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

CONTRA COSTA HEALTH PLAN

Contract Number: **04-36067 A21**

Audit Period: May 1, 2016
Through
April 30, 2017

Report Issued: February 15, 2018

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I. INTRODUCTION

Contra Costa Health Plan (CCHP or the Plan) has contracted with the State of California to provide health care services to Medi-Cal beneficiaries in Contra Costa County since 1984. CCHP is a county sponsored Health Maintenance Organization (HMO) and was the first federally qualified HMO in the country that is administered by a local government. The Plan was licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act on April 6, 1978. The Contra Costa County Board of Supervisors exercises oversight of the Plan through a Joint Conference Committee that consists of the Board of Supervisors and the Plan.

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. CCHP 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 Community Provider Network (individual providers), Contra Costa Regional Medical Center (CCRMC), and Kaiser Permanente to provide or arrange comprehensive health care services. CCHP provides health care for public and private employee groups, private individuals, Medi-Cal and Medicare beneficiaries, and low-income county residents.

As of March 2017, CCHP had 195,566 members of which 182,583 were Medi-Cal members. The Plan also covers Medicare (422), county employees (6,981), commercial (1,968), and uninsured recipients (3,612).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of May 1, 2016 through April 30, 2017. The onsite review was conducted from June 12, 2017 through June 22, 2017. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on November 28, 2017 with the Plan. The Plan was allowed 15 calendar days from the date following the Exit Conference to provide supplemental information addressing the preliminary audit report findings. After the exit conference the Plan submitted supplemental information, which is reflected in this report.

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

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan did not always adhere to the mandated timeframes for appeal acknowledgement and resolution letters.

The Plan did not use the appropriate *Member Appeals Process* policy for some of their member appeals filed by providers on their behalf. The Plan used its Provider Grievance and Complaint Process policy instead. Member appeals, whether filed by member or provider, are governed by the Member Appeals Process policy.

The Plan did not perform an annual oversight audit on its subcontractor during the audit period. The DHCS CCHP audit of 2016 and associated Corrective Action Plan (CAP) cited the Plan must perform annual oversight audits of delegated entities utilization management to ensure the obligations are met in the contractual agreement. The CAP close-out letter of 3/10/2017 described how the plan was proceeding, but changes had not been implemented by the time of the current audit. ***This is an ongoing finding.***

The Plan did not provide quarterly Utilization Management (UM) reports from three of their delegated subcontractors for the audit period. The DHCS audit of 2016 and Corrective Action Plan (CAP) cited the Plan must require and document receipt of quarterly UM reports for delegated entities UM. The CAP close-out letter of 3/10/2017 described how the plan was proceeding, but changes had not been implemented by the time of the current audit. ***This is an ongoing finding.***

Category 2 – Case Management and Coordination of Care

The Plan did not ensure that its policies, provider informing materials, trainings, and clinical practice guidelines were completely stated to contract requirements for ensuring

that providers adhere to the current edition of the *Guide to Clinical Preventive Services* of the USPSTF for provision of preventive screening, testing, and counseling services and that the status of current recommended services is documented.

Category 3 – Access and Availability of Care

The Plan did not have a reliable system in place to forward misdirected claims to the appropriate capitated provider within 10 working days of receipt. The Plan acknowledged misdirected claims surpassed the 10 working day timeframe and stated they have initiated re-training of their claim staff to minimize any future discrepancies.

Category 4 – Member's Rights

There were no findings noted.

Category 5 – Quality Management

The Plan did not ensure the delivery of all preventive services and medically necessary diagnostic services for adult members by ensuring use of the latest edition of the Guide to Clinical Preventive Services.

The Plan did not provide documentation of quarterly reporting of quality improvement activities by two of its subcontractors and annual review of clinical practice guidelines by another subcontractor.

Category 6 – Administrative and Organizational Capacity

There were no findings noted.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch (MRB) to ascertain that services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the state contract.

PROCEDURE

The onsite review was conducted from June 12, 2017 through June 22, 2017. 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 Plan administrators, staff, and providers.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization, Concurrent and Retrospective Reviews: Twenty (20) medical and twenty (20) pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Prior Authorization Appeal Process: Eighteen (18) prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Behavioral Health Treatment (BHT): Twenty-two (22) Plan files were reviewed to confirm required elements, including Plan-approved treatment plans, were in place for medically necessary BHT services.

Individual Health Assessment (IHA): Thirty-nine (39) medical records were reviewed to confirm required elements, including documented evidence of the status of required preventive service, were in place within 120 days of enrollment in the health plan.

