MEDICAL REVIEW – NORTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

CALIFORNIA HEALTH AND WELLNESS PLAN

Contract Numbers: 13-90157 and 13-90161

Audit Period: December 1, 2018
Through
November 30, 2019

Report Issued: July 10, 2020

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I. INTRODUCTION

The California Legislature awarded California Health and Wellness Plan (Plan) a contract by the California Department of Health Care Services (DHCS) to provide Medi-Cal services in 19 counties as of November 1, 2013. The Plan is a wholly-owned subsidiary of Centene Corporation, a publicly-traded company that serves as a major intermediary for both government-sponsored and privately-insured health care programs.

This Contract was implemented under the State's Medi-Cal Managed Care Rural Expansion program. The expansion program included members eligible for Temporary Assistance for Needy Families and Children's Health Insurance Program.

The Plan's provider network includes independent providers practicing as individuals, small and large group practices, and community clinics.

During the audit period, the Plan served 192,759 Medi-Cal members in the following counties: Alpine 66; Amador 1,186; Butte 38,600; Calaveras 4,978; Colusa 3,211; El Dorado 17,246; Glenn 7,358; Imperial 60,222; Inyo 1,806; Mariposa 828; Mono 879; Nevada 8,184; Placer 9,085; Plumas 2,564; Sierra 223; Sutter 10,503; Tehama 11,569; Tuolumne 4,955; Yuba 9,296.

II. EXECUTIVE SUMMARY

This report presents the audit findings of DHCS medical audit for the period of December 1, 2018 through November 30, 2019. The onsite review was conducted from February 24, 2020 through March 3, 2020. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on June 11, 2020. The Plan was allowed 15-calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan did not submit a response after the Exit Conference.

DHCS issued the prior medical audit (for the period of December 1, 2017 through November 30, 2018) on June 12, 2019. This audit examined the Plan's compliance with its DHCS Contract and assessed implementation of its prior year Corrective Action Plan (CAP). The CAP closed January 15, 2020.

The Plan developed a new methodology to address Initial Health Assessment (IHA) completion.

The Plan also identified and remediated family planning claims denied in error.

The Plan implemented a system to monitor grievance cases to ensure proper documentation prior to case closure.

The full scope 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 summary of the findings by category follows:

Category 1 – Utilization Management

No deficiencies noted during this review period.

Category 2 – Case Management and Coordination of Care

The Plan is required to maintain a Physician Certification Statement (PCS) form for all Non-Emergency Medical Transportation (NEMT) services rendered. A PCS form is required to determine the level of service for members. The Plan did not obtain PCS forms for some members receiving NEMT service.

Category 3 – Access and Availability of Care

No deficiencies noted during this review period.

Category 4 – Member's Rights

No deficiencies noted during this review period.

Category 5 – Quality Management

No deficiencies noted during this review period.

Category 6 – Administrative and Organizational Capacity

No deficiencies noted during this review period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the 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 onsite review was conducted from February 24, 2020 through March 3, 2020. 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 the policies. Documents were reviewed and interviews were conducted with Plan staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization review requirements: 66 medical prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Prior authorization appeal process: 34 medical prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

IHA: Nine medical records were reviewed to ensure the Plan's conformance with its contractual requirement to complete an IHA to each new member within 120 calendar days of enrollment.

15 Non-Medical Transportation and 15 NEMT member records were reviewed for completeness and compliance to the Contract.

Category 3 – Access and Availability of Care

Emergency service and family planning claims: 15 emergency service and 15 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance procedures: 24 quality of care and 15 quality of service grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality rights: Ten cases were reviewed for proper reporting of all suspected

and actual breaches to the appropriate entities within the required timeframe.

Category 6 – Administrative and Organizational Capacity

Fraud and abuse reporting: 12 cases were reviewed for proper reporting of all suspected fraud, waste, and abuse.

2.4 NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICALTRANSPORTATION

2.4.1 Physician Certification Statement

Non-Emergency Medical Transportation (NEMT) services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services may be subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code Section 1250.

Managed Care Plans (MCP) and transportation brokers must use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of services for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization. All NEMT PCS forms must include, at a minimum, the following components: Function Limitations Justification, Date of Services Needed, Mode of Transportation Needed, and Certification Statement. Each MCP must have a mechanism to capture and submit data from the PCS form to DHCS. *All Plan Letter 17-010*

Plan policy, CA.MBRS.18 (Revision date: 12/10/18), states that member services department assists members with scheduling transportation. Member services is responsible for validating member's transportation eligibility and benefits. The Plan delegates transportation services to a subcontractor.

Finding: The Plan did not ensure that the subcontractor obtained a signed PCS form prior to providing transportation services for some NEMT services to members. The PCS form provides the justification for the service, determines the appropriate level of services, dates of service, and the mode of transportation.

The verification study and onsite interviews conducted with the Plan staff confirms the subcontractor did not obtain the PCS form prior to providing transportation for some members. Eleven of the 15 records in the verification study do not include a PCS form.

Plan staff acknowledged they had not obtained PCS forms for transportation services provided to some members. The Plan stated that in order to ensure access to care, they utilized a provision in policy and procedure, *CA.MBR8.18*, which allows members to receive three courtesy rides during the PCS completion process. The Plan did not follow up to ensure that the PCS forms were completed, signed, and returned by the

member's Primary Care Provider (PCP).

Policy and procedure number *CA.MBRS.18*, states that the subcontractor shall have a mechanism to capture and submit data from the PCS form to DHCS. The policy also states that if the PCS forms are not completed following utilization of two courtesy rides, members are reminded on their third courtesy ride request that subsequent rides require a completed PCS form. The Plan or the subcontractor can make outreach calls to the PCP to request a completed form.

The Plan must request the PCS form prior to providing the transportation services as required by the Contract *Exhibit A, Attachment 9 & 10, All Plan Letter 17-010, California Code of Regulations, Title 22, section 51303 (a), P & P #CA.MBRS.18*.

If the Plan does not obtain and use the required PCS form, members may not receive the appropriate level of transportation services they need.

Recommendation: 2.4.1 Establish a system to ensure PCS are utilized to determine the appropriate level of transportation services for Medi-Cal members.

MEDICAL REVIEW – NORTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

CALIFORNIA HEALTH AND WELLNESS PLAN

Contract Numbers: 13-90158 and 13-90162
State Supported Services

Audit Period: December 1, 2018
Through
November 30, 2019

Report Issued: July 10, 2020

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I. INTRODUCTION

This report presents the audit findings of California Health and Wellness Plan (Plan) State Supported Services Contract Numbers 13-90158 and 13-90162. The State Supported Services Contracts covers contracted abortion services with the Plan.

The onsite audit was conducted from February 24, 2020 through March 3, 2020. The audit period is December 1, 2018 through November 30, 2019 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: California Health and Wellness Plan

AUDIT PERIOD: DECEMBER 1, 2018 THROUGH NOVEMBER 30, 2019
DATE OF AUDIT: FEBRUARY 24, 2020 THROUGH MARCH 3, 2020

STATE SUPPORTED SERVICES

FINDING(S): The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Coding System Codes: 59840 through 59857 and Health Care Finance Administration (HCFA) Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Services (DHS) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract. *(Contract, Exhibit A, (1))*

The Plan has complied with the State Supported Services Contract. No prior year findings.

RECOMMENDATION(S): None