mechanism or algorithm to analyze member specific data and to identify newly enrolled SPD members in higher risk groups with more complex health care needs and lower risk groups within 44 days of enrollment. Based on the results of the health risk stratification, the Plan is required to administer the DHCS - approved HRA survey within 45 days for SPD members deemed to be at higher health risk. The Plan must use the HRA to comprehensively assess each newly enrolled SPD members' current health risk, re-classify members as higher or lower risk and initiate care plans for those who have been identified as high risk members based on the HRA.

The Plan did not conduct a stratification analysis to identify newly enrolled SPD members as higher or lower risk. The Plan did not conduct HRAs within the required 45-day time frame for newly enrolled members identified as higher risk. The Plan did not comprehensively assess each newly enrolled SPD member's current health risk based on the HRA or initiate care plans for members identified as higher risk based on HRA results.

The Plan did not ensure that all providers performed and documented required components of an IHA: comprehensive history and physical, complete Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA), and preventive services identified as U.S. Preventive Services Task Force (USPSTF) “A” & “B” recommended services.

The Plan shall execute a Memorandum of Understanding (MOU) with the local county mental health plan (MHP). The MOU must describe a review process to facilitate timely resolution of clinical and administrative disputes. The Plan’s MOU with the county MHP did not describe a review process for timely resolution of clinical and administrative disputes regarding mental health and other covered services.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding access to care, Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for medically necessary services, and the adjudication of claims for Emergency Room services and Family Planning services.

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in the network provider offices, telephone calls (to answer and return), and waiting times to obtain first prenatal visit appointments that need to be available within two weeks upon request. The Plan did not implement its procedures to monitor wait times at provider’s offices and wait times to answer and return telephone calls. The Plan’s procedures to monitor the first prenatal appointment did not accurately measure the Plan’s ability to ensure appointments are available within two weeks upon request.

The Plan shall not improperly deny or contest a claim or portion thereof. The Plan is required to include interest with the late payment of emergency service claims at either $15 for each 12-month period or 15 percent per year for the period that the payment is late, whichever is greater. The Plan improperly denied an entire family planning claim when a single service in the claim was billed incorrectly and did not include interest with its late payment of emergency service claims.

The Plan is required to cover transportation services as required in the Contract and directed in All Plan Letter (APL) 17-010 to ensure members have access to medically necessary services. The Plan is required to ensure contracted network providers are enrolled in the Medi-Cal program, use a DHCS-approved NEMT Physician Certification Statement (PCS) form to determine the appropriate level of service for members, and ensure all necessary written consent forms are received prior to arranging transportation for unaccompanied minors. The Plan did not ensure contracted NEMT providers were enrolled in the Medi-Cal program and did not use a DHCS-approved PCS forms or a transportation service request form that included all the required components for determining the appropriate level or service. The Plan did not collect written consent forms for unaccompanied minors requiring NEMT and NMT services.

Category 4 – Member's Rights

Category 4 includes the requirements for handling of grievances, Protected Health Information (PHI) and a Cultural and Linguistics Services Program.

The Plan is required to establish and maintain written procedures for submittal, processing, and resolution of all grievances. A complaint is the same as a grievance. When the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. Exempt grievances are expressions of dissatisfaction received over the telephone that are not coverage disputes and disputed health care services involving medical necessity that are resolved by the next business day. Resolved means that the grievance has reached a final conclusion with respect to the member's submitted grievance. Grievances related to medical quality of care issues are required to be referred to the Plan's Medical Director.

The Plan's grievance system had significant systemic deficiencies in capturing and identifying grievances, processing grievances, and addressing problems identified. Captured grievances were either inconsistently classified as exempt or were not fully resolved. Quality of care issues were not referred to the Medical Director for review.

The Plan is required to conduct a thorough background check of employees before the Plan's employee may access DHCS PHI. The Plan did not ensure that all employees with PHI access had complete background checks

Category 5 – Quality Management

Category 5 includes requirements to maintain an effective quality improvement system (QIS), including delegation of quality improvement and provider training.

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers. The Plan did not thoroughly investigate and evaluate Potential Quality Issues (PQIs) prior to closing cases.

The Plan is required to include in their subcontract specific delegated functions and activities of the Plan and delegate. The Plan did not describe specific delegated quality improvement activities and reporting requirements for PQI investigations in the delegation agreement with one delegate. The Plan did not specify training responsibilities for newly contracted providers in written agreements with four delegates.

The Plan is required to collect and review the subcontractors' ownership and control disclosure information. The Plan did not ensure collection and completion of ownership and control disclosure forms.

The Plan is required to conduct training for all network providers within ten working days after it places a newly contracted Network Provider on active status. The Plan did not ensure it conducted provider training for all newly contracted providers within ten working days after placement of active status.

Category 6 – Administrative and Organizational Capacity

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

The Plan may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. Each subcontract shall contain specification of the services to be provided by the subcontractor. The Plan's written agreement with a delegate did not specify the delegate's responsibility to provide and evaluate health education services.

The Plan is required to implement and maintain policies and procedures to investigate potential compliance problems and conduct, complete, and report to DHCS, the results of a preliminary investigation of suspected fraud and/or abuse within ten working days of the date the Plan first becomes aware. The Plan did not investigate all identified suspected fraud, waste or abuse issues and did not report all suspected fraud, waste or abuse cases to DHCS within ten working days.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The onsite review was conducted from August 17, 2020 through August 28, 2020. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. Documents were reviewed and interviews were conducted with the Plan's administrators, staff, providers, and delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 24 medical prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: Ten prior authorization appeals were reviewed for appropriate and timely adjudication.

Delegated prior authorization requests: Nine prior authorization cases from a single delegate were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

IHA requirements: 15 medical records were reviewed to confirm coordination of care and fulfillment of IHA requirements.

HRA requirements: 30 files were reviewed to confirm coordination of care and fulfillment of HRA requirements.

Category 3 – Access and Availability of Care

Claims: 20 emergency services and 17 family planning claims were reviewed for appropriate and timely adjudication.

NMT: 22 claims were reviewed for timeliness and appropriate adjudication.

NEMT: 15 claims were reviewed for timeliness and appropriate adjudication. Contracted NEMT providers were reviewed for Medi-Cal enrollment.

Category 4 – Member's Rights

Grievance procedures: 83 grievances, including 42 quality of service, 20 quality of care, ten exempt, one expedited and ten inquiries were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality rights: Ten Health Insurance Portability and Accountability Act/PHI breach and security incidents were reviewed for processing and timeliness requirements.

Background check verification: 16 samples were reviewed to determine if appropriate procedures were performed.

Category 5 – Quality Management

New provider training: 36 new provider training records were reviewed for timely Medi-Cal managed care program training.

PQI: Seven PQI cases were reviewed for timely evaluation and effective action taken to address needed improvements.

Category 6 – Administrative and Organizational Capacity
Fraud and abuse: Eight cases were reviewed for compliance of procedures to guard against fraud and abuse.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: May 1, 2019 through April 30, 2020
DATE OF AUDIT: August 17, 2020 through August 28, 2020

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW

1.2.1 Written Criteria or Guidelines for Medical Prior and Concurrent Authorizations

The Plan shall ensure that there is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. (*Contract, Exhibit A, Attachment 5(2) (D)*)

The Plan shall ensure that the covered services and other services required in this Contract are provided to a Member in an amount no less than what is offered to beneficiaries under fee-for-service (FFS). The Plan has the primary responsibility to provide all medically necessary covered services, including services which exceed the services provided by local education agencies, regional centers, or local governmental health programs. (*Contract, Exhibit A, Attachment 10(1)*)

The Plan's policy *UM 15.002 Utilization Review Criteria and Guidelines (reviewed 2/28/19)* stated that written clinical criteria or guidelines are used in the utilization review process to ensure consistent review and decision-making by the UM staff. The clinical criteria and guidelines utilized by the UM staff may be product line specific, evidence-based, and/or derived from standards respected in the health care industry.

Finding: The Plan used incorrect criteria to deny medical service requests.

The verification study of 24 medical service requests and ten service requests from the appeals files determined the following:

- Four cases were requests for speech therapy for pediatric members. The decision makers used Apollo criteria instead of Medi-Cal Early and Periodic Screening Diagnostic and Treatment (EPSDT) criteria.

- One case was a request for physical therapy for a pediatric member. The decision-maker used Apollo criteria instead of Medi-Cal (EPSDT) criteria.

- One case was a request for admission for pulmonary hypertension and right sided heart failure. The decision maker used InterQual criteria for left sided heart failure instead of for right sided heart failure.

- One case was a request for a mental health evaluation prior to gastric bypass surgery. The decision maker used a combination of Medi-Cal and commercial criteria. In this case, the criteria the Plan used was more restrictive than the Medi-Cal FFS criteria.

When asked about speech therapy, the Plan stated they were unaware of the requirements for coverage of EPSDT services for members <21 years old. In their August 2019 meeting, medical consultants discussed speech therapy criteria but arrived at an incorrect interpretation of coverage. The minutes stated that speech therapy for members three years old to 18 years old was covered through the school system and the Plan would consider coverage only if the school system denied it. For the case of the member with right sided heart failure the Plan agreed that they used the incorrect criteria. Lastly, in the case that involved a request for mental health evaluation prior to gastric bypass surgery, the Plan stated that they discussed the criteria in the medical consultant March 2019 meeting and came to a consensus to use specific quantitative requirements for weight loss program attendance. However, this was more restrictive than the Medi-Cal FFS criteria. The same incorrect criteria for mental health evaluation prior to gastric bypass surgery was being used during the prior audit.

As a corrective action to the prior audit finding, the Plan included a standing item to their UM committee meetings to discuss any changes to criteria (Interqual and Apollo) and to discuss new DHCS APLs. In addition, the Plan contracted with a vendor in August 2019 to utilize the vendor's criteria and guidelines for the Plan's decision making process. The Plan also revised policy *UM 15.002* which now stated that the physician who was the ultimate decision maker would verify that the nurse who chose the criteria had made the correct choice. The Plan's medical consultants also reviewed various criteria and policies in their monthly medical consultants' work group meetings. Furthermore, part of their inter-rater reliability process was to determine if the correct criteria was used. The Plan implemented its corrective actions; however, the deficiency was not corrected.

If incorrect or outdated criteria is used to make medical determinations, there is a risk that members will be inappropriately denied services, which could lead to poor health outcomes.

This is a repeat of the prior year finding 1.2.2 - Written Criteria or Guidelines for Medical Prior Authorization.

Recommendation: Implement policies, procedures, and effective corrective actions to ensure that all UM staff use updated, correct and appropriate criteria to make medical authorization decisions. When using a hierarchy of criteria, ensure that Medi-Cal criteria is used first. Criteria should be based on sound medical evidence, consistently applied, regularly reviewed, and updated.

1.2.2 Time Frames for Medical Authorization

The Plan shall ensure that decisions for concurrent review of authorization for treatment regimen already in place shall be made within five working days or less, consistent with urgency of the member's medical condition and in accordance with *Health & Safety Code section 1367.01(h)(3)*, or any future amendments thereto. (*Contract, Exhibit A, Attachment 5(3) (D)*)

Decisions for routine authorizations shall be made within five working days but no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only when it is in the member's best interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. (*Contract, Exhibit A, Attachment 5(3) (G)*)

Decisions for retrospective review shall be made within 30 calendar days. (*Contract, Exhibit A, Attachment 5(3) (E)*)

Plan policy *15.015a Timeliness of the Utilization Review Decision and Communication (reviewed 2/28/19*) stated, upon receipt of all necessary information, decisions affecting routine care shall be made within five business days or within a time frame appropriate for the enrollee's condition, but no later than 14 calendar days unless a time frame extension is required. Upon receipt of current clinical information, decisions affecting inpatient or ongoing ambulatory care that is already in place shall be made within 24 hours (for urgent concurrent care). Decisions affecting retrospective care, including reimbursement requests shall be made no later than 30 days from receipt of the authorization request.

