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

REPORT ON THE MEDICAL AUDIT OF

Community Health Group Partnership Plan

2021

Contract Number: 09-86155

Audit Period: June 1, 2019 Through May 31, 2021

Report Issued: October 19, 2021

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I. INTRODUCTION

Incorporated in 1982, Community Health Group Partnership Plan (Plan) first contracted with the Department of Health Care Services (DHCS), formerly known as the Department of Health Services, in 1986 to provide services to Medi-Cal members. In 2005, the Plan obtained a Knox-Keene license from the California Department of Managed Health Care to services its Medi-Cal members.

The Plan currently contracts with DHCS to provide services to Medi-Cal beneficiaries under the Geographic Managed Care program in San Diego County. The Plan provides health care services through contracts with community clinics, medical groups, and individual physicians. The Plan provides pharmacy services through a contract with Pharmacy Benefits Manager, MedImpact Healthcare Systems, Inc.

As of June 2021, the Plan served 292,125 members through the following programs: Medi-Cal 285,274 and Cal MediConnect 6,851.

II. EXECUTIVE SUMMARY

This report presents the results of the full scope medical audit for the two-year audit period of June 1, 2019 through May 31, 2021. DHCS conducted the audit of the Plan from June 21, 2021 through July 2, 2021. The audit consisted of document review, verification studies, and interviews with Plan personnel.

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

An Exit Conference with the Plan was held on September 30, 2021. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. Based on the Plan's written remarks on October 12, 2021, the Plan decided not to submit a response to the audit findings.

The prior DHCS medical audit issued on November 20, 2019, for the audit period of June 1, 2018 through May 31, 2019, identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP closeout letter dated March 11, 2020, documented that DHCS closed all previous findings.

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

The summary of the current findings by category follows:

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements for Initial Health Assessment (IHA) and Complex Case Management.

The Plan shall cover and ensure the provision of an IHA to each new member within 120 days of enrollment. An IHA consists of a comprehensive history and physical examination, preventive services, and an Individual Health Education Behavioral Assessment (IHEBA). Prior to the Public Health Emergency (PHE), the Plan did not ensure the provision of a timely and comprehensive IHA.

The Plan shall ensure the provision of comprehensive medical case management to each member through the provision of either basic or Complex Case Management activities based on the medical needs of the member. Although basic case management services were provided, the Plan did not ensure the provision of Complex Case Management services.

Category 3 – Access and Availability of Care

Category 3 includes the requirements to provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for members.

In accordance with All Plan Letter (APL) 17-010, *Non-Emergency Medical and Non-Medical Transportation Services*, the Plan must provide door-to-door medically appropriate NEMT services to members who cannot reasonably ambulate or are unable to stand or walk without assistance. Plan policy and procedures lack APL language of the NEMT requirement that door-to-door assistance will be performed by the transportation provider and ensured by the Plan.

The Plan must ensure its NMT and NEMT providers are enrolled in the Medi-Cal program. The Plan contracted with transportation vendors not enrolled in the Medi-Cal program.

Category 5 – Quality Management

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

The Plan is required to conduct training regarding the Medi-Cal Managed Care program for all new providers within ten-working-days after the Plan places a newly contracted provider on active status. The Plan did not provide training for newly contracted providers within ten-working-days.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The review was conducted from June 21, 2021 through July 2, 2021. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 20 denied medical and 20 denied pharmacy prior authorization requests were reviewed. All claims were evaluated for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Delegation of UM: 20 prior authorization cases from a delegate were reviewed for appropriate and timely adjudication.

Appeal Procedures: 20 prior authorization appeals were reviewed. The Plan does not delegate appeals. All appeals were evaluated for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services: Five medical records were reviewed for completeness, timeliness, and evidence of coordination of care between the Plan and providers.

Initial Health Assessment: 32 medical records were reviewed for provision, completeness, and timeliness of IHAs.

Complex Case Management: Six medical records were reviewed for coordination of care.

Behavioral Health Treatment: 20 medical records were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

Continuity of Care: 13 medical records were reviewed for completeness and timeliness.

