

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

**Community Health Group
Partnership Plan**

Contract Number: 09-86155

Audit Period: April 1, 2014
Through
March 31, 2015

Report Issued: December 14, 2015

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I. INTRODUCTION

Community Health Group (CHG), incorporated in 1982, first contracted with the Department of Health Services (DHS) 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 serves its Medi-Cal membership. The Plan's Medicare membership is licensed as Community Health Group Plan.

The Plan is currently contracted with Department of Health Care Services 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.

As of March 31, 2015, CHG serves members in two programs. These programs are Medi-Cal and Cal MediConnect. Total enrollment in these programs is 246,538.

- Medi-Cal 240,658
- Cal MediConnect 5,880

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of April 1, 2014 through March 31, 2015. The on-site review was conducted from June 22, 2015 through July 3, 2015. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held with the Plan on November 10, 2015. The Plan was allowed fifteen (15) calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report findings. The Plan submitted supplemental information after the exit conference which is reflected in this report. In written comments on our draft report, the Plan provided information on actions that it had taken or planned to take to address our recommendations.

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

The prior DHCS medical audit (for the period of May 1, 2011 through April 30, 2012, with on-site review conducted from December 3 through 14, 2012) was issued April 22, 2013. The *corrective action plan* (CAP) closeout letter dated November 25, 2013 noted that all previous findings were closed. Overall, the Plan revised its policies and procedures but had not implemented much of the CAP as of this audit. **Repeat findings** were identified and appear in the body of the report.

The summary of the findings by category follows:

Category 1 – Utilization Management

Time frames to process four medical prior authorizations were exceeded.

Category 2 – Case Management and Coordination of Care

The Plan did not ensure that *Initial Health Assessments* for five new members were completed within 120 days of enrollment. The Plan used an untested methodology to monitor compliance with the *Initial Health Assessment* requirement.

Category 3 – Access and Availability of Care

The Plan did not ensure that appointments are available within the required time frames. The Plan's Member Guide/Evidence of Coverage lacks the appointment standard for initial prenatal visit.

The Plan insufficiently monitors emergency pharmaceutical services.

Category 4 – Member’s Rights

Grievance written acknowledgement and resolution notices were not provided to members. Time frames to resolve grievances were exceeded. No oversight was conducted by clinical personnel to ensure proper identification of clinical/quality of care grievances. Grievance Quarterly Reports sent to the DHCS were inaccurate.

The Plan’s policies and procedures lacked the Plan’s process to assess, identify, and track the linguistic capability of interpreters.

Breach incidents were not reported to the Managed Care Operations Division Contracting Officer and the DHCS Information Security Officer.

Category 5 – Quality Management

The Plan did not ensure completion of provider training for six new providers. The Plan did not train two new providers within the 10 working day time frame.

Category 6 – Administrative and Organizational Capacity

The Plan’s policies and procedures lacked pertinent language. The Plan did not report one suspected fraud and abuse case to the DHCS within the required time frame.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (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 22, 2015 through July 3, 2015. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 16 medical and 10 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Notification of Prior Authorization Denial, Deferral, or Modification: 58 notification letters were reviewed for written notification requirements.

Appeal Procedures: 52 prior authorization appeals were reviewed for appropriate and timely adjudication. Appeals were processed timely and adjudicated appropriately.

Category 2 – Case Management and Coordination of Care

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

Initial Health Assessment: 23 medical records were reviewed for completeness and timely completion.

Complex Case Management: 5 medical records were reviewed for evidence of coordination of care between the Plan and the providers.

Category 3 – Access and Availability of Care

Appointment Availability: 14 providers from the Plan's *in-network* providers of routine, urgent, specialty, and prenatal care were reviewed. The third next available appointment was used to measure access to care.

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

Category 4 – Member’s Rights

Grievance Procedures: 19 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

New Provider Training: 9 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Community Health Group Partnership Plan

AUDIT PERIOD: April 1, 2014 through March 31, 2015

DATE OF AUDIT: June 22, 2015 through July 3, 2015

CATEGORY 1 - UTILIZATION MANAGEMENT

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)

GMC 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, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

GMC 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(a)(1) or any future amendments thereto.

GMC 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(h)(1), 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.

GMC Contract A.5.3.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 by providing written notification to members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.