Finding: The Plan did not process routine, concurrent, and retrospective service requests within required time frames. The Plan did not consistently apply its policy regarding timeliness of utilization review decisions.

A verification study showed the following were not processed within the required time frames:

- Four of 17 routine service requests were processed between 31 and 35 calendar days
- One of three concurrent service requests was processed in ten days
- One of two retrospective requests was processed in 31 days

In interviews, the Plan acknowledged challenges with meeting service request time frames. As a corrective action to the prior year's findings, the Plan revised its process to have clerks convert service requests into electronic format; this task was previously the responsibility of the Health Plan Authorization Representatives and often delayed the processing of service requests 5 to 14 days. The Plan also implemented a turnaround time tracking dashboard to monitor open service requests with due dates for each request in August 2020. The Plan's corrective action did not correct the prior year's finding.

If medical authorizations are not determined in a timely manner, this may lead to a delay in providing necessary care for members, which could lead to poor health outcomes.

This is a repeat of the prior year finding 1.2.6 - Timeframes for Medical Authorization.

Recommendation: Implement policies, procedures, and corrective actions to ensure that UM staff follow correct time frames for processing all service requests.

1.2.3 Notice of Action (NOA) "Your Rights" attachment

The Plan must give members timely and adequate notice of an adverse benefit determination in writing. (*Code of Federal Regulations* (*CFR), Title 42, section 438.404(a)*)

Effective July 1, 2017, the Plan shall utilize the revised NOA templates and corresponding "Your Rights" attachments included in this APL. The Plan shall not make any changes to the NOA templates or "Your Rights" attachments without prior review and approval from DHCS, except to insert information specific to beneficiaries as required. (*APL 17-006*)

Plan policy *15.015a Timeliness of the Utilization Review Decision and Communication (reviewed 2/28/19*) stated that part of the documentation required in their written communication to members and providers included grievance, Independent Medical Review (IMR), and "Your Rights" attachment. The "Your Rights" attachment provided by DHCS was included in the policy.

Finding: The Plan did not update the information included in the "Your Rights" attachment sent with NOA letters, specifically for concurrent cases.

A verification study showed that two of three concurrent cases had NOA letters with "Your Rights" attachments that included outdated information. The form stated that the member could file an appeal with the Plan and ask for a State Hearing at the same time. However, new federal regulations require beneficiaries to exhaust the Plan's internal appeal process and receive notice that the Adverse Benefit Determination has been upheld prior to proceeding to a state hearing. It also stated that a grievance needed to be filed within 180 days from the day of incident or action instead of anytime. It did not include general information on the IMR rights.

As a corrective action to the prior audit finding, the Plan updated the NOA "Your Rights" attachment and revised policy *UM 15.015a.* The revised policy demonstrated the updated information and was listed under "documentation required in written communication" for prior authorization, concurrent and retrospective denials. However, although the attachment and policy were updated, the verification study demonstrated that these changes were not implemented for concurrent NOA letters.

If written member information is not updated, members may be prevented from filing appeals or grievances timely. The potential outcome is denial of necessary services and delayed provision of health care.

This is a repeat of the prior year finding 1.2.7 - Notice of Action "Your Rights" Attachment.

Recommendation: Implement policies, procedures, and corrective actions to ensure that current NOA "Your Rights" information is sent to members and providers.

1.3 APPEAL PROCEDURES

1.3.1 Member Notice to Present Evidence/Testimony for Expedited Appeals

The Plan "must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, sufficiently in advance of the resolution timeframe" for expedited appeals. (*Contract, Exhibit A, Attachment 14(6) (B)*)

The Plan's *Member Appeals Committee Charter* stated that "CCHP members/ recipients and/or their appointed representative are informed in advance of the meeting of their right to attend this meeting to present their case. The appeal acknowledgement letter provides a phone number for the member/recipient or appointed representative to call for meeting information."

The Plan's policy *Member Services Policy MS 8.018 Appeal Process for Medi-Cal Members (revised 10/19*) stated that "A member who files an expedited appeal will receive an acknowledgment letter within 24 hours in their preferred language. This letter will include: The right of the member to present additional relevant information."

Finding: The Plan did not inform members of the limited time available to present evidence or testimony in person or in writing sufficiently in advance of the appeal resolution for expedited appeals.

A verification study showed that in three out of three expedited appeals, the Plan did not inform members of the right to present testimony or evidence sufficiently in advance of the Appeals Committee meeting where appeals determinations were conducted.

- In two expedited appeals cases, the Plan faxed acknowledgement letters to the providers who filed the expedited appeal on the members' behalf. The acknowledgement letters did not explain how the members could provide additional evidence or testimony at the Appeals Committee meeting or in writing.

- In one expedited appeals case, the Plan notified the member of the right to present testimony at that day's Appeals Committee meeting through a voicemail and email sent less than one hour prior to the scheduled meeting.

These cases were discussed with the Plan during the audit interview. For the two expedited appeals cases, the Plan's documentation did not show evidence that members were provided complete information about the expedited appeal process.

When members are not notified of the limited time to present evidence and testimony sufficiently in advance of the resolution, members may miss the opportunity to submit adequate evidence for appeals resolution. The decision maker may not have sufficient information to make a fully informed decision, which could lead to upheld denials of necessary services.

Recommendation: Develop and implement policies and procedures to ensure timely member notification of the right to present additional evidence or testimony sufficiently in advance of the appeal resolution for expedited appeals.

1.3.2 Written Criteria for Appeals

The Plan shall ensure that covered services are provided to a member in an amount no less than what is offered to beneficiaries under fee-for-service Medi-Cal. (*Contract, Exhibit A, Attachment 10(1) (A)*)

The Plan shall cover and ensure provision of screening, preventive and medically necessary diagnostic and treatment services for members under 21 years of age including services listed under 42 U.S. Code Section 1396d(r). Early and periodic screening, diagnostic, and treatment (EPSDT) services include services to correct or ameliorate defects, physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan *(Contract, Exhibit A, Attachment 10 (5) and* (*U.S. Code, Title 42, Section 1396d(r))*

The Plan shall ensure "there is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated." *(Contract, Exhibit A, Attachment 5 (2) (D)).*

Plan policy *UM 15.002 Utilization Review Criteria and Guidelines (revised 1/2019)* stated, evidence based written clinical criteria are used in the utilization review process. In addition, Medi-Cal criteria are used as first priority for elective admissions, specialty care referrals, and outpatient and ancillary services.

Finding: The Plan upheld denials for appeals determinations based on the use of incorrect or unclear written criteria that were more restrictive than Medi-Cal FFS criteria.

A verification study showed that criteria that did not align with Medi-Cal criteria were used to uphold denials in two out of ten appeals cases.

- In one case, the Plan upheld the denial for a mental health evaluation prior to gastric bypass surgery. The decision maker applied weight management program requirements from the Plan's Commercial gastric bypass surgery policy, which were more restrictive than the Medi-Cal FFS criteria to this Medi-Cal member.

- In another case, the Plan upheld the denial for additional physical therapy for a pediatric member with ongoing pain and symptoms. The Plan applied Apollo criteria which were more restrictive than Medi-Cal's EPSDT services benefit criteria.

For gastric bypass surgery evaluation, the Plan's UM physicians agreed to use the Plan's Commercial policy criteria for Medi-Cal members in March 2019. However, this criteria was more restrictive than the Medi-Cal FFS criteria. For the physical therapy case, the Plan acknowledged that Medi-Cal's EPSDT criteria were not applied and should have been used to overturn the denial of physical therapy services. The Plan stated that the UM physicians were not educated on EPSDT requirements until November 2019; however, the appeal was resolved after this education.

If written criteria that are more restrictive than Medi-Cal criteria are used for appeals determinations, there is a risk of upheld denials of medically necessary services.

Recommendation: Develop and implement policies and procedures to ensure written criteria that align with Medi-Cal criteria are used to make appeals determinations

1.5 DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Delegation Oversight/Specific Delegated Functions

If the Plan delegates quality improvement functions (i.e., Utilization Management (UM)), the Plan and the delegated entity (subcontractor) shall include in their subcontract, at minimum: quality improvement responsibilities, and specific delegated functions and activities of the Plan and delegate. (*Contract, Exhibit A, Attachment 4 (6) (A) (1)*)

Plan policy *QM 14.301 Delegation Oversight Process (revised 8/2/2019)* stated delegation arrangements were part of the contracting process, but did not state subcontracts with delegates must include specific delegated functions.

The *MOU* between a delegate and the Plan stated the purpose of the document was to describe the delivery of mental health services to Medi-Cal beneficiaries served by both entities.

Finding: The Plan did not include in its subcontract with a delegate UM responsibilities and specific delegated functions and activities of the Plan and delegate.

The Plan delegated UM responsibilities for the provision of mild to moderate mental health services but did not have a separate written agreement that specifically described these responsibilities. The Plan instead used its MOU with the subcontractor to describe each entity's responsibilities. The MOU did not describe multiple delegated responsibilities, though the Plan included them as subcontractor responsibilities in its annual audit, and in Plan policy *QM 14.301 Delegation Oversight Process*:

- The MOU did not describe the delegate's responsibility for developing, approving and regularly reviewing UM policies and procedures, an organizational chart for the UM program, a UM Program Description and annual work plan.

- The MOU did not describe how the Plan would ensure qualified behavioral health staff were responsible for the UM Program.

- It did not describe the delegate's responsibility to routinely review and approve evidence-based criteria for making UM decisions about mild to moderate mental health services.

- It did not describe the time frames for making UM decisions.

- It did not describe the delegate's responsibilities for sending member and provider NOA letters using DHCS-required templates, content, and attachments timely for adverse UM decisions.

- It did not describe the requirement that the subcontractor perform Inter-Rater Reliability testing of its UM decision-makers.

The Plan did not delegate appeals about mild to moderate mental health service decisions, and the MOU did not clearly state the subcontractor would forward these to the Plan for resolution.

Plan policies and the *UM Program Description* did not describe the requirement for a delegation agreement specifying UM responsibilities about the delivery of mild to moderate mental health services. In an interview, the Plan stated it agreed with the delegate's decision to revise the MOU to satisfy the requirement.

If a contract or agreement does not describe specific delegated functions and activities, the Plan's delegate may not perform all expected UM responsibilities and may be non-compliant with DHCS and Plan requirements.

Recommendation: Revise the written agreement with the delegate to include specific and contract required UM responsibilities regarding mild to moderate mental health services of both the Plan and the delegate.

1.5.2 UM Delegation Oversight/Ensuring Compliance with DHCS Standards/Mental Health Parity

The Plan shall maintain a system to ensure accountability for delegated quality improvement activities that at a minimum ensures subcontractor meets standards set forth by the Plan and the DHCS. (*Contract, Exhibit A, Attachment 4(6) (B) (2)*)

The Plan must be in compliance with Mental Health Parity requirements in Subpart K, CFR, Title 42, section 438.910. (*APL 17-018*)

The Plan may not impose a process to establish medical necessity for mental health benefits unless it applies comparable processes no more stringently than it does for medical/surgical benefits in the classification (i.e., inpatient, outpatient, emergency care, and prescription drugs). (*CFR, Title 42, section 438.910*)

The 2020 *MOU* between the Plan and a subcontractor stated that both entities would ensure treatment limitations for mental health and substance use disorder benefits were not more restrictive than those applied to medical or surgical benefits.

