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

REPORT ON THE MEDICAL AUDIT OF:

Contra Costa Health Plan

Contract Number: 04-36067

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

Report Issued: September 19, 2019

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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 (HMO). 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 exercise 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 April 30, 2019, the Plan had 186,982 members of which 177,587 were Medi-Cal including 15,087 Seniors and Persons with Disabilities (SPD) members. The Plan also covers county employees (6,538), commercial (2,120), and uninsured recipients (737).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of June 1, 2018 through March 31, 2019. The onsite review was conducted from April 8, 2019 through April 19, 2019. 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 (QM), and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of June 1, 2017 through May 31, 2018 was issued on February 1, 2019.

The summary of the findings by category are as follow:

Category 1 – Utilization Management

Category 1 covers procedures and requirements for a Plan's utilization management (UM) program, including delegation of UM, prior authorization review, and the appeal process.

The audit revealed several deficiencies in the Plan's UM program. The Plan did not ensure integration of its UM program into the Quality Improvement System and did not have systematic methods for detecting over and under-utilization of health care services. The Plan did not conduct inter-rater reliability testing or other procedures to ensure consistent application of criteria on all UM staff involved in clinical decision-making.

The Plan shall ensure there is a set of written criteria or guidelines for utilization review that is consistently applied. The Plan inappropriately denied medical prior authorization requests and used incorrect criteria to make medical prior authorization determinations. The Plan also mistakenly required prior authorization for initial mental health assessments from network mental health providers.

The Plan is required to ensure that its prior authorization, concurrent review, and retrospective review be conducted by a qualified health care professional. The Plan did not ensure a qualified health care professional provided clear reasons for their decisions in the concurrent cases. The Plan also did not consistently conduct a medical necessity review of retrospective requests.

The Plan shall ensure that all written member information such as, Notice of Action letter, contain a clear and concise explanation for the decision and is written at a sixth grade reading level. The Plan did not ensure the letters included clear and concise explanations. Members received letters that contained complex medical jargon. The Plan also sent letters with “Your Rights” attachment that had outdated filing timeframe information.

The Plan is required to ensure accountability for delegated UM activities. The Plan did not continuously monitor and evaluate the activities of its Behavioral Health delegate.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to provide Initial Health Assessments (IHA) to new members, Health Risk Assessments (HRA) for seniors and persons with disabilities, and Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for medically necessary services.

The Plan is required to cover and ensure the provision of an IHA to each new member within 120 days of enrollment. The Plan did not ensure that new members receive an IHA.

The Plan is required to complete HRAs for new members who are seniors and persons with disabilities. Care plans should be initiated by the Plan for those who have been determined as high risk members based on the HRA. During the audit period, the Plan did not complete HRAs and did not initiate care plans.

The Plan is responsible for ensuring all necessary written consent forms are received prior to arranging transportation for unaccompanied minors. The Plan did not require written consent forms in the provision of NEMT and NMT services for unaccompanied minors.

The Plan is required to use a Physician Certification Statement (PCS) form to determine the appropriate level of NEMT service. The Plan did not use a DHCS approved PCS form; instead the Plan requested providers to submit Justification forms which varied by transportation provider.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding access to care and the adjudication of claims for emergency room services and family planning services.

The Plan is required to monitor time to obtain various types of appointments including the first prenatal. The Plan did not monitor initial prenatal appointment availability during the audit period.

The Plan shall take appropriate steps to ensure the accuracy of the information for each provider listed in the Plan’s provider directory and shall, at least annually, review and update the entire directory. The Plan did not maintain an accurate provider directory.

The Plan is required to reimburse non-contracted family planning services and emergency services at no less than the Medi-Cal fee-for-service rate. Although the Plan updated reimbursement codes on its claims system quarterly, several emergency service and family planning claims were not adjudicated at the minimum reimbursement rate.

Category 4 – Member's Rights

Category 4 includes the requirements for handling grievances and Protected Health Information (PHI).

The Plan is required to implement and maintain procedures to monitor the Member's Grievance System. The Plan did not adjudicate quality of care grievances in accordance with the contract and its policies and procedures. The Plan determined that several quality of care grievances involved potential quality issues (PQI), however, the Plan did not take further action to address the PQI. Furthermore, the Plan did not track and trend all PQIs identified. The Plan also did not adequately classify, process, and resolve exempt grievances. The Plan did not identify and process all expressions of dissatisfaction as grievances.

The Plan is required to investigate and notify DHCS of any security incidents, breaches, or unauthorized use or disclosure of PHI. The DHCS contract manager and DHCS information system officer, two of three required parties, were not notified of these reported incidents.

The Plan is required to conduct a thorough background check of employees before access to PHI is allowed. The Plan did not provide documentation of complete background checks on individuals who had access to PHI.

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 shall ensure its governing body approves the overall quality improvement system and the annual report of the QIS. The Plan's governing body, the Joint Conference Committee (JCC) did not review and approve the Plan's 2019 Quality Program Description, 2019 Quality Work Plan, and 2018 Quality Program Evaluation. The Plan followed an unapproved Quality Program Description and Work Plan during the audit period.

The Plan is required to ensure accountability for delegated quality improvement activities. The Plan did not continuously monitor and evaluate the activities of its credentialing delegates.

The Plan is required to maintain policies and procedures to communicate all applicable laws, contract requirements, reporting requirements and other DHCS guidance to all subcontractors and delegated entities. In addition, the Plan is also required to maintain policies and procedures for imposing corrective action and financial sanctions on subcontractors upon discovery of noncompliance. The Plan did not have these required policies or procedures.

The Plan is required to collect and review their subcontractors' ownership and control disclosure information. The Plan did not collect and review complete ownership and control disclosure information for their quality improvement and utilization management delegates.

The Plan is required to ensure all new providers receive training regarding the Medi-Cal Managed Care program and operate in full compliance with the contract. The Plan did not ensure all new directly contracted providers and new providers of delegated entities received provider training.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to implement and maintain a health education system and compliance program.

The Plan shall monitor performance of providers that are contracted to deliver health education services to ensure effectiveness. The Plan did not review the effectiveness of health education classes provided to members.

The Plan is required to establish administrative and management arrangements or procedures to detect and prevent fraud, waste, and abuse including a compliance program. The Plan did not completely implement the anti-fraud procedures specified in its compliance program.

The Plan is required to report all overpayments identified or recovered to the state, specifying the overpayments due to potential fraud. Although the Plan identified and recovered overpayments during the audit period, the Plan did not report them to the state.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The onsite review was conducted from April 8, 2019 through April 19, 2019. 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

Prior authorization requests: 22 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 20 prior authorization appeals were reviewed for appropriate and timely adjudication.

Delegated prior authorization requests: 4 service requests were reviewed for appropriate adjudication.

Category 2 – Case Management and Coordination of Care

Coordination of care and IHA requirements: 10 medical records were reviewed to confirm coordination of care and fulfillment of IHA requirements.

Coordination of care and HRA requirements: 9 files were reviewed to confirm coordination of care and fulfillment of HRA requirements.

Non-medical transportation (NMT): 20 claims were reviewed to confirm compliance with NMT requirements.

Non-emergency medical transportation (NEMT): 20 claims were reviewed to confirm compliance with the NEMT requirements.

Category 3 – Access and Availability of Care

Appointment availability verification: 30 providers of routine, urgent, specialty, and prenatal care from the Plan's directory were reviewed. The first next available appointments were used to measure access to care.

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

Category 4 – Member's Rights

Grievance procedures: 70 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality rights: 3 privacy incident cases were reviewed for appropriate and thorough investigation.

Background check verification: 10 samples were reviewed to determine if appropriate procedures were performed.

Category 5 – Quality Management

New provider training: 15 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and abuse: 4 cases were reviewed for compliance of procedures to guard against fraud and abuse.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: June 1, 2018 through March 31, 2019
DATE OF AUDIT: April 8, 2019 through April 19, 2019

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM/ REFERRAL TRACKING SYSTEM / DELEGATION OF UM / MEDICAL DIRECTOR & MEDICAL DECISIONS

UM Program Requirements:
Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. …(as required by contract)
2-Plan Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, consistently applied, regularly reviewed, and updated.
2-Plan Contract A.5.2.C

Review of Utilization Data:
Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect member utilization patterns shall be reported to DHCS upon request.
2-Plan Contract A.5.4

Referral Tracking System:
Contractor must ensure the UM program includes: … An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.
2-Plan Contract A.5.1.F

Delegated Utilization Management (UM) Activities:
Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.
2-Plan Contract A.5.5

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: June 1, 2018 through March 31, 2019
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1.1	UTILIZATION MANAGEMENT PROGRAM/ REFERRAL TRACKING SYSTEM / DELEGATION OF UM / MEDICAL DIRECTOR & MEDICAL DECISIONS

Medical Director:
Contractor shall maintain a full-time physician as Medical Director pursuant to California Code of Regulations (CCR), Title 22, section 53857 whose responsibilities shall include, but not be limited to, the following:

A. Ensuring that medical decisions are:
   1) Rendered by qualified medical personnel.
   2) Are not influenced by fiscal or administrative management considerations.
B. Ensuring that the medical care provided meets the standards for acceptable medical care.
C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
D. Developing and implementing medical policy.
E. Resolving grievances related to medical quality of care.
F. Direct involvement in the implementation of Quality Improvement activities.
G. Actively participating in the functioning of the Plan's grievance procedures.

2-Plan Contract A.1.6

Medical Decisions:
Contractor shall ensure that medical decisions, including those by sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management.
2-Plan Contract A.1.5

SUMMARY OF FINDING(S):

During the audit period, the Plan did not have a permanent UM Director which resulted in lack of oversight of the quality, appropriateness, consistency, and timeliness of UM processes, decisions, and reporting.

1.1.1 Utilization Management Integration into the Quality Improvement System (QIS)

The Plan shall ensure that the UM program includes the integration of UM activities into the QIS, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. (*Contract, Exhibit A, Attachment 5 (1)(G)*).

The Plan's 2018 and 2019 UM Program Description stated that on an ongoing basis, the Quality Council receives reports and updates regarding the UM program. The Board of Supervisors delegates their oversight responsibilities for development and implementation of the Plan's UM program to the Joint Conference Committee (JCC). The Quality Council reports to the JCC. The Plan's Quality Council serves as the UM Committee. The Quality Council reviews utilization reports, makes recommendations, and approves reports, criteria, and guidelines as needed. The Medical Director or designee, the UM Manager, and staff review information from many sources that have the potential to impact utilization activities. UM information is reported to the Quality Council, the JCC, and the Managed Care Commission as needed.

The Plan did not ensure integration of their UM program into the QIS.

A review of documents including Quality Council Committee meeting minutes revealed that there was minimal discussion of the UM program activities. Issues reviewed in the Quality Council meetings were the new inter-rater reliability process and changes to some UM policies. There was no evidence of integration of reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate quality staff. Furthermore, there was no evidence that the Quality Council reviewed over and under-utilization reports. The Plan also has another committee, the Managed Care Commission (MCC), who are the principal public advisory board to the Plan. One set of MCC meeting minutes dated 12/5/18 showed that the Plan reviewed UM reports from 2016-2017 but data for the audit period was not discussed. Additionally, the Plan did not adhere to their UM program description regarding its reporting to the Quality Council.

During interviews, the Plan confirmed that they had limited UM integration into the (QIS) due to compliance issues with the previous UM Director.

If the Quality Council does not receive regular UM reports then the Board, in this case the JCC, is also not receiving important UM documents that involve member care. This explains that there is no oversight, which could affect quality and cost-effectiveness of care.

1.1.2 Under and Over-Utilization Reports

The Plan shall include within the UM program mechanisms to detect both under and over-utilization of health care services. (*Contract, Exhibit A, Attachment 5 (4)*).

Plan policy *15.008 Under-Over Utilization Reviewed* stated, that upon analysis of the aggregated data, the Medical Director will direct the follow up activities which may include, but is not limited to:

1. Discussing any process modifications deemed necessary for the improvement of services with the Plan's providers

2. Discussing with individual providers areas of concern and need for improvement; obtaining an external peer review or establishing a panel review

3. Reporting findings to the Quality Council and the problematic activities identified, including data analysis

4. Discussions with providers, strategies for improvement, and any implemented or needed follow up

The Plan's 2019 UM program description stated that they have a variety of ways to monitor over and under-utilization. The Medical Director and UM Manager staff review information from many sources and this information is reported to the Quality Council, the JCC, and MCC as needed.

The Plan did not have systematic methods for detecting over- and under-utilization of health care services.

The Plan documented approved bed days per 1000 members, Emergency Department visits per 1000 members, Skilled Nursing Facility (SNF) length of stay per month, SNF admission rates, community hospital admissions, and Current Procedural Terminology (CPT) Code over-utilization report. These results were not compared to local, regional, state, or national data (i.e. benchmarked) with the exception of pharmacy metrics. In addition, the Plan did not identify any deficiencies or areas of concern based on these reports. The results were thus of limited value in evaluating the Plan's utilization patterns.

Benchmarking in healthcare is essential in learning where an organization is meeting industry standards and where it needs improvement. If a comparison of metrics is not done, the quality of care to members may be negatively affected.