Category 3 – Access and Availability of Care

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

NEMT and NMT: 30 records (15 NEMT and 15 NMT) were reviewed to confirm compliance with the NEMT and NMT requirements. Contracted NEMT and NMT providers were reviewed for Medi-Cal enrollment.

Category 4 – Member's Rights

Grievance Procedures: 45 standard grievances (25 Quality of Service and 20 Quality of Care), ten exempt grievances, and ten call inquiries were reviewed for timely resolution, appropriate classification, response to complainant, submission to the appropriate level of review, and translation in member's preferred language (if applicable).

Confidentiality Rights: 14 security incidents were reviewed for processing and reporting requirements.

Category 5 – Quality Management

Potential Quality Incidents (PQI): 12 PQI cases were reviewed for timely evaluation and effective action taken to address needed improvements.

Provider Qualifications: Ten new network provider training records were reviewed for the timeliness of Medi-Cal Managed Care program training. The Plan is accredited with the National Committee Quality Assurance effective September 2, 2020 through September 2, 2023. Three existing network providers were reviewed for appropriate re-credentialing.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 18 fraud and abuse cases were reviewed for processing and reporting requirements.

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

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Monitoring IHA Completion

Pursuant to APL 20-004, *Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19* (revised March 9, 2021), Medi-Cal managed care Health Plans (MCPs) may defer the completion of IHAs for all members newly enrolled in the Plan between December 1, 2019 and the end of the PHE. DHCS temporarily suspended the requirement to complete an IHA within the timeframes outlined in the Contract until the COVID-19 emergency declaration is rescinded. Once the PHE is over, DHCS will require IHA completion for these members. The findings in the section below pertain to the period from June 1, 2019 to November 30, 2019.

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

The Plan shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult members. *(Contract, Exhibit A, Attachment 10(5)(B))*

The Plan's policy 7615, *Initial Health Assessment* (revised December 1, 2019), tasks Primary Care Providers (PCP) to provide an IHA (complete history and physical examination) to each adult member within 120 days after enrollment according to the recommendation of the USPSTF. The Plan monitors IHA completeness by identifying members who have and have not had an initial encounter with their PCP within 60 and 90 days of enrollment. A list of members not having an encounter is sent to the respective PCP with the request to contact the member and schedule for an initial assessment as soon as possible. On a quarterly basis, the Plan determines the individual PCP and overall Plan IHA compliance rate.

The Plan's policy 7615.2, *Individual Health Education Behavioral Assessment (Staying Healthy Assessment – SHA Tool)* (revised December 1, 2019), requires network providers to complete an IHEBA to all members as part of the IHA within 120 days of enrollment using the DHCS approved SHA tool. The Plan's Corporate Quality

Department will monitor providers' documentation of the SHA as a component of the Facility Site Review (FSR) process, which includes a medical record review. If a PCP is non-compliant with the IHEBA policies, the Plan will require a CAP.

Finding: The Plan did not ensure the provision of timely, complete, and comprehensive IHAs.

The verification study revealed 19 of 32 member medical records did not have a complete IHA pursuant to Contract requirements. All 19 members did not have an age-appropriate IHEBA. Of the 19 members, eight did not have preventive screening (i.e., tuberculosis, HIV, hepatitis C, depression, and immunization status) and four did not have a timely IHA.

In a written response, the Plan stated it monitors PCP's IHA and IHEBA completeness by performing quarterly IHA validations, aside from FSRs, to comply with contractual requirements. The Plan validates a sample of high volume clinics with high rates of IHA completion against the medical records for IHA as outlined in the Plan's desk top procedure, *Medi-Cal IHA Validation*. The assessment will ensure members receive a comprehensive medical history and physical examination that are age and gender specific; ensure completion of an age-appropriate IHEBA; and verify assessments were performed within 120 days of enrollment. The Plan provided IHA validation reports for second quarter 2019 through fourth quarter 2020. However, the reports did not identify any deficiencies regarding IHA and IHEBA completeness.

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

Recommendation: Revise and implement policies and procedures to ensure monitoring and completion of timely and comprehensive IHAs.