Finding: The Plan did not ensure a subcontractor met mental health and medical service parity standards established by DHCS. The Plan did not ensure the delegate used comparable processes and applied them no more stringently than those used for providing outpatient medical/surgical benefits.

The Plan's behavioral health delegate provided members experiencing potential mental health disorders with a mental health screening that did not require prior authorization. If a member met screening criteria, the delegate referred the member to an in-network mental health provider, allowing eight outpatient office visits for mental health assessment, diagnosis, and treatment. The delegate required that the mental health provider submit a prior authorization if the member required more than eight visits. For in-network medical outpatient office visits to specialists, with exceptions, the Plan allowed seven visits without initial prior authorization. More than seven visits required a prior authorization.

- Mental health providers who accepted referrals and members for an initial eight mental health visits had to submit a *Behavioral Health Initial Authorization* request, and a *Network Provider Client Registration and Admission* as part of the treatment initiation process and for payment of services. The Plan's *2020 Provider Manual* did not describe a similar requirement for medical specialists who received referrals to treat members; they only had to submit claims for payment after the requesting provider sent a copy of the referral to the Plan and the specialist.

- The Plan's delegate required submission of a five page prior authorization request including patient and provider wet signatures to continue outpatient mild to moderate mental health treatment. The delegate could delay and ultimately deny service requests missing wet signatures. The Plan did not require provider and member wet signatures for medical service prior authorization requests or a lengthy prior authorization request.

- The Plan allowed the delegate to limit adults to individual or group therapy mental health visits; medical service prior authorization. A requests did not include comparable limitations.

- For ongoing outpatient visits to medical providers, the Plan did not require an annual reassessment (an annual prior authorization) as did the delegate for ongoing visits to outpatient mental health providers.

In an interview, the subcontractor reported that it applied the same processes and criteria to members with mild to moderate benefit as it did for its specialty mental health patients.

When the Plan does not ensure its subcontractors comply with DHCS standards for mental health parity, barriers to care, limited access, and underutilization of needed mental health services may result.

Recommendation: Revise and implement oversight policies and processes to ensure parity between processes for providing medical/surgical services and mild to moderate mental health services.

1.5.3 UM Delegate Oversight / Appropriate UM Processes

The Plan shall maintain a system to ensure accountability for delegated quality improvement activities that at a minimum ensures subcontractor meets standards set forth by the Plan and DHCS. (*Contract, Exhibit A, Attachment 4(6) (B) (2)*)

The Plan shall maintain a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. (*Contract, Exhibit A, Attachment 5(1)*)

A Plan's subcontractor's *Care Management Unit Program Description (CMUPD)* stated it would use California Code of Regulations (CCR) Title 9 criteria to determine the medical necessity of prior authorization requests for mild to moderate mental health services.

Finding: The Plan did not ensure that the delegate used appropriate processes to review and approve the provision of medically necessary covered services.

A verification study of nine denials showed the Plan did not ensure the delegate used appropriate UM processes:

- In eight of nine cases, the delegate used Title 9 clinical criteria for specialty mental health to assess prior authorization requests for mild to moderate (less severe) mental health services. Title 9 criteria do not apply to mild to moderate mental health conditions.

- In four cases, the delegate denied services using subjective and administrative rather than medical necessity criteria for its mild to moderate mental health determinations. In one case, the delegate denied a request for additional visits for "not clearly defining how the additional modality would address the client's mental health symptoms/functional impairments" though the case met medical necessity. In other cases, the delegate denied services for missing wet signatures (plus registration form and partnership plan), not including an updated problem, and submitting an erroneous diagnosis code.

- In an additional case, the delegate denied mild to moderate mental health services for a member less than 21 years old without consideration for EPSDT service criteria, which required approving services that could ameliorate or maintain a member's condition.

The delegate's *2019 CMUPD* and *MOU* did not describe separate processes for the provision of mild to moderate mental health services, and did not describe using EPSDT criteria to assess requests for mild to moderate mental health treatment for under-21-year-old members.

Plan policy *QM 14.301 Delegation Oversight Process (revised 8/2/19)* described the Plan's monitoring process, which included reviewing quarterly reports, checking medical records, and conducting annual audits. The latter involved reviewing denied service requests and the delegate's policies and procedures.

The delegate reported that it traditionally applied Title 9 criteria to specialty mental health service requests and applied the same processes to requests for mild to moderate mental health services upon subcontracting with the Plan in 2014.

The Plan audited the delegate in 2019 and did not cite it for using Title 9 criteria and for not considering EPSDT criteria to assess mild to moderate service requests. In an interview, the Plan reported that DHCS' *APL 17-018* allowed the delegate to require prior authorization for mild to moderate mental health requests and did not specify the criteria it could use.

When the Plan does not ensure a delegate uses appropriate processes to review and approve the provision of medically necessary covered services, members may not receive medically necessary services.

Recommendation: Revise Plan policies and implement processes to ensure the Plan's delegate complies with contractual and regulatory requirements.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	**BASIC CASE MANAGEMENT** **CALIFORNIA CHILDREN'S SERVICES (CCS)** **EARLY INTERVENTION / DEVELOPMENTAL DISABILITIES** **INITIAL HEALTH ASSESSMENT**

2.1.1 Health Risk Stratification

The Plan shall apply a DHCS approved health risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs within 44 days of enrollment. The health risk stratification shall be done in accordance with APL 17-013. (*Contract, Exhibit A, Attachment 10(4)*)

The Plan is required to use a risk stratification mechanism or algorithm to analyze member-specific FFS utilization data or Health Information Form/Member Evaluation Tool (HIF/MET) data (when it exists) and to identify newly enrolled SPD members in higher risk groups with more complex health care needs and lower risk groups. The Plan may choose to consider all newly enrolled SPD members as higher risk. (*APL 17-013*)

Plan policy *CM 16.019 SPD Health Risk Assessment and HIF/MET Process (reviewed 3/20)* stated it used a risk process stratification based on the initial data that it received from DHCS. The risk stratification would identify members as being higher or lower risk based on their health care utilization; the risk stratification process would be completed within 45 days of SPD enrollment.

Finding: The Plan did not conduct stratification to identify newly enrolled SPD members as higher or lower risk. The Plan's policy erroneously stated the health risk stratification required completion timeline is 45 days from the member's SPD enrollment date.

A verification study of 30 newly enrolled SPD members did not show members' data was analyzed for health risk stratification.

In interviews and written correspondence, the Plan provided conflicting statements on its health risk stratification process, but did not provide documentation to demonstrate its stratification efforts. The Plan acknowledged its policy incorrectly stated the time frame for stratification due to an inadvertent policy revision in March 2020.

When the Plan does not conduct health risk stratifications for newly enrolled members, health risk assessments may be delayed with resultant adverse health effects.

Recommendation: Revise and implement policies and procedures to stratify each newly enrolled SPD member's current health care condition within 44 days of SPD enrollment.

2.1.2 HRA Completion Time Frames

Based on the results of the health risk stratification, the Plan shall also administer the DHCS-approved HRA survey within 45 days for SPD beneficiaries deemed to be at higher health risk, and 105 days for those determined to be at lower health risk. (*Contract, Exhibit A, Attachment 10(4)*)

Plan policy *CM 16.019 SPD Health Risk Assessment and HIF/MET Process (reviewed 3/20)* stated based on the results of the health risk stratification, the Plan shall administer the DHCS-approved health risk assessment survey within 45 days for SPD members deemed to be at higher health risk, and 105 days for those determined to be at lower health risk.

Finding: The Plan did not conduct HRAs within the required 45 day time frame for newly enrolled members identified as higher risk.

A verification study of 30 newly enrolled SPD members identified as higher risk found the following:

- Eleven member HRAs were not conducted until between 56 and 290 days after SPD enrollment.

- Three member HRAs were not conducted.

The Plan stated all newly enrolled SPD members were stratified as higher risk as of their SPD enrollment date; this meant all newly enrolled SPD members should receive the HRA within 45 days from their enrollment dates. The Plan did not provide a reason for the delay of the HRA completion.

When the Plan does not conduct HRAs timely, this may lead to delays in identifying needed member care.

Recommendation: Implement policies and procedures to assess each newly enrolled SPD member's current health risks within the required time frames.

2.1.3 HRA Outreach

The Plan shall also administer the DHCS-approved health risk assessment (HRA) survey within 45 days for SPD members deemed to be at higher health risk, and 105 days for those determined to be at lower health risk. The HRA shall be done in accordance with APL 17-013. (*Contract Exhibit A, Attachment 10(4)*)

The Plan is required to have a process for contacting members within the required assessment time frames that includes repeated efforts (letter followed by at least two phone calls) to contact each member. (*APL 17-013*)

Plan policy *CM 16.019 SPD Health Risk Assessment and HIF/MET Process (reviewed 3/20)* stated the Plan contacts members by mailing them the HRA within two business days of receiving stratification information for newly enrolled SPD members. If the member did not return the HRA within 30 days, the Plan would attempt at least two telephone calls within seven days.

Finding: The Plan did not consistently implement its policy to send HRA letters to its newly enrolled SPD members or make the necessary two telephone call attempts to conduct the HRA with the member.

A verification study of 30 newly enrolled SPD members found 14 members were not sent HRA letters and one member did not receive the two required telephone call attempts.

In an interview, the Plan stated it automatically mailed HRA letters to SPD members within the first week of their enrollment. The Plan would manually resend the HRA letters if review of a monthly report showed the automatic mailing was not completed. However, Plan documents did not demonstrate the completion of these steps.

If the Plan does not contact members to complete the HRA, it may result in missed opportunities to improve members' care.

Recommendation: Implement policies and procedures to send HRA letters and make two required telephone calls within the required time frames.

2.1.4 Comprehensive Assessment and Reclassification of HRA results

The Plan shall administer a DHCS-approved HRA survey in accordance with APL 17-013. (*Contract, Exhibit A, Attachment 10(4)*)

The Plan must use the HRA to comprehensively assess each newly enrolled SPD members' current health risk and re-classify members as higher or lower risk*. (APL 17-013)*

Plan policy *CM 16.019 SPD Health Risk Assessment and HIF/MET Process (reviewed 3/20)* stated the health risk stratification and assessment shall be done in accordance with W&I Code Sections 14182 (c) (11) to (13) and PL 14-005 (superseded by APL 17-013).

Finding: The Plan did not comprehensively assess each newly enrolled SPD member's current health risk based on the HRA. The Plan did not have a process to identify members as higher or lower risk based on the HRA.

A verification study found 26 of 30 newly enrolled SPD members with documented HRAs. Twenty-two of 26 HRAs did not comprehensively assess members as higher or lower risk. Documentation did not show the Plan assigned members as higher or lower risk based on the HRA.

When documentation of members' HRA levels was requested the Plan responded "at this time, there is not a HRA scoring process." The Plan did not provide documentation of a process to comprehensively assess newly enrolled SPD member's current health risk.

When the Plan does not comprehensively assess newly enrolled SPD members, higher risk members may not be identified and provided needed medical care.

Recommendation: Develop and implement a process to comprehensively assess each newly enrolled SPD member's current health risks based on the HRA.