1.1.3 Inter-Rater Reliability (IRR) and Consistent Application of Criteria

The Plan shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet minimum requirements including: a set of criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. *(Contract, Exhibit A, Attachment 5(2)(B)).*

Plan's policy *UM 15.006 Tracking Utilization Management Systems* discussed an audit process of authorization requests for services denied by a physician reviewer. However, this policy did not address the IRR process for nurses.

The Plan's 2018 UM program description stated, "On an at least semi-annual basis, inter-rater reliability is performed and clinical staff (including MD's, RN's and Pharmacists) participates in inter-rater reliability activities to ensure operational processes are clear and criteria are correctly and consistently applied."
The Plan did not conduct IRR testing on all UM nurses involved in clinical decision-making. Furthermore, the nurses' IRR testing did not include a scoring system nor a defined threshold for passing or failing.

During interviews, the Plan stated IRR testing for nurses was done quarterly. One lead Registered Nurse (RN) was in charge of choosing the cases and administering the test to all the UM nurses. The nurses completed a questionnaire, which was graded by the lead RN using a key answer sheet. There was no scoring system and no defined threshold for passing or failing. The results summary simply stated that no discrepancies were found and that answers on the questionnaire were consistent between each participant. The Plan stated in the instance of an outlier a note is sent to the UM Director and Medical Director for further review. The documents reviewed did not show that this process was effective in ensuring consistent application of criteria.

The Plan confirmed that the RN who administered the IRR testing did not participate in the IRR testing. This RN was involved in clinical decision making.

If IRR studies are not conducted on all UM staff whether they participate in approvals or denials of medical and pharmacy requests, there is a risk of not consistently applying criteria and guidelines, which can lead to inappropriate decision-making and ultimately poor health outcomes.

1.1.4 Monitoring and Oversight of UM Delegates

The Plan is responsible for all UM functions and responsibilities that are delegated to subcontractors. (*Contract, Exhibit A, Attachment 4(6)(A)*)

The Plan shall maintain a system to ensure accountability for delegated quality improvement activities that at a minimum, includes the continuous monitoring, evaluation and approval of the delegated functions. (*Contract, Exhibit A, Attachment 4(6)(B)(3)*)

The Plan's policy, *UM15.007, UM Delegation* stated that during the Plan's annual UM delegation onsite visit, each delegated entity's UM Program document and their policies and practices are reviewed. The onsite visit evaluates program activities and effectiveness by reassessing activities identified during the prior reviews that need improvement and reviewing denial/modification files.

The Plan did not fully implement its delegation review policy to continuously monitor and evaluate the functions of its Behavioral Health delegate. The Plan did not ensure accountability for all delegated activities.

The Plan's annual oversight audit of its Behavioral Health delegate shows the Plan did not conduct a complete review of all delegated functions identified on the Plan's audit tool. In an interview, the Plan stated they will conduct a complete review of all audit tool objectives during the first year and only activities found to be deficient in the first year will be reviewed in subsequent years.

Therefore, if there are no deficiencies after a complete review, the Plan will not conduct an oversight review the following year.

Without continuous monitoring and oversight of all delegated activities, the Plan cannot ensure that the delegates meet standards set forth by the Plan and DHCS.

1.1.5 Quarterly Reporting of UM Delegates

The Plan is responsible for all UM functions and responsibilities that are delegated to subcontractors. (*Contract, Exhibit A, Attachment 4(6)(A)*)

The Plan shall require subcontractors to report findings and actions taken as a result of quality improvement activities at least quarterly. (*Contract, Exhibit A, Attachment 4(6)(A)(3)*)

The Plan did not ensure receipt of all contractual and regulatory reports for its Behavioral Health UM delegate during the audit period.

The Plan's Memorandum of Understanding (MOU) with their UM delegate required the submission of quarterly UM Summary Reports. In an interview, the Plan confirmed it did not adhere to its MOU in requiring the receipt of quarterly UM reports. The Plan stated it did review a 2018 UM year summary.

Review of Quality Council meeting minutes did not show any quarterly reporting from the Plan's UM delegate. During the audit period, the Plan reviewed one UM activity report at the December 2018 Quality Council meeting minutes. The UM activity report included information on counts of referral reasons and average days from referral to close; however, the report did not include information on the number of denied services, the number of modified services, or the turnaround times for service requests. The Plan's UM delegate's activity report did not include information on all UM activities.

Without continuous monitoring and oversight of all delegated activities, the Plan cannot ensure that the delegates meet standards set forth by the Plan and DHCS.

1.1.6 UM Delegation Agreement

If the Plan delegates any activity or obligation to a subcontractor, whether directly or indirectly, the subcontract or written agreement shall:

1. Specify delegated functions and activities of the Plan and subcontractor.

2. Specify the Plan's oversight, monitoring, and evaluation processes.

3. Specify the subcontractor's responsibility to report findings and actions taken as a result of the quality activities at least quarterly.

4. Specify the Plan's actions if subcontractor obligations are not met.

(*Contract, Exhibit A, Attachment 4(6)(A)*)

The Plan's policy *QM14.301, Delegation Oversight Process* stated, the Plan monitors delegation via routine reporting and/or onsite audits of delegated providers on an annual basis.

The Plan did not specify in its written agreement the Plan's oversight, monitoring, and evaluation processes for its Behavioral Health delegate.

Without specifying the Plan's oversight processes, the Plan cannot hold its delegate accountable to comply with the Plan's oversight processes.

RECOMMENDATION(S):

1.1.1 Develop and implement policies and procedures to ensure that UM activities are integrated into the quality improvement system.

1.1.2 Develop and implement comprehensive and systematic methods for detecting under- and over-utilization of services throughout the Plan, including comparisons (benchmarking) of utilization patterns to other similar organizations.

1.1.3 Revise and implement policies and procedures to ensure that all UM staff who are involved in clinical decision-making participate in the Plan's chosen method (e.g. IRR studies) to maintain consistency in the application of criteria. Furthermore, policies and procedures should include a scoring system and a defined threshold for passing or failing.

1.1.4 Implement policies and procedures to continuously monitor and evaluate all UM delegated functions.

1.1.5 Develop and implement policies and procedures to ensure receipt of delegated UM activity reports at least quarterly and adherence to delegate contract reporting requirements.

1.1.6 Revise delegation agreements to ensure the Plan's oversight, monitoring, and evaluation processes are in writing.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: June 1, 2018 through March 31, 2019
DATE OF AUDIT: April 8, 2019 through April 19, 2019

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:
Contractor shall ensure that its pre-authorization, concurrent review, and retrospective review procedures meet the following minimum requirements…(as required by contract)
2-Plan Contract A.5.2.A, B, D, F, H, and I.

Exceptions to Prior Authorization:
Prior authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
2-Plan Contract A.5.2.G

Timeframes for Medical Authorization
Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code, section 14185 or any future amendments thereto.
2-Plan Contract A.5.3.F

Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the member or the member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information, and how it is in the member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
2-Plan Contract A.5.2.H

Denial, Deferral, or Modification of Prior Authorization Requests:
Contractor shall notify members of a decision to deny, defer, or modify requests for prior authorization, in accordance with California Code of Regulations (CCR), Title 22 sections 51014.1 and 53894 by providing written notification to members and/or their authorized representative...This notification must be provided as specified in CCR 22 sections 51014.1, 51014.2, and 53894, and Health and Safety Code section 1367.01.
2-Plan Contract A.13.8.A

SUMMARY OF FINDING(S):

1.2.1 Denial of Medical Prior Authorizations

The Plan shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. (*Contract, Exhibit A, Attachment 5(1)*)

The Plan shall ensure that there is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. (*Contract, Exhibit A, Attachment 5(2)(B)*)

Plan's policy *UM 15.002 Utilization Review Criteria and Guidelines* stated, "Written clinical criteria or guidelines are used in the utilization review process to ensure consistent review and decision-making by the UM staff. The clinical criteria and guidelines utilized by the UM staff may be product line specific, evidence-based, and/or derived from standards respected in the health care industry."

The 2019 UM program description stated, "When clinical criteria are applied, the individual needs of the member, such as age, comorbidities, complications, progress of treatment, physical limitations, home environment, psychosocial situation, complications, and progress of treatment are considered."

The Plan inappropriately denied medical prior authorization requests.

The verification study showed that 5 of 22 medical prior authorization requests and 3 of 20 requests from the appeals files were inappropriately denied:

- In one case, a provider requested for a type 1 diabetic member with high risk factors to see vascular surgery for a test needed to determine if one has narrowing of the peripheral arteries. The reason for denial was conservative measures had not been tried and failed. However, the member needed to be diagnosed before measures could be started.

- In three cases, a request was for mental health evaluation prior to gastric bypass surgery. The reason for denial was there was no evidence that the member had participated in a support program such as food addicts in recovery anonymous or a certified weight management program. However, the criteria the Plan used was more restrictive than the Medi-Cal fee-for-service criteria. Furthermore, the Plan had providers complete a prior authorization gastric bypass form that combines Medi-Cal and commercial criteria. Two of the cases were appealed and overturned.

- In three other cases, the request was for hospital admissions that had a mental health symptom as well as a physical health symptom. In one case, the admitting team needed to rule out a neurocognitive cause, another case needed follow up of lab results for cerebral spinal fluid, HIV, and urine tests. Lastly a patient with hyponatremia (low sodium in the blood) and secondary syphilis. For all cases the reason for denial was, continued inpatient stay appeared to be related to a mental health condition rather than a physical condition and therefore "carved out." A "carve out" means that a certain set of benefits are not covered by the Plan.

- In one case, the member was a liver transplant patient. The request was to see an out-of-network hepatologist (liver specialist). The request was denied for being out- of-network but should have been approved for continuity of care. This was ultimately appealed and overturned.

Most of these cases were reviewed with the Plan while onsite and they agreed that they needed to re-visit their process, in particular a review of their criteria and consistent application.

If appropriate processes with a set of correct criteria and guidelines are not in place, there is a risk that members will be inappropriately denied services, which could lead to poor health outcomes.

1.2.2 Written Criteria or Guidelines for Medical Prior Authorizations

The Plan shall ensure that there is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. (*Contract, Exhibit A, Attachment 5(2)(B)*).

The Plan's policy *UM 15.002 Utilization Review Criteria and Guidelines* stated, "Written clinical criteria or guidelines are used in the utilization review process to ensure consistent review and decision-making by the UM staff. The clinical criteria and guidelines utilized by the UM staff may be product line specific, evidence-based, and/or derived from standards respected in the health care industry."

The Plan used incorrect criteria to make medical prior authorization determinations.

The verification study showed that 6 of 20 medical prior authorizations, 2 of 20 requests from the appeals files, and 7 of 22 NEMT requests were determined using incorrect or outdated criteria. Examples included:

- Two cases that involved continued hospitalization, the decision-maker used criteria from 2014. One case involved a 66 year-old SPD member with many risk factors admitted for chest pain, urinary tract infection, and altered mental status. The other case involved a 40 year-old member also with many risk factors admitted for heart failure, possible stroke, and elevated lactic acid.

- A case that involved a referral to a specialist for a test done to determine if one has narrowing of the peripheral arteries. In making the determination, the Plan used the criteria for vascular surgery which was not the service requested.

- Three cases that involved a mental health evaluation prior to gastric bypass surgery, the decision maker used a combination of Medi-Cal and commercial criteria. In these cases the criteria the Plan used was more restrictive than the Medi-Cal fee-for-service criteria.

- Two other cases that involved continued hospitalization for both mental and physical symptoms. The decision maker used the Evidence of Coverage (EOC) from 2017-2018 rather than using the most current 2018-2019 EOC. Although both EOCs stated the county covered specialty mental health services, the Plan did not use additional criteria to determine if continued hospitalization was appropriate based on the members' physical symptoms. The Plan only focused on the mental aspect of the cases.

- Seven NEMT cases where the decision maker used outdated Medi-Cal criteria from 2004 instead of the most current criteria applicable. These requests included wheelchair van, litter van and ambulance. The 2004 was more restrictive compared to the current criteria.

These cases were reviewed with the Plan onsite. They agreed that their processes needed to be reviewed and modified. The Plan stated that the Physician Consultants depend on their nurses to choose the correct criteria. There is no verification of correct criteria by the physician who is the ultimate decision maker. In the cases that involve a request for mental health evaluation prior to gastric bypass surgery, the Plan has developed their own form that providers need to complete. This form has combined Medi-Cal and commercial criteria that members need to meet prior to approval. The Plan stated that this was done because the commercial criteria was more specific and believed this would help providers.

If incorrect or outdated criteria is used to make medical determinations, there is a risk that members will be inappropriately denied services, which could lead to poor health outcomes.

1.2.3 Documentation of Reasons for Decisions

The Plan shall ensure that its pre-authorization, concurrent review, and retrospective review procedures include that qualified health care professionals supervise review decisions and review all denials, and that reasons for decisions are clearly documented. (*Contract, Exhibit A, Attachment 5(2)(A)(C)*).

The 2019 UM program description stated, "Utilization Management nurses review the care of hospitalized members on a concurrent basis in order to determine that service delivery and level of care are appropriate. Review may include physician communication, telephonic review, onsite, medical record review, and on-going communication with other health care professionals who are involved in the member's care." There is no discussion regarding documentation of reasons for decisions by a qualified health care professional.