Category 3 – Access and Availability of Care

Emergency Service Claims: Twelve (12) emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: Fifteen (15) family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: Thirty-one (31) grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. (QOC – 15/QOS – 16)

Category 5 – Quality Management

Potential Quality Issue's (PQI): Five (5) PQI's were reviewed for appropriateness of clinical decision making and appropriate response to the quality issues identified.

Category 6 – Administrative and Organizational Capacity

Verification Study not performed for this category; no prior year findings reported.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Contra Costa Health Plan	
AUDIT PERIOD: May 1, 2016 - April 30, 2017	DATE OF AUDIT: June 12, 2017 - June 22, 2017

CATEGORY 1 - UTILIZATION MANAGEMENT

1.4	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 FINDINGS:

1.4.1 **Timeframes for Appeal Acknowledgement and Resolution Letters**

The Plan must provide a member notice…within 45 days from the day Plan receives the appeal. The member notice…must include the result and date of the appeal resolution. *(Contract, Exhibit A, Attachment 14, (5)(B))*

The Plan is to provide a written acknowledgement of a grievance (appeal) receipt to the member within five calendar days and provide the date of receipt, name of Plan representative handling the appeal, and the telephone number at which said representative can be contacted. *(Title 28 CCR, §1300.68(d)(1), Grievance System)*

The member is to be notified within five days of the receipt of the appeal. The Appeals Committee will make a decision on the appeal and notify the member of their determination no later than 30 days after original receipt of the standard appeal. *(Policy #: MS8.018, Member Appeal Process)*

The Plan did not always adhere to the mandated timeframes for appeal acknowledgement and resolution letters. The appeals verification study demonstrated the following:

1) No acknowledgement letter for one member.
2) Delayed acknowledgement letters for two members (one sent at 15 days and one sent at 22 days).
3) Delayed resolution letters for four members (one sent at 48 days, two sent at 63 days, and one sent at 53 days).

When applicable timeframes are not followed for acknowledgment letters, members are not promptly informed of their additional appeals rights, of who they are to contact for questions, and of the deadline for submitting additional information relevant to their appeal. This might lead to

the inability of members to properly exercise their appeal rights and to suboptimal appeals decisions from absence of member submitted information. Delayed resolution of appeals might lead to medical harm to members if medical services are provided in a delayed manner when such services are of a time sensitive nature.

1.4.2 Application of Members Appeals Policy

The Plan shall have a procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues. To this end, the Plan shall ensure that any grievance involving the appeal of a denial based on lack of medical necessity……..shall be resolved by a health care professional with appropriate clinical expertise in treating the member's condition or disease*. (Contract, Exhibit A, Attachment 14, (2)(D))*

During the appeal the member must have a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. The member must be given the opportunity before and during the appeals process to examine his/her case file, including medical records and any other documents and records considered during the appeals process. *(Contract, Exhibit A, Attachment 14, (4)(C))*

The purpose of the Plan's *Member Appeals Process* policy is to describe the mechanism for members or their authorized representatives to request reconsideration (appeal) of delayed, denied, or modified requested covered services. Members are notified within five days of receipt of appeals and the Appeals Committee will make a decision and notify members no later than 30 days from original standard appeals receipt. *(Policy #: MS8.018, Member Appeals Process)*

The purpose of the Plan's *Provider Grievance and Complaint Process* (also covers appeals) policy is to implement a systematic and timely process for the evaluation and resolution of grievances (appeals) and complaints that are not related to denial of claims or denial of medical services. Within 15 workdays of receipt, a letter is sent to the provider confirming receipt of the grievance and within 30 workdays, the provider will receive the resolution letter for the resolved grievance. Within 30 days of receipt of this resolution, the provider may submit an appeal to the Plan Medical Director, along with any new information or documentation. *(Policy #: PA9.800, Provider Grievance and Complaint Process)*

The Plan did not use their *Member Appeals Process* policy for some of their member appeals filed by providers on their behalf. They were using the *Provider Grievance and Complaint Process* policy instead. Member appeals, whether filed by member or provider, are governed by the *Member Appeals* Process policy. Appeals governed by the *Provider Grievance and Complaint Process* policy are referred to by the Plan as "straight" provider appeals.

