

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

REPORT ON THE MEDICAL AUDIT OF

Contra Costa Health Plan

2021

Contract Number: 04-36067

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

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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 June 30, 2021, the Plan had 214,729 members of which 207,005 were Medi-Cal including 14,556 Seniors and Persons with Disabilities (SPD) members. The Plan also covers 5,350 county employees, 2,259 commercial members, and 115 uninsured recipients.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of July 1, 2020 through June 30, 2021. The review was conducted from August 2, 2021 through August 13, 2021. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on October 29, 2021. 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 (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of May 1, 2019 through April 30, 2020 was issued on December 21, 2020. This audit examined documentation for compliance and to determine to what extent the Plan has implemented their Corrective Action Plan (CAP).

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 UM program, including delegation of UM, prior authorization review and the appeal process.

The Plan is required to send a Notice of Action (NOA) letter and "Your Rights" attachment information, informing members of a denial, in whole or in part, of a requested covered service. The NOA packet letter must include DHCS standardized templates for the NOA and "Your Rights" attachment. A nondiscrimination notice and language assistance tagline must be included with the NOA. The Plan did not utilize the required DHCS NOA letter template, sent outdated "Your Rights" information, and did not send a nondiscrimination notice and a language assistance tagline.

The Plan is required to ensure decisions regarding prior authorization are explained clearly and concisely in the NOA letters, and that for medical necessity denials, include a clinical reason for the denial and how the member's condition did not meet the criteria or guidelines. The Plan did not provide clear explanations of the reasons for the decisions, or a clinical reason and explicit explanation of how member's condition did not meet the criteria for medical necessity denials in the NOA letters.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to provide Health Risk Assessments (HRA) for SPD, California Children's Services (CCS), early intervention and developmental disabilities, complex case management, and mental health and substance abuse services.

The Plan must use the HRA to comprehensively assess 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 HRA must include specific Long Term Services and Supports (LTSS) referral questions; however, the LTSS questions are not to be used in member classification. The Plan incorrectly used the LTSS referral questions for classifying members as high risk through the HRA.

The Plan is required to develop and implement written policies and procedures to ensure that contracting providers understand that CCS reimburses only CCS-paneled providers and CCS-approved hospitals within Plan's network; and only from the date of referral. The Plan did not have policies and procedures to ensure contracting providers understand CCS reimbursement policies.

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 and family planning services.

The Plan is required to pay qualified family planning providers a fixed add-on amount for certain family planning services within 90 calendar days of receiving clean claims or accepted encounters as required by All Plan Letter (APL) 20-013. The Plan did not distribute add-on payments for specified family planning service claims within 90 calendar days.

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.

Prior to granting access to DHCS PHI, the Plan is required to conduct a thorough background screening to ensure that employees given access to DHCS PHI do not pose a risk for theft of confidential data. 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 is required to implement and maintain policies that specify the governing body must approve the QIS, the annual QIS report, and written description of the QIS. The Plan's governing body did not review and approve the Plan's 2021 Quality Improvement Program Description, 2021 Quality Work Plan, and 2020 Quality Program Evaluation.

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 new provider training within ten working days of placing a newly contracted provider on active status, and if the Plan delegates this function, the subcontract must specify the delegated activities, respective responsibilities and include the Plan's oversight, monitoring and evaluation processes. The Plan did not specify responsibilities for training newly contracted providers or its oversight processes in its delegation agreements.

Category 6 – Administrative and Organizational Capacity

No findings noted for the audit period.

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 review was conducted from August 2, 2021 through August 13, 2021. 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

Service Requests: A total of 28 cases, which included five SPD members, were reviewed for timeliness, consistent application of criteria, and appropriate review. Of the 28 cases, four were retrospective requests, 21 were prior authorization requests, and three were concurrent requests.

Appeal Procedures: A total of 20 appeals, which included seven SPD members, were reviewed for appropriate and timely adjudication.

Delegated Prior Authorization Requests: 18 prior authorization requests, which included eight SPD members were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

HRA Requirements: 14 files concerning SPD members were reviewed to confirm coordination of care and fulfillment of HRA requirements.