The Plan did not ensure that a qualified health care professional clearly documented in its concurrent cases the reasons for decisions.

The verification study showed that in 8 of 8 concurrent/inpatient reviews a physician did not document the reasons for decisions.

In interviews, the Plan stated the Physician Consultants reviewed the cases with the nurses and a denial letter was formulated based on their discussion. The letter was reviewed and signed by the medical consultant. Records showed that a summary of the case was documented by a RN but it was not followed by a physician's documentation of his/her findings.

A qualified health care professional making a decision on requests for health care services is ultimately responsible for the member and therefore documentation of reasons for decisions in clinical charts is imperative. A review of medical necessity must be clear and it must be from the qualified health care professional.

1.2.4 Medical Notice of Action (NOA) Letters

The Plan shall ensure that all written member information is provided to members at a sixth grade reading level. (*Contract, Exhibit A, Attachment 13(4)(C)*).

All Plan Letter 17-006, *Grievance and Appeal Requirements and Revised Notice Templates and* "*Your Rights" Attachments* effective July 1, 2017 stated that the written NOA shall contain a clear and concise explanation of the reasons for the decision.

Plan's policy *UM 15.015a Timeliness of the Utilization Review Decision and Communication* stated, that documentation of decisions would be clear, concise, and include an understandable explanation of reason for the decision.

The Plan did not ensure that NOA letters included clear and concise explanations and that information provided was at a sixth grade reading level.

The verification study showed that 18 of 18 medical prior authorization denials included NOA letters that contained uncommon medical terms and were not clear and concise. Examples of language used included:

- "Chronic ischemia"; "non-invasive"; "conventional angiography"
- "Wound classified as Wagner grade III or higher"
- "Vertebral crush fracture syndrome"
- Inpatient charts had boxes for reasons for denials and included a comment of why service was denied which was meant only for the provider, but the letter was sent to both provider and member
- "Molecular diagnosis of an inheritable disease"; "completion of conventional diagnostic studies"

During interviews, the Plan stated that nurses prepared NOA letters and the medical consultant performed the final review. After review of the cases described above, the Plan acknowledged that language could be modified and made more clear and concise.

If written information to members is not clear, concise, and at a sixth grade reading level, they will not understand the health plan's processes, decisions, and their ability to make informed health decisions.

1.2.5 Review of Retrospective Requests

The Plan is required to ensure that its pre-authorization, concurrent review, and retrospective review procedures meet specific minimum requirements; which include that qualified health care professionals supervise review decisions, that a qualified physician will review all denials that are made on the basis of medical necessity, and that a determination of retrospective reviews will be made within 30 calendar days in accordance with *Health and Safety Code section 1367.01(h)(1*). *(Contract, Exhibit A, Attachment 5 (2)(A(3)(E)*).

Plan's policy *UM 15.015a Timeliness of the Utilization Review Decision and Communication* stated, "Decisions affecting retrospective care, including reimbursement requests shall be made no later than 30 days from receipt of the authorization request. The maximum time allowed for a provider to submit a retroactive authorization is 180 days from the date of service. However, the Plan may decide, on a case-by-case basis, to process a retroactive authorization beyond the maximum timeframe noted above when there is documented evidence of extenuating circumstances."

The 2019 UM program description stated, "Retrospective review is the review of member care and service after it has been rendered and/or the patient has been discharged from a health care setting. Review includes, but is not limited to, medical necessity, appropriateness, site of service, and quality of care."

The Plan did not consistently conduct a medical necessity review of retrospective requests.

A verification study showed that two of three retrospective requests were not reviewed for medical necessity. Denial reason documented was, "admitting facilities are responsible for notifying Health Plans within 24 hours of an admission or the next business day if the admission occurred during non-business hours." Therefore, the Plan denied the requested inpatient hospitalization days. Both retroactive authorizations were submitted before the maximum allowed time of 180 days.

- One case involved a patient with end-stage liver disease due to hepatitis C. He presented with swelling of legs who required hospital admission to assist with removing excess fluids using intravenous (within a vein) medication.

- Another case involved a patient with acute onset of abdominal pain, abnormal imaging, and labs who required surgery and found to have hemorrhagic and gangrenous cholecystitis (bleeding and infected gallbladder).

The Plan was unable to explain why a medical necessity review of these retrospective requests had not taken place.

If the Plan does not review retrospective requests this may lead to a denial of covered benefits without a medical necessity review by a physician as well as inappropriate denial of payment to providers.

1.2.6 Timeframes for Medical Authorization

The Plan shall ensure that decisions for concurrent review of authorization for treatment regimen already in place shall be made within five working days or less, consistent with urgency of the member's medical condition and in accordance with *Health & Safety Code section 1367.01*, or any future amendments thereto. (*Contract, Exhibit A, Attachment 5(3)(D)*

Decisions for routine authorizations shall be made within five working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, and out-of-network not otherwise exempt from prior authorization) in accordance with *Health & Safety Code, section 1367.01*, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. (*Contract, Exhibit A, Attachment 5(3)(D)(G).*)

All Plan Letter 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments stated, "In instances where the MCP cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the MCP shall send out the NOA "delay" template to the provider and beneficiary within the required timeframe or as soon as the MCP becomes aware that it will not meet the timeframe."

The Plan's policy *15.015a Timeliness of the Utilization Review Decision and Communication* stated, upon receipt of all necessary information, decisions affecting routine care shall be made within 5 business days or within a timeframe appropriate for the enrollee's condition, but no later than 14 calendar days. Upon receipt of current clinical information, decisions affecting inpatient or ongoing ambulatory care that is already in place shall be made within 24 hours (for urgent concurrent care). The policy further stated that in order for the Plan to extend the timeframe, the Plan must notify the provider and the enrollee the need for an extension in writing as soon as the initial timeframe expires or as soon as the Plan becomes aware that it will not make the initial deadline and that the delay is in the member's interest. Additionally, the policy stated that enrollee notification of denial, delay or modification of care request was via written notification within 3 business days from the date of the decision. For the requesting provider, verbal or facsimile notification to the requesting provider (or treating provider for care underway) within 24 hours, followed by written communication within 3 business days.

The Plan did not meet timeframe contract requirements for routine and concurrent authorization requests. They did not send deferral letters when the 14-calendar day timeframe expired for routine authorization requests.

A verification study showed that 2 of 10 routine prior authorization requests were not processed within the required timeframe. The routine requests were processed in 15 and 19 calendar days with no deferral letters sent to members. The verification study also showed that 1 of 8 concurrent authorization request was not processed within the required timeframe. The concurrent request was processed in 20 calendar days.

The Plan stated that the Physician Consultant checks when the authorization is set to expire and if he/she determines that additional time will be needed he/she requests that deferral letter be sent to the member and provider. The Plan stated that they only send a deferral letter if additional clinical information is needed.

As for the concurrent case, the Plan stated that the late determination was due to a lag time in getting the clinical information needed to make a decision, which was never received by the Plan. A request for records was sent two times.

The Plan did not consistently apply its policy regarding timeliness of utilization review decisions.

If medical authorizations are not determined in a timely manner this may lead to a delay in providing necessary care for members, which could lead to poor health outcomes.

1.2.7 Notice of Action "Your Rights" Attachment

The Plan must give members timely and adequate notice of an adverse benefit determination in writing. *(Code of Federal Regulations (CFR) 42, section 438.404(a))*

The *All Plan Letter 17-006, Grievance and Appeal Requirements and Revised Notice Templates* and "*Your Rights*" *Attachments* effective July 1, 2017, clarifies and provides guidance regarding the application of new federal and existing state regulations for processing grievances and appeals. Due to the significant impact that these new changes have on beneficiaries' appeal rights, DHCS has deemed it necessary to create two distinct "Your Rights" attachments to accommodate the following scenarios: 1) beneficiaries who receive a NOA and 2) beneficiaries who receive a Notice of Appeal Resolution (NAR). A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.

The Plan did not update the information included in the "Your Rights" attachment sent with NOA letters, specifically for concurrent/inpatient cases.

A verification study showed that 8 of 8 concurrent/inpatient cases had NOA letters with "Your Rights" attachments that included outdated information. The form stated that the member could file an appeal with the Plan and ask for a State Hearing at the same time. However, new federal regulations require beneficiaries to exhaust the Plan's internal appeal process and receive notice that the Adverse Benefit Determination has been upheld prior to proceeding to a state hearing. It also stated that a State Hearing needed to be requested within 90 days from the date of receiving the NOA instead of 120 days and that a grievance needed to be filed within 180 days from the day of incident or action instead of anytime. It did not include general information on the Independent Medical Review (IMR) rights.

During interviews, the Plan confirmed that they were not aware the information in the "Your Rights" attachment was not up-to-date.

If written member information is not updated with current information, such as with new timeframes on when to file an appeal, IMR or State Hearing, members may be prevented from exercising their right to file in a timely manner. The potential outcome is denial of services and delayed provision of health care.

RECOMMENDATION(S):

1.2.1 Develop and implement policies and procedures to ensure that UM staff carefully reviews and uses the appropriate criteria to make medical necessity decisions to avoid inappropriately denying services.

1.2.2 Develop and implement policies and procedures to ensure that all UM staff uses updated criteria to make medical authorization decisions. Criteria should be based on sound medical evidence, consistently applied, regularly reviewed, and updated.

1.2.3 Develop and implement policies and procedures to ensure that all UM staff document their reasons for decisions for all medical authorizations.

1.2.4 Develop and implement policies and procedures to ensure that all NOA letters are clear, concise, and at a sixth grade reading level.

1.2.5 Develop and implement policies and procedures to ensure that a medical necessity review of retrospective requests is performed.

1.2.6 Develop and implement policies and procedures to ensure that correct timeframes for processing all medical authorizations are followed by UM staff. Develop and implement policies and procedures to ensure that delay letters are sent to the providers and members in cases where the timeframe is extended an additional 14 calendar days.

1.2.7 Develop and implement policies and procedures to ensure that NOA "Your Rights" information sent to members is correct and updated.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Contra Costa Health Plan
AUDIT PERIOD: June 1, 2018 through March 31, 2019 **DATE OF AUDIT:** April 8, 2019 through April 19, 2019

1.3	PRIOR AUTHORIZATION APPEAL PROCESS
Appeal Procedures: There shall be a well-publicized appeals procedure for both providers and patients. 2-Plan Contract A.5.2.E	

SUMMARY OF FINDING(S):

1.3.1 Written Consent from Members for Appeals Filed by a Provider

If State law permits and with the written consent of the member, a provider or an authorized representative may request an appeal or file a grievance, on behalf of an enrollee*. (CFR, 42, section 438.402(c)(1)(ii))*

The *All Plan Letter 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments* effective July 1, 2017 stated that appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary. The Plan shall continue to comply with this existing requirement in accordance with the DHCS contract and federal regulations.

The Plan's policy *MS 8.018 Appeal Process for Medi-Cal Members, Fair Hearing and Independent Medical Review Process* stated that a provider acting on behalf of the member, and with the member's written consent, may file an appeal.

The Plan did not obtain written consent from a member when a provider filed an appeal on the member's behalf.

The verification study showed that 6 of 7 appeals filed by a provider on the member's behalf did not include written consent from the member.

In interviews, the Plan stated they obtain written consent from a member when a provider files an appeal on the member's behalf. They send a form for members to complete and return to the Plan. However, this form was not included in the files that were reviewed. For the medical appeal, there was documentation in the file that stated that they were unable to process the appeal because there was no signed consent form included. In this case, they accepted a verbal consent from the member but they did not require a written consent to follow.

The pharmacy provider appeals were processed by the Pharmacy Department instead of the Grievance and Appeal Department. The Plan stated that they do not wait for the member's consent as they felt that this was not in the members' best interest. Additionally, they do not attempt to obtain a written consent at any point in the process.

Not obtaining written consent from a member when a provider files an appeal on their behalf may interfere with patient autonomy, which is the right patients have to make decisions about their medical care without their health care provider's influence.

1.3.2 Provider Manual

The Plan shall issue a provider manual and updates to the providers of Medi-Cal services. The manual and updates shall serve as a source of information to health care providers regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access and special requirements. (*Contract, Exhibit A, Attachment 7(4)*).

The *All Plan Letter 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments* effective July 1, 2017 stated, "Existing federal regulations and state laws currently require beneficiaries to request a State Hearing within 90 days from the date of the NOA. However, new federal regulations require beneficiaries to request a State Hearing within 120 calendar days from the date of the NAR, which informs the beneficiary that the Adverse Benefit Decision has been upheld."

Plan policy *MS 8.018 Appeal Process for Medi-Cal Members, Fair Hearing and Independent Medical Review Process* stated, "The beneficiary has the right to request a State Hearing within 120 days only after filing an internal appeal with the Plan and receiving notice that the Adverse Benefit Determination has been upheld."

The Plan did not update its provider manual to include the new timeframe for filing a State Hearing. The manual stated that members' have 30 days after the denial of services to file a State Hearing instead of 120 days.

During interviews, the Plan confirmed that they were not aware the provider manual had not been updated.

If the provider manual is not updated with current information, such as with new timeframes on when to file a State Hearing, members' may not receive timely care.