The appeals verification study indicated the Plan did not use their *Member Appeals Process* policy for some member appeals (filed by providers on their behalf). After discussion of cases in the appeals interview, the Plan sent an email to us stating they were allowed additional time for these cases' notification letters; these were processed as "straight provider appeals not filed on behalf of the members" and not as "member appeals." The appeals cases in question were all member appeals (filed by their providers) and all involved previous medical necessity denials, making them appropriate for processing via the member appeals process only. The appeals cases and medical necessity denial service types were as follows:

1) physical therapy
2) durable medical equipment
3) genetic testing
4) podiatric surgery
5) durable medical equipment

Categorizing and processing these member appeals improperly as provider grievances (appeals) governed by a different appeals policy could lead to member harm. Members might not receive acknowledgement and resolution letters, would not be notified of their rights to further appeal, would not know who to call for questions, and would not know about rights to submit more information to support their appeal. Their appeal would not be processed as a true member appeal. There would not be mandated medical director resolution of these appeals related to denials of medical necessity.

RECOMMENDATIONS:

1.4.1 Ensure that appropriate timeframes for appeal acknowledgement and resolution letters are followed.

1.4.2 Ensure that staff can properly categorize and process member and provider appeals.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Contra Costa Health Plan	
AUDIT PERIOD: May 1, 2016 - April 30, 2017	DATE OF AUDIT: June 12, 2017 - June 22, 2017

1.5	DELEGATION OF UTILIZATION MANAGEMENT
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	

SUMMARY OF FINDINGS:

1.5.1 **Delegated Annual Oversight Audits**

The Plan is accountable for all utilization management functions and responsibilities that are delegated to subcontractors. "If the Plan delegates the UM activities, the Plan shall comply with Exhibit A, Attachment 4, Provision 6. *Delegation of Quality Improvement Activities*." *(Contract, Exhibit A, Attachment 5, (5))*

The Plan shall maintain a system to ensure accountability for delegated quality improvement activities, that at 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. *(Contract, Exhibit A, Attachment 4, (6)(B)(1))*

The Plan did not perform an annual oversight audit on a subcontractor to which it delegates UM responsibilities during the audit period. As outlined in the delegation agreement between the Plan and subcontractor, the Plan will conduct ongoing oversight of delegated activities, including annual evaluation review to ensure that contract requirements are met.

The DHCS CCHP audit of 2016 and associated Corrective Action Plan (CAP) cited the Plan must perform annual oversight audits of delegated entities utilization management to ensure the obligations are met in the contractual agreement. The CAP close-out letter of 3/10/2017 described how the plan was proceeding, but changes had not been implemented by the time of the current audit.

Without annual oversight audits of delegated entities, the Plan cannot ensure that members have access to appropriate care and services consistent with contractual requirements. This may lead to adverse health care consequences for delegated members. ***This is an ongoing finding.***

1.5.2 **Utilization Management Monitoring of Delegated Subcontractors**

The Plan is accountable for all utilization management functions and responsibilities that are delegated to subcontractors. "If the Plan delegates the UM activities, the Plan shall comply with Exhibit A, Attachment 4, Provision 6. *Delegation of Quality Improvement Activities.*" *(Contract, Exhibit A, Attachment 5, (5))*

The Plan is accountable for all quality improvement functions and responsibilities that are delegated to subcontractors. If Plan delegates quality improvement functions, Plan and delegated entity (subcontractor) shall include in their Subcontract…the Plan's reporting requirements and approval process. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. *(Contract, Exhibit A, Attachment 4, (6)(A)(3))*

The Plan did not provide quarterly Utilization Management (UM) reports from three of their delegated subcontractors for the audit period.

The previous DHCS audit of 2016 and Corrective Action Plan (CAP) cited the Plan must require and document receipt of quarterly UM reports for delegated entities UM. The CAP close-out letter of 3/10/2017 described how the plan was proceeding but changes had not been implemented by the time of the current audit.

Without these quarterly delegate reports of UM, the Plan was not able to ensure integrity and ongoing improvement in the delegates' UM programs. This may lead to adverse health care consequences for delegated members. ***This is an ongoing finding.***

RECOMMENDATIONS:

1.5.1 Continue implementation of UM annual oversight audits for Plan's subcontractors.

1.5.2 Continue to implement monitoring and oversight of delegated entities through the timely receipt and analysis of quarterly UM reports.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE	
2.4	**INITIAL HEALTH ASSESSMENT**

The Plan must cover and ensure the provision of an Initial Health Assessment (IHA) in conformance with *CCR, Title 22, sections 53851(b), 53902(m), and 53910.5(a)(1)* to each new Member within timelines stipulated in Provision 5 and Provision 6. An IHA consists of a comprehensive history and physical examination and the Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the member's current acute, chronic, and preventive health needs…

Provision of IHAs for Adults, Age 21 and older
The Plan shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment. Plan shall ensure that the performance of the initial comprehensive history and physical exam for adults includes, but is not limited to:
1) A comprehensive history including, but not limited to, mental and physical systems, and social and past medical history.
2) Status of currently recommended preventive services.
3) Comprehensive physical and cognitive exam sufficient to assess and diagnose acute and chronic conditions.
4) Diagnoses and plan of care including follow-up activities.