CCS: Five medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Complex Case Management: Six medical records, which included one SPD member, were reviewed for coordination of care.

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

Category 3 – Access and Availability of Care

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

NMT: 25 claims were reviewed for timeliness and appropriate adjudication.

NEMT: 25 claims were reviewed for timeliness and appropriate adjudication. Contracted NEMT providers were reviewed for Medi-Cal enrollment.

Category 4 – Member's Rights

Grievances: 50 standard grievances, which included 24 for SPD members, 11 exempt grievances, one expedited grievance, and 15 call inquiries were reviewed for timely resolution, appropriate classification, response to complainant, and submission to the appropriate level for review. The 50 standard grievance cases included 25 quality of service and 25 quality of care grievances.

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

Background Check Verification: Ten samples were reviewed to determine if appropriate procedures were performed.

Category 5 – Quality Management

Potential Quality Incidents (PQI): Ten PQI cases were reviewed for timely evaluation and effective action taken to address needed improvements.

Provider Training: 35 new provider training records were reviewed for the timeliness of Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 12 fraud and abuse cases were reviewed for appropriate reporting and processing.

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: July 1, 2020 through June 30, 2021

DATE OF AUDIT: August 2, 2021 through August 13, 2021

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Contents of Notice of Action (NOA) and “Your Rights” Attachment Packet

NOA is a formal letter, in a format approved by DHCS, informing a member of the denial or limited authorization of a requested covered service; the reduction, suspension, or termination of a previously authorized covered service; a denial, in whole or in part, of payment for a covered service; the failure to authorize covered services in a timely manner; the decision to extend the time frame to authorize a covered service; and an expedited service authorization decision. (*Contract, Exhibit A, Attachment 14(4) (A)*)

Members must receive written notice of an Adverse Benefit Determination. Content requirements of the NOA packet include DHCS standardized templates for the NOA and “Your Rights” attachment. Plans 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 members. Templates for nondiscrimination notice and language assistance tagline must be sent to members in conjunction with the NOA. Superseded by APL 21-011, August 31, 2021. (*APL 17-006*)

Plan policy *UM 15.011 Inpatient Utilization Review (reviewed/approved 4/13/2021)* stated, “depending upon product line, the UM nurse sends a facility notification or denial notice (along with appeal rights) to member and provider explaining the principle/clinical reason(s) for continued stay and payment denial.”

Plan policy *UM 15.015a Timeliness of the Utilization Review Decision and Communication (revised 1/18/2021)* listed general contents of the NOA letter and “Your Rights” attachment and contained the correct DHCS “Your Rights” attachment template. The policy did not include information on the requirements to use DHCS standardized NOA templates and to send a nondiscrimination notice and language assistance tagline with NOAs.

Finding: The Plan did not send all required contents of the NOA and “Your Rights” attachment packet to the member for denials involving inpatient days. The Plan did not utilize the required DHCS “Deny” NOA letter template, sent outdated “Your Rights” information, and did not send a nondiscrimination notice and a language assistance tagline.

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A verification study showed that in four of four denials of inpatient days (involving one retrospective service request and three concurrent review service requests), the Plan sent a NOA letter and “Your Rights” attachment with incomplete and incorrect information to members. The NOA letter did not use the DHCS “Deny” NOA letter template and contained additional information on provider appeals not included in the DHCS template. The Plan did not use the required DHCS “Your Rights” attachment template and sent outdated information for State Fair Hearing (SFH) filing process, grievance filing timeframe, Independent Medical Review (IMR) process, and Department of Managed Health Care contact information. For all four cases, the Plan did not send the required nondiscrimination notice and language assistance taglines.

During the interviews, the Plan explained that for inpatient stays it used a facility notification template as the member NOA letter and “Your Rights” attachment. Although Plan policy *UM 15.015a* included the correct “Your Rights” attachment, the facility notification template did not contain the required “Your Rights” information. The Plan acknowledged it did not send a nondiscrimination notice and language assistance tagline in addition to the facility notification letter. The Plan stated that the facility notification template was approved by DHCS. However, DHCS did not approve use of an alternate NOA letter and “Your Rights” attachment for member notifications involving inpatient stays.