2.2	COMPLEX CASE MANAGEMENT

2.2.1 Provision of Complex Case Management Services

The Plan shall ensure the provision of comprehensive medical case management to each member through the provision of either basic or Complex Case Management activities based on the medical needs of the member. The Plan shall maintain procedures for monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside the Plan's provider network. *(Contract, Exhibit A, Attachment 11.1)*

Complex Case Management services are provided by the Plan, in collaboration with the PCP, and shall include, at a minimum:

1) Basic case management services
2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3) Intense coordination of resources to ensure member regains optimal health or improved functionality
4) With member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually.

(Contract Addendum A03, Exhibit A, Attachment 11.1)

The Plan's policy 7255.1.a, *Complex Case Management* (revised April 30, 2020), states the Plan coordinates services for members that require case management and have complex conditions. The Plan refers to the Complex Case Management Program (CCMP) as the Case Management Department activities. This involves a comprehensive assessment of the member's condition, which include assessment for management of acute or chronic illness, including behavioral and social support issues by a multidisciplinary case management team; determination and coordination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow up to ensure that members regain optimal health or improved functionality. After intake and assessment of the member, a care plan is developed. The Plan monitors and evaluates the care plan process which ensures that services provided are consistent with the care plan.

Finding: The Plan did not ensure the provision of Complex Case Management services.

The verification study found the Plan did not provide Complex Case Management services for all six member records reviewed. The Plan did not have documentation of

case management activities, including plan of care, communication with the member and providers, referrals, community resources, and health education.

During the interview, the Plan stated it monitors the CCMP on an annual basis through the Quality Improvement Program Evaluation (QIPE). This involves analyzing metrics such as member satisfaction, emergency room hospital visits, percentages of completed assessments and care plans, and contact with Case Managers. However, the Plan's 2019 QIPE, approved by the Board of Directors on July 28, 2020, did not identify any deficiencies with the Plan's CCMP.

The Plan's inability to provide Complex Case Management services to members may negate improvement of health complexities and result in poor health care outcomes.

Recommendation: Revise and implement policies and procedures to monitor the provision of Complex Case Management services.

3.8	NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION

3.8.1 Non-Emergency Medical Transportation

The Plan shall cover transportation services as required in the Contract and directed in APL 17-010 to ensure members have access to all medically necessary services. *(Contract Amendment A18, Exhibit A, Attachment 10(8)(H))*

The Plan is required to provide NEMT services to members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. Furthermore, the Plan shall ensure door-to-door assistance for all members receiving NEMT services. *(APL 17-010 (Revised 09/08/2020), Non-Emergency Medical and Non-Medical Transportation Services)*

Finding: The Plan did not have a policy to ensure subcontractors offer door-to-door services for members.

Although the Plan provides door-to-door services for members receiving NEMT services, the Plan's policy 6059a, *Non-Emergency Medical Transportation & Non-Medical Transportation* (revised February 26, 2020), does not state the requirement that door-to-door assistance will be performed by the transportation provider and ensured by the Plan.

As a result of the Plan's 2019 CAP, the Plan provided Managed Care Quality and Monitoring Division (MCQMD) with an amended policy 6059, dated November 18, 2019. These amendments were not included in the Plan's current policy 6059a. The Plan's Compliance Committee Meeting Minutes, dated November 22, 2019, indicated that staff were working on the completion of the 2019 CAP. There were no further discussions of the 2019 CAP and the amended policy 6059.

In a written response, the Plan stated it was unable to update its policy with the amendments submitted to MCQMD due to staff changes, including the appointment of a new Director of Member Services in October 2020. The Director of Member Services is responsible for overseeing the Transportation Dispatch Coordinator and Drivers.

As the Plan does not have policies established to ensure NEMT providers perform door-to-door assistance, members may not receive access to all medically necessary

services.

This is a repeat finding of 2019 audit finding 2.4.1 – Non-Emergency Medical and Non-Medical Transportation.

Recommendation: Revise and implement policies to ensure the Plan's subcontractors provide door-to-door assistance.