Plans must adhere to the current edition of the Guide to Clinical Preventive Services of the US Preventive Services Task Force (USPSTF), specifically USPSTF "A" and "B" recommendations for providing preventive screening, testing and counseling services. Plan shall ensure that the status of current recommended services is documented.

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Preventive Services – Adults 21 and Older
The Plan shall cover and ensure the delivery of all preventive services and Medically Necessary diagnostic and treatment services for adult Members. Plan shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the USPSTF is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members [age 21 or older]. All preventive services identified as USPSTF "A" and "B" recommendations must be provided. As a result of the IHA or other examination, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services. In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the IHA for adults described above shall be offered in the frequency required by the USPSTF Guide to Clinical Preventive Services.

Two-Plan Contract Exhibit A.10
MMCD Policy Letter Initial Comprehensive Health Assessment 08-003

The Plan must develop and implement a process to provide information to providers and to train providers on a continuing basis regarding clinical protocols, evidence-based practice guidelines…

Two-Plan Contract Exhibit A.7

SUMMARY OF FINDING:

2.4.1 **Adult preventive services for Initial Health Assessment (IHA)**

The Plan must cover and ensure that each new member receives an Initial Health Assessment (IHA) within 120 calendar days of enrollment. An IHA consists of a comprehensive history and physical examination and the Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to assess the member's current acute, chronic, and preventive health needs. *(Contract, Exhibit A, Attachment 10)*

The Plan must ensure that the latest edition of the *Guide to Clinical Preventive Services* published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult members [age 21 or older]. All preventive services identified as USPSTF "A" and "B" recommendations must be provided. The Plan is required to develop and implement a process to provide information to providers and to train providers on a continuing basis regarding clinical protocols and evidence-based practice guidelines. *(Contract, Exhibit A, Attachment 10, (6)(B)(1))*

The Plan did not ensure that its policies, provider informing materials, trainings, and clinical practice guidelines were completely stated to the contract requirements for ensuring that providers adhere to the current edition of the *Guide to Clinical Preventive Services* of the USPSTF for provision of preventive screening, testing, and counseling services and that the status of current recommended services is documented.

The Plan promoted some, but not all, of the USPSTF "A" and "B" recommended preventive screenings through the Plan's provider manual, clinical practice guidelines, and provider bulletins.

According to the provider manual, the Plan follows the USPSTF guidelines for preventive health services for adults, but the manual only lists seven of the 39 recommendations for adults under 65. The following recommended services are among those not included in the Plan's provider manual:

- Breast cancer preventive medications
- Colorectal cancer and lung cancer screening
- Depression screening
- Diabetes and gestational diabetes screening
- Hepatitis B & C screening
- HIV, gonorrhea, and syphilis screening

According to *Policy #: QM14.701 Preventive Services/Initial Health Assessment,* the Plan established clinical guidelines that address preventive care recommendations that follow the current edition of the USPSTF's Guide to Clinical Preventive Services. However, the Plan's clinical guidelines contained only 13 of the 39 USPSTF "A" and "B" recommended services for adults.

The Plan's summer 2016 provider bulletin reminded providers that the IHA/IHEBA is required for all new members within 120 calendar days and includes assessment of the need for preventive screenings or services. The bulletin does not mention the required USPSTF "A" and "B" recommended services.

During interviews, Plan personnel verified that the USPSTF recommendations were not listed in their entirety in the provider manual, clinical practice guidelines, or provider bulletins. The Plan's medical leadership explained that providers were expected to use their clinical judgement in the selection of preventive services for each member during their IHA/IHEBA, regardless of which recommendations were listed in provider informing materials. A review of sampled medical records showed, however, the providers did not document all applicable preventive screenings or the status of those services. Plan personnel were not able to demonstrate that providers were trained on a continuing basis regarding the evidence-based USPSTF recommended services.