When the Plan does not use DHCS required templates for NOA and “Your Rights” packet information, members may not receive complete and correct information on the denial of services and how to exercise the member’s rights including appeals, SFHs, IMRs, legal help, and language assistance.

Recommendation: Revise and implement policies and procedures for denials of inpatient days to ensure required contents of the DHCS NOA letter and “Your Rights” attachment packet are sent, including a nondiscrimination notice and language assistance tagline.

1.2.2 Explanation of Reason for Decision in NOA

The Plan shall ensure prior authorization, concurrent review and retrospective review procedures meet the following minimum requirement: reasons for decisions are clearly documented. (*Contract, Exhibit A, Attachment 5(2) (E)*)

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For decisions based in whole or in part on medical necessity, the written NOA shall contain the clinical reasons for the decision. The Plan shall explicitly state how the member's condition does not meet the criteria or guidelines. For all other adverse benefit determinations (e.g., denials based on a lack of information, or benefit denials, etc.) that are not based on medical necessity, Plans shall ensure that the NOA still provides a clear and concise explanation of the reasons for the decision. (APL 17-006)

Plan policy *UM15.015a Timeliness of the Utilization Review Decision and Communication (revised 1/18/2021)* stated that for decisions involving denial, delay, or modification of services, the Plan was required to document a clear, concise and understandable explanation of reason for the decision as well as the clinical reasons for medical necessity denials in NOA letters.

Finding: The Plan did not provide a clear explanation of the reason for the decision in NOA letters. The Plan did not provide a clinical reason for the decision and did not explicitly state how the member's condition did not meet the criteria for medical necessity denials, and did not provide a clear explanation for denials not based on medical necessity.

A verification study revealed that in four of 28 prior authorization, concurrent review, and retrospective service requests, the Plan did not provide a clear explanation or clinical reason for the decision in the NOA letter.

- In one retrospective review case involving medical necessity, the reason for denial was "You do not meet Medi-Cal guidelines". The Plan did not state why the member's condition did not meet Medi-Cal criteria for supplemental oxygen, such as details of the member's oxygenation status.
- In one concurrent review request based on medical necessity, the reason for denial of inpatient days was unclear. The NOA letter stated there was a delay in discharging the member to a skilled nursing facility. However, the NOA did not explicitly describe why the member's medical status no longer met criteria for acute inpatient hospitalization.

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- In one prior authorization case involving medical necessity, the reason for denial was “your child is getting speech services from the Regional Center” and “this request...is considered a duplicate request”. The pediatric member was receiving speech therapy once a week from the Regional Center, and the provider submitted a new request for additional sessions per week at a different center because the member required more frequent treatment. The Plan incorrectly considered this as a duplicate and did not thoroughly explain that the request was denied because the additional speech therapy sessions requested could be provided by the Regional Center.
- In one prior authorization request for transgender services that was not based on medical necessity, the reason for denial was “CCHP has asked for a letter from a mental health professional clearing you for surgery. As of today, this letter has not been received.” The NOA letter did not clearly explain that the Plan did receive one evaluation letter from the member’s mental health provider but did not receive the required second mental health evaluation letter from a different mental health professional.

In a written statement, the Plan stated the UM physician is responsible for ensuring the NOA letter explanation is clear and describes the clinical reason for denial. During the interview, the Plan stated that for some medical necessity decisions, it is too complicated to accurately explain why the member did not meet clinical criteria; therefore, the Plan uses simple language stating that criteria were not met in order to maintain a sixth grade reading level.

When the Plan does not provide a clear explanation of the reason for denial of services, providers and members may not understand the Plan’s processes, criteria, and decisions, which can impact the ability to make informed health care decisions.