3.8.2 Medi-Cal Enrollment of NEMT and NMT Providers

The Plan must ensure that all network providers are enrolled in the Medi-Cal program. *(Code of Federal Regulations, Title 24, section 438.608(b))*

All MCP network providers must enroll in the Medi-Cal program. MCPs 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, Provider Credentialing / Recredentialing and Screening / Enrollment)*

The Plan's policy 7700, *Physician Initial Credentialing* (revised February 2021), states that initial credentialing includes the verification of practitioner participation status with Medi-Cal through the National Practitioner Data Bank and various sanction websites.

The Plan's policy 7700.4, *Re-Credentialing Process* (revised February 2021), states the Plan re-credentials in a non-discriminating manner all independent licensed non-hospital based practitioners no more than 36 months of the previous credentialing decision to verify practitioner's qualification for continuing participation in the provider network. This includes the practitioner's participation status with Medi-Cal.

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

The verification study found that four of the ten NEMT and NMT providers were not enrolled in the Medi-Cal program. Of the four providers, three were actively providing services to members.

The Plan's Ancillary Services Provider Agreement required that providers must be enrolled in the Medi-Cal program and provide verification of enrollment. However, the Plan's policy 7700 does not identify provider types other than physicians that are subject to the Medi-Cal verification process during initial credentialing.

In a written response, the Plan inaccurately stated that APL 19-004 does not require NMT providers to have Medi-Cal active status. All network providers must enroll in the Medi-Cal program pursuant to APL 19-004.

If the Plan contracts with transportation providers that are not enrolled in the Medi-Cal program, it cannot ensure that Medi-Cal members receive transportation services in adequate and safe conditions.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Community Health Group Partnership Plan

AUDIT PERIOD: June 1, 2019 through May 31, 2021
DATE OF AUDIT: June 21, 2021 through July 2, 2021

CATEGORY 5 – QUALITY MANAGEMENT

5.3	PROVIDER QUALIFICATIONS

5.3.1 New Provider Training Requirements

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

The Plan's policy 5101, *New Provider Orientation* (revised April 7, 2019) states that new provider training must be conducted no later than ten-working-days of a newly contracted provider being placed on active status.

Finding: The Plan did not ensure completion of new provider training for newly contracted providers within ten-working-days.

A verification study of ten new providers found that two providers did not receive training within the ten-working-days requirement. These providers received training 19 and 22 days after becoming active with the Plan.

The Plan stated that in August 2020, the Director of Claims Administration implemented a process improvement to capture active status dates and monitor the completion of new provider training to prevent delays. However, the Plan's policy does not reflect this process improvement.

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

Recommendation: Revise and implement policies and procedures to ensure new provider training is conducted within ten-working-days after the newly contracted provider is placed on active status.

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

REPORT ON THE CAL MEDICONNECT AUDIT OF

Community Health Group Partnership Plan

2021

Contract Number:	13-90493 Cal MediConnect Three-Way Contract
Audit Period:	June 1, 2020 Through May 31, 2021
Report Issued:	October 19, 2021

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I. INTRODUCTION

The Department of Health Care Services (DHCS) operates a program in collaboration with the Centers for Medicare and Medicaid Services (CMS) to integrate care for beneficiaries who are eligible for both Medicare and Medi-Cal, known as Cal MediConnect (CMC). The CMC program is an alternative effort under the Coordinated Care Initiative and provides enrolled beneficiaries with a more coordinated, person-centered care experience along with access to new services. Starting in 2014, DHCS began enrollment of CMC beneficiaries in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara Counties.

Community Health Group Partnership Plan (Plan) first contracted with DHCS, formerly known as the Department of Health Services, in 1986 to provide services to Medi-Cal members. In 2005, the Plan obtained a Knox-Keene license from the California Department of Managed Health Care to service its Medi-Cal members.

The Plan currently contracts with DHCS to provide services to Medi-Cal beneficiaries under the Geographic Managed Care (GMC) program in San Diego County. The Plan provides health care services through contracts with community clinics, medical groups, and individual physicians.