2.1.5 HRA Survey Requirements

The Plan is required to conduct a DHCS approved HRA survey for SPD members. The health assessment shall be done in accordance with APL 17-013. (*Contract, Exhibit A, Attachment 10(4)*)

The Plan is required to include the following elements in its HRAs: identification of medical care needs, needed referrals, caregiver involvement and need, help in facilitating timely access to care, help in facilitating communication among member's providers, need for other activities or services to improve member health, coordination of care need, a process for ensuring appropriate discharge planning, and a process for reassessment (at least annually) and the circumstances for re-determination of member risk level. The Plan is required to utilize specific Long-Term Services and Support (LTSS) referral questions verbatim. (*APL 17-013*)

Plan policy *CM 16.019 SPD Health Risk Assessment and HIF/MET Process (reviewed 3/20)* stated based on the results of the health risk stratification, the Plan shall administer the DHCS-approved HRA survey.

Finding: The Plan did not conduct a complete HRA of newly enrolled SPD members. The Plan did not use a DHCS-approved tool that included all the required elements of an HRA.

The Plan did not utilize DHCS-approved HRA questions according to a review of a Plan's compliance report. The Plan utilized an automated voice system to conduct its HRA surveys. Documentation showed the Plan's HRA process did not address the following required elements:

- Identification of needed referrals
- Identification of help in facilitating communication among member's providers
- Identification of coordination of care need
- No member was asked about their medical care needs
- No member was asked about needed referrals for home-delivered food or energy assistance programs
- Three of ten LTSS questions were not verbatim
- Four of ten LTSS questions were not included
- Two of ten LTSS questions were included but not asked to a single member (two are multipart questions)

This was a finding in the prior year's audit. The Plan's corrective action was to revise policy *CM 16.019*'s HRA tool to include all the required HRA elements and LTSS questions. The Plan's corrective action did not incorporate these policy revisions into its automated system for conducting HRAs. The Plan's corrective action did not address the prior year deficiency.

Using an HRA survey that does not address all required elements may not provide thorough HRA, and may hinder members from receiving all needed services.

This is a repeat of prior year finding 2.1.3 – Health Risk Assessment

Recommendation: Revise and implement procedures and effective corrective action to ensure HRA completion using DHCS required questions.

2.1.6 HRA Individualized Care Plans

The Plan is required to develop individual care plans (ICP) for members identified as higher risk based on the HRA results. The ICP components shall include, at the minimum, identification of the members' medical care needs, referrals to community resources, caregivers' involvement, time frames for reassessment and redetermination of risk level. (*WIC 14182(12) (B)*)

The Plan must develop ICPs for members found to be at higher risk after the completion of the HRA, and coordinate referrals for identified LTSS, as needed. (*APL 17-013(B) (1)*)

Plan policy *CM 16.019 SPD Health Risk Assessment and HIF/MET Process (reviewed 3/20)* stated, based on the information identified through the HRA process, the Plan would develop a care plan with the following components: caregivers' involvement, identification of medical care needs, referrals to community resources, identification of needs for coordination of care, and at least annually a reassessment, and if necessary, the circumstances or conditions that require redetermination of risk level.

Finding: The Plan did not develop individualized care plans for members identified as higher risk based on the HRA results.

A verification study found two of two newly enrolled SPD members assessed as higher risk based on the HRA survey did not have ICPs.

Plan desktop procedure instructed staff to create a care plan when they provide assistance with resources or appointments for members. In an interview, the Plan confirmed this desktop procedure was its process for care plan development.

Plan documentation did not demonstrate staff created an ICP for addressing needed medical care or referrals that the HRA identified, caregiver involvement, or time frames for reassessment or redetermination of risk.

As a corrective action to the prior year's finding, the Plan revised policy *CM 16.019* to include how ICPs are initiated, implemented and monitored for higher risk members. The Plan did not implement its corrective action to address the prior year's finding.

When the Plan does not develop ICPs, higher risk SPD members may not receive the necessary assistance with their needed care.

This is a repeat of prior year finding 2.1.4 – Individualized Care Plans

Recommendation: Implement procedures and effective corrective action to develop ICPs for members identified as higher risk through the HRA process.

2.1.7 Required Components of the Initial Health Assessment

The Plan must cover and ensure the provision of an Initial Health Assessment (IHA) to each new member within 120 calendar days of enrollment. An IHA consists of a comprehensive history and physical examination, preventive services, and the Individual Health Education Behavioral Assessment (IHEBA). (*Contract, Exhibit A, Attachment 10(5) (A) and MMCD Policy Letter 08-003*)

The Plan is required to follow the latest edition of the Guide to Clinical Preventive Services published by the USPSTF to provide preventive services to asymptomatic, healthy adult members. All preventive services identified as USPSTF "A" and "B" recommendations must be provided and the status must be documented. (*Contract A15, Exhibit A, Attachment 10(6) (B) (1), and MMCD Policy Letter 08-003*)

The Plan shall ensure that all members receive necessary immunizations at the time of any health care visit. Documented attempts that demonstrate the Plan's unsuccessful efforts to provide the immunization shall be considered sufficient in meeting this requirement. (*Contract, Exhibit A, Attachment 10(5) (C) and (6) (C)*)

The Plan must ensure that its providers who perform periodic health assessments on children between the ages of six months to six years, comply with current laws and guidelines for blood lead level testing. (*APL 18-017*)

Plan policy *QM14.701 Preventive Services/Initial Health Assessment (revised 2/28/20),* required providers to complete the IHA within 120 days of enrollment with the Plan for all new members, and document all components of the IHA. The policy required providers to follow the latest edition of the Guide to Clinical Services published by the USPSTF and to provide A and B recommended services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Contra Costa Health Plan
AUDIT PERIOD: May 1, 2019 through April 30, 2020 **DATE OF AUDIT:** August 17, 2020 through August 28, 2020

Finding: The Plan did not ensure that all providers performed and documented required components of an IHA: comprehensive history and physical, complete Individual Health Education Behavioral Assessment (IHEBA)/ Staying Healthy Assessment (SHA), and preventive services identified as USPSTF "A" & "B" recommended services, particularly blood lead screening for pediatric members and tobacco smoking cessation/lung cancer screening for adult members.

A verification study was conducted on five sampled members' (ages two to six years old) medical records to determine if documentation contained the required components of an IHA. Review of the medical records showed the following:

- In two records, members did not have the blood lead screenings documented.
- In four records, members did not have documentation of a SHA or the SHAs were incomplete
- In one record, the member's immunizations were not documented.

A verification study was conducted on ten sampled adult members' medical records to determine if documentation contained the required components of an IHA. Review of the medical records showed the following:

- In seven records, members did not have documentation of a SHA or the SHAs were incomplete
- In four records, members did not have a comprehensive history and/or physical examination documented
- In six records, members did not have the necessary immunizations documented.
- In six records, screenings for tobacco smoking cessation and screening for lung cancer were missing. Documentation did not show these members were asked about tobacco use, and therefore no interventions were provided.

The Plan's corrective action for the prior year's finding was to revise policy *QM14.701* to include the required IHA components. The Plan stated reminders and specifically lung cancer screening recommendation were topics in the Medical Director's quarterly meetings with providers. However, review of the sampled medical records did not show this finding was corrected.

When the Plan does not ensure it includes all IHA components, important preventive screening services may not be provided; members' risks for preventable diseases may increase as a result.

This is a repeat of the prior year finding 2.1.2 - Required Component of the IHA.

Recommendation: Implement policies, procedures, and corrective action to ensure provision and documentation of all IHA components, including applicable preventive services.

2.5 MENTAL HEALTH AND SUBSTANCE ABUSE

2.5.1 Memorandum of Understanding Requirements

The Plan shall execute a MOU with the local county mental health plan (MHP). (*Contract, Exhibit A, Attachment 11(6) (B)*)

Disputes between the Plan and the local county mental health plan regarding mental health or other covered services shall be addressed collaboratively as specified by the MOU to achieve a timely and satisfactory resolution. (*Contract, Exhibit A, Attachment 11 (6) (A) (3)*)

The MOU must include elements described in detail in the MOU Template. *Attachment 2* stated the MOU must describe a process for resolving clinical and administrative disputes between the Plan and MHP and must agree to follow the dispute resolution process in accordance with CCR, Title 9, section 1850.505. (*APL 18-015*)

The Plan's MOU with the county MHP stated the entities would agree upon a process for timely resolution of clinical and administrative disputes.

Finding: The Plan's MOU with the county MHP did not describe a mutually agreed upon review process for timely resolution of clinical and administrative disputes regarding mental health and other covered services.

The *Dispute Resolution* section of the Plan's MOU with the county MHP stated the two entities would agree upon a review process to facilitate timely resolution of clinical and administrative disputes, including differences of opinion about whether the Plan or county MHP should provide mental health and substance use disorder services. It stated the process would include tracking and reporting on disputes. The MOU did not describe the process, or include details outlined in CCR, Title 9, including stating whether the disputing parties could engage in binding arbitration to resolve disputes, or that the parties could apply to the DHCS if they could not resolve disputes using the process described in the MOU; it did not identify points of contact for dispute resolution as required in APL 18-015. It erroneously stated it would comply with dispute resolution processes described in CCR, Title 9, section 1850.505.1 instead of the required section 1850.505.

The MHP confirmed it did not have a policy describing the dispute resolution process between itself and the Plan.

Without a formal dispute resolution process between itself and the MHP, the Plan cannot consistently resolve, document and report on disputes that may affect the delivery of medical and mental health services to members.

Recommendation: Revise the MOU to describe the process for resolution of clinical and administrative disputes between the Plan and the MHP.

2.5.2 Mental Health Services Provided by Primary Care Providers

The Plan's policies and procedures shall define and describe the mental health services Primary Care Providers (PCPs) can provide. (*Contract, Exhibit A, Attachment 10(8) (E)*)

Plan policy *PA 9.828 MH Services by a PCP or Licensed MH Care Provider (reviewed 12/19*) stated PCPs could perform mental health, tobacco and alcohol abuse screenings.

Finding: The Plan's policies did not define and describe the mental health services PCPs could provide.

Plan policies *PA 9.828* and *UM 15.012 Access to Mental Health Services (reviewed 2/28/19)* incompletely described mental health services PCPs could provide.

In a written response, the Plan stated it did not have a policy dictating what sort of care a provider could or could not provide in an outpatient setting. PCPs could also:

- Prescribe certain psychiatric medications
- Provide brief counseling
- Order mental health-related laboratory studies

Plan policies *PA 9.828* and *UM 15.012,* and the *2020 Provider Manual* did not include the above duties.

Incomplete descriptions of PCP duties in Plan policies may lead to substandard delivery of mental health service.

Recommendation: Revise plan policies to comprehensively describe the mental health services PCP's can provide.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1 APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 Procedures of Monitoring Initial Prenatal Appointments

The Plan is required to ensure that the first prenatal visit for a pregnant member will be available within two weeks upon request. The Plan is required to develop, implement, and maintain a procedure to monitor waiting times to obtain various types of appointments including first prenatal visit. (*Contract, Exhibit A, Attachment 9(3) (B) and (C)*)

Plan policy *QM14.101 Access to Care Standards (revised 10/21/19)* stated that for Initial Prenatal Visits, the standard is 14 days, and that twice a year, Quality Department will conduct studies and report on compliance. For one delegate, the Plan will run a report to identify pregnant women. From that report, the Plan will record the request date and the date of appointment logged from the Electronic Health Record. For the other networks, the Plan assumed that the diagnosis date will be the request date. If the Plan cannot access medical charts to determine first visit, the Plan will use claims information.

Finding: The Plan's procedures did not accurately measure waiting times to obtain first prenatal visit appointments.