RECOMMENDATION(S):

1.3.1 Revise and implement policies and procedures to ensure that written consent is obtained when a provider files an appeal on the member's behalf.

1.3.2 Develop and implement policies and procedures to ensure that correct timeframes to file an appeal are reflected in provider informing materials including the provider manual.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: June 1, 2018 through March 31, 2019
DATE OF AUDIT: April 8, 2019 through April 19, 2019

1.4	MENTAL HEALTH AND SUBSTANCE ABUSE

Mental Health and Substance Abuse Services:
Contractor shall cover outpatient mental health services that are within the scope of practice of Primary Care Physicians (PCP). Contractor's policies and procedures shall define and describe what services are to be provided by Primary Care Physicians. In addition, Contractor shall cover and ensure the provision of psychotherapeutic drugs prescribed by its Primary Care Providers, except those specifically excluded in this contract as stipulated below.
2 Plan Contract, A10(D)

SUMMARY OF FINDING(S):

1.4.1 Outpatient Mental Health Services

The Plan shall ensure that written member information shall ensure members' understanding of the health plan processes and ensure the member's ability to make informed health decisions. (*Contract, Exhibit A, Attachment 13(4)(C)*).

The *All Plan Letter 17-018, Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services* stated, the Plan shall not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. The Plan shall notify beneficiaries of this policy, and the Plan's informing materials must clearly state that referral and prior authorization are not required for a beneficiary to seek an initial mental health assessment from a network mental health provider.

The Plan inappropriately required prior authorization for initial mental health assessments from network mental health providers. Additionally, the Plan did not ensure that informing materials clearly state that referral and prior authorization are not required for a member to seek an initial mental health assessment.

The Plan stated they did not require prior authorization, however a verification study revealed that in 4 of 4 initial mental health assessment requests, the Plan did require prior authorization. In all cases the members received a NOA letter.

The Plan's Evidence of Coverage (EOC) handbook for members stated that outpatient mental health services (mild to moderate) and substance use disorder services were covered and listed which services were covered by the Plan. However, the EOC also stated that the member's PCP would make a referral for additional mental health screening to a specialist within the Plan's network to determine the level of impairment.

The process of coverage and referring was also described in the provider manual. In the manual it stated that members can self-refer or be referred by the PCP.

In both the EOC and provider manual it did not clearly state that a referral and prior authorization were not required for a member to seek an initial mental health assessment from a network mental health provider.

Furthermore, the Plan's new provider training materials for behavioral health outpatient assessment incorrectly stated that prior authorization was required.

Additionally, the mental health delegate's 2019 program description stated, "Providers must obtain initial authorization of all non-emergent services before billing for assessment and providing treatment services."

If Plans require referral and/or prior authorization for initial mental health assessments this may impose a barrier for members to receive mental health services.

RECOMMENDATION(S):

1.4.1 Revise and implement policies and procedures to ensure that referral and prior authorization are not required for members to obtain an initial mental health assessment. Develop and implement processes to ensure that members' and providers' informing materials clearly state that a referral and prior authorization are not required.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: June 1, 2018 through March 31, 2019
DATE OF AUDIT: April 8, 2019 through April 19, 2019

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:
Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with CCR, Title 22, sections 53851(b)(1) to each new member within timelines stipulated in Provision 5 and Provision 6 below.
2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21
For members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger, whichever is less.

For members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.
2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

1) Contractor shall cover and ensure that an IHA for adult members is performed within 120 calendar days of enrollment.
2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
   a) blood pressure,
   b) height and weight,
   c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
   d) clinical breast examination for women over 40,
   e) mammogram for women age 50 and over,
   f) pap smear (or arrangements made for performance) on all women determined to be sexually active,
   g) Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
   h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,

2.1	INITIAL HEALTH ASSESSMENT

i) health education behavioral risk assessment.
2-Plan Contract A.10.6

Contractor shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement.
2-Plan Contract A.10.3.D

SUMMARY OF FINDING(S):

2.1.1 Provision of Initial Health Assessment (IHA)

The Plan must cover and ensure the provision of an IHA to each new member within 120 calendar days of enrollment. (*Contract, Exhibit A, Attachment 10 (5) (A).* An IHA consists of a comprehensive history and physical examination, preventive services, and the Individual Health Education Behavioral Assessment (IHEBA) *(Contract, Exhibit A, Attachment 10 (3) and MMCD Policy Letter 08-003).*

Plan policy *QM14.701, Preventive Services/ Initial Health Assessment*, required providers to complete the IHA within 120 days of enrollment for new members. The Plan monitored IHA during facility site reviews, which were conducted initially upon provider credentialing and every three years thereafter.

The Plan did not ensure that new members receive an IHA within 120 days from enrollment.

The Plan's method for monitoring IHA completion used IHEBA as a proxy, but was not validated. Review of the Plan's monthly monitoring report showed that the Plan did not monitor completion of IHA, rather it monitored IHEBA completion.

For one delegated entity network, the Plan conducted IHEBA as a proxy to IHA. The Plan assumed that an IHA was done when an IHEBA was completed and scanned in the new member's medical records. According to its leadership staff, the Plan did not validate that an IHA was completed.

For its community provider network, the Plan used encounter data to identify completed IHAs. The Plan used procedure codes for both new and established members to identify completed IHAs. The Plan's explanation did not address the use of procedure codes for established members.

Without the provision of an IHA, providers will not be able to comprehensively assess and manage the healthcare needs of the member.

2.1.2 Required Component of the Initial Health Assessment

The Plan must cover and ensure the provision of an IHA to each new member within timelines stipulated in the contract. An IHA consists of a comprehensive history and physical examination, preventive services, and the individual health education behavioral assessment *(Contract, Exhibit A, Attachment 10 (3) and MMCD Policy Letter 08-003).*

The Plan is required to follow the latest edition of the *Guide to Clinical Preventive Services* published by the U.S. Preventive Services Task Force (USPSTF) to provide preventive services to asymptomatic, healthy adult members. All preventive services identified as USPSTF "A" and "B" recommendations must be provided and the status must be documented. *(Contract A15, Exhibit A, Attachment 10 (6) (B) (1), and MMCD Policy Letter 08-003).*

Plan's policy, *QM14.701 Preventive Services/ Initial Health Assessment*, required providers to complete the IHA within 120 days of enrollment with the Plan for all new members, and document all components of the IHA. The policy required providers to follow the latest edition of the *Guide to Clinical Preventive Services* published by the USPSTF, specifically "A" and "B" recommended services.

The Plan did not ensure that all providers performed and documented a required component of an IHA: preventive services identified as USPSTF "A" & "B" recommended services, particularly lung cancer screening.

The Plan's provider resources for preventive services were not consistent with the current edition of the *Guide to Clinical Preventive Services* published by the USPSTF. The Plan's report of its adherence to practice guidelines for 2013-2018 and the Plan's electronic health maintenance dashboard did not include lung cancer screenings.

A verification study on ten sampled members medical records showed that lung cancer screening, a USPSTF grade "B" recommended preventive service, was not consistently provided, or its status documented. Member's records revealed that documented evidence of age appropriate screenings for lung cancer were missing in 5 out of 10.

- In three records, the member's smoking status and history were not documented.

- In one record, the provider documented the member stopped smoking two years ago, but did not specify the quantity used and the length of the member's smoking history. This information was required to determine whether the member met the screening criteria of 30 pack-year history. (Heavy smoking means a smoking history of 30 "pack years" or more. A "pack year" is smoking an average of 1 pack of cigarettes per day for 1 year. The risk of developing lung cancer increases with the amount a person smokes and the length of time a person smokes).

- In one record, the provider documented the member smoked one pack of cigarettes daily with 47 pack-year history, and yet lung cancer screening was not done.

Preventive screening services are important to assess and reduce members risks for diseases and to identify and prevent illnesses.

2.1.3 Health Risk Assessment (HRA)

The Plan is required to implement mechanisms to assess each member identified by the State as having special health care needs in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. *(CFR, Title 42, 438.208 (c)(2))*

The Plan is also required to assess a member's current health risk by administering a risk assessment survey tool approved by the Department. *(Welfare and Institutions Code Section 14182 (c)(12)(A))*

All Plan Letter (APL) 17-013 Requirements for HRA of Medi-Cal SPD, effective January 1, 2018, specifies that Managed Care Plans (MCP) must submit its policies, procedures, and tools related to health risk stratification and assessments to DHCS for approval. APL 17-013 also stated that each Plan must use the HRA to comprehensively assess each newly enrolled SPD member's current health risk and use the result of HRA to re-classify the member as higher or lower risk. The elements which Plans are required to include in the HRAs are enumerated on the APL under section B.2.d-m. Plans are required to utilize the standardized Long-Term Services and Supports (LTSS) referral questions verbatim to identify and ensure the proper referral of members who may qualify for and benefit from LTSS services.

Plan's policy, *CM 16.019 SPD Health Risk Assessment and Process,* outlines the Plan's process to assess new SPD enrollees to the Plan. According to the policy, the Plan evaluated the fee-for-service utilization data and completed Health Information Form from DHCS to stratify the members into high and low risk groups. The results are downloaded

into the Plan's case management database within one business day of receipt of information from DHCS for use in completing high-risk HRA's within 45 days and low-risk within 105 days. The Plan mails its HRA Tool to members and a telephone outreach will be attempted at least twice within 7 days if the HRA Tool is not returned within 30 days of mailing.

The Plan did not conduct a complete HRA of newly enrolled SPD members. The Plan did not implement its policy as written instead it changed its process for conducting HRAs. The tool used by the Plan did not include all the required elements of a HRA and was not approved by DHCS.

A verification study of 9 SPD members found four were newly enrolled SPD members:

- In one record, the Plan sent transportation, housing, and fall prevention resources to the member. There was no documentation that a health risk assessment was completed.

- In two records, the Plan completed an assessment using a version of its HRA Tool with 20 questions. This tool did not include the standardized LTSS question.

- In another record, the Plan completed an assessment using a third version of its HRA Tool. This tool included some of the standardized LTSS questions but not verbatim.

The HRA Tool titled *SPD Health Assessment Tool* used by the Plan did not include all the required elements of an HRA such as assessment of functional limitations on activities of daily living, housing, and health literacy. In an interview, the Plan stated that management decided to shorten the form because they were too long and members often gave up on completing them. However, the Plan did not submit the revised forms to DHCS for review and approval.

Starting March 2018, the Plan changed its procedures related to health risk stratification and assessments of newly enrolled SPD members. The Plan decided to have all newly enrolled SPD members stratified as high-risk and conduct HRAs through an automated telephone call. This new procedure was not submitted to DHCS for approval. The information gathered during the automated call did not include all the required elements of an HRA such as identifying member needs related to substance abuse providers, energy assistance programs, health education, hospitalization, and LTSS services.

Health risk assessments determine the higher risk and more complex health care needs of SPD members. Assessments of these members' needs identify members who may qualify for and benefit from various services. Use of shortened tools to assess members may impair the development of individualized care management plans for these members.

2.1.4 Individualized Care Plans

The Plan is required to produce treatment or service plans for enrollees who require Long-Term Services and Supports (LTSS), or with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan is developed with member participation, and in consultation with any providers caring for the enrollee. The treatment or service plan must be reviewed and revised upon reassessment of functional needs, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the enrollee. *(42 CFR, Section 438.208 (c)(3)(i to v)*

All Plan Letter 17-013 Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities, effective January 1, 2018, specifies that after the completion of the HRA, the Plan must develop individualized care plans (ICPs) for members found to be at higher risk and coordinate referrals for identified Long-Term Services and Supports (LTSS), as needed.

Plan policy *CM16.019 SPD Health Risk Assessment and Process* stated that the Plan's case management develops a care plan based on information identified through the HRA process. The components of the care plan described in the policy included:

- Identifying the need for appropriate involvement of care givers
- Referral to community based organizations for members with intellectual/developmental disabilities as identified in the HRA
- Facilitating timely access to medical appointments, equipment, medication and other health services
- Assisting with self-management skills, health education, and other modalities to improve health status
- Identifying the need for coordinated care across all settings including those outside the provider network

- Identifying the need for referrals to community resources and other agencies for services outside the scope of responsibility of the plan, including mental and behavioral health, personal care, housing, home-delivered meals, etc.

- Determining the timeframes for reassessment at least annually and, if necessary, the circumstances that require redetermination of risk level.

The Plan did not initiate a care plan for a member identified as high risk through the HRA process.

A verification study of 9 SPD members found 1 member was classified as high risk based on the HRA. Plan documentation showed that community resources were mailed to the member, however, there was no evidence that an Individualized Care Plan was developed for the member. According to the Plan when a member is case managed internally or externally, a notation is made on the member's file. There was no notation in the member's profile about being enrolled in case management hence a care plan was not created. The Plan did not provide an explanation why care plans were not initiated.

Individualized Care Plans for higher risk members are essential for effective health care management. These members need additional help and guidance to manage their high risk health care needs. The lack of care plan provision blocks these members access to supportive services and the opportunities to better manage their health.

RECOMMENDATION(S):

2.1.1 Develop and implement procedures to ensure the provision of an IHA to new members within 120 calendar days from enrollment.

2.1.2 Implement policies and procedures to ensure provision and documentation of all components of an IHA, including applicable preventative services.