Recommendation: Implement policies and procedures to ensure that NOA letters contain clear explanations of the reasons for denials. For decisions involving medical necessity, ensure that a clinical reason for a denial explicitly states why the member did not meet criteria.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	BASIC CASE MANAGEMENT CALIFORNIA CHILDREN’S SERVICES
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2.1.1 Use of Long-Term Services and Support Referral Questions

The Plan must use the HRA to comprehensively assess each newly enrolled SPD member’s current health risk. In addition, the HRA must include specific LTSS referral questions. These questions are intended to assist the Plan in identifying members who may qualify for, and benefit from, LTSS services. These questions are for referral purposes only and are not meant to be used in classifying high and low risk members. (APL 17-013)

Plan policy *CM 16.019 SPD Risk Stratification and Health Risk Assessment and HIF/MET Process (reviewed 2/12/2021)* stated that the Plan evaluates the data received from the member’s HRA to re-stratify using the risk stratification tool based on the member’s self-reported conditions and may re-designate the member as high or low risk. Based on the information identified through the HRA process, the Plan’s case management develops a care plan and coordinates referrals to identified LTSS.

Finding: The Plan incorrectly used LTSS referral questions for classifying members as higher risk through the HRA.

During the interviews, the Plan stated members that answer “yes” to three or more questions on the HRA form, including the LTSS referral questions, are classified as higher risk. Members classified as higher risk are referred to case management for development of care plans and coordination of care, including LTSS services.

Subsequent to the Exit Conference, the Plan stated that its staff misspoke during the interview. Members’ answers in response to the Plan’s LTSS questions have no impact on classifying or reclassifying the member as high or low risk. Additional documentation was not provided to support the Plan’s statements.

When the Plan inaccurately classifies a member as higher or lower risk, the result may be inappropriate access to, and delivery of, healthcare services.

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Recommendation: Revise and implement procedures to use LTSS referral questions for referral purposes only, and not for HRA classification as higher or lower risk.

2.1.2 California Children's Services Provider-Informing Materials

Plan shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program and inform contracting providers that CCS reimburses only CCS-paneled providers and CCS-approved hospitals within Plan's network; and only from the date of referral.

(Contract, Exhibit A, Attachment 11(9))

Plan policy *UM 15.038 Coordinating Care with Specialized Programs (reviewed 07/2021)* stated in order to facilitate coordination of care between the Primary Care Provider and the CCS provider, the UM Unit or designee will inform contracted providers of Plan members receiving care with a CCS specialty providers. The Plan's policy did not describe how providers would be informed of CCS reimbursement policies.

Finding: The Plan does not have policies and procedures to ensure contracting providers understand CCS reimbursement policies.

The Plan's provider informing materials and provider training did not inform contracting providers that CCS reimburses only CCS-paneled providers and CCS-approved hospitals within Plan's network; and only from the date of referral.

During the interview, the Plan stated that the Plan informs providers of its policies and procedures for identifying and referring children to the CCS program; and, for coordinating services for children receiving CCS authorized services through onboarding materials, online, policies and procedures, provider trainings, and quarterly provider newsletters. However, Plan documentation did not discuss CCS reimbursement policies.

When the Plan does not maintain policies and procedures to inform providers of CCS reimbursement procedures, the Plan cannot ensure compliance with Contract requirements.

Recommendation: Develop and implement policies and procedures to ensure provider informing materials include information that CCS reimburses only CCS-paneled providers and CCS-approved hospitals within Plan's network; and only from the date of referral.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.6	FAMILY PLANNING CLAIMS
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3.6 Proposition 56 Family Planning Payments

The Plan is required to reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal Fee-For-Service rate. *(Contract, Exhibit A, Attachment 8(9))*

The Plan shall comply with all existing policy letters and APLs issued by DHCS. *(Contract, Exhibit E(2) (1) (D))*

The Plan is required to directly or through their delegated entities pay qualified family planning providers a fixed add-on amount for specified family planning services listed in APL 20-013, using Proposition 56 appropriated funds. This payment obligation applies to contracted and non-contracted providers. The uniform dollar add-on amounts for the services listed are in addition to whatever other payments eligible providers would normally receive from the Plan. For clean claims or accepted encounters with dates of service between July 1, 2019, and the date the Plan receives payment from DHCS, the Plan must ensure that payments required by this APL are made within 90 calendar days. *(APL 20-013)*

Finding: The Plan did not distribute add-on payments for specified family planning service claims as required by APL 20-013.