The Plan described its process for monitoring the initial prenatal appointments:

- In one network, the Plan will estimate the date of first prenatal appointment by subtracting 40 weeks from the expected date of delivery. The time frame was calculated by subtracting the date of pregnancy test performed in its facility from the first estimated prenatal appointment date. The Plan's monitoring process did not include information on when the first prenatal appointment was requested and did not measure if the appointment was provided within two weeks of the member's request.

The Plan affirmed that the sample data was collected only from members who performed the pregnancy test within the Plan's network. It did not include members that did not receive pregnancy test outside of Plan's network.

As a corrective action for the prior year finding 3.1.1 monitoring of Prenatal Appointments, the Plan developed a process to measure wait times to obtain initial prenatal appointments. However, the process performed by the Plan did not accurately measure waiting times to obtain first prenatal visit appointments and resulted in an ineffective corrective action.

Inaccurate monitoring of initial prenatal appointments may lead to members not receiving proper care during the earlier stages of pregnancy.

Recommendation: Revise and implement policies and procedures to ensure initial prenatal appointments are adequately monitored for timely access.

3.1.2 Monitoring of Wait Times at Providers' Offices and Telephone Calls

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in the network providers' offices and for telephone calls (to answer and return). (*Contract, Exhibit A, Attachment 9(3) (C)*)

Plan policy *QM14.101 Access to Care Standards (revised 10/21/19*) stated that monitoring and reviewing member satisfaction survey results will be used to monitor and measure wait time standards for telephone responsiveness and provider office visit wait time.

Finding: The Plan did not implement its procedures to monitor wait times at provider's offices and wait times to answer and return telephone calls.

The Plan's member satisfaction survey did not contain information about wait times at providers' offices and wait times for telephone calls. The Plan did not provide any documented evidence of monitoring wait times at provider's offices and to answer and return telephone calls.

Without tracking of wait times at providers' offices and telephone calls, the Plan cannot ensure that members are able to receive the care they need timely.

Recommendation: Implement policies and procedures to monitor wait times at providers' offices and to answer and return telephone calls.

3.5 EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

3.5.1 Interest Payment

The Plan is required to reimburse each complete claim, or portion thereof, no later than 45 working days after receipt. (*CCR, Title 28, section 1300.71 (g)*)

The Plan is required, for late payment of emergency services claims, to include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late. (*CCR, Title 28, section 1300.71 (i) (1)*)

Plan policy *CLM 4.007e: Claims Processing, Determination Timeliness, Internal Monitoring (reviewed 9/15/15)* stated if a claim is not reimbursed within 45 working days, interest will accrue at a rate of 15 percent per year.

Plan policy *CLM 4.501e Claims Processing Guidelines* (reviewed 11/1/2016) stated for emergency services claims, interest will be paid at $15 per year unless the interest calculation is greater than $15.

Finding: The Plan did not include interest with the late payment of emergency service claims.

A verification study found two of 20 emergency services claims were not paid with interest. Both claims were not processed until four months after receipt of all necessary information.

If the Plan does not pay interest on claims, this may discourage providers from participating with the Plan and limit members' access to care.

Recommendation: Implement policies and procedures to include interest with the late payment of emergency services claims.

3.5.2 Denial of Claims

The Plan shall not improperly deny or contest a claim or portion thereof. For each claim that is denied or contested the Plan shall provide an accurate and clear written explanation of the specific reasons. (*CCR, Title 28, section 1300.71 (d) (1) and (h)*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: May 1, 2019 through April 30, 2020
DATE OF AUDIT: August 17, 2020 through August 28, 2020

Plan policy *CLM 4.501e Claims Processing Guidelines (revised 11/1/16)* stated the Plan would ensure accurate processing of claims.

Finding: The Plan improperly denied a family planning claim based on other services submitted on the claim.

A verification study found the Plan incorrectly denied one of 17 family planning service claims because a sterilization service code on the claim was incorrectly billed; the code required a signed consent form. The Plan denied the entire claim for lack of a consent form; the provider correctly billed service code 58301, removal of intrauterine device, which does not require a consent form.

During an interview, the Plan stated its process is to deny entire claims if there is a denial reason for one service in the claim. The Plan processes and adjudicates on a claim-by-claim basis and not a line-by-line basis.

If the Plan improperly denies covered services, providers may be discouraged from treating Plan members; members' access to care may be limited.

Recommendation: Revise and implement procedures to ensure claims are appropriately adjudicated.

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION AND NON-MEDICAL TRANSPORTATION

3.8.1 Unaccompanied Minor Written Consent Form

The Plan is required to cover transportation services as required in the Contract and directed in APL 17-010 to ensure members have access to medically necessary services. Plan shall cover NEMT services and NMT services. (*Contract, Exhibit A, Attachment 10(8) (H)*)

The Plan may arrange transportation for a minor who is unaccompanied by a parent or a guardian with written consent. Additionally, the Plan is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor. (*APL 17-010*)

Plan policies *UM 15.064 Non-Emergency Medical Transportation (approved 12/12/19)* and *UM 16.028.1 Non-Emergency Medical Transportation (origin 7/7/17)* stated, with written consent of a parent or guardian, the Plan may arrange NEMT for an unaccompanied minor. The Plan is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

Plan policy *CM 16.301 Non Medical Transportation (revised 3/6/20*) stated all members under 18 years of age must provide additional transportation authorization from parent/guardian. The Plan will not authorize transportation for a solo minor.

Finding: The Plan did not collect written consent forms for unaccompanied minors requiring NEMT and NMT services.

A verification study of five NEMT and nine NMT services rendered to minors identified the following deficiencies:

- One NEMT sample did not have the unaccompanied minor written consent form.
- One NMT samples did not have the unaccompanied minor written consent form.

As a corrective action for the prior year's audit finding, the Plan revised its policies and procedures to require the parent/guardian written consent form prior to arranging transportation for an accompanied minor. However, the Plan did not implement the written consent form requirement.

Without unaccompanied minor consent forms, the Plan cannot document parent or guardian authorization for transportation of minor children. Parents or guardians may be unware of potential risks to minor children.

This is a repeat of prior year finding 2.4.1 - Unaccompanied Minor Written Consent Form.

Recommendation: Implement policies and procedures to ensure written consent forms are received prior to arranging NMT and NEMT services for unaccompanied minors.

3.8.2 Physician Certification Statement

The Plan is required to cover NEMT services required by members to access Medi-Cal services, subject to Plan's Physician Certification Statement (PCS) form being completed by the member's provider. (*Contract, Exhibit A, Attachment 10 (H)*)

Plans and transportation brokers must use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. All NEMT PCS forms must include, at a minimum, the following components: documentation of specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles, dates of service needed, mode of transportation needed, and PCS of medical necessity. (*APL 17-010*)

Plan policies *UM 15.064 Non-Emergency Medical Transportation* (*approved 12/12/19)* and *UM 16.028.1 Non-Emergency Medical Transportation (approved 7/7/2017)* stated the Plan must use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. The NEMT PCS form must include: the member's specific physical and medical limitations that preclude the member's ability to reasonably ambulate with assistance or be transported by public or private vehicles, dates of service needed, mode of transportation needed, and the prescribing physician's statement certification.

Finding: The Plan did not use a DHCS-approved PCS form or a transportation service request form that documented all the required components to determine the appropriate level of service for Medi-Cal members.

A verification study of 15 cases identified the following deficiencies:

- In seven cases, the Plan allowed the submission of its prior authorization form or a vendor form which did not collect/contain all the required PCS information.

- In three cases, the Plan allowed its transportation vendors to use their own request forms. Three forms did not have the dates of service and two did not have the modes of transportation needed.

- In five cases, the Plan did not have documentation of any requests or order form on file.

In an interview, the Plan stated that it allowed the vendors' NEMT order forms to be used in place of the PCS form; however, the verification study revealed that the forms were missing required components.

As a corrective action for the prior year's audit finding, the Plan stated it would implement policy *UM16.028.1* and ensure the use of a DHCS approved form. The Plan did not implement its corrective action.

If the Plan does not utilize a DHCS-approved PCS form, the Plan cannot determine the appropriate level of service for members.

This is a repeat of prior year finding 2.4.2 – Physician Certification Statement

Recommendation: Implement policies, procedures, and effective corrective action to ensure collection of all required information on DHCS-approved PCS forms for NEMT.

3.8.3 Unenrolled NEMT Transportation Providers

The Plan is required to comply with all Policy Letters and APL issued by DHCS. (*Contract, Exhibit E, Attachment 2(1) (D)*)

All Managed Care Plan network providers must enroll in the Medi-Cal program. Managed Care Plans have the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through DHCS. (*APL 19-004*)

Plan policy *CR 11.027 Enrollment and Screening* (*revised 12/19)* stated the Plan would ensure provider enrollment through the DHCS website. If the provider was not enrolled with DHCS, the provider would be placed on hold until all three elements were completed (enrolled, credentialed and contracted).

Finding: The Plan did not ensure contracted NEMT providers were enrolled in the Medi-Cal program.

A verification study revealed seven of 13 contracted NEMT providers were not enrolled in the Medi-Cal Program.

In a written response, the Plan stated it utilized contracted NEMT providers that have been screened, enrolled, credentialed, and contracted. However, documentation did not support this assertion.

If the Plan contracts with NEMT providers that are not enrolled in the Medi-Cal program, it cannot ensure that providers meet Medi-Cal requirements.

Recommendation: Implement policies and procedures to ensure NEMT providers are enrolled in the Medi-Cal program.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Resolution

The Plan is required to implement and maintain a Member Grievance System in accordance with CCR, Title 22, section 53858 and Title 28, Section 1300.68. (*Contract, Exhibit A, Attachment 14(2)*)

The Plan is required to establish and maintain written procedures for submittal, processing, and resolution of all grievances. (*CCR, Title 22, section 53858(a)*)

Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the Plan's grievance system, including entities with delegated authority. (*CCR, Title 28, section 1300.68(a) (4)*)

Plan policy *MS 8.001 Handling of Complaints and Grievances (approved 10/24/19)* stated resolved means the grievances have reached a final conclusion with respect to the beneficiary. Any grievance about quality of service issue, which cannot be resolved by the Member Services Department, will be forwarded to the appropriate area for investigation. The Grievance Nurse will identify quality of care grievances for investigation and resolution. The resolution letter will contain an explanation of the conclusion of the grievance addressing all reported issues.

Finding: The Plan sent resolution letters without completely resolving all member complaints.

A verification study found 11 of 42 standard quality of service, three of 20 standard quality of care, and one of one expedited grievances did not investigate and resolve all member complaints.

- Seven standard quality of service grievances did not address all member complaints. In one case, the Plan closed the grievance without completing its investigation into the member's complaints. The provider was unavailable to respond to the Plan's investigation at the time; the Plan's resolution was to follow-up with the member upon the provider's return.

- In three standard quality of services grievances a member's representative submitted several grievances requesting intensive feeding therapy and occupational therapy services. The Plan's first resolution stated "Intensive Feeding Therapy is hard to characterize and a prior authorization for Occupational Therapy was received". The Plan's resolution did not address the member's complaint. The Plan's resolution to the second grievance did not address either member complaint; case documentation does not show the Plan investigated either member complaint. The member filed an Independent Medical Review (IMR); the decision overturned the Plan's denial for feeding therapy and occupational therapy. The member's third grievance complained the Plan had not provided intensive feeding therapy or occupational therapy services; the Plan's resolution still did not resolve the member's complaint to provide services as determined by the IMR decision. The member's compliant was resolved in a later grievance.