2.1.3 Develop and implement policies and procedures to completely and accurately assess each newly enrolled SPD member's current health risk in accordance to *APL 17-013*.

2.1.4 Implement policies and procedures to initiate and develop individualized care plans for members identified through the HRA process as high-risk. Develop and implement a process to monitor the initiation of Individual Care Plans.

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2.4	NON-EMERGENCY NON-MEDICAL TRANSPORTATION

Non-Emergency Medical Transportation (NEMT) means ambulance, litter van and wheelchair van medical transportation services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per CCR, Title 22, sections 51231.1 and 51231.2 rendered by licensed providers.
COHS/GMC/2-Plan Contracts E.E.1 Definitions

Non-Emergency Medical Transportation Requirements
NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when it is prescribed in writing by a physician, dentist, or podiatrist. NEMT services are 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 (HSC) section 12501.
MMCD All Plan Letter 17-010

NEMT Physician Certification Statement Forms
Medi-Cal Managed Care Plans (MCP) and transportation brokers must use Physician Certification Statement (PCS) forms to determine the appropriate level of service for Medi-Cal members. Once the member’s treating physician prescribes the form of transportation, the MCP cannot modify the authorization.
MMCD All Plan Letter 17-010

Non-Medical Transportation (NMT) means transportation of members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.
COHS/GMC/2-Plan Contracts E.E.1 Definitions

2.4	NON-EMERGENCY NON-MEDICAL TRANSPORTATION

Non-Medical Transportation Requirements
NMT has been a covered benefit when provided as an EPSDT service15. Effective July 1, 2017, NMT is a Medi-Cal managed care benefit for all members to obtain medically necessary covered services. Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal fee-for-service (FFS) delivery system. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with State and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver.
MMCD All Plan Letter 17-010

Non-Medical Transportation Authorization
MCPs are required to authorize NMT for each member prior to the member using NMT services. The MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter.
MMCD All Plan Letter 17-010

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards
MCPs are contractually required to meet timely access standards (CCR, 28, section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability). MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in CCR, Title 28, section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.
MMCD All Plan Letter 17-010

Conditions for Non-Medical Transportation Services:
- MCP shall use prior authorization processes for approving NMT services and shall re-authorize services every 12 months when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.

2.4	NON-EMERGENCY NON-MEDICAL TRANSPORTATION

- With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- NMT does not cover trips to a non-medical location or for appointments not related to medically necessary covered Medi-Cal benefits.
- The member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
  - Has no valid driver's license.
  - Has no working vehicle available in the household.
  - Is unable to travel or wait for medical or dental services alone.
  - Has a physical, cognitive, mental, or developmental limitation.

MMCD All Plan Letter 17-010

Written Member Information
The Member Services Guide … shall include the following information: …12) Procedures for obtaining any transportation services to service sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available.
COHS/GMC/2-Plan Contracts E.A.13.4.D

SUMMARY OF FINDING(S):

2.4.1 Unaccompanied Minor Written Consent Form

The Plan is required to cover NEMT services required by members to access Medi-Cal services, as provided for in CFR, Title 22, section 51323. *(Contract Amendment 24, Exhibit A, Attachment 10(H))*

The Plan is required to authorize all NMT) services for members to obtain medically necessary covered services in accordance with the requirements and guidelines set forth in *APL 10-010*. *(Contract Amendment 24, Exhibit A, Attachment 10(H))*

All Plan Letter 17-010 Non-Emergency Medical and Non-Medical Transportation Services stipulates the following: With the written consent of a parent or guardian, Plans may arrange transportation for a minor who is unaccompanied by a parent or a guardian. Additionally, the Plan is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

The Plan's policy, *16.028.1 Non-Emergent Medical Transportation* stated, the Plan must provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service. The Plan is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor. Plan's policy, *16.028 Non-Medical Transportation (NMT)* did not address unaccompanied minor consent forms.

The Plan did not require written consent forms in the provision of NEMT and NMT services for unaccompanied minors.

During the interview, the Plan stated it did not have unaccompanied minor consent forms. When asked how the Plan processed transportation requests for unaccompanied minors, it stated they accepted a verbal consent.

If the Plan does not require unaccompanied minor consent forms, this may lead to potential harm if a minor suffers detrimental health effects due to a decision that a parent or guardian was unaware of.

2.4.2 Physician Certification Statement (PCS)

The Plan is required to cover NEMT services required by members to access Medi-Cal services, as provided for in *CFR, Title 22, section 51323*, subject to Plan's PCS form being completed by the member's provider. *(Contract A24, Exhibit A, Attachment 10 (H))*

The Plan is required to cover medical transportation subject to utilization controls. *(Welfare and Institutions Codes, section 14132(i)).*

All Plan Letter 17-010 Non-Emergency Medical and Non-Medical Transportation Services stated, Plans and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members.

Plan policy, *16.028.1 Non-Emergent Medical Transportation (NEMT)* required the use of DHCS approved PCS forms. There was no DHCS approved PCS form attached to the policy and the policy was not implemented.

The Plan did not use a DHCS approved PCS form.

In 20 of 20 NEMT cases reviewed, the Plan did not maintain the appropriate PCS form as prescribed by DHCS. During an interview, the Plan confirmed that it did not require PCS forms because it was not aware of the PCS form requirement. Instead, the Plan required providers to submit Justification forms which varied by transportation vendor and these forms were not approved by DHCS.

Due to the lack of a DHCS approved PCS form, the Plan reviewed and denied NEMT requests based on varying information. Without a standardized form, there is a risk of members being denied medically necessary services.

RECOMMENDATION(S):

2.4.1 Develop and implement policies and procedures to establish the use of written consent forms to meet contractual requirements for NMT and NEMT services for unaccompanied minors.

2.4.2 Implement policies and procedures to establish the use of DHCS approved PCS forms for NEMT.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

Appointment Procedures:
Contractor shall implement and maintain procedures for members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult Initial Health Assessments. Contractor shall also include procedures for follow-up on missed appointments.
2-Plan Contract A.9.3.A

Members must be offered appointments within the following timeframes:
3) Non-urgent primary care appointments – within ten (10) business days of request;
4) Appointment with a specialist – within 15 business days of request;
2-Plan Contract A.9.4.B

Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant member will be available within two (2) weeks upon request.
2-Plan Contract A.9.3.B

Monitoring of Waiting Times:
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments…
2-Plan Contract A.9.3.C

SUMMARY OF FINDING(S):

3.1.1 Monitoring Initial Prenatal Appointments

The Plan is required to ensure that the first prenatal visit for a pregnant member will be available within two weeks upon request. The Plan is required to develop, implement, and maintain a procedure to monitor waiting times to obtain various types of appointments including first prenatal visit. *(Contract, Exhibit A, Attachment 9(3)(B)and (C))*

Plan's policy, *QM 14.101 Access to Care Standards* stated, access standards will be monitored utilizing a variety of methods such as member satisfaction surveys, member grievances, facility site reviews, provider satisfaction surveys, appointment availability surveys, appointment wait time reports, and HEDIS reporting. The policy did not specifically address the Plan's process for monitoring initial prenatal appointments.

The Plan did not monitor initial prenatal appointment availability.

The Plan stated that a few years ago, a health educator who was bilingual called all newly pregnant members to help with appointments. The Plan stated they stopped monitoring initial prenatal appointments because for a period of time they were compliant with providing appointments within the required timeframe. However, the contract requires continuous monitoring of first prenatal appointment availability.

Lack of initial prenatal appointment monitoring may lead to members not receiving proper care during the earlier stages of pregnancy.

3.1.2 Provider Directory Accuracy

The Plan is required to distribute a provider directory that includes the following information: name, provider number, and telephone number of each service location. In the case of a medical group/foundation or independent practice association, the medical group name, provider number, address and telephone number shall appear for each physician provider *(Contract, Exhibit A, Attachment 13(4)(D)(4)).*

The Plan is required to provide, upon request, a list of contracting providers and update this information at least quarterly. The Plan is required to ensure the accuracy of the provider directory information by updating the online directory at least weekly or more frequently and when informed of and upon confirmation by the Plan of any information that affects the content or accuracy of the provider directory. Health plans shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the Plan's provider directory in accordance with this section, and shall, at least annually, review and update the entire provider directory. *(Health & Safety Code, section 1367.27)*.

Plan's policy, *PA 9.802 Maintenance of Provider Network Data and Review of Network Provider Availability* stated, that on a quarterly basis, the Plan reviews provider network data for any changes to be made on provider directories. For the community provider network providers, the Plan sends a Provider Network Update (PNU) form and requires providers to confirm if the information listed in the provider directory is accurate or report updated information. Upon verification of changes, Plan staff enters data changes into Provider Maintenance Information System (PMIS), and updates provider directories within 30 days of receipt of the update. For the other network integrated with the county, the Plan uses the monthly provider report produced by the county medical office staff to verify the changes in provider information. Unlike with community provider network providers, county medical office staff enters the data changes into PMIS instead of the Plan staff having to enter data. Information in the provider directory is obtained from the PMIS.

The Plan did not update its provider directory. The Plan did not fully implement its procedures for ensuring accurate provider network data.

DHCS conducted an appointment availability verification study that included 42 providers. This study measured the Plan's average member wait times to obtain an appointment and verified the accuracy of the Plan's provider directory information. The following deficiencies related to the Plan's printed and online provider directory information were identified:

- 6 of 42 providers were not practicing physicians or were no longer practicing at the location identified on the provider directory.

- 12 of 38 providers had incorrect hours and/or business days listed on the provider directory.

- 4 of 37 providers had incorrect information about accepting new patients on the provider directory.

In interviews, the Plan staff stated they reach out to providers in their Community Provider Network (CPN) quarterly to determine the accuracy of providers' information. For the other network integrated with the county, the Plan had a contact person who was responsible to communicate any changes in provider information with provider relations.

Auditor requested providers update emails from the audit period sent to three providers in the CPN network. However, for two of the three providers requested, the Plan provided emails sent after the audit period. In addition, phone calls to three providers in this network and one provider from the county integrated network, confirmed that the Plan reached out to them on an annual or semi-annual basis, not quarterly, as stated in interviews.

Inaccurate information on the provider directory may lead to barriers for members' access to care.

RECOMMENDATION(S):

3.1.1 Develop and implement policies and procedures to ensure initial prenatal appointments are monitored for timely access.

3.1.2 Implement policies and procedures to ensure updates are made to the provider directory to reflect accurate information.

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3.3	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims):
Contractor is responsible for coverage and payment of emergency services, post stabilization care services, and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the plan.
2-Plan Contract A.8.13.A

Contractor shall pay for emergency services received by a member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including medically necessary inpatient services rendered to a member until the member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the member is stabilized sufficiently to permit discharge….
2-Plan Contract A.8.13.C

At a minimum, Contractor must reimburse the non-contracting Emergency Department and, if applicable, its affiliated providers for physician services at the lowest level of Emergency Department Evaluation and Management CPT Codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
2-Plan Contract A.8.13.D

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 U.S. Code section 1396u-2(b)(2)(D). 3
2-Plan Contract A.8.13.E

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, section 1300.67(g) and Title 22 CCR section 53216.
2-Plan Contract A.9.7.A

Family Planning (Claims):
Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate….(as required by Contract)
2-Plan Contract A.8.9

SUMMARY OF FINDING(S):

3.3.1 Claims Processing

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

At a minimum, the Plan is required to reimburse non-contracting Emergency Departments at the lowest level of Emergency Department evaluation and management Physician's Current Procedural Terminology (CPT) codes. (*Contract Exhibit A, Attachment 8(13)*)

Plan's policy, *CLM 4.007e Claims Determination and Timeliness* stated that, unless otherwise specified, claims are paid at Medi-Cal rates. The policy stated that the Medi-Cal rates are system driven; the Plan's reimbursement rates were pre-set in their claims system.

Plan's policy, *CLM 4.573e Sensitive Services, HIV, Family Planning & Sexually Transmitted Diseases,* provided a table with Medi-Cal reimbursement rates. Not all codes were included.

The Plan paid non-contracted family planning services and emergency services at less than the Medi-Cal FFS rate.

A verification study found 2 of 20 family planning claims and 2 of 20 emergency services claims were not paid at the appropriate Medi-Cal FFS rate.

According to the Plan's remittance advices, family planning and emergency service claims were processed at Medi-Cal FFS rates. In an interview, the Plan stated that their claims system was automatically updated to ensure the required Medi-Cal reimbursement rates were correct. However, the family planning and emergency service claims were paid at less than the required Medi-Cal FFS rates.

Plan's policy, *CLM 4.573e,* included the correct reimbursement rate for one family planning claim, but the Plan did not pay the claim according to the policy. The reimbursement rate table contained in the policy was updated manually, while the reimbursement rate in the Plan's claim system was based on an automatic update.

In an interview, the Plan stated that its system updated CPT codes on a quarterly basis. The Plan provided a copy of the report for the most recent updated codes. However, the report did not show that the CPT codes that were incorrectly paid had been updated. The Plan stated that their claims system has occasional technical errors when processing claims. Due to technical errors, CPT codes were inconsistently paid at less than the required Medi-Cal FFS rates.