Chronic conditions such as sexually transmitted diseases, cancer, and diabetes are among the most preventable health problems (CDC 2016). The guidance to health care providers regarding preventive services is based on research that demonstrated the power to prevent and detect the same chronic diseases (USPSTF 2016). When managed care health plans implement evidence-based preventive services both lives and health care dollars may be saved (Maciosek, Coffield, Flottemesch, Edwards, & Solberb, 2010).

1 Centers for Disease Control and Prevention. (2016). Chronic Diseases: The Leading Causes of Death and Disability in the United States. Retrieved from http://www.cdc.gov/chronicdisease/overview/

2 United States Preventive Services Taskforce. (2016). Recommendations. Retrieved from https://www.uspreventiveservicestaskforce.org/

3 Maciosek, M.V., Coffield, A.B., Flottemesch, T.J., Edwards, N.M., & Solberg, L.I. (2010). Greater use of preventive services in U.S. health care could save lives at little or no cost. *Health Affairs* 29(9):1656-1660. doi:10.1377/hlthaff.2008.0701

RECOMMENDATION:

2.4.1 Develop and implement policies, systems, and training that direct and support compliance with the requirements regarding the provision of USPSTF “A” and “B” recommended preventive health services during the IHA/IHEBA.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE	
3.5	**EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS**

Emergency Service Providers (Claims):
Contractor is responsible for coverage and payment of Emergency Services and 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 Physician's Current Procedural Terminology (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 USC 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

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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

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section…Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.
2-Plan Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).
CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDING:

3.5.1 **Timely Forwarding of Claims to Appropriate Providers**

The Plan is required to maintain sufficient claims processing/tracking/payment systems capability to comply with applicable State and Federal law, regulations, and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims…*(Contract, Exhibit A, Attachment 8, (5)(D))*

For a provider claim involving emergency service and care, the Plan shall forward the claim to the appropriate capitated provider within ten (10) working days of receipt of the claim that was incorrectly sent to the Plan. *(Title 28 CCR, §1300.71(b)(A), Claims Settlement Practices)*

The Plan will make every effort to identify and forward misdirected claims sent to the Plan for delegated members within 10 working days of receipt. This requirement will be monitored using a monthly report generated by CCHP's Analysis & Reporting Unit, which is submitted to their claims unit for review. *(Policy#: CLM 4.536e: …Member Claims)*

The Plan did not have a reliable system in place to forward misdirected claims to the appropriate capitated provider within 10 working days of receipt. The emergency service verification study showed the Plan did not forward misdirected claims to the appropriate capitated provider within 10 working days of receipt.

The Plan verified that the Analysis & Reporting Unit Claims-Tapestry report is used to track and monitor misdirected claims. The report is generated on a monthly basis and is their only monitoring system. The Plan states in 2015 they revised their policy for misdirected claims and that staff was trained at that time. However, due to staff turn-over and oversight of this issue being addressed during quarterly Joint Operation Meetings, the Plan acknowledged that misdirected claims have surpassed the 10 working day timeframe. In response, the Plan states they have initiated re-training of claim staff to minimize any future discrepancies.

Without having a reliable system in place to forward misdirected claims, provider payments can be delayed. As a result, providers may leave the Plan's network due to untimely payment, which may ultimately effect member access and availability of care to services within and outside of the Plan's network of providers.

RECOMMENDATION:

3.5.1 Establish a reliable system to ensure continued training of claims staff and to establish a system to address current or potential quality issues within the claims department during operation meetings.

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CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM

General Requirements:
Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, 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 [Quality Improvement System] that shall include the following:

A. 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.
B. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QIS committee(s), and staff within the Contractor's organization.
C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.
D. A description of the system for provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.
E. The role, structure, and function of the quality improvement committee.
F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members…and that all Covered Services are provided in a culturally and linguistically appropriate manner.
G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that Members are able to obtain appointments within established standards.
H. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.
I. Description of the activities, including activities used by Members that are Seniors and Persons

5.1	QUALITY IMPROVEMENT SYSTEM

with Disabilities or persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.
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 body including at a minimum the following:

A. Approves the overall QIS and the annual report of the QIS.
B. Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS.
C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.
D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

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

Reference Cited:

Title 28 CCR Section 1300.70 – Health Care Service Plan Quality Assurance Program

SUMMARY OF FINDING:

5.1.1 **Adult Preventive Services**

The Plan shall cover and ensure the delivery of all preventive services and medically necessary diagnostic and treatment services for adult members. The Plan must ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services

Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult members [age 21 or older]. *(Contract, Exhibit A, Attachment 10, (6)(B)(1))*

Contract requirements were mirrored in CCHP policy, which states that Preventive Guidelines for Adults are based on the latest edition of the Guide to Clinical Preventive Services published by the USPSTF. CCHP shall use these guidelines to determine the provision of clinical preventive services to asymptomatic, healthy adult members [age 21 or older]. This includes all Grade A and Grade B recommendations. *(Policy #: QM14.701, Preventive Services/Initial Health Assessment))*

Preventive services guidelines are reviewed and approved by the Quality Council at least every two years and revised as necessary. When relevant new standards are published before the two year review period, the guideline will be reviewed by the Plan medical consultants who will make a determination regarding the timing of the revision interval. If a significant change in guideline is published, CCHP will expedite revision through the Clinical Leadership Group and Quality Council and ensure members and practitioners are alerted as soon as prudently possible when an issue of patient safety arises. *(Policy #: QM14.603, Clinical Practice and Preventive Health Guidelines)*

The Plan did not ensure the delivery of all preventive services and medically necessary diagnostic services for adult members by ensuring use of the latest edition of the Guide to Clinical Preventive Services. There was no real-time alert system to ensure use of the most recent and current adult preventive services guidelines, necessary because changes and additions to guidelines may occur on a frequent and unpredictable basis. According to interviews, the Plan updated the guidelines every two years and if they became aware of changes or additions to guidelines.

To ensure that the latest guidelines are utilized to provide appropriate preventive care services for members, a real-time alert system must be operational within the Plan. The guideline changes can then be promptly reviewed, approved, and implemented by the Plan medical consultants and *ad hoc* committee meetings. Lack of such a process might lead to members not receiving all of the appropriate and recommended preventive health services and the potential for member harm exists.

RECOMMENDATION:

5.1.1 Implement a real-time system to rapidly identify new or changed adult preventive services

guidelines so that they can be immediately approved and integrated into the Plan's preventive medicine system.

5.3	DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

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:

5.3.1 **Quality Improvement Responsibilities of Delegated Subcontractors**

The Plan is accountable for all quality improvement functions and responsibilities that are delegated to subcontractors. If the Plan delegates quality improvement functions, Plan and delegated entity (subcontractor) shall include in their subcontract, at minimum: quality improvement responsibilities, and specific delegated functions and activities of the Plan and subcontractor; Plan'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. *(Contract, Exhibit A, Attachment 4, (6)(A)(1 and 3))*

The Plan's delegation agreement between its subcontractors included quarterly reporting of quality improvement activities and an annual review of clinical practice guidelines. *(Policy #: QM14.301, Delegation Oversight Process)*

The Plan did not provide documentation of quarterly reporting of quality improvement activities by two of its subcontractors and annual review of clinical practice guidelines by another subcontractor.

The DHCS audit of 2016 Corrective Action Plan (CAP) cited the Plan must require and document receipt of quarterly quality reports for subcontractors' delegated quality improvement activities. The CAP close-out letter of 3/10/2017 described how the Plan was proceeding, but changes had not been implemented by the time of the current audit.

Without quarterly delegate reports of quality improvement activities from Plan subcontractors and annual review of clinical practice guidelines, the Plan cannot ensure integrity and ongoing improvement of its subcontractors' quality improvement programs. This may lead to adverse health care consequences for members. ***Lack of quarterly quality reporting activities is an ongoing finding.***

RECOMMENDATION:

5.3.1 Continue to implement monitoring and oversight of delegated entities through the timely receipt and analysis of quarterly quality improvement reports and other data.

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

CONTRA COSTA HEALTH PLAN

Contract Number: **03-75796 A12**
State Supported Services

Audit Period: May 1, 2016
Through
April 30, 2017

Report Issued: February 15, 2018

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INTRODUCTION

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

The audit period was May 1, 2016 through April 30, 2017. The onsite audit was conducted from June 12, 2017 through June 22, 2017.

An exit conference was held on November 28, 2017 with the Plan.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Contra Costa Health Plan	
AUDIT PERIOD: May 1, 2016 - April 30, 2017	DATE OF AUDIT: June 12, 2017 - June 22, 2017

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion *Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:* *Current Procedural Coding System Codes*: 59840 through 59857* *HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336* **These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.* *State Supported Services Contract Exhibit A.1*

SUMMARY OF FINDING:

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

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

RECOMMENDATION:

None