GMC Contract A.13.8.A

SUMMARY OF FINDINGS:

1.2.1 Prior Authorization Time Frames

The Plan is required to process routine medical Prior Authorizations (PAs) within five working days from receipt of the information reasonably necessary to render a decision, but, no longer than 14 calendar days from the receipt the request. The decision may be deferred and the time limit extended an additional 14 calendar days only when the member or the member's provider requests an extension or the need for additional information is in the member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. [Contract, Exhibit A, Attachment 5 (3)(H)]

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The Plan did not consistently meet time frames to process Prior Authorizations. A sample of sixteen medical PAs was examined as part of the verification study. Four medical PAs were processed 42 to 116 days after the receipt of request. The four medical PAs were associated with power-assisted wheelchairs. The Plan implemented a new procedure to confirm that the members met the medical necessity requirements. The new procedure included an in-home physical therapy evaluation. This resulted in the delay of the PA decision.

RECOMMENDATION:

1.2.1 Process medical prior authorization requests according to required time frames.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4

INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:

Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with 22 CCR 53910.5(a)(1) to each new member within timelines stipulated in Provision 5 and Provision 6 below.

GMC 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 60 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.

GMC Contract A.10.5.A

IHAs for Adults, Age 21 and older

Contractor shall cover and ensure that an IHA for adult members is performed within 120 calendar days of enrollment. Contractor shall ensure that the performance of the initial comprehensive history and physical exam for adults includes...(as required by Contract)

GMC Contract A.10.6.A

Contractor shall make repeated attempts, if necessary, to contact a member and schedule an IHA.

Contractor shall make at least three documented attempts...Contact methods must include at least one telephone and one mail notification....

GMC Contract A.10.3.E

SUMMARY OF FINDINGS:

2.4.1 Initial Health Assessments

The Plan is required to ensure the provision of an Initial Health Assessment (IHA) in conformance with *California Code of Regulations, Title 22, § 53910.5 (a)(1)* to each new member within 120 calendar days of enrollment. [Contract, Exhibit A, Attachment 10 (3)(A)]

The Plan did not ensure that members receive IHAs within 120 calendar days of enrollment. The Plan's *Policy CQ 7615, Initial Health Assessments*, states the Plan will cover and ensure the provision of an IHA for all new members age 18 months and older within 120 calendar days of enrollment.

The Plan sends welcome letters explaining IHA requirements to new members to encourage initial appointments. However, the Primary Care Physicians (PCPs) schedule the IHAs. The Plan tracks member contacts through Member Services, medical records, and New Member Enrollment Rosters. PCPs access the enrollment rosters for purposes of contacting members to schedule the IHA. During provider site interviews, the consistent practice of active encouragement for IHA appointments was not found. Although some providers used information from enrollment rosters to contact newly enrolled members for IHA appointment scheduling, other providers waited for new members to contact their office for an IHA appointment. This method to ensure IHA completion is inadequate.

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The DHCS medical audit included a verification study of 23 medical records. Five (5) medical records identified members received IHAs beyond 120 calendar days of enrollment. These members received IHAs within 129 to 295 days. **This is a REPEAT finding.**

2.4.2 Plan Methodology to Monitor Initial Health Assessment Compliance

The Plan is required to ensure the provision of an IHA in conformance with *California Code of Regulations, Title 22, § 53910.5 (a)(1)* to each new member within 120 calendar days of enrollment [*Contract, Exhibit A, Attachment 10 (3)(A)*] and to have procedures to monitor IHA completion (*MMCD Policy Letter No. 08-003 Initial Comprehensive Health Assessment*).

The Plan's method to monitor IHA completion was inadequate. The Plan conducts a Facility Site Review (FSR) every three years to monitor and ensure comprehensive medical assessment and follow-up care is rendered. The Plan reported the IHA completion rate ranging from 32% to 60% for members who must have a completed IHA within 120 calendar days of enrollment. Retrospective review of IHA completion every three years during FSRs does not constitute effective monitoring of IHA completion.

The Plan's methodology to monitor IHA compliance was incomplete. Certain Current Procedural Terminology (CPT) codes were assumed to represent an IHA, but the Plan did not test the data's validity. The Plan utilizes encounter data to track and report IHA completion on a quarterly basis. This method does not compare encounter data to the medical record.

RECOMMENDATION:

- 2.4.1 Ensure that new members receive an IHA within 120 calendar days of enrollment.
- 2.4.2 Ensure procedures for monitoring IHA compliance are based on validated methodology.