If the Plan does not pay family planning and emergency service claims at the appropriate Medi-Cal rates, this may discourage providers from participating with the health plan and limit members' access to care.

RECOMMENDATION(S):

3.3.1 Implement policies and procedures to process non-contracted family planning and emergency service claims at the appropriate Medi-Cal FFS rate. Including configuration of claims system and monitoring to ensure reimbursement rates are updated and accurate.

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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance System in accordance with CCR, Title 28, section 1300.68 and 1300.68.01, CCR, Title 22, section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and CFR, 42, 438.420(a)-(c).
2-Plan Contract A.14.1

Contractor shall implement and maintain procedures…to monitor the Member Grievance System and the expedited review of grievances required under CCR,Title 28, sections 1300.68 and 1300.68.01 and CCR, Title 22, section 53858….(as required by Contract)
2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in CCR, Title 22 section 53858(e).
2-Plan Contract A.14.3.A

SUMMARY OF FINDING(S):

4.1.1 Quality of Care Grievances

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. (*Contract, Exhibit A, Attachment 4(1)*).

Plan's policy, *MS8.001 Handling of Complaints and Grievances* stated, "Quality of Care grievances are those issues relevant to the actual medical care or treatment that a member experienced or perceived, such as an undesirable outcome of care. The member service Department will identify and refer quality of care grievances to the Quality Management Department for investigation and resolution. A grievance nurse reviews all incoming grievances to ensure clinical issues are handled by clinical staff. Quality of Care issues are determined because the member perceives there is a Quality of Care issue even though after investigation the actual quality of care may not be inadequate or inappropriate."

Plan's policy, *QM14.502 Quality of Care Potential Quality Incident/Occurrence Review* stated, "A Potential Quality Incident (PQI) is a concern or situation that may result from concerning provider behavior, non-standard clinical care, questionable outcomes of care, or access to care that could have impacted medical care. A PQI becomes an occurrence if the medical consultant reviewing it decides it is important enough to be extensively researched, rather than merely tracked and trended, as with PQIs."

The Plan did not appropriately adjudicate quality of care grievances.

The verification study showed that 4 of 10 sampled quality of care grievances were not duly resolved based on the contract requirements and the Plan's policy and procedures. The Plan used a tool to level cases for severity and the medical consultants completed a form based on their review, which included a recommendation for follow up.

- Two cases were not handled as a PQI as defined above. In one case a provider did not perform a pelvic exam on a member who presented with pelvic pain and in the other case a nurse administered a vaccine to a two-month old member without the member's parent consent. The medical consultants leveled the case appropriately at a level one meaning "no physical injury occurred; patient experienced anxiety, emotional distress" however, the recommendation was "no further action." These cases presented issues involving non-standard clinical care and questionable outcomes of care, respectively. Neither case was further evaluated to ensure procedures were set in place to prevent these issues from recurring. Additionally, because these cases were not treated as PQIs they were not tracked and trended as stated in their policy.

- Another case involved a member who was admitted for chest pain. The provider discharged the member without a clear explanation of the treatment plan. The medical consultant leveled the case appropriately at a level one, however, the recommendation was "no further action" although the consultant agreed that there had been a communication issue. This incident presented a matter of concerning provider behavior. In the forms completed by the medical consultants there was an option to check "counsel provider" which could have been considered given the acknowledgement of the communication issue.

- In one other case, a grievance was filed because the member felt discriminated against for being deaf. The member requested a live American Sign Language interpreter but one was not available. In the emergency room, a remote video was used instead and per records, the staff did experience technical issues. The leveling of this case was zero, meaning "no potential or actual injury or adverse effect" even though the member experienced emotional distress. The recommendation was "no further action needed." This case warranted follow-up of a possible system issue that impacted member's access to care.

During interviews, some of the cases above were reviewed with the Plan. There was general agreement that the leveling and recommendations of some of the cases needed further evaluation.

If quality of care grievances are not appropriately adjudicated, there is a risk of not capturing suspected deviation from provider performance that has the potential to affect the level of care being provided to members.

4.1.2 Grievance Identification and Processing

The Plan is required to implement and maintain procedures to monitor the Member Grievance System and the expedited review of grievances required under *CCR, Title 28, sections 1300.68 and 1300.68.01 and CCR, Title 22, section 53858 (Contract, Exhibit A, Attachment 14(2)).*

Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response (*CCR, Title 28, section 1300.68 (d)(8)).*

The Plan's policy, *MS 8.001 Handling of Complaints and Grievances* stated, that Member Service Representatives (MSR) will attempt to resolve all member questions or requests at the time when the first contact is made. If an inquiry or problem cannot be resolved at this entry level, the MSR will open a grievance and document all issues researched. The Member Service Department will identify and refer quality of care grievances to the Quality Management Department for investigation and resolution. A grievance nurse reviews all incoming grievances to ensure clinical issues are handled by clinical staff. The term "exempt grievance" refers to a written or oral complaint, or any expression of dissatisfaction by a member or their authorized agent not associated with coverage disputes, disputed health care services or experimental or investigational treatment.

The Plan did not consistently implement their procedure regarding exempt grievance classification and processing. The member services representative and grievance analyst inconsistently classified and processed multiple grievances as exempt grievances instead of processing them as standard grievances.
A review of 10 exempt grievances found that 6 cases were not properly classified, processed, and resolved.

- In 5 of 6 cases, the initial complaint was regarding the primary care provider of a member. The Plan's action to resolve the member's complaint was to change the member's PCP but did not perform any investigation or additional steps to review the complaint. For example, a member complained about not obtaining sleep disorder equipment supplies from the Pulmonologist Department. The Plan did not investigate the doctor on the cause of delay in obtaining the sleep disorder equipment supplies.

- In 1 of 6 cases, the member complained about the replacement of an expired medical equipment for a sleeping disorder but was unable to obtain timely authorization. Documents revealed that the grievance took more than 24 hours to resolve. Therefore, the grievance was not properly classified as a standard grievance.

By classifying standard grievances as exempt grievances, the Plan is not complying with regulatory requirements to ensure grievance acknowledgment letters are sent to complainants in a timely manner.

4.1.3 Capturing all Grievances

The Plan is required to have procedures for filing a grievance, either orally or in writing, including procedures for appealing decisions regarding member's coverage, benefits, or relationship to the organization or other dissatisfaction with the Plan and/or providers. The Plan shall implement and maintain a Member Grievance System in accordance with CCR, Title 22, section 53858. *(Contract, Attachment 13(4)(D)(12), Attachment 14(1))*

The Plan is required to establish and maintain written procedures for the submittal, processing and resolution of all grievances. *(CCR, Title 22, section 53858(a))*

Plan's policy, *MS 8.001 Handling of Complaints and Grievances* stated, that a grievance can be filed in writing or verbally with the health plan or at any health plan provider's office. All complaints and grievances will be submitted immediately to the Plan's Member Services Department for processing according to health plan regulations. The Member Services unit works closely with staff of non-delegated providers to assure prompt investigation of complaints and grievances. Partially delegated providers are required to have copies of the Plan's grievance policy and procedure and associated forms available for members upon their request or they may use their internal complaint and grievance forms as per agreement with the Plan for members. All complaints and grievances will be submitted immediately to the Plan's Member Services Department for resolution.

The Plan's grievance system did not capture and process all complaints and expressions of dissatisfaction.

During the onsite visits to contracted clinics, 5 of 6 providers stated that grievances were processed internally and not forwarded to the Plan. Document review showed that newly contracted provider training PowerPoint presentation materials did not include training on the grievance process. In one case the verification study revealed that the provider office did not have the Provider Complaint form and was unaware of the procedures on the grievance process. Another case revealed that the provider did not submit the complaint immediately. It took the provider 18 days to determine that the member was a Medi-Cal beneficiary.

When grievances are not processed by the Plan, member complaints may not be addressed, investigated, and resolved appropriately. Additionally, these grievances will not be tracked and trended.

RECOMMENDATION(S):

4.1.1 Revise and implement policies and procedures to ensure that quality of care grievances are appropriately investigated and adjudicated. Implement policy and procedures to ensure categorization of quality of care grievances as PQIs when a potential quality issue is identified.

4.1.2 Implement policies and procedures to ensure grievances are appropriately classified, processed and resolved.

4.1.3 Develop and implement policies and procedures to capture all grievances.

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4.2	CULTURAL AND LINGUISTIC SERVICES

Cultural and Linguistic Program:
Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of CCR, Title 22, section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the group needs assessment requirements…
2-Plan Contract A.9.13

Contractor will assess, identify, and track the linguistic capability of interpreters or bilingually employed and contracted staff (clinical and non-clinical).
2-Plan Contract A.9.13.B

Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program.
2-Plan Contract A.9.13.F

Linguistic Services:
Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. section 2000d, 45 C.F.R. Part 80) that prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.
2-Plan Contract A.9.12

Contractor shall comply with CCR, Title 22 section 53853(c) and ensure that all monolingual, non-English-speaking, or Limited English Proficient Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact…either through interpreters, telephone language services, or any electronic options…
2-Plan Contract A.9.14.A

Types of Linguistic Services:
Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal members or potential members:

1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those that speak the threshold or concentration standards languages.

4.2	CULTURAL AND LINGUISTIC SERVICES

2) Fully translated written informing materials…
3) Referrals to culturally and linguistically appropriate community service programs.
4) Telecommunications Device for the Deaf (TDD).

2-Plan Contract A.9.14.B

Key Points of Contact Include:

1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care providers including pharmacists.
2) Non-medical care setting: member services, orientations, and appointment scheduling.

2-Plan Contract A.9.14.D

SUMMARY OF FINDING(S):

4.2.1 Monitoring Multi-Lingual Staff

The Plan shall implement policies and procedures to assess the performance of individuals who provide linguistic services as well as the overall monitoring and evaluation of the cultural and linguistic services program. (*Contract, Exhibit A, Attachment 9(F))*

Plan's policy, *CL 20.005 Assessment of Linguistic and Cultural Competencies* stated, the Plan's bilingual staff are assessed by a qualified vendor regarding their linguistic capabilities. The test is conducted by phone or computer then staff are given a pass or fail grade. No other procedures to monitor and evaluate linguistic services performed were described in the policy.

The Plan did not monitor and evaluate the performance of individuals who provide linguistics services to members.

In an interview, the Plan stated that staff were given a linguistic capabilities exam by a vendor at the time of hire when it is determined staff speak other languages. The staff member is then given a pass or fail grade but no other performance monitoring was conducted by the Plan after the staff member passes the vendor exam.

Without an evaluation of its linguistic services, the Plan cannot ensure that those services are adequate and effective in its communication with members.

RECOMMENDATION(S):

4.2.1 Develop and implement policies and procedures to monitor the quality of linguistic services provided by multilingual staff for propriety and effectiveness.

4.3	CONFIDENTIALITY RIGHTS

Members' Right to Confidentiality
Contractor shall implement and maintain policies and procedures to ensure the members' right to confidentiality of medical information.

1) Contractor shall ensure that facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
2) Contractor shall counsel members on their right to confidentiality and Contractor shall obtain member's consent prior to release of confidential information, unless such consent is not required pursuant to CCR, Title 22, section 51009.

2-Plan Contract A.13.1.B

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:
Business Associate agrees:

Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Protected Health Information (PHI), including electronic PHI, that it creates, receives, maintains, uses, or transmits on behalf of DHCS, in compliance with CFR, Title 45, sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of CFR, Title 45, section 164, subpart C, in compliance with CFR, Title 45, section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

2-Plan Contract G.III.C.2.

Breaches and Security Incidents. During the term of this agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS**. (1) To notify DHCS immediately by telephone call plus email or fax upon the discovery of a breach of unsecured PHI or Personal Information (PI) in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided

4.3	CONFIDENTIALITY RIGHTS

to DHCS by the Social Security Administration. (2) To notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this agreement and this addendum, or potential loss of confidential data affecting this agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer, or other agent of Business Associate.

2. **Investigation and Investigation Report**. To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
3. **Complete Report**. To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

2-Plan Contract G.III.J

SUMMARY OF FINDING(S):

4.3.1 Breach Notification Procedure and Corrective Action of Business Associate

The Plan is required to ensure that any agents, including subcontractors, agree to the same restrictions and conditions that apply to the Plan with respect to such PHI. Upon discovery of a breach, the Plan shall take prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment. *(Contract Amendment 02, Exhibit G, (3)(H)(1))*

A breach shall be treated as discovered by a covered entity or by a Business Associate as of the first day on which such breach is known to such entity or associate, respectively, (including any person, other than the individual committing the breach, that is an employee, officer, or other agent of such entity or associate, respectively) or should reasonably have been known to such entity or associate (or person) to have occurred. *(U.S. Code, Title 42, section 17932 (c))*

Plan's policy, *ADM1.039 Reporting of Improper Disclosures* stated, that a breach shall be treated as discovered by the Plan or sub contracted Business Associates as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer, or other agent of the Plan or Business Associate.

The Plan did not notify DHCS of a breach immediately or within 24 hours of discovery.

The verification study revealed that in 1 of 2 cases reviewed, the Plan did not ensure its Business Associate reported breach or security incidents within 24 hours of discovery. The Plan did not take prompt corrective action to correct the Business Associate's deficiency.