A verification study found in three of three family planning claims the Plan did not distribute add-on payments according to APL 20-013.

In a written response, the Plan stated delays in payments were due to staffing issues. The Plan acknowledged that the add-on payments were not distributed for the three family planning claims.

When the Plan does not distribute payments within the required timeframe, this may discourage providers from participating with the Plan and limit members' access to care.

Recommendation: Develop and implement procedures to distribute Family Planning Service add-on payments within 90 calendar days of receiving a clean claim or accepted encounter.

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CATEGORY 4 – MEMBER’S RIGHTS

4.3	CONFIDENTIALITY RIGHTS
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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 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, 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 *2021-1 CCHP Personnel Hiring and On-Boarding (revised 01/2021)* stated after prospective Plan staff are made an offer for the position; the county conducts a background check. Plan staff will receive a notification from the Contra Costa County Health Services Division Background Clerk that states the background check process is completed.

Plan policy *CR 11.016 Credentialing Licensed CCHP Staff (reviewed 12/2020)* stated 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 includes 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 ten personnel background checks revealed the following:

- One of seven files reviewed in the current year were not complete. The Live Scan fingerprinting was missing.
- Three of three files reviewed from the prior year's audit were still not complete. Three were missing Live Scan fingerprinting and one was missing a sanction check.

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During the interview, the Plan stated Contra Costa County only began requiring background checks for all new hires in 2018. The Plan stated Contra Costa County Counsel has indicated that if the Plan wants to conduct background checks on previously hired employees, the unions would have to be involved. The Plan and county counsel have yet to come to an agreement on how to implement background checks for current employees.

This was a finding in 2019 and 2020. As part of its CAP, the Plan stated it would compile a list of Plan staff and determine for which staff the background check could not be located. The listing indicates the Plan is only checking employees who started with the Plan in 2018 and beyond. The Plan's corrective action did not resolve conducting missing background checks on current employees.

When the Plan does not complete background checks of all individuals who have PHI access this may increase the risk of theft or unauthorized use of members' PHI.

This is a repeat of prior years' findings, 4.3.3 (2019) and 4.3.1. (2020), Background Check.

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

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CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM
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5.1.1 Governing Body Approval of Quality Improvement System

The Plan shall implement and maintain policies that specify the responsibilities of the governing body including approval of the overall QIS and the annual report of the QIS. (*Contract, Exhibit A, Attachment 4(3) (A)*)

The Plan shall implement and maintain a written description of its QIS that shall include the organizational commitment to the delivery of quality health care services as evidenced by goals and objectives, which are approved by the Plan’s governing body and periodically evaluated and updated. (*Contract, Exhibit A, Attachment 4(7) (A)*)

The Plan’s *2021 Quality and Performance Improvement Program Description* stated, “The Joint Conference Committee (JCC) of the Board of Supervisors and the Plan is the mechanism by which the Contra Costa Board of Supervisors exercises oversight of CCHP. Responsibilities of the JCC include: review, evaluate, and make recommendations to the board, annually or more frequently as required, regarding modifications of the Annual Quality Program Description, Annual Quality Program Evaluation and Quality Work Plan.”

Finding: The Plan’s governing body did not review and approve the Plan’s 2021 Quality Improvement Program Description, 2021 Quality Work Plan, and 2020 Quality Program Evaluation.

In a written response, the Plan explained that information from the Quality Department, including approved documents from the Quality Council, are sent to the JCC for review 72 hours prior to the JCC meeting. The board members vote to approve all quality documents during the JCC meeting.

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The Plan's 2021 Quality Improvement Program Description, 2021 Quality Work Plan, and 2020 Quality Program Evaluation documents showed signature approval from the Quality Council chairs during the audit period, but were missing signature approval from the JCC representatives. JCC meeting minutes and packets demonstrated that brief highlights from the Quality Work Plan Roadmap were discussed, but there was no evidence or documentation that the JCC reviewed the complete annual quality program documents. In addition, the JCC meeting minutes and packets did not show the JCC's review and approval of Quality Council meeting minutes and packets. The Plan's Quality Director position was vacant during the time the quality documents would have been submitted to the JCC.