The CMC contract is a three-way contract between CMS, DHCS, and the Plan. CMC members enrolled in the Plan's CommuniCare Advantage Cal MediConnect Plan receive all Medicare and Medi-Cal benefits. Benefits include medical care, behavioral health services, long-term services and supports, home-and community-based services, community based adult services, multipurpose senior services program, non-emergency transportation services, and care in nursing facilities.

As of June 2021, the Plan served 6,851 members through the CMC line of business.

II. EXECUTIVE SUMMARY

This report presents the results of the Cal MediConnect audit for the audit period of June 1, 2020 through May 31, 2021. DHCS conducted the audit of the Plan from June 21, 2021 through July 2, 2021. The audit consisted of document review, verification studies, and interviews with Plan personnel.

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

An Exit Conference with the Plan was held on September 30, 2021. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. Based on the Plan's written remarks on October 12, 2021, the Plan decided not to submit a response to the audit finding.

The prior DHCS CMC medical audit issued on November 1, 2018, for the audit period of June 1, 2017 through May 31, 2018, identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP closeout letter dated December 17, 2018, documented that DHCS closed all previous findings.

The summary of the current findings by category follows:

Category 1 – Utilization Management

There were no findings in this category.

Category 2 – Case Management and Coordination of Care

The Plan is required to facilitate the coordination of Medicaid-based services with other services delivered under CMC through the member's assigned Primary Care Physician (PCP) or the Interdisciplinary Care Team (ICT). The ICT is a team comprised of the PCP, Care Coordinator, and other providers at the discretion of the member. The Plan does not have procedures to monitor and ensure members' election of PCP participation in the ICT.

Category 3 – Access and Availability of Care

There were no findings in this category.

Category 4 – Member's Rights

There were no findings in this category.

Category 5 – Quality Improvement Systems

There were no findings in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS, Medical Review Branch to ascertain that the Medicaid-based medical services provided to CMC members complied with the Three-Way Contract, the federal and state laws and regulations, applicable guidelines, and the State's GMC Managed Care Contract.

PROCEDURE

The review was conducted from June 21, 2021 through July 2, 2021. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: Seven denied medical and 11 denied pharmacy prior authorization requests were reviewed. All requests were evaluated for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Category 2 – Case Management and Coordination of Care

Health Risk Assessment (HRA): 24 medical records were reviewed for completeness and timeliness.

Category 4 – Member's Rights

Quality of Service Grievances: Six Quality of Service Grievances were reviewed to verify the reporting timeframes and investigation process.

Category 5 – Quality Management

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

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

❖ COMPLIANCE AUDIT FINDINGS – Cal MediConnect ❖
PLAN: Community Health Group Partnership Plan
AUDIT PERIOD: June 1, 2020 through May 31, 2021 **DATE OF AUDIT:** June 21, 2021 through July 2, 2021

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	HEALTH RISK ASSESSMENT, INDIVIDUALIZED CARE PLANS, AND CARE COORDINATION

2.1.1 Interdisciplinary Care Team

The Plan will complete HRAs for all members. An HRA is an assessment tool which identifies member health needs. For members identified as higher risk, the Plan will complete the HRA within 45-calendar-days of enrollment and 90-calendar-days of enrollment for those identified as lower risk. Reassessments will be conducted at least annually. The HRA will serve as the starting point for the development of the Individualized Care Plan (ICP).

The Plan will develop a comprehensive, person-centered ICP for each member that includes goals and preferences, measurable objectives, and timetables to meet member needs. The ICP must be completed within 90-calendar-days of enrollment. The Plan will provide the ICP to members no less than annually.

The Plan shall offer an ICT for each member. The ICT is a team comprised of the PCP, Care Coordinator, and other providers at the discretion of the member. Members may request the exclusion of any ICT member. The ICT works with the member to develop, implement, and maintain the ICP. *(Three-Way Contract, sections 1.53, 1.59, 2.5.2.8, 2.8.2, and 2.8.3)*

The Plan's policy 7292.b, *Interdisciplinary Care Team* (revised April 2020), indicated members are involved in determining the ICT composition. PCPs are invited to participate in person or by teleconference during ICT case conferences when their patients are discussed if the member indicated the need or request.

Finding: The Plan does not have procedures to monitor and ensure members' election of PCP participation in the ICT.