The contract between the Plan and the Business Associate stated that once the Business Associate becomes aware of suspected or actual breach of security, unauthorized use or disclosure of PHI, the Business Associate shall notify the Plan within 24 hours. The Plan did not provide an explanation as to why the incident was not reported within the required timeframe by the Business Associate and why corrective action was not taken. The Plan did not fully implement the procedures described in the Plan policy *ADM1.039.*

By ensuring that the Business Associate reports all suspected security incidents within the required timeframe, the Plan will meet its contractual and regulatory requirements in safeguarding the privacy of members' PHI.

4.3.2 Suspected Security Incident or Breach Notification Procedure

Upon discovery of a breach or suspected security incident, the Plan shall notify the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer *(Contract Amendment 02 XIV, Exhibit G, (3)(H)(1)).*

The Plan's policy *ADM1.039 Reporting of Improper Disclosures* states, that upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, the Plan shall report to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer.
The Plan did not report the discovery of PHI breaches or suspected security incidents to the DHCS Contract Manager and DHCS Information System Officer.

The verification study revealed that in 2 of 2 cases reviewed, the Plan did not send the notification to the DHCS Program Contract Manager and DHCS Information Systems Officer. The Plan did not implement its policy to report discovery of breaches to all required officers.

The prior DHCS audit found the Plan did not report breaches or suspected security incidents to the DHCS Program Contract Manager and DHCS Information Systems Officer. As a corrective action the Plan developed a policy to report breaches or suspected security incidents to all three DHCS officers, however, the Plan did not implement its policy during the audit period.

When the Plan does not send all required notifications, the Plan risks not mitigating the potential harm of unauthorized use of PHI.
This is a repeat finding.

4.3.3 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. *(Contract Amendment 02, Exhibit G(3)(C)(3b))*

DHCS requires that a background check must be conducted for all employees who will have access to DHCS PHI. A covered entity must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of PHI. *(MMCD All Plan Letter 09-014 Dated September 29, 2009; CFR, Title 45, 164. 530 - Administrative requirements)*

Plan's policy *CR.11.016 Credentialing License CCHP Staff*, revised 2/2019 stated, background checks on all persons having access to PHI are required as a condition of any type of employment. This includes but is not limited to persons from outside staffing agencies and subcontractors to prevent unauthorized access to PHI.

The Plan did not provide documentation of background checks on all persons having access to PHI. This included subcontractors and health care professionals.

A review of 9 personnel (7 permanent employees and 2 subcontractors) background checks showed 6 had incomplete verification of identity. The personnel files did not include live scan fingerprint and sanction checks.

In an interview, the Plan stated that the subcontractors were employees of the county and therefore the county was responsible for the background check. The Plan did not maintain copies of background checks of their subcontractors. The audit team requested background checks of permanent employees while onsite, however, the Plan did not provide them onsite or post-onsite.

Subsequent to the exit conference, in a written response, the Plan stated that as part of Contra Costa County, the county's Human Resource Department is responsible for performing background checks. The Plan submitted the county's *Contra Costa Health Services policy 216PM Reference Checking, License Verification and Pre-employment LiveScan Fingerprint Clearance,* which stated through formal requests the Plan can obtain access to personnel files maintained by the county. However, there is no evidence that the Plan requested and evaluated the background check files of its county-employed subcontractors.

The prior DHCS audit found the Plan did not perform background check procedures of their UM Director. As a corrective action, the Plan amended their policy to include background checks, fingerprinting, and identity verification for all employees, including subcontractors, prior to obtaining access to any system allowing access to PHI. The Plan had not implemented the revised policy during the audit period.

Without a background check of all individuals who will have access to PHI, the Plan increases the risk of theft or unauthorized use of members' PHI.

This is a repeat finding.

RECOMMENDATION(S):

4.3.1 Develop and implement procedures to ensure Business Associates report breach or security incidents within required timeframes. Implement policies and procedures to take prompt corrective action on Business Associates to correct any deficiencies.

4.3.2 Implement policies and procedures to ensure the Program Contract Manager and Information Systems Officer are included in notifications to DHCS.

4.3.3 Implement policies and procedures to ensure verification of identity for all employees and maintain documentation of background checks performed including, but not limited to, persons from outside staffing agencies, subcontractors and county employees.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: June 1, 2018 through March 31, 2019
DATE OF AUDIT: April 8, 2019 through April 19, 2019

CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM

General Requirements:
Contractor shall implement an effective QIS in accordance with the standards in CCR, Title 28, section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all covered services regardless of the number of contracting and subcontracting layers between Contractor and the provider.
2-Plan Contract A.4.1

Written Description: Contractor shall implement and maintain a written description of its QIS …(as required by contract)
2-Plan Contract A.4.7.A-I

Accountability: Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a Quality Improvement Committee with oversight and performance responsibility, the supervision of activities by the Medical Director, and the inclusion of contracted physicians and contracted providers in the process of QIS development and performance review. Participation of non-contracting providers is discretionary.
2-Plan Contract A.4.2

Governing Body*:* Contractor shall implement and maintain policies that specify the responsibilities of the governing…(as required by contract)
2-Plan Contract A.4.3.A-D

Provider Participation: Contractor shall ensure that contracting physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.
2-Plan Contract A.4.5

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

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5.1	QUALITY IMPROVEMENT SYSTEM

Delegation of Quality Improvement Activities:

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, credentialing and site review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their subcontract, at minimum:
   1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
   2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
   3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
   4) Contractor's actions/remedies if subcontractor's obligations are not met.

B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:
   1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
   2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
   3) Includes the continuous monitoring, evaluation, and approval of the delegated functions.

2-Plan Contract A.4.6

SUMMARY OF FINDING(S):

5.1.1 Quality Improvement System (QIS) Written Description, Work Plan and Evaluation

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 Contractor's governing body and periodically evaluated and updated. (*Contract, Exhibit A, Attachment 4 (7)(A)*)

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

The 2019 Quality Program Description stated, "The work of the QM Unit is reviewed and approved by the Plan's executive management. QM Work Plan, Program Description, and Annual Program Evaluation receive approval from the Quality Council and our governing body, the Joint Conference Committee, which is chaired by a Board of Supervisors Member to provide oversight and appropriate review."

The Plan's governing body, the JCC, did not review and approve the Plan's 2019 Quality Program Description, 2019 Quality Work Plan, and 2018 Quality Program Evaluation.

The Plan stated that their goal is to review and approve these documents early in the year, January or February. While onsite, they provided signed copies of their 2019 documents dated January 25, 2019. In an interview, the Plan stated that these documents were reviewed and approved in the March 25, 2019 meeting. A review of the December 2018 and March 2019 JCC meeting minutes did not demonstrate that an approval of these documents had taken place. This analysis revealed that these documents were signed prior to approval by the governing board. The validity of the reviewed documents and the approval process could not be corroborated based on the information provided by the Plan.

The Board, in this case the JCC, is accountable for the overall quality and safety of the Plan's members. If key quality documents such as those described above are not reviewed, and approved by the governing body there is risk of overlooking important priorities and objectives.

5.1.2 Monitoring and Oversight of Quality Improvement (QI) Delegates

The Plan shall maintain a system to ensure accountability for delegated QI activities that at a minimum, includes the continuous monitoring, evaluation, and approval of the delegated functions. (*Contract, Exhibit A, Attachment 4(6)(B)(3)*)

The Plan shall require subcontractors to report findings and actions taken as a result of QI activities at least quarterly. (*Contract, Exhibit A, Attachment 4(6)(A)(3)*)

The Plan's policy *PR11.024 Peer Review and Credentialing Committee* stated, the Plan's credentialing committee responsibilities include reviewing reports of delegated credentialing actions, policies, and activities. The Plan's policy did not address its delegates' quarterly reporting requirements.

The Plan did not continuously monitor and evaluate the functions of its QI delegates.

The Plan did not ensure receipt of all quarterly credentialing activity reports from 4 of 6 QI delegates during the audit period.

The Plan's Peer Review and Credentialing Committee reports showed the Plan did not receive all quarterly reports for two delegates and received activity reports from two other delegates that included multiple quarters at one time rather than the required quarterly submission.

Without continuous monitoring and oversight of all delegated activities, the Plan cannot ensure that the delegates meet standards set forth by the Plan and DHCS.

5.1.3 Communication of Requirements to QI Delegates/Subcontractors

All Policy Letters issued by Managed Care Quality and Monitoring Division and Managed Care Operations Division shall be complied with by the Plan. (*Contract, Exhibit E, Attachment 2(1)(D)*)

The Plan is responsible for ensuring that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; contract requirements; reporting requirements; and other DHCS guidance including, but not limited to, APLs. The Plan is required to maintain policies and procedures to communicate these requirements to all subcontractor and delegated entities. (*All Plan Letter 17-004*)

The Plan's policy *QM14.301 Delegation Oversight Process* stated, that delegation arrangements are part of the contracting process. The Plan's policy did not address communicating regulatory and contract requirements.

The Plan did not have policies or procedures to communicate federal, state, contract, or DHCS requirements to its delegated entities and subcontractors.

When the Plan does not maintain policies and procedures to communicate the necessary requirements, the Plan cannot ensure its delegated entities and subcontractors will comply with all applicable requirements under the contract.

5.1.4 Financial Sanctions and Subcontractor Non-compliance Reporting

All Policy Letters issued by Managed Care Quality and Monitoring Division and Managed Care Operations Division shall be complied with by the Plan. (*Contract, Exhibit E, Attachment 2(1)(D)*)

The Plan is required to maintain policies and procedures for imposing corrective action and financial sanctions on subcontractors upon discovery of noncompliance with the subcontract or other Medi-Cal requirements. (*All Plan Letter 17-004*)

The Plan's policy *QM14.301 Delegation Oversight Process* stated, that the Plan monitors delegation via routine reporting and/or onsite audits of delegated providers on an annual basis. If opportunities for improvement have been identified, a Corrective Action Plan (CAP) request for the contracted provider will also be written and sent. The Plan's policy did not address imposition of financial sanctions and reporting significant non-compliance to its MCOD Contract Manager.

The Plan did not have any policies or procedures for imposing financial sanctions on its subcontractors and delegated entities. The Plan did not have any policies or procedures for reporting significant non-compliance, imposition of corrective action, or financial sanctions of its subcontractors and delegated entities to its MCOD Contract Manager within three business days.

In an interview, the Plan was unaware of the requirement to report significant non-compliance, imposition of corrective action, or financial sanctions to its MCOD Manager.

Subsequent to the exit conference in a written response, the Plan conveyed their difficulty of imposing financial sanctions on county affiliated delegated entities. The Plan does not have a mechanism to impose financial sanctions for non-compliance.

When the Plan does not have any policies or procedures to impose financial sanctions on noncompliant subcontractors, the Plan cannot ensure current and future subcontractors will comply with the contract requirements.

5.1.5 Ownership and Control Disclosure Reviews

The Plan shall collect and review their subcontractors' ownership and control disclosure information as set forth in *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. (*All Plan Letter 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 or in any subcontractor, in which the subcontractor has direct or indirect ownership of 5 percent or more; (2) whether any of the persons named is related to another as spouse, parent, child, or sibling; (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. The Plan shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information. (*CFR, Title 42, section 455.104*)

Plan's policy *QM14.301 Delegation Oversight Process* stated, delegated quality monitoring status is granted to contracted providers upon successful demonstration of the required scope of quality monitoring activities. The Plan's policies did not address collection and review of delegates' ownership and control disclosure information.

The Plan did not collect and review complete ownership and control disclosure for their QI and UM delegates.

One of 4 sampled delegate's ownership disclosures did not include any ownership information. Three of 4 sampled delegates' control disclosures did not include the delegates' Officers, Directors, or managing employees. In a written response, the Plan stated that two of its QI delegates are divisions under Contra Costa County and are government entities; therefore, the Plan did not collect control disclosures. While two of the delegates are government entities under Contra Costa County, the Plan is required to collect control disclosures for each entities individuals with controlling interest such as Directors and managing employees. The Plan did not have a consistent process of collecting and reviewing its delegates' ownership and control disclosure information. When the Plan does not collect and review ownership and control disclosure information of their QI delegates, they cannot ensure that the delegates owners and controlling interest individuals are eligible for program participation.

5.1.6 Quality Improvement (QI) Delegation Agreement

If the Plan delegates any activity or obligation to a subcontractor, whether directly or indirectly, the subcontract or written agreement shall:

1. Specify delegated functions and activities of the Plan and subcontractor.

2. Specify the Plan's oversight, monitoring, and evaluation processes.

3. Specify the subcontractor's responsibility to report findings and actions taken as a result of the quality activities at least quarterly

4. Specify actions if subcontractor obligations are not met

(*Contract, Exhibit A, Attachment 4(6)(A)*)

Plan's policy *QM14.301 Delegation Oversight Process* stated, the Plan monitors delegation via routine reporting and/or onsite audits of delegated providers on an annual basis.

The Plan did not specify in its written agreement with one credentialing delegate the Plan's oversight, monitoring, evaluation processes, and the delegate's responsibility to report findings and actions quarterly to the Plan. In an interview, the Plan stated that the oversight processes and quarterly reporting were included in the agreement; however, review of delegation agreement did not include these requirements.

