State of California—Health and Human Services Agency
Department of Health Care Services

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September 5, 2017

Ms. Norma Diaz
Chief Executive Officer
Community Health Group Partnership Plan
2420 Fenton Street, Suite 100
Chula Vista, CA 91914

PLAN NAME: **Community Health Group Partnership Plan**
CONTRACT NUMBER: **Contract # 09-86155**
CASE NUMBER: **C029-2017**
AUDIT PERIOD: **June 1, 2016 through May 31, 2017**

Dear Ms. Diaz:

We have completed the medical audit of Community Health Group Partnership Plan (Plan) for the audit period June 1, 2016 through May 31, 2017. This audit was conducted in accordance with Welfare and Institutions Code, section 14456. In conducting this medical audit, the audit team evaluated the Plan's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity.

In accordance with the California Code of Regulations, Title 22, section 51021, an Exit Conference was offered to the Plan on September 1, 2017. The Plan declined to hold an exit conference since there were no areas of noncompliance found in this review. The report reflects the Plan's actions taken to address the prior year's audit findings. Please review the enclosed audit report. Managed Care Quality and Monitoring Division will be contacting the Plan for further discussion.

If you have any questions, please contact Julie Woodward, Section Chief, Medical Review Branch at (619) 688-6465.

Sincerely,

Mark P. Mimnaugh, R.N., CCRN, M.P.A.
Chief, Medical Review Branch
Audits and Investigations Division
Department of Health Care Services

Enclosure

Golden State Overnight

cc: Nathan Nau, Chief ***(Via E-Mail)***
Program Monitoring and Compliance Branch
DHCS-- Managed Care Quality and Monitoring Division (MCQMD)

Andrew Kilgust, Chief ***(Via E-Mail)***
Contract Compliance Section
DHCS-- Managed Care Quality and Monitoring Division (MCQMD)
Program Monitoring and Compliance Branch

Brenda Gomez, Contract Manager ***(Via E-Mail)***
Local Operations Unit
DHCS—Managed Care Operations Division (MCOD)
Managed Care Systems and Support Branch

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

Community Health Group Partnership Plan

Contract Number: 09-86155

Audit Period: June 1, 2016 Through May 31, 2017

Report Issued: September 5, 2017

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I. INTRODUCTION

Community Health Group (CHG), incorporated in 1982, first contracted with the Department of Health Services in 1986 to provide services to Medi-Cal members. In 2005, the Plan obtained a Knox-Keene license from the California Department of Managed Health Care for CHG Foundation dba Community Health Group Partnership Plan which services its Medi-Cal membership. In 2014, CHG received a three-year Commendable Accreditation from the National Committee for Quality Assurance (NCQA) for its Medi-Cal line of business. For the audit period, CHG continues with a NCQA accredited status.

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

As of July 28, 2017, CHG serves members in two programs, Medi-Cal and Cal MediConnect. Total enrollment was as follows:

Program	Members
Medi-Cal	284,304
Cal MediConnect	5,254
Total Enrollment	289,558

II. EXECUTIVE SUMMARY

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

The DHCS medical audit was conducted for the period of June 1, 2016 through May 31, 2017. The audit confirmed the Plan acted upon prior findings and revised its policies and procedures.

An exit conference was offered to the Plan on September 1, 2017. The Plan declined to hold an exit conference since there were no areas of noncompliance found in this review.

Through a risk assessment, discussions with management, and review of documentation, the audit identified key areas with the greatest significance to include in this audit. The audit consisted of document review, verification studies, and interviews with Plan personnel.

The audit evaluated six categories of performance: Utilization Management, Case management and Coordination of Care, Access and Availability of Care, Member Rights, Quality Management, Administrative and Organizational Capacity.

Implementation of Prior Year Audit Recommendations
The prior DHCS medical audit for the audit period of June 1, 2015 through May 31, identified deficiencies. The Plan addressed the deficiencies in a corrective action plan (CAP). The CAP closeout letter dated January 30, 2017 noted that all previous findings were closed.

The following section presents previous audit deficiencies. This section includes the actions the Plan took to implement the CAP recommendations.

<u>Case Management and Coordination of Care</u>
The prior year audit found that the Plan's procedure to monitor Initial Health Assessments (IHA) lacked a system to detect differences between encounter data and member's medical records. In addition, the member's IHA did not to contain the necessary components to reflect a comprehensive evaluation.

To address the prior year audit findings, the Plan developed and fully implemented a Medi-Cal IHA validation system to compare encounter data to the medical records on a quarterly basis. The Plan utilizes the IHA validation system to review the medical records to ensure it reflects the components of a comprehensive health assessment. The system includes a new member monitoring and notification process and revised tools for staff utilization. In addition to the new validation system, the Plan continues to conduct facility site reviews and monthly member outreach.