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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.

GMC 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;*

GMC 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.

GMC 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...

GMC Contract A.9.3.C

SUMMARY OF FINDINGS:

3.1.1 Appointment Availability Time Frames

The Plan is required to ensure that appointments are available for routine care, specialty care, and initial prenatal care within certain time frames. [*Contract, Exhibit A, Attachment 9 (3)(B) and (4)(B)*]

The Plan did not ensure that providers offer members appointments within the required time frames.

These factors indicate providers were not in compliance with timely access requirements:

- The Plan monitored appointment wait times for routine and specialty care appointments through the Industry Collaborative Effort (ICE) Appointment Availability Survey for 76 providers sampled from three delegated medical groups. The survey showed providers were unable to offer timely appointments. Among the results, 30 percent of primary care providers were unable to offer members timely routine appointments within 10 business days. Additionally, 50 percent of Cardiology and Dermatology providers were unable to offer specialty appointments to members within 15 business days.
- The Plan's 2014 Consumer Assessment of Health Plans Survey (CAHPS®) results showed the Plan scored at or below National Committee for Quality Assurance's 25th percentile rank in two composite measures: *Getting needed care* and *Getting care quickly*. Respondents reported they did not get an appointment for health care as soon as they thought they needed. The Plan identified these areas as opportunities to improve.

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- The second highest complaint was related to access issues. This finding correlates with the non-compliance rates with timely access standards.

The DHCS medical audit included an appointment availability verification study. The study illustrated non-compliance with wait times to obtain appointments for routine, specialty, and prenatal care. The auditor reviewed fourteen providers from the Plan's Provider Directory. The *third next available appointment* was used to measure access to care.

According to the *National Quality Measures Clearinghouse*, "Access is a measure of the patient's ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Counting the *third next available appointment* is the healthcare industry's standard measure of access to care and indicates how long a patient waits to be seen. This measure is used to assess the average number of days to the third next available appointment for an office visit for each clinic and/or department. This measure does not differentiate between "new" and "established" patients."

The verification study found a total of five providers non-compliant with access standards. The results of the verification study are as follows:

3.1.2 Appointment Standards Publication

The Plan is required to establish acceptable accessibility requirements in accordance with *California Code of Regulations, Title 28, § 1300.67.2*. This includes informing members regarding accessibility of services. [Contract, Exhibit A, Attachment 9 (3)]

The Member Guide/Evidence of Coverage lacks the appointment standard for initial prenatal visit. The appointment standard is within two weeks upon request. This information was not available in any other sources available to members such as the Plan's website and member newsletters.

RECOMMENDATIONS:

- 3.1.1 Ensure that members are offered appointments for routine care, specialty care, and initial prenatal care within the required time frames.
- 3.1.2 Update the Member Guide/Evidence of Coverage to include the standard for timely appointments for initial prenatal care of two weeks as required in the Contract.

| Provider Type | Contract Standards | Average Third Next Available Appointment |
|--|-------------------------------------|--|
| Non-urgent primary care | within ten business days of request | 12.4 business days |
| Specialty care | within 15 business days of request | 20.2 business days for new patients 19.6 business days for established patients |
| First prenatal visit for a pregnant member | within two weeks upon request | 17.8 calendar days |

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3.6

ACCESS TO PHARMACEUTICAL SERVICES

Pharmaceutical Services and Prescribed Drugs:

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours.... Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation.

GMC Contract A.10.8.G.1

SUMMARY OF FINDINGS:

3.6.1 Emergency Pharmaceutical Services Monitoring

The Plan is required to have written policies and procedures to describe how it and/or its network hospitals will monitor compliance with ensuring member access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. *[Contract, Exhibit A, Attachment 10 (8)(G)(1)(a)]*

The Plan did not effectively monitor compliance to ensure member access to at least a 72-hour drug supply in an emergency situation.

Policy 7311, *24-hour Pharmacy Access*, states the Plan monitors emergency pharmaceutical services from member complaints. The Members Services Department documents member's drug supply access complaints that resulted from an emergency situation.

The Member Services Department compiles and reviews pharmaceutical services complaints. The department reports findings quarterly in its Member Complaint Analysis report. The Member Services Department addresses identified issues. The Pharmacy Process was the top member complaint according to the Call Tracking Complaint Log.