Subsequent to the Exit Conference, the Plan submitted an affidavit from the governing body attesting that the JCC annually approves the Quality Work Plan; however, documentation provided did not demonstrate the Annual Quality Program documents were reviewed or approved during the audit period.

When the Plan's governing body does not review and approve key quality program documents, important priorities and objectives may be overlooked.

Recommendation: Develop and implement policies and procedures to ensure that the Plan's governing body reviews and approves the annual Quality Improvement Program Description, Quality Work Plan, and Quality Program Evaluation.

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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 Code of Federal Regulations (*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 09/2019)* 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.

A review of eight quality improvement delegates revealed the following deficiencies:

- The Plan did not collect complete disclosure form information from seven delegates. The delegates' disclosure forms listed "not applicable" for the names of individuals with ownership and control.
 - In one example, the Plan received a letter from its delegate stating its ownership and control is comprised of a Board of Directors and a management team. However, the Plan did not collect any information on these individuals.
- One delegate's disclosure form included the names of the Board of Directors, however it did not contain the social security numbers, address, and date of birth of all individuals with control interest.

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This was a finding in 2019 and 2020. The prior year's audit found the Plan did not ensure collection and completion of ownership and control disclosure information. As a corrective action, the Plan implemented a new process to include the use of a checklist to ensure all required ownership and control interest information is collected. If the information collected is not complete, the Plan would return the form to the delegates; however, the Plan did not utilize the checklist for two delegates and did not return six incomplete forms for correction. The Plan did not fully implement its corrective action to resolve the prior year's finding.

Subsequent to the Exit Conference, the Plan responded that disclosure of a social security number and DOB are only required if an individual owns the entity. However, the Plan is also required to collect information on individuals with controlling interest such as but not limited to Board of Director members and managing employees.

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 prior year findings, 5.1.5 (2019) and 5.2.1 (2020), Ownership and Control Disclosures of Delegates.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

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

DATE OF AUDIT: August 2, 2021 through August 13, 2021

5.3

PROVIDER QUALIFICATIONS

5.3.1 Delegated Provider Training

The Plan may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. In doing so, the Plan is required to 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)*)

If the Plan delegates any activity or obligation to a subcontractor, whether directly or indirectly, the subcontract or written agreement shall specify any and all delegated activities and obligations. (*APL 17-004*)

Plan policy *PA 9.830 Sub Contracts and Delegation (reviewed 06/2021)* stated written agreements shall specify any and all delegated activities, obligations, and related reporting responsibilities if the Plan delegates any activity or obligation.

Plan desk process *CCHP New Provider Orientation Email Notifications (revised 5/17/2021)* stated the Plan is responsible for sending and conducting new provider orientations for a subset of providers for the two delegates.

The written agreements for the two delegates stated the delegates shall conduct provider orientation within ten business days for all new network providers after being placed active in the network.

Finding: The Plan's delegation agreements did not specify the division of provider training responsibilities between the Plan and the two delegates. The agreements inaccurately assigned all provider training responsibilities to the delegates.

During the interview, the Plan stated it is responsible for sending and conducting new provider orientations for two of its delegates within Contra Costa, Solano, and Alameda Counties. For providers who fall outside those areas, the two delegates are responsible for conducting new provider orientations. The Plan stated there was an understanding between the Plan and its delegates regarding the Plan's responsibility to conduct provider orientations for providers located within Contra Costa, Solano, and Alameda Counties. However, this is not specified in the two delegation agreements.

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This was a finding in 2019 and 2020. The prior year's audit found the Plan did not specify new provider training responsibilities for its delegated entities in its written agreements. As a corrective action, the Plan revised the delegation agreements. However, two of the revised delegation agreements do not specify the division of training responsibilities between the Plan and its delegates.

Subsequent to the Exit Conference, the Plan stated it verified with its credentialing staff and the two-delegated entities, that all new provider training was being performed by the delegated entities as written in the delegation agreement. The Plan's desk process and written response during the onsite stated there was a division of provider training responsibilities for the two delegates. Additional documentation was not provided to support the Plan's post-exit statements.