The verification study found that the Plan did not comply with the members' requests regarding their PCP's participation for nine of 24 members' records when establishing an ICT:

- Four members' records showed the Plan did not include their PCP in ICT meetings, although the members indicated on their HRA to have their PCP

participate in the ICT. The Plan did not send an invitation to the members' PCP prior to the meeting.
- Five members' records showed the Plan sent invitations to their PCP to attend an ICT meeting. However, the members indicated on their HRA or through the Plan's Case Coordinator to exclude their PCP in the ICT.

While the Plan's policy 7292.b indicated members are involved in determining the ICT composition, the Plan did not have monitoring procedures in the establishment of each ICT to ensure members' requests was reviewed. The Plan provided a statement that ICT invitations are automatically sent through the Plan's electronic system to PCPs for all initial and annual ICTs.

If the Plan does not consider members' requests when establishing an ICT, it may result in a lack of member or their PCP's participation in the identification of their needs. If member needs are not identified, this may cause a decline in health status or a lack of resources to manage current health conditions.

Recommendation: Develop and implement procedures to monitor and ensure members' election of PCP participation in the ICT.

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

REPORT ON THE STATE SUPPORTED SERVICES AUDIT OF

Community Health Group Partnership Plan

2021

Contract Number: 09-86156
State Supported Services

Audit Period: June 1, 2019
Through
May 31, 2021

Report Issued: October 19, 2021

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I. **INTRODUCTION**

This report presents the audit findings of Community Health Group Partnership Plan (Plan) State Supported Services Contract No. 09-86156. The State Supported Services contract covers contracted abortion services with the Plan.

The audit period is June 1, 2019 through May 31, 2021. The review was conducted from June 21, 2021 through July 2, 2021, and consisted of document review, verification study, and interviews with the Plan.

The audit reviewed 15 State Supported Services claims for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Community Health Group Partnership Plan
AUDIT PERIOD: June 1, 2019 through May 31, 2021 **DATE OF AUDIT:** June 21, 2021 through July 2, 2021

STATE SUPPORTED SERVICES

SSS.1 Timely Abortion Claims Reimbursement

The Plan's Hyde Contract specifies that the Plan and Department of Health Care Services (DHCS) agree to be bound by all applicable terms and conditions of the Primary Contract. *(State Supported Services Contract, Exhibit E, section 1(A))*

The Plan is required to reimburse complete claims within 45-working-days after the date of receipt, unless the complete claim or portion thereof is contested or denied. *(California Code of Regulations, Title 28, section 1300.71(g))*

The Plan must maintain a sufficient claims processing/tracking/payment system that complies with applicable state and federal law, regulations and Contract requirements, determines the status of received claims, and calculates the estimate for incurred and unreported claims. *(Contract, Exhibit A, Attachment 8, section 5)*

The Plan's policy 7813, *Reimbursement for Freedom of Choice/Family Planning Services* (revised May 1, 2019), states that Freedom of Choice or family planning services are automatically processed in the Plan's claims system, QXNT, which recognizes services based on diagnosis and procedure codes. Prompt payment will be made by processing claims within 45-working-days of receipt.

Finding: The Plan did not reimburse abortion service claims timely.

While the Plan's policy 7813 outlines procedures for claim payment turnaround time, there is no mention on how the claims payment process is monitored. During the interview, the Plan explained that QXNT automatically processes claims that do not require administrative edits, other insurance, or are identified as a duplicate. However, claims are processed in excess of 45-working-days when manual review is required. The Plan's claims adjudication process involves reviewing the oldest receivable first, which can allow other claims to continue aging before undergoing manual review.

The verification study found that four of 15 out-of-network claim samples were reimbursed beyond 45-working-days from the date of receipt. The four claim samples reviewed were flagged for either an incorrect National Drug Code number, a claim adjustment to meet Hyde reimbursement requirements, or for contracted case rates.

Failure to timely reimburse claims may discourage providers from participating with the Plan and impact members' access to abortion services.

Recommendation: Develop and implement policies and procedures to ensure abortion service claims are reimbursed within 45-working-days.