Although the Plan maintains policies and procedures to monitor adequate supply of drugs in an emergency, it had no effective system to monitor its network hospitals' compliance of the 72-hour drug supply in an emergency situation. Sole reliance on members to report emergency pharmaceutical issues through the grievance process does not by itself constitute an effective monitoring procedure.

RECOMMENDATION:

- 3.6.1 Implement an effective system to monitor network hospitals' compliance with ensuring member access to a 72-hour drug supply in an emergency situation.

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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 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c).

GMC Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member’s grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858....(as required by Contract)

GMC 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 Title 22 CCR Section 53858(e).

GMC Contract A.14.3.A

SUMMARY OF FINDINGS:

4.1.1 Grievance written acknowledgement and resolution notices were not provided to members.

The Plan is required to process grievances in accordance with California Code of Regulations, Title 28, § 1300.68; this includes providing a written acknowledgement and a written resolution to members. [Contract, Exhibit A, Attachment 14 (1)(A)]

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. [California Code of Regulations, Title 28, § 1300.68(d)(8)] The regulation defines a complaint the same as a grievance.

According to the Plan’s *Policy 5510, Member Grievances and Appeals*, a grievance is a written or oral expression of dissatisfaction. Grievances are usually resolved promptly. If a grievance cannot be resolved by the close of the next business day after its receipt, also known as *non-exempt* grievances, *written acknowledgement requirements* apply. The Plan sends a written acknowledgement for all Quality of Care (QOC) and non-exempt grievances within five days. The Plan notifies the member in writing of the grievance resolution within thirty (30) days.

The Plan’s grievance system failed to appropriately process 189 *non-exempt* grievances in regards to the Plan and providers. *Non-exempt* grievances require the written acknowledgment notifications. The Plan did not send acknowledgement and resolution letters to members.

The Plan receives grievances primarily through the Member Services Call Center. Member Services Representatives review and usually resolve member grievances by the close of the next business day. Member Services Representatives forward *non-exempt* grievances to the Grievance and Appeals Manager to process. Grievances received by mail, the internet, or fax are processed directly by the Grievance and Appeals Manager.

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The Grievance and Appeals Manager logs clinical grievances as QOC grievances and all other grievances as Quality of Service (QOS) grievances. When grievances are processed by the Grievance and Appeals Manager, members receive an acknowledgement letter within five days for all QOC and QOS grievances. The Grievance and Appeals Manager consults with the Member Services Manager to resolve QOS grievances. The Plan notifies members of the resolution within thirty (30) days.

The Member Services Call Center received and processed 3,552 grievances during the audit period. Our review found 189 of the 3,552 grievances were *non-exempt*, Member Services Representatives failed to forward these grievances. As a result, the Grievance and Appeals Manager failed to oversee these cases. Consequently, the Plan failed to monitor the proper treatment of these grievances. The Plan failed to send members a written acknowledgement or resolution notices.

A verification study sampled 21 *non-exempt* grievances from the Plan's Call Tracking Log 2014-2015, which included complaints regarding access to care, pharmacy process, Plan benefits, enrollment eligibility, and primary provider quality of care. The Plan failed to process these grievances according to Contract requirements associated with written acknowledgment and resolution notices.

The grievance system did not allow for prompt review of grievances. The Plan did not monitor or conduct any internal audit of the Plan's Call Tracking Log to ensure that potential systemic issues and grievances were identified. The Plan was noncompliant with the grievance written acknowledgment and resolution notices.

4.1.2 Grievance Resolution Time Frames

The Plan is required to resolve each grievance and provide written notice to the member within 30 calendar days of receipt [*Contract, Exhibit A, Attachment 14 (1)(A)*].

Policy 5510, *Member Grievances and Appeals*, states the Plan notifies the member in writing of the grievance resolution within thirty (30) days.

The systemic issues associated with grievances resulted in the resolution time to exceed Contract requirements. Members were not notified of the grievance results within thirty days.

The audit identified 76 grievances resolved by the Member Services Call Center exceeded 30 days; 17 ranged between 31 – 167 days to resolve and 59 had no resolution date. The Plan attributed this oversight to staff turnover.

Additionally, a verification study reviewed QOC grievances and found that the Plan mailed 12 resolution letters beyond the 30 calendar day time frame. In these instances, the Grievance and Appeals