- One standard quality of service grievance was closed prior to the Plan resolving the member's complaint. A member's complaint of a delay of a bariatric services referral was not addressed in the resolution letter; the Plan closed the grievance prior to receiving the provider's response. The Plan sent an additional letter three weeks after the resolution date informing the member of the completed resolution.

- Three standard quality of care grievances did not investigate or resolve members' complaints of inappropriate provider care or the poor appearance of a provider's office. In one complaint about provider care, the resolution did not address both dates addressed in the grievance.

- One expedited grievance did not investigate or resolve a member's complaint of getting needed anxiety medication or the rude behavior of a provider.

In April 2020, the Plan conducted an internal audit of quality of care grievances and found grievance resolutions did not directly address, confirm, or refute complaints made by members. The review found the grievance investigation did not address specific members' complaints and overlooked services issues; provider responses from the grievance investigation focused on clinical complaints and did not directly address all members' complaints.

Subsequent to the Exit Conference, the Plan provided additional statements identifying how these grievances were resolved; additional documentation was not provided to support all the Plan's statements. In one case, the Plan stated a member's complaint was processed as an appeal; however, the Plan's list of appeals did not show the Plan processed an appeal for the member's complaint for a social skills service.

Incomplete resolution of member grievances may result in missed opportunities for improved health care delivery and poor health outcomes for members.

Recommendation: Implement policies and procedures to ensure all complaints are resolved prior to sending a resolution letter to members.

4.1.2 Grievance Classification and Processing

The Plan is required to implement and maintain procedures to monitor the Member 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)*)

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 acknowledgment and response. (*CCR, Title 28, section 1300.68(d) (8)*)

Plan policy *MS 8.001 Handling of Complaints and Grievances (approved 10/24/19)* stated that Member Service Representatives (MSR) will attempt to resolve all member questions or requests at the time when the first contact is made. If an inquiry or problem cannot be resolved at this entry level, the MSR will open a grievance and document all issues researched. Exempt grievances are expressions of dissatisfaction received over the telephone by a member or authorized representative that are not coverage disputes, disputed health care services involving medical necessity that are resolved by the next business day (24 hours). The Grievance Nurse will determinate whether the member's grievance is quality of care or quality of services.

Finding: The Plan inconsistently classified and processed standard grievances as exempt grievances. The Plan did not consistently implement its procedure regarding exempt grievance classification and processing.

A verification study of ten exempt grievances found six grievances were not resolved and closed by next business day.

- In three cases, members complained of a provider or case manager not assisting the member. The Plan's resolution included changing the member's PCP or case manager; the Plan did not investigate the members' complaints. In one case, the member complained their case manager was not assisting with medication refills, helping with appointments, or returning phone calls. The Plan did not investigate whether the case manager was providing inadequate assistance; the Plan's resolution was to request a change in a case manager. The resolution was closed without confirming the member was assigned to a new case manager.

- In one case, a member complained about a delegate's denial of NMT services to a dental appointment. The grievance was closed without any resolution of the member's complaint.

This was a finding in the prior audit. As a corrective action, the Plan stated it revised its policy and procedures to include a review of all closed grievances by the Grievance Nurse for proper classification. However, review of Plan policy *MS 8.001* did not show any revisions documenting this process.

In an interview, the Plan stated the review of all closed grievances for proper classification, i.e. exempt versus standard, was implemented in October 2019. Review of five of five exempt grievances received as of November 2019 did not show a review by any Plan staff for proper classification. The Plan did not provide any additional grievances to demonstrate implementation of its stated corrective actions as an example. The Plan did not take any corrective actions to address the prior year's finding.

Subsequent to the Exit Conference, the Plan provided additional statements identifying how these grievances were resolved by close of next business day; additional documentation was not provided to support all the Plan's statements.

By classifying standard grievances as exempt grievances, grievances are not fully investigated or resolved, and members do not receive the required written communication about their grievances.

This is a repeat prior year finding 4.1.2 - Grievance Identification and Processing.

Recommendation: Develop and implement policies, procedures, and effective corrective actions to ensure exempt grievances are appropriately classified, processed, and resolved.

4.1.3 Grievance Identification

The Plan is required to implement and maintain a Member Grievance System in accordance with CCR, Title 22, section 53858 and Title 28, Section 1300.68. (*Contract, Exhibit A, Attachment 14(2)*)

The Plan is required to establish and maintain written procedures for submittal, processing, and resolution of all grievances. (*CCR, Title 22, section 53858(a)*)

An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Plan processes. A complaint is the same as a grievance. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. (*APL 17-006*)

Plan policy *MS 8.001 Handling of Complaints and Grievances (approved 10/24/19*) stated a complaint is the same as a grievance. When the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Plan processes. If an inquiry or problem cannot be resolved at this entry level, the member services representative will open a grievance and document all issues researched.

Finding: The Plan did not process and resolve all member expressions of dissatisfaction as grievances.

A verification study found two of ten inquiries and one of 42 standard quality of service grievances were incorrectly processed as member inquiries.

- In one case, the member complained of a bill sent to collections. The inquiry was closed with the provider response that the bill is placed on hold while under review. Case notes did not show the Plan confirmed the member would no longer be billed.

- In another case, the member complained of a bill sent to collections. The Plan resolved the member complaint eight days after it was received.

- In one standard quality of service grievance, documentation showed the Plan classified a member complaint about needing an extension for a community based social skills class for a member with autism as an inquiry and did not resolve the member's complaint as part of the standard grievance.

Subsequent to the Exit Conference, the Plan stated that the two inquiries who had bills sent to collections were not grievances as the members requested "assistance". However, these cases were not requests for information nor were any questions posed to the Plan and do not meet the requirements to be classified as inquiries. In one grievance case, the Plan stated a member's complaint was processed as an appeal; however, the Plan's list of appeals did not show the Plan processed an appeal for the member's complaint for a social skills service.

When member expressions of dissatisfactions are not processed as grievances, members will not receive notice of members' rights and their complaints may not be fully resolved.

Recommendation: Develop and implement procedures to ensure all member expressions of dissatisfaction are appropriately processed.

4.1.4 Quality of Care Grievance Identification

The Plan is required to implement and maintain a Member Grievance System in accordance with CCR, Title 22, section 53858 and Title 28, Section 1300.68. (*Contract, Exhibit A, Attachment 14(2)*)

The Plan is required to implement and maintain a procedure to ensure every grievance submitted is reported to an appropriate level, i.e. quality of care versus quality of service. Grievances related to medical quality of care issues are required to be referred to the Plan's medical director. (*Contract, Exhibit A, Attachment 14(2) (C) and (D)*)

Plan policy *MS 8.001 Handling of Complaints and Grievances (approved 10/24/19*) stated the grievance nurse would review all incoming grievances to ensure that clinical staff handled all potential quality of care issues and that the Member Services Department handled the quality of service related grievances. The Grievance Nurse would determine whether the member's grievance was quality of care or quality of service. Quality of care grievances would be investigated by the Grievance Nurse and the Medical Director.

Finding: The Plan did not ensure all quality of care issues were referred to the Medical Director.

A verification study of ten exempt grievances showed all ten grievances were closed without a quality of care review. Five exempt grievances contained quality of care issues that were not reviewed by the Plan's Medical Director.

- One grievance concerned a member being prescribed medication that the member would have an allergic reaction to.

- One grievance alleged ineffective medical care.

- Three grievances concerned providers and a case manager not assisting with medications.

A verification study of 42 standard quality of service grievances showed one grievance was misclassified as quality of service issue and not reviewed by the Plan's Medical Director. In one case, a member complained about not receiving care that fully addressed their medical issues. Documentation did not show the Plan investigated the quality of care issue or that the Medical Director reviewed the grievance.

Subsequent to the Exit Conference, the Plan disagreed with three samples that occurred prior to its corrective actions to have its grievance nurse review all exempt grievances. However, this was not a finding in the prior audit. The Plan's corrective actions to properly classify exempt vs standard grievances are separate from the requirement to ensure all grievances are referred to the Medical Director.

When quality of care issues are not referred to the Medical Director, the Plan may miss quality improvement opportunities and may not fully address member health care concerns.

Recommendation: Implement policies and procedures to ensure quality of care issues are consistently referred to the Medical Director.

4.1.5 Capturing all Grievances at Provider's Offices

The Plan is required to have procedures for filing a grievance, either orally or in writing, including procedures for appealing decisions regarding member's coverage, benefits, or relationship to the organization or other dissatisfaction with the Plan and/or providers. The Plan shall implement and maintain a Member Grievance System in accordance with CCR, Title 22, section 53858. (*Contract, Attachment 13(4) (D) (12), Attachment 14(1)*)

Plan policy, *MS 8.001 Handling of Complaints and Grievances (approved 10/24/19),* stated a grievance could be filed in writing or verbally with the Plan. The Plan required that a delegate have in place a system to bring grievances about care to its attention. The delegate could use the Plan's or its internal complaint and grievance forms, and should immediately submit all complaints and grievances to the Plan's Member Services Department for resolution.

Finding: The Plan's grievance system did not capture and process all complaints and expressions of dissatisfaction.

Provider interviews with contracted clinics found five of five providers processed grievances internally and did not forward them to the Plan. The providers stated they first attempted to resolve member complaints; if the providers were unable to resolve the member's complaints or a member wanted to submit a formal grievance, the providers would then direct the member to the Plan's member services department, or forward the grievance to the delegate's provider relations department.

This was a finding in the prior audit. As a corrective action, the Plan revised its new provider training materials and informed providers in its summer 2019 provider bulletin that grievances regarding providers were to be sent to the Plan for resolution.

In an interview, the Plan stated it provided education to one delegate during a joint meeting. Plan documentation showed it conducted outreach grievance training with a small group of providers. The Plan's corrective actions did not ensure providers forwarded all grievances to the Plan for processing.

When the Plan does not process grievances, member complaints may not be addressed, investigated, and resolved appropriately.

This is a repeat of prior year finding 4.1.3 - Capturing all Grievances.

Recommendation: Implement policies, procedures, and effective corrective action to capture all grievances.

4.1.6 Report of Grievances to Quality Assurance Committee

The Plan is required to have in place a system in accordance with CCR, Title 22, section 53858 and Title 28, section 1300.68. (*Contract, Exhibit A, Attachment 14(1)*)

Member grievance procedures shall include submittal, at least quarterly, of all member grievances to the Plan's quality assurance committee or review and appropriate action. Member grievance shall include but not be limited to those related to access to care, quality of care, and denial of services. Procedures shall also include review and analysis. (*CCR, Title 22, section 53858*)

A grievance about a denial of service is an appeal. (*APL 17-006*)

Plan policy *MS 8.001 Handling of Complaints and Grievances (approved 10/24/19)* stated grievance reports would be submitted semiannually to the Plan's Quality Assurance Committee (Quality Council) for review and appropriate action. The Plan would use this information to analyze how its existing programs or services could be modified and/or improved.

Finding: The Plan did not report all grievances to the quality assurance committee at least quarterly.

Review of quality committee minutes showed the Plan reported grievances related to access to care and denial of services only semiannually on 9/26/2019 and 3/26/2020. In an interview, the Plan confirmed grievances were only reported semi-annually to the quality committee.

Subsequent to the Exit Conference, the Plan provided additional committee minutes for its governing body, the Joint Commission Council. The meeting minutes show grievance information was presented to the council on 9/11/2019 and 3/13/2020. Documentation did not demonstrate the Plan reviewed the required grievance information quarterly.

When the Plan does not report all grievances quarterly to its quality assurance committee, the Plan cannot ensure appropriate actions are taken timely regarding grievances.

Recommendation: Revise and implement policies and procedures to ensure quarterly reporting of all grievances.

