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

REPORT ON THE MEDICAL AUDIT OF

Community Health Group Partnership Plan

Contract Number: 09-86155

Audit Period: June 1, 2018 Through May 31, 2019

Report Issued: November 20, 2019

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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 service 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 1, 2019, the Plan served 261,811 members through the following programs: Medi-Cal 255,691 and Cal MediConnect 6,120.

II. EXECUTIVE SUMMARY

The DHCS, conducted an onsite audit from July 1, 2019 through July 3, 2019. This report presents the results of the DHCS limited scope medical audit that includes Seniors and Persons with Disabilities (SPD) population for the audit period of June 1, 2018 through May 31, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on October 23, 2019. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in the report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

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 issued on November 1, 2018 (for the audit period of June 1, 2017 through May 31, 2018) did not identify material discrepancies with respect to the Plan's ability to provide health care services, peer review effectiveness, and utilization control mechanisms.

The summary of the current findings by category follows:

Category 2 – Case Management and Coordination of Care

Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) Services

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. The Plan must use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for members.

The Plan did not have policies and procedures in place or a monitoring method to ensure subcontractors offer door-to-door services to members. Additionally, the Plan did not provide evidence of utilizing PCS forms to determine the appropriate level of service for members.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The onsite review was conducted from July 1, 2019 through July 3, 2019. 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. To ensure parity in services, the verification studies included both SPD and non-SPD members in the samples.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 40 denied medical (sample included 20 SPD) and 40 denied pharmacy (sample included 20 SPD) 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 Utilization Management: 20 prior authorization cases from a delegate were reviewed for appropriate and timely adjudication.

Appeal Procedures: 36 prior authorization appeals (sample included 16 SPD) were reviewed. In addition, 20 prior authorization appeals from the delegated entity were reviewed. All appeals were evaluated for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment: 45 medical records (sample included 28 SPD) were reviewed for completeness and timeliness.

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

Category 3 – Access and Availability of Care

Appointment Availability: 15 providers from the Plan's provider network were reviewed. The first available appointment was used to measure access to care.

Category 4 – Member's Rights

Grievance Procedures: 80 grievances (40 Quality of Service and 40 Quality of Care) were reviewed for the Medi-Cal and SPD line of business. All grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level of review.

Confidentiality Rights: 12 breach and security incidents were reviewed for processing and reporting requirements.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Five 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.

2.4 NON-EMERGENCY MEDICAL TRANSPORTATION/ NON-MEDICALTRANSPORTATION

2.4.1 Non-Emergency Medical and Non-Medical Transportation Services

The Plan is required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Plan shall also ensure door-to-door assistance for all members receiving NEMT services. [*APL 17-010 Non-Emergency Medical and Non-Medical Transportation Services*]

Finding: The Plan does not ensure subcontractors offer door-to-door services to members. Although the Plan provides NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, the Plan's Provider Manual and policy 6059, *Non-Emergency Medical Transportation & Non-Medical Transportation*, does not state the requirement that door-to-door assistance will be performed by the transportation provider and ensured by the Plan. The Plan staff stated during the interview that NEMT providers are contractually obligated to provide door-to-door assistance if needed by the member. However, review of the Plan's Ancillary Provider Service Agreement did not support the Plan's assertion.

Further, the audit team was unable to conduct a verification study to determine if the Plan's subcontractors provided door-to-door assistance. The audit team requested transportation logs and other documentation that would demonstrate how the Plan monitors NEMT and NMT services. The Plan was unable to provide information in a log format or other documents within the audit period pertaining to this request.

As the Plan does not have policies or provisions established to ensure NEMT providers perform door-to-door assistance, members may not receive full access to medically necessary services.

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

2.4.2 Physician Certification Statement Forms

The Plan is required to use a DHCS approved PCS form to determine the appropriate level of service for members. The PCS forms must include at a minimum: function limitations justification, dates of service needed, mode of transportation needed, and certification statement. The Plan must have a mechanism to capture and submit data from the PCS form to DHCS. [*APL 17-010 Non-Emergency Medical and Non-Medical Transportation Services*]

Finding: The Plan staff stated during the interview that the capture and submission of data from the PCS form is manual through call tracking and authorization counts. Further, the Plan's policy 6059, *Non-Emergency Medical Transportation & Non-Medical Transportation*, outlines the Plan's use of PCS forms for NEMT services. However, the Plan did not provide evidence that they utilized PCS forms to determine the appropriate level of service for members.

The audit team requested transportation logs and other documentation that would demonstrate the Plan's monitoring efforts of NEMT and NMT services in relation to the PCS forms. The Plan did not provide information in a log format or other documents within the audit period pertaining to this request. Thus, the audit team was unable to conduct a verification study to test if the Plan utilizes the PCS form to determine the appropriate level of service for members.

The Plan does not have a method to monitor the use of PCS forms to determine the appropriate level of service for members; therefore, members may not receive the proper transportation services they require. This may also affect the Plan's under- or over-utilization of services.

Recommendation: Develop and implement a monitoring method to ensure that the Plan is utilizing PCS forms to determine the appropriate level of service for members.

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

REPORT ON THE MEDICAL AUDIT OF

Community Health Group Partnership Plan

Contract Number: 09-86156
State Supported Services

Audit Period: June 1, 2018
Through
May 31, 2019

Report Issued: November 20, 2019

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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 onsite audit was conducted from July 1, 2019 through July 3, 2019. The audit period is June 1, 2018 through May 31, 2019, and consisted of document review of materials supplied by the Plan and interviews conducted onsite. An Exit Conference with the Plan was held on October 23, 2019.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Community Health Group Partnership Plan
AUDIT PERIOD: June 1, 2018 through May 31, 2019 **DATE OF AUDIT:** July 1, 2019 through July 3, 2019

STATE SUPPORTED SERVICES

The Contract requires the Plan to provide, or arrange to provide, State Supported Services for Current Procedural Terminology (CPT) codes 59840 through 59857 and Healthcare Common Procedure Coding System (HCPCS) codes X1516, X1518, X7724, X7726, and Z0336. Members may go to any provider in- or out-of-network for all abortion services without prior authorization.

The Plan's policy 7809, *Claims for Abortion Services,* states abortion is a covered benefit regardless of the gestational age of the fetus. Abortion services are "sensitive" and "freedom of choice" services and do not require prior authorization. Members may obtain abortion services from providers and facilities both in and outside the Plan's contracted network. Minors of any age may consent for the performance of an abortion. The Plan covers CPT codes 59840-59857, and HCPCS codes X1516, X1518, X7724, X7726, and Z0336.

The Plan informs members and providers about abortion services through the Evidence of Coverage (Member Handbook) and the Provider Manual. The Provider Manual and Member Handbook are available on the Plan's website. Members may also call the Plan's Member Services Department for more information.

The Plan's claims payment system contains all of the required pregnancy termination billing codes. The Plan automatically adjudicates the claims in the Plan's system without prior authorization.

The audit found no exceptions with the contractual requirements.

Recommendations: None