The Plan promotes timely access and informs members of the importance of an IHA through the member handbook, member newsletters, and website. Additionally, the Plan monitors IHA encounters and conducts follow-up reminders to members when an IHA has not been performed within 120 days of enrollment.

The Plan's policy and procedures, which includes the United States Preventive Services Task Force (USPSTF), American Academy of Pediatrics (AAP), and American College of Obstetrics and Gynecologists (ACOG) criteria, informs providers of the IHA requirement. The Plan informs providers of the IHA criteria through provider training, provider newsletters, and the Plan's web portal.

During the audit period, the Plan had a system to ensure a complete comprehensive IHA within 120 calendar days and had procedures to monitor IHA completion.

Access and Availability of Care

The prior year audit finding determined the Plan did not meet the members' appointment demands within the contractual timeframe for certain specialties. As a result, the Plan contracted with outside consultants to perform secret shopper surveys to identify opportunities to expand the specialty network. The consultants also conducted a follow-up with specific providers who did not meet the access standards. The Plan also conducts its own internal secret shopper provider surveys twice per year.

In addition, the Plan developed a "Pay for Performance" initiative, which allows the Plan to contract with high needs specialty providers. In the first quarter of 2017, the Plan added 109 specialists to the provider network.

The Plan implemented the recommendations from the prior year audit. The Plan stated it will continue its efforts to acquire more specialists and monitor member appointment accessibility through member grievances and provider surveys.

Member's Rights

In 2015, the DHCS audit found significant systemic issues within the Plan's grievance system. This led to non-compliance with the grievance contractual requirements. The 2016 DHCS audit documented the Plan's progression to resolve these issues.

Over the past two years, an outside consultant assisted the Plan to resolve the grievance system deficiencies. The Plan revised its policies and internal procedures to reflect the contractual requirements. The Plan developed work groups and added additional resources to conduct audits that focused on appropriate classification, accuracy, and timely resolution of the grievances. All Plan staff received extensive training on the grievance process. The Plan also implemented multiple review levels to ensure governmental agencies receive accurate grievance reports.

During the audit period, the Plan implemented the recommendations from the prior years' audits. The Plan has a system to appropriately and accurately process, monitor, and report member grievances.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The on-site review was conducted from June 26, 2017 through June 28, 2017. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management
Prior Authorization Requests: 20 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeals Procedures: 20 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care
Initial Health Assessment: 20 medical records were reviewed for completeness and timeliness.

Behavioral Health Treatment: 20 medical records were reviewed for evidence of coordination of care between the Plan and providers.

Category 3 – Access and Availability of Care
Appointment Availability: 15 providers from the Plan's Provider Network were reviewed. The third next available appointment was used to measure access to care.

Emergency Services and Family Planning Claims: 15 emergency service claims and 11 family planning claims were reviewed for appropriate and timely adjudication.

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

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

Community Health Group Partnership Plan

Contract Number: 09-86156
State Supported Services

Audit Period: June 1, 2016
Through
May 31, 2017

Report Issued: September 5, 2017

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II. COMPLIANCE AUDIT FINDINGS 2

INTRODUCTION

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

The on-site audit was conducted from June 26, 2017 through June 28, 2017. The audit period is June 1, 2016 through May 31, 2017 and consisted of document review of materials supplied by the Plan and interviews conducted on-site.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Community Health Group Partnership Plan	
AUDIT PERIOD: June 1, 2016 through May 31, 2017	DATE OF AUDIT: June 26, 2017 through June 28, 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 FINDINGS:

The Plan's *Referral and Prior Authorization System* (Policy No. 7251) states abortion services are considered a "sensitive service" that does not require prior authorization for out-patient abortion services. The policy also states members may go to any provider of their choice for abortion services, at any time for any reason, regardless of network affiliation.

The prior year's audit found the Plan's policies and the member handbook contained language to limit the member's access to in-network providers. The Plan revised its policies to include the provision that abortion services do not require prior authorization, regardless of network affiliation. The Plan also updated the Member Handbook/Evidence of Coverage with the same language.

Policy 7809, *Claims for Abortion Services*, states the Plan covers both surgical abortions Current Procedural Terminology CPT-4 codes 59840 through 59857; Healthcare Common Procedure Coding (HCPCS) codes A4649-U1 (X1516) and A4649-U2 (X1518); and medical abortions HCPCS codes S0199 (Z0336), S0190 Mifepristone 200 mg RU-486 (X7724), and S0191 Misoprostol 200 mcg (X7726).

The Member Handbook/Evidence of Coverage informs members of their rights to receive "sensitive services" in- or out-of-network without prior authorization. Members can also contact the Member Service Call Center for assistance. The Plan informs providers of the members' rights to abortion services without prior authorization in the Provider manual, which can be found on the website via the Provider's Web Portal.

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

The audit found the Plan complies with the contractual requirements.