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

Community Health Group Partnership Plan

Contract Number: 09-86155

Audit Period: June 1, 2017 Through May 31, 2018

Report Issued: November 1, 2018

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I. INTRODUCTION

Community Health Group (CHG), incorporated in 1982, first contracted with 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 for CHG Foundation dba Community Health Group Partnership Plan which services its Medi-Cal membership.

The Plan is currently contracted with the Department of Health Care Services (DHCS) to provide services to Medi-Cal beneficiaries under the Geographic Managed Care (GMC) program in San Diego County. Health care services are provided through contracts with community clinics, medical groups, and individual physicians. Pharmacy services are provided through a contract with Pharmacy Benefits Manager (PBM), MedImpact Healthcare Systems, Inc.

As of June 1, 2018, CHG serves members in two programs, Medi-Cal and Cal MediConnect. Total enrollment was as follows:

• Medi-Cal	271,842
• Cal MediConnect	5,907
Total Enrollment	277,749

II. EXECUTIVE SUMMARY

Under the authority of California Welfare and Institutions Code §14456, the Department of Health Care Services (DHCS), Audits & Investigations, Medical Review Branch, conducts annual medical audits of contracting health plans. These audits assist the Department with its overall monitoring effort and identify areas of deficiencies that form the basis for corrective actions.

This report presents the results of the Department of Health Care Services (DHCS) full scope medical audit for the period of June 1, 2017 through May 31, 2018. The on-site review was conducted from June 25, 2018 through June 27, 2018. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held with the Plan on October 16, 2018. The Plan was allowed fifteen (15) calendar days from the date of the exit conference to provide supplemental information addressing the preliminary audit report. No additional documents were submitted.

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. There were no material discrepancies noted with respect to the Plan's ability to provide health care services, peer review effectiveness, and utilization control mechanisms. The Plan maintains systems and procedures to provide health care benefits to its members. Community Health Group (CHG), has an established system to comply with federal and state regulations and guidelines.

The Utilization Management Program Description delineates the role of the Chief Medical Officer, clinical and non-clinical staff roles in the prior authorization process. The Plan's utilization control mechanisms ensure that its pre-authorization, concurrent review and retrospective review procedures are made by qualified health care professionals, and decisions and appeals are made in a timely manner. Records reviewed showed that decisions met contractual requirements, including medical appropriateness and notification. The Plan maintains a system to ensure accountability for delegated oversight to delegated entities.

The Plan maintains procedures for its members to access health care services. Through its case management process, the Plan coordinates care provided to members. The Plan ensures early detection and preventive care for members through the provision of the Initial Health Assessment and Initial Health Education Behavioral Assessment. Records reviewed show coordination of care, including Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder.

The Plan's Quality Improvement Program (QIP) meets contractual requirements. The Plan does not delegate any of its Quality Improvement (QI) activities. The Plan monitors, evaluates, and takes effective action to address any needed improvements in

the quality of care delivered by its providers.

The Plan appropriately and accurately processes, monitors, and reports member grievances. The grievances reviewed were processed within contractual timeframes with adequate notification provided to the member regarding the grievance resolution.

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 on-site review was conducted from June 25, 2018 through June 27, 2018. 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 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeal Procedures: 25 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care
Basic and Complex Case Management: 5 medical records were reviewed for evidence of coordination of care between the Plan and providers.

California Children's Services (CCS): 5 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Initial Health Assessment: 30 medical records were reviewed for completeness and timeliness.

Behavioral Health Treatment Services: 30 medical records were reviewed for evidence of coordination of care between the Plan and providers.

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.

Emergency Services and Family Planning Claims: 15 emergency service claims and 20 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights
Grievance Procedures: 40 grievances (20 Quality of Service and 20 Quality of Care) were reviewed for timely resolution, response to complainant, and submission to the appropriate level of review.

Category 5 – Quality Management
Provider Qualifications: 10 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: 5 fraud and abuse cases were reviewed for processing and reporting requirements.

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

Community Health Group
Partnership Plan

Contract Number: 09-86156
State Supported Services

Audit Period: June 1, 2017
Through
May 31, 2018

Report Issued: November 1, 2018

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I. **INTRODUCTION**

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

The on-site audit was conducted from June 25, 2018 through June 27, 2018. The audit period is June 1, 2017 through May 31, 2018, and consisted of document review of materials supplied by the Plan and interviews conducted on-site.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Community Health Group Partnership Plan
AUDIT PERIOD: June 1, 2017 through May 31, 2018 **DATE OF AUDIT:** June 25, 2018 through June 27, 2018

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services: Current Procedural Coding System Codes*: 59840 through 59857 HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336 **These codes are subject to change upon the Department of Health Care Services' (DHCS') 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.* *State Supported Services Contract Exhibit A.1*

SUMMARY OF FINDINGS:

The Plan's Policy No. 7251, *Referral and Prior Authorization*, states that members may go to any provider of their choice for abortion services, at any time for any reason, regardless of network affiliation; and is not subject to prior-authorization. Plan's Policy No. 7809, *Claims for Abortion Services*, lists Current Procedural Terminology (CPT) codes 59840, 59841, 59850-59852, and 59855-59857 for surgical abortion; Healthcare Common Procedure Coding System (HCPCS) codes S0199 (Z0336), S0190 (X7724), and S0191 (X7726) for medical abortions; and A4649-U1 (X1516) and A4649-US (X1518) for miscellaneous medical surgical supplies.

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 Plan's Member Guide informs members that termination of pregnancy is a covered service. Plan members may go to a provider of their choice without the need of prior authorization for outpatient services. Further, Member Guide includes information regarding providers' right to refuse services and to contact Member Service Call Center for assistance. The Plan informs providers of the members' rights to abortion services without prior authorization in the provider manual.

The audit found no exceptions with the contractual requirements.