4.1.7 Grievances Alleging Discrimination

The Plan must submit copies of all member or eligible beneficiary grievances alleging discrimination because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56 to DHCS for review and appropriate action. (*Contract, Exhibit E, Attachment 2(28) (C)*)

Plan policy *MS 8.001 Handling of Complaints and Grievances (approved 10/24/19)* stated the Plan complied with applicable Federal civil rights laws and did not discriminate on the basis of race, color, national origin, age, disability, or sex.

Finding: The Plan did not forward grievances alleging discrimination to DHCS for review and appropriate action.

A verification study of 43 standard and 20 quality of care grievances showed members alleged discrimination in three instances:

- One for health status
- Two for race

Grievance files did not show the Plan referred the cases to DHCS for review. The Plan's grievance policy *MS 8.001* did not describe the requirement to report grievances alleging discrimination to DHCS.

In a written response, the Plan provided copies of emails from 2014 showing agreement among multiple health plans that DHCS no longer required reporting of grievances alleging discrimination and that the plans were not reporting them. The Plan did not provide a DHCS document confirming this exemption.

When the Plan does not follow DHCS reporting requirements, alleged discrimination may not receive appropriate investigation.

Recommendation: Develop and implement processes to ensure the Plan reports grievances alleging discrimination to DHCS.

4.2 CULTURAL AND LINGUISTIC SERVICES

4.2.1 Children with Special Health Care Needs (CSHCN)

The Plan shall have a Cultural and Linguistic Services Program that incorporates the requirements of CCR, Title 22, section 53876. The Plan shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. (*Contract, Exhibit A, Attachment 9(13)*)

Plans are required to conduct a Population Needs Assessment (PNA). Plans must address the special needs of SPDs, children with special health care needs, members with limited English proficiency and other member subgroups from diverse cultural and ethnic backgrounds in the PNA findings. (*APL 19-011*)

Finding: The Plan did not address the needs of the children with special health care needs.

The Plan's 2020 PNA, 2019 Cultural & Linguistic Program description, 2019 and 2020 Cultural & Linguistic Work Plan, and the 2020 PNA Action Plan did not identify any needs, findings, goals or objectives for the children with special health care needs population.

In written responses, the Plan stated the APL has no stringent requirements for any particular population and that it has been guided to condense the PNA. Upon reviewing the children with special health care needs section of the 2020 PNA, there is only information on the following: the number of Medi-Cal children currently enrolled in both CCS and the Plan and the top five diagnoses of children with special health care needs.

Plan policy and procedures did not discuss requirements for the PNA.

Subsequent to the Exit Conference, the Plan submitted a response reiterating they addressed this population in an integrated way throughout the report; however, the PNA did not have sufficient information for addressing the special needs of the children with special health care needs population.

If the Plan does not identify the needs of the children with special health care needs population, the Plan may miss opportunities to improve services for one of the most vulnerable subgroups.

Recommendation: Develop and implement a process to ensure the PNA addresses the needs of the children with special health care needs population.

4.3 CONFIDENTIALITY RIGHTS

4.3.1 Background Check

The Plan is required to conduct a thorough background check of employees before the Plan's employee may access DHCS protected health information (PHI) and evaluate the results to assure there is no indication that the worker may present a risk for theft of confidential data. The Plan is required to maintain each workforce member's background check documentation for a period of three years after the employee contract is terminated. (*Contract Amendment 23, Exhibit G (A) (I) (D)*)

DHCS requires that a background check must be conducted for all employees who will have access to DHCS PHI. (*APL 09-014 and CFR, Title 45, section 164.530*)

Plan policy *CR 11.016 Credentialing Licensed CCHP Staff (reviewed 2/19)* states background checks on all persons having access to PHI are required. The policy referenced *Contra Costa County Administrative Bulletin 415* which states its pre-employment background investigation included a fingerprint check, drug screening, license check, and other appropriate requirements.

Finding: The Plan did not ensure that all employees with PHI access had complete background checks.

A verification study of 16 personnel background checks revealed the following:

- Nine of ten files reviewed in the current year were not complete. Two were missing the Live Scan fingerprinting, nine were missing pharmacology checks, and five were missing the sanction checks.
    - In one of ten files, the Plan allowed an employee to work knowing the background check was not completed.
- Six of six files reviewed from the prior year's audit were still not complete. Three were missing Live Scan fingerprinting, four were missing pharmacology checks, and four were missing the sanction checks.

In an interview, the Plan stated Contra Costa County Personnel completed pre-employment screening and background checks.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: May 1, 2019 through April 30, 2020
DATE OF AUDIT: August 17, 2020 through August 28, 2020

This was a finding in the prior year's audit. As a corrective action plan, the Plan stated it followed the policies and procedures of the county for hiring of new employees and subcontractors. The Plan provided no evidence of actions to correct the prior year's deficiency.

Subsequent to the Exit Conference, the Plan submitted a response stating that all employees were hired outside the audit period and it cannot go back to perform background checks on staff that have been hired in previous years due to union and employment agreements. These employees had access to PHI during the audit period without having a background check completed. The Plan stated, effective August 2019 for new hires, they are requesting a copy of the background check from the county. The Plan did not provide documentation to support this statement.

Failure to complete background checks of all individuals who will have PHI access increases the risk of theft or unauthorized use of members' PHI.

This is a repeat of the prior year finding 4.3.3. - Background Check.

Recommendation: Implement policies, procedures, and effective corrective actions to ensure background checks are completed for all individuals prior to providing them with access to PHI.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Contra Costa Health Plan
AUDIT PERIOD: May 1, 2019 through April 30, 2020 **DATE OF AUDIT:** August 17, 2020 through August 28, 2020

CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM

5.1.1 Investigation of Potential Quality Issues

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers. (*Contract, Exhibit A, Attachment 4(1)*)

Plan policy *QM 14.502 Potential Quality Issue (revised 2/24/20)* stated if the Medical Director determines there is not enough information for the Potential Quality Issue (PQI) investigation, the Plan sends a request for additional information, including clinical data. The Medical Director closes the review when the PQI is complete. For PQI cases referred to one delegate's peer review committee, the Plan contacts the delegate after 30 days to document when the case underwent peer review.

Finding: The Plan did not thoroughly investigate and evaluate potential quality issues prior to closing cases.

A verification study showed that complete investigation beyond the initial grievance response form, which was filled out by the relevant supervisor, was not conducted for two of seven PQI cases where further investigation was necessary.

- In one case, an elderly member with chronic dizziness sustained significant physical harm due to an unattended fall at a skilled nursing facility. The Plan sent a response form to the facility and closed the case with an indication that the evidence submitted did not corroborate with the member's allegations. The Plan did not request the following items: California Department of Public Health (CDPH) investigation records of the same incident, clinical records indicating the member's chronic medical problems and vital signs from the member's stay at the facility, and testimony from the facility's physician staff.

- In another case, a member experienced sedating side effects from prescribed medications and filed a grievance against a delegate's provider. The Plan sent a response form to the provider's supervisor; the delegate subsequently referred the case to its peer review committee. After receiving the response form, the Plan documented peer review and case closure dates. The Plan did not investigate or receive the delegate's peer review recommendations or final actions.

For the case of the unattended fall, the Plan stated that requesting records from CDPH was not part of the current process and requesting records from physician staff would be of minimal use. When asked about the PQI process involving the delegate's providers, the Plan stated it requests the date of the delegate's peer review but does not request the delegate's peer review's final recommendations or implemented actions due to confidentiality issues.

If the Plan does not thoroughly investigate, evaluate, and take appropriate actions for PQIs, this may lead to poor quality of care for members, repeat instances, and missed opportunities for addressing underlying problems.

Recommendation: Revise and implement policies and procedures to ensure thorough investigation of PQIs prior to closing cases.

5.1.2 PQI Delegation Agreement

If the Plan delegates quality improvement functions, the Plan and delegate shall include in their subcontract, at a minimum, quality improvement responsibilities and specific delegated functions and activities of the Plan and delegate; and the Plan's reporting requirements. (*Contract, Exhibit A, Attachment 4(6) (A)*)

Plan Policy *QM 14.301 Delegation Oversight Process (revised 8/2/19)* stated the Plan partially delegates quality improvement functions to one delegate.

Plan Policy *QM 14.502 Potential Quality Issue* (*revised 2/24/20)* stated for Potential Quality Issue (PQI) cases referred to one delegate's peer review committee, the Plan contacts the delegate after 30 days to document when the case underwent peer review.

The Plan's delegation agreement with one delegate stated in the event that it identifies services as unsatisfactory, the delegate shall investigate and cooperatively work with the Plan to resolve and address the quality issues. Such cooperation shall include the delegate providing information and data to the Plan.

Finding: The Plan did not describe specific delegated quality improvement activities and reporting requirements for PQIs adjudication in the delegation agreement with one delegate.

One of seven sampled PQI cases involved the delegate. In the case, a member experienced sedating side effects from prescribed medications and filed a grievance against a delegate's provider. The Plan sent a response form to the provider's supervisor; the delegate subsequently referred the case to its peer review committee.

The Plan documented the delegate's peer review and case closure dates. The Plan did not investigate or receive the delegate's peer review recommendations or final actions.

The Plan's delegation agreement did not specify the delegate's responsibilities for reporting detailed investigation information or peer review actions to the Plan.

The Plan acknowledged its delegation agreement did not specify actions related to PQIs. For the PQI process involving the delegate's providers, the Plan stated it requests the date of the delegate's peer review but does not request the delegate's peer review's final recommendations or implemented actions due to confidentiality issues. The Plan stated the delegate would report serious quality concerns affecting a provider's privileges to the Plan's Peer Review and Credentialing Committee (PRCC). Based on PRCC meeting documents, the delegate's quarterly credentialing and recredentialing reports reviewed by PRCC listed limited information on the credentialing status of the delegate's providers. The delegate stated if there was a serious quality concern, the delegate would hold a joint case conference with the Plan to review the case. The Plan's delegation agreement, Plan policies, and the delegate's policy *Hospital Policy No. 616: Patient Grievance/Complaint Process* did not outline the process or responsibilities for the delegate to report detailed peer review and investigative information to the Plan.

If the Plan does not specify delegated quality improvement functions and reporting requirements, it is unclear which entity is responsible, and the Plan cannot ensure complete investigation and resolution of PQIs which may lead to poor health outcomes.

Recommendation: Revise delegation agreements to include specific delegated quality improvement activities and reporting requirements for PQI evaluation.

5.2 DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

5.2.1 Ownership and Control Disclosures of Delegates

The Plan shall collect and review their subcontractors' ownership and control disclosure information as set forth in *CFR, Title 42, section 455.104*. The Plan must make the subcontractors' ownership and control disclosure information available, and upon request, this information is subject to audit by DHCS. (*Contract, Exhibit A, Attachment 1(2) (B) and APL 17-004*)

The Plan must require each subcontractor to disclose the following information: (1) the name and address of each person with an ownership or control interest in the subcontractor; (2) whether any of the persons named is related to another; (3) the name of any other subcontractor in which a person with an ownership or control interest in the subcontractor also has an ownership or control interest; (4) the name, address, date of birth, and social security number of any managing employee. (*CFR, Title 42, section 455.104*)

Plan policy *PA 9.830 Subcontractual Relationships and Delegation (reviewed 9/19)* stated the Plan shall collect and review its subcontractors' ownership and control disclosure information as set forth in *CFR, Title 42, section 455.104*.

Finding: The Plan did not ensure collection and completion of ownership and control disclosure forms.