When the division of 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 prior years' findings, 5.2.2 (2019) and 5.3.2 (2020), Delegation of Provider Training.

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

5.3.2 Oversight of Delegated 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))*

The Plan is accountable for all quality improvement functions and responsibilities that are delegated to subcontractors. If the Plan delegates quality improvement functions, the written agreement shall include the Plan's oversight, monitoring, and evaluation processes and the subcontractor's agreement to such processes. *(Contract, Exhibit A, Attachment 4(6))*

Plan policy *PA 9.816 Provider Training (revised 10/2020)* stated delegated entities have linked the Plan's Provider Manual to their orientation process, which is reviewed prior to performing services on any member. Providers are required to sign an attestation to acknowledge they have received training on the Provider Manual.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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Finding: The Plan did not conduct oversight of new provider training for four delegated entities to ensure completion of provider training within ten working days. The Plan's written agreements with the four delegates did not specify the Plan's oversight processes.

The four delegation agreements stated the delegates would provide the Plan's orientation within ten business days for all new network providers after being placed active in the network. The delegation agreements did not specify the Plan's oversight process.

During the interview, the Plan stated it conducts oversight of its provider training delegates through the annual credentialing audit. However, the Plan also stated the credentialing audit tool did not include new provider training requirements. Review of the annual delegation audits confirmed new provider training requirements were not reviewed.

In a written response, the Plan further stated it annually verifies its delegates' provider training information is consistent with Plan processes. Plan documentation shows it verified its delegates' provider training information was compliant; however, the Plan did not verify provider training was conducted for its delegates' newly contracted providers.

Subsequent to the Exit Conference, the Plan stated the delegation agreements do contain audit language for the oversight of provider orientation on an annual basis. However, while the delegation agreements do discuss oversight, it is specific to the credentialing and re-credentialing process. Oversight language of provider training is not included in the delegation agreements.

When the Plan does not conduct oversight of its delegated functions and the Plan's oversight processes are not specified in the written agreements, the Plan cannot ensure that contractual requirements are fulfilled by the delegated entities and the Plan.

Recommendation: Develop and implement oversight policies and procedures to ensure delegated provider training is conducted within ten working days after being placed on active status. Revise delegate agreements to include the Plan's oversight processes.

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

REPORT ON THE MEDICAL AUDIT OF

Contra Costa Health Plan

2021

Contract Number: 03-75796
State Supported Services

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

Report Issued: November 24, 2021

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II. COMPLIANCE AUDIT FINDINGS2

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 2, 2021 through August 13, 2021. The audit period was July 1, 2020 through June 30, 2021. The audit consisted of document review of materials supplied by the Plan, verification study, and interviews.

20 State Supported Services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

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STATE SUPPORTED SERVICES

SSS.1 Proposition 56 State Supported Service Payments

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology Codes*: 59840 through 59857. (*Hyde Contract, Exhibit A(1)*)

The Plan is required to comply with applicable terms and conditions of the primary Contract. (*Hyde Contract, Exhibit E(1) (A)*)

The Plan shall comply with all existing policy letters and All Plan Letters (APL) issued by the Department of Health Care Services. (*Contract, Exhibit E(2) (1) (D)*)

The Plan is required to reimburse individual rendering providers that are qualified to provide and bill for medical pregnancy termination services with dates of service on or after July 1, 2017, using Proposition 56 appropriated funds. The Plan, or its delegated entities and subcontractors, are required to pay updated rates for service codes 59840 and 59841 as listed in APL 19-013. This payment obligation applies to contracted and non-contracted providers. The Plan is required to distribute the payments required by this APL within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services. (*APL 19-013*)

Finding: The Plan did not distribute payments for State Supported Services claims required by APL 19-013.

A verification study found in 11 of 11 State Supported Service claims the Plan did not pay the updated rates according to APL 19-013.

In a written response, the Plan acknowledged it had not made payments according to APL 19-013 due to staffing issues.

When the Plan does not distribute payments within the required timeframe, this may discourage providers from participating with the Plan and limit members' access to care.

Recommendation: Develop and implement procedures to distribute State Supported Services payments in compliance with Contract requirements.