Without specifying the Plan's oversight processes the Plan cannot ensure the delegate will comply with the Plan's oversight processes.

RECOMMENDATION(S):

5.1.1 Develop and implement policies and procedures to ensure that the Plan's governing board reviews and approves the Quality Improvement Program Description, Quality Program Work Plan, and the Quality Improvement Evaluation.

5.1.2 Develop and implement policies and procedures to ensure receipt and review of delegated QI activity reports at least quarterly.

5.1.3 Develop and implement policies and procedures to communicate federal, state, contract, or DHCS requirements to its subcontractors and delegated entities.

5.1.4 Develop and implement policies and procedures for imposing financial sanctions on subcontractors and delegated entities. Develop and implement policies and procedures for reporting significant non-compliance, imposition of corrective action, financial sanctions of subcontractors, and delegated entities to the Plan's MCOD Contract Manager within three business days.

5.1.5 Revise and implement policies and procedures to collect and review all delegates' ownership and control disclosure information.

5.1.6 Revise delegation agreements to ensure the Plan's oversight, monitoring, evaluation processes, and the delegates' responsibility to report findings and actions quarterly are in writing.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

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5.2	PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:
Contractor shall develop and maintain written policies and procedures that include initial credentialing, re-credentialing, recertification, and reappointment of physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.
Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
2-Plan Contract A.4.12

Standards:
All providers of covered services must be qualified in accordance with current applicable legal, professional, technical standards, and appropriately licensed, certified or registered….Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
2-Plan Contract A.4.12.A

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status….
2-Plan Contract A.7.*5*

Delegated Credentialing:
Contractor may delegate credentialing and re-credentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, delegation of Quality Improvement activities…
2-Plan Contract A.4.12.B

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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5.2	PROVIDER QUALIFICATIONS

Disciplinary Actions:
Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.
2-Plan Contract A.4.12.D

SUMMARY OF FINDING(S):

5.2.1 Completion of Provider Training

The Plan is required to ensure that all providers receive training regarding the Medi-Cal managed care services, policies, procedures and any modifications to existing services, policies or procedures. The Plan is required to conduct training for all providers within ten (10) working days after the Plan places a newly contracted provider on active status. (*Contract, Exhibit A, Attachment 7(5))*

Plan's policy *PA 9.816 Provider Training* stated, provider relations staff orients newly credentialed providers to the health plan within 10 business days after peer review, credentialing approval, completion of a contract, and being placed active in the network. During the orientation, provider relations staff distributes and reviews the provider manual with the provider and/or provider office staff. The policy stated that after orientation, the provider is required to sign a verification form that they have received training on the provider manual.

The Plan did not ensure provider training was conducted within 10 business days for all newly contracted providers.

The Plan did not implement its provider training policy and procedures during the audit period. In an interview, the Plan stated that provider relations sends an email to newly contracted providers that includes a link to the provider manual and an orientation PowerPoint presentation. The Plan also stated that provider relations facility site review nurses conduct onsite provider orientation with PCPs and OB-GYNs and by request for contracted specialty, ancillary, facility, or vendor.

The verification study found the following deficiencies:

- The Plan did not provide onsite orientation for 15 of 15 sampled new providers.

- The Plan sent orientation packets to the 15 new providers, however 4 did not have the signed attestations and two had signed attestations but 10 days after the active date.

The verification study only included providers related to the Community Provider Network. The Plan did not conduct training for newly contracted providers of its delegated entities. In interviews, the Plan stated the delegated entities were responsible for training their newly contracted providers. However, provider training is not a delegated function specified in their written agreements.

When the Plan does not ensure that training is conducted for newly contracted providers, they may not be aware of the key contract requirements pertaining to the Medi-Cal program.

5.2.2 Delegation of 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 shall meet the subcontracting requirements as stated in *CCR, Title 22, section 53867*. Each subcontract shall contain specification of the services to be provided by the subcontractor. (*Contract, Exhibit A, Attachment 6(13)(B)(1))*

All subcontracts shall be in writing and in accordance with the requirements of the Knox-Keene Health Care Services Plan act of 1975. A subcontract means a written agreement entered into by the Plan with a provider of health care services who agrees to furnish covered services to members. (*Contract, Exhibit E, Attachment 1(100))*

All Plan Letter 17-004 Subcontractual Relationships and Delegation stated, that if a 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, obligations, and related reporting responsibilities.

Plan's policy *PA 9.816 Provider Training* stated, provider relations staff orients newly credentialed providers to the health plan within 10 business days after peer review, credentialing approval, completion of a contract, and being placed active in the network.

The Plan's policy did not include training procedure responsibilities of delegated entities.

The Plan did not specify in its written agreement provider training responsibilities for their delegated entities.

In an interview, the Plan stated that the delegated entities were responsible for their own training, but this was not specified in the delegation agreements with the Plan. The Plan did not conduct oversight of provider training conducted by the delegated entities. Delegated oversight audits by the Plan revealed that new provider training procedures were not reviewed since this was not a delegated function.

When specific delegated provider responsibilities are not in a written agreement, the Plan cannot ensure that contractual requirements are met by the delegated entities.

RECOMMENDATION(S):

5.2.1 Develop and implement policies and procedures to ensure training for all new providers is conducted within 10 business days.

5.2.2 Develop and implement policies and procedures to ensure delegated agreements specify all delegated activities, obligations, and related reporting responsibilities; and ensure they are performed.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY	
6.1	**HEALTH EDUCATION PROGRAM**

Health Education:

1) Contractor shall implement and maintain a health education system that include programs, services, functions, and resources necessary to provide health education, health promotion, and patient education for all members.
2) Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator.
3) Contractor shall provide health education programs and services at no charge to members directly and/or through subcontracts or other formal agreements with providers that have expertise in delivering health education services to the member population.
4) Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for members and effective in achieving behavioral change for improved health.
5) Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.
6) Contractor shall maintain a health education system that provides educational interventions...
7) Contractor shall ensure that members receive point of service education as part of preventive and primary health care visits. Contractor shall provide education, training, and program resources to assist contracting medical providers in the delivery of health education services for members.
8) Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to ensure effectiveness.
9) Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements….(as required by contract)

2-Plan Contract A.10.8.A

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SUMMARY OF FINDING(S):

6.1.1 Health Education Classes

The Plan shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to ensure effectiveness. *(Contract, Exhibit A, Attachment 10(8))*

Plan's policy *HE 19.003 Provider Compliance* stated, that health education compliance for the contracted facility is conducted by the Plan facility review nurse. Evaluation of classes was not discussed in the Plan's health education policies.

The Plan did not evaluate the effectiveness of its health education classes.

The Plan developed a 2019 Health Education Work Plan but it did not include a process for evaluating health education classes for appropriateness and effectiveness.

In an interview, the Plan stated that during the audit period they did not perform an evaluation of their health education classes. The Plan was unable to provide an explanation as to why evaluations were not performed.

When an evaluation of available health education classes is not conducted to determine appropriateness and effectiveness, members may receive inaccurate health information.

RECOMMENDATION(S):

6.1.1 Develop and implement policies and procedures to conduct an evaluation of classes made available to members.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: June 1, 2018 through March 31, 2019
DATE OF AUDIT: April 8, 2019 through April 19, 2019

6.2	FRAUD AND ABUSE

Fraud and Abuse Reporting
Contractor shall meet the requirements set forth in CFR, Title 42, 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse:

1) Contractor shall establish an anti-fraud and abuse program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
2) Contractor shall provide effective training and education for the compliance officer and all employees.
3) Contractor shall make provision for internal monitoring and auditing, including establishing effective lines of communication between the compliance officer and employees, and enforcement of standards through well-publicized disciplinary guidelines.
4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity….
5) Tracking Suspended Providers—Contractor shall comply with CFR, Title 42, 438.610. Additionally, Contractor is prohibited from employing, contracting, or maintaining a contract with physicians or other health care providers that are excluded, suspended, or terminated from participation in the Medicare or Medi-Cal/Medicaid programs….

2-Plan Contract E.2.26.B

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Contra Costa Health Plan
AUDIT PERIOD: June 1, 2018 through March 31, 2019 **DATE OF AUDIT:** April 8, 2019 through April 19, 2019

SUMMARY OF FINDING(S):

6.2.1 Reporting of Overpayments

The Plan is required to implement and maintain arrangements or procedures that are designed to detect and prevent Fraud, Waste, and Abuse (FWA). The arrangements or procedures must include the provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. *(42 CFR 438.608(a)(2))*

Plan's *policy CSU 4.159e Refund Request from Providers* stated, that the Plan has two processes in recovery of overpayments to providers. The internal process is managed by the claims department while the overpayment related to FWA is outsourced to a vendor for daily operations and managed by the analysis and reporting department. Per policy, the Plan will submit a report to DHCS on an annual basis with the following information: (1) overpayment to network providers, (2) overpayment to non-network providers, and (3) provide network provider's fraud, waste, and abuse reports.

The Plan did not report all overpayments identified or recovered to the State.

During the audit period, the Plan generated a report of all overpayments identified on a monthly basis. Although the Plan had a policy for reporting, these identified overpayments were not reported to the State. In addition, the Plan did not provide documentation of overpayments that may have been identified by its vendor.

When Plans do not report overpayment to the State, it may lead to missed opportunities to detect and prevent FWA.

6.2.2 Fraud Waste and Abuse Detection

The Plan shall meet the requirements set forth in *CFR, Title 42, 438.608* by establishing administrative and management arrangements or procedures to detect and prevent FWA including a compliance program. *(Contract, Exhibit E, Attachment 2 (26))*

The Plan's compliance program must include the establishment and implementation of procedures and a system with dedicated staff for internal monitoring and auditing of compliance risk, prompt response to compliance issues as they are raised, investigation of potential compliance problems, correction of such problems promptly and thoroughly to reduce the potential of recurrence, and ongoing compliance with the requirements under the contract. *(42 CFR 438.608 (a)(1)(vii))*

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: June 1, 2018 through March 31, 2019
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The Plan's policy *CSU 4.159e Refund Request from Providers* detailed, procedures to recover payments from providers for claims that had been paid in error. The Plan contracted the daily operation of FWA function to an outside vendor. The policy stated that the Plan's claims and analytical reporting units monitor quarterly reports to review any fraudulent or wasteful billing practices. The policy also stated that the analysis & reporting unit reviews claim details for quarterly reporting to CEO, CAO and Compliance Officer. Quarterly, all FWA and payment recovery reports are reviewed to identify trends that may need provider education and outreach interventions.

Plan's policy *ADM. 1.006 Anti-Fraud Program* stated, that if a potential or suspected fraud case is reported to the Anti-Fraud Unit, the Anti-Fraud Officer should log all anti-fraud inquiries and convene a meeting with the Anti-Fraud Unit to evaluate the reported incident for validity. The Anti-Fraud Unit/Compliance Fraud Subcommittee will meet to review the program and make recommendations for improvements to assure the success of the program in preventing, detecting, investigation, and reporting fraud.

The Plan did not completely implement its procedures to detect and prevent FWA. The Plan was unable to demonstrate that it fully implemented the anti-fraud procedures described in its policies. The Plan did not maintain a log for all anti-fraud inquiries.

Review of the contract with the vendor revealed that the vendor is to provide comprehensive FWA prevention and detection services. In an interview, the Plan stated that they did not review quarterly reports from the FWA vendor to monitor any fraudulent or wasteful billing practices. The Plan did not provide the quarterly reports described in Plan's policy *CSU 4.159e Refund Request from Providers.*

In an interview, the Plan stated that they keep a log of confirmed fraud and abuse incidents but not of potential or suspected fraud and abuse incidents reported. The Plan did not have a written criteria to use in the determination of suspected and actual fraud and abuse incidents, instead the Plan's compliance staff utilized its own judgement to determine if fraud existed. The Plan did not keep a log of all anti-fraud inquiries as described in its anti-fraud program.

When the Plan does not implement all of its anti-fraud procedures, there is a risk of failure to detect healthcare FWA activities.

RECOMMENDATION(S):

6.2.1 Implement policies and procedures to identify and report overpayments to the State.

6.2.2 Implement policies and to establish administrative and management arrangement or procedures to prevent FWA.

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

REPORT ON THE MEDICAL AUDIT OF

Contra Costa Health Plan

State Supported Services
Contract Number: 03-75796

Audit Period: June 1, 2018
through
March 31, 2019

Report Issued: September 19, 2019

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INTRODUCTION

This report presents the audit findings of Contra Costa Health Plan (CCHP) State Supported Services contract No. 03-75796. The State Supported Services contract covers contracted abortion services with CCHP.

The onsite review was conducted from April 8, 2019 through April 19, 2019. The audit period was June 1, 2018 through March 31, 2019. The audit consisted of document review of materials supplied by the Plan, verification study, and interviews conducted.

The following verification study was conducted:

State Supported Services

Claims: 15 state supported services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: June 1, 2018 through March 31, 2019
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STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion
Contractor agrees to provide, or arrange to provide, to eligible members the following State Supported Services:
Current Procedural Terminology Coding System Codes*: 59840 through 59857
Health Care Finance Administration (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 FINDING:

No deficiencies were identified in this audit.

RECOMMENDATION:

N/A