Review of disclosure forms of ten quality improvement delegates revealed the following deficiencies:

- The Plan did not collect disclosure forms from two delegates; in a written response, the Plan stated that the delegates are Contra Costa County divisions and government entities; therefore, the Plan did not collect control disclosures. While two of the delegates are government entities under Contra Costa County, the Plan is required to collect control disclosures for each entity's individuals with controlling interest such as Directors and managing employees.

- The Plan did not collect complete information for eight delegates. Six disclosure forms did not disclose all owners and/or individuals with control interest. One disclosure form did not contain tax identification number. Eight disclosure forms did not contain social security numbers, percentage of ownership or control interest, address, and date of birth of all owners and individuals with ownership and/or control interest.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: May 1, 2019 through April 30, 2020
DATE OF AUDIT: August 17, 2020 through August 28, 2020

As a corrective action to the prior audit finding, the Plan developed policy *PA 9.830* to ensure the Plan collects and reviews all delegates' ownership and control disclosure information. However, the Plan did not collect and review all the required ownership and control disclosure information.

When the Plan does not collect and review ownership and control disclosure information of all delegates, it cannot ensure that the delegates' owners and controlling interest individuals are eligible for program participation.

This is a repeat of the prior year finding 5.1.5 - Ownership and Control Disclosure Reviews.

Recommendation: Implement policies, procedures, and effective corrective action to ensure collection and completion of all subcontractor's ownership and control disclosure information.

5.3	PROVIDER QUALIFICATIONS

5.3.1 Completion of Provider Training

The Plan is required to conduct training for all Network Providers within ten working days after it places a newly contracted Network Provider on active status. The Plan shall ensure training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. (*Contract, Exhibit A Attachment 7 (5) A)*)

Plan Policy *PA 9.816 Provider Training (reviewed 10/19)* stated Provider Relations staff orients new network providers to the Plan within ten business days after placement in active status. The policy stated after the orientation the provider is required to sign an attestation form acknowledging they have received training on the provider manual.

Finding: The Plan did not ensure it conducted provider training within ten working days after placement on active status for all newly contracted providers.

A verification study of 36 new providers found that 21 providers did not receive training within the ten day working requirement. These providers received training between 11 and 300 days after they became active with the Plan.

The prior audit found the Plan did not ensure provider training was conducted within ten working days. As a corrective action, the Plan stated it already ensured its policy ensures new providers are trained within 10 working days of being placed on active status. The Plan did not provide a corrective action plan.

Subsequent to the Exit Conference, the Plan submitted a response stating for new provider orientations, a new electronic process was implemented in November 2019 for directly contracted providers and January 2020 for its delegate's providers to ensure provider orientations were sent out. However, providers still did not receive provider training until between 12 and 167 working days after the provider orientations were sent.

When the Plan does not ensure the provider training is conducted timely for newly contracted providers, providers may not be aware of the key contract requirements related to the Medi-Cal program.

This is a repeat of the prior year finding 5.2.1 - Completion of Provider Training.

Recommendation: Implement policies, procedures, and effective corrective action to ensure training for all new providers are conducted within ten working days of being places on active status.

5.3.2 Delegated Provider Training

The Plan may enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. The Plan shall meet the subcontracting requirements as stated in APL 17-004. Each subcontract shall contain specification of the services to be provided by the subcontractor. (*Contract, Exhibit A, Attachment 6(14)*)

Plan policy *PA 9.830 Sub Contracts and Delegation (reviewed 9/3/19)* stated written agreements shall specify any and all delegated activities, obligations, and related reporting responsibilities if the Plan delegates any activity or obligation.

Finding: The Plan did not specify training responsibilities for newly contracted providers in written agreements with four delegates.

In an interview, the Plan stated it delegates provider training to four delegates.

The prior year's audit found the Plan did not specify provider training responsibilities for its delegated entities in its written agreements. As a corrective action, the Plan developed policy *PA 9.830* which states written agreements shall specify any and all delegated activities, obligations, and related reporting responsibilities if the Plan delegates any activity or obligation. The Plan did not adhere to its policies and did not specify in the written delegation agreements new provider training responsibilities.

When delegated provider training responsibilities are not specified in the written agreements, the Plan cannot ensure that contractual requirements are completely fulfilled by the delegated entities.

This is a repeat of the prior year finding 5.2.2 - Delegation of Provider Training.

Recommendation: Implement policies, procedures, and effective corrective action to ensure written agreements include newly contracted provider training responsibilities.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.1	HEALTH EDUCATION PROGRAM

6.1.1 Delegated Health Education

The Plan may enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. The Plan shall meet the subcontracting requirements as stated in APL 17-004. Each subcontract shall contain specification of the services to be provided by the subcontractor. (*Contract, Exhibit A, Attachment 6(14)*)

Plan policy *HE 19.003 Provider Compliance with the Provision of Health Education Services* (*revised 10/16/19*) stated health education services (materials and classes) are to be provided and evaluated by the delegate.

Finding: The Plan's written agreement with a delegate did not specify the delegate's responsibility to provide and evaluate health education services.

In an interview, the Plan stated a delegate provides and evaluates health education classes. These delegated functions were not included in the delegation agreement.

If the Plan's delegation agreement does not include information about the delegate's responsibility to provide and evaluate health education services, the Plan cannot ensure that contractual requirements are completely fulfilled by the delegated entities.

Recommendation: Revise delegation agreement to specify the delegate's responsibility to provide and evaluate health education services.

6.2	FRAUD AND ABUSE

6.2.1 Reporting Potential Fraud, Waste, or Abuse incidents

Fraud means an intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to himself or other person. (*Contract, Exhibit E, Attachment 2(26) (A)*)

The Plan is required to implement and maintain policies and procedures designed to detect and prevent Fraud, Waste, and Abuse. (*Contract, Exhibit E, Attachment 2(26) (B) (1)*)

The Plan is required to promptly refer any potential Fraud, Waste, or Abuse incidents. The Plan is required to conduct, complete, and report to DHCS, the results of a preliminary investigation of suspected fraud and/or abuse within ten working days of the date the Plan first becomes aware of, or is on notice of, such activity. (*Contract, Exhibit E, Attachment 2(26) (B) (7)*)

Plan policy *ADM 1.006, CCHP Anti-Fraud Program (revised 10/2019)* stated if a potential or suspected fraud case is reported to the Anti-Fraud Unit or Compliance Officer, the Compliance Officer will log all anti-fraud inquiries and evaluate the reported incident for validity; a reportable incident is determined if the proper fraud elements exists. The fraud elements include material, a material fact was misrepresented or not disclosed, and willful, it is clear and convincing that there was an intentional misrepresentation. Based upon the supporting documentation the case may be closed with no further action or referred for further investigation and referral to the Program Integrity Unit of DHCS within ten working days the Plan first becomes aware of or is on notice of such activity.

Finding: The Plan did not report all suspected fraud, waste or abuse cases to DHCS within ten working days.

A verification study of eight suspected fraud and abuse cases found the Plan did not report four cases to DHCS within ten working days.

- In one grievance case, a member reported a suspected fraud case regarding a provider not delivering billed equipment. The case was reported to the Plan's Anti-Fraud unit; the Plan's preliminary investigation determined there was not fraudulent activity but the case was not reported to DHCS.

- In three cases, the Plan received suspected fraud detection reports from a vendor; the Plan did not report any of these cases to DHCS. The vendor is responsible for reviewing claims data, identifying, and conducting preliminary investigations for possible fraud, waste, and abuse. The Plan is responsible for making a final determination and initiating any necessary actions. For example, a vendor report informed the plan of suspect billing by a provider: upcoding of office visits, duplicate services, and billing of excessive services.

Plan policy *ADM 1.006* to include written criteria for determining a reportable suspected fraud case. The revisions include two elements: willful and material, as well as the detailed component requirements of each element. Plan policy, *ADM 1.006*, limits the Plan's reporting of all potential FWA incidents. The Plan's determination that a case be willful (intentional misrepresentation) is verification that a case is not suspected but confirmed fraud.

In an interview, the Plan stated that it did not consider its vendor's reports to be a completed investigation subject to being reported within ten working days.

Subsequent to the Exit Conference, the Plan stated once a final determination is made for its vendors' reports, it has ten working days to report suspected the fraud. The final investigation, determination, made by the Plan is not the preliminary investigation. The Plan is required to report the results of its preliminary investigation, which includes the preliminary investigation reports of its vendors within ten working days.

By not reporting all suspected cases of fraud and/or abuse, the Plan is out of compliance with the Contract.

Recommendation: Revise and implement policies and procedures to ensure all suspected fraud, waste, and abuse cases are reported to DHCS within ten working days.

6.2.2 Fraud, Waste, and Abuse Investigations

The Plan 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. The Plan is required to implement and maintain policies and procedures designed to detect and prevent fraud, waste, and abuse. The procedures must include investigation of potential compliance problems as identified in the course of self-evaluation and audits. (*Contract, Exhibit E, Attachment 2(26) (B) (1)*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: May 1, 2019 through April 30, 2020
DATE OF AUDIT: August 17, 2020 through August 28, 2020

Plan policy *ADM 1.006, CCHP Anti-Fraud Program (revised 10/19)* stated if a potential or suspected fraud case is reported to the Anti-Fraud Unit or Compliance Officer, the Compliance Officer will log all anti-fraud inquiries and evaluate the reported incident for validity. The Anti-Fraud Officer will coordinate the conduct of all launched investigations and may involve appropriate plan staff in any investigation.

Finding: The Plan did not investigate all identified suspected fraud, waste, or abuse issues.

A verification study of eight fraud and abuse cases found three cases were not fully investigated.

- In one case, the Plan received a suspected fraud referral report for potential upcoding of office visits and billing of unnecessary services. The Plan's investigation concluded services billed were medically appropriate; the investigation did not address the issues of potential upcoding.

- In another case, the Plan received a suspected fraud referral report for potential upcoding of office visits, duplicate billing of similar services on the same day, and billing of home health supervision without corresponding home health service claims. Documentation showed the Plan conducted a partial investigation into the home health issue but did not document the Plan's final determination. Documentation did not support any other potential fraud issues were investigated or discussed.

- In one grievance case, a member reported a suspected fraud case regarding a durable medical equipment provider not delivering billed equipment. The case was reported to the Plan's Anti-Fraud unit; documentation did not show the Plan attempted to verify the member's fraud claim regarding not receiving equipment billed.

When suspected fraud, waste, or abuse cases are not appropriately investigated the Plan cannot ensure it is meeting its obligation to guard against fraud, waste, and abuse.

Recommendation: Implement policies and procedures to ensure all suspected cases of fraud, waste, or abuse are investigated.

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

REPORT ON THE MEDICAL AUDIT OF

Contra Costa Health Plan

Contract Number:	03-75796 State Supported Services
Audit Period:	May 1, 2019 Through April 30, 2020
Report Issued:	December 21, 2020

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the audit findings of Contra Costa Health Plan (Plan) State Supported Services Contract No. 03-75796. The State Supported Services contract covers contracted abortion services with the Plan.

The onsite review was conducted from August 17, 2020 through August 28, 2020. The audit period was May 1, 2019 through April 30, 2020. The audit consisted of document review of materials supplied by the Plan, verification study, and interviews.

An Exit Conference with the Plan was held on November 19, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

The following verification study was conducted:

Claims: 20 state supported services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: May 1, 2019 through April 30, 2020
DATE OF AUDIT: August 17, 2020 through August 28, 2020

STATE SUPPORTED SERVICES

SUMMARY OF FINDING(S):

No deficiencies were identified in this audit.

RECOMMENDATION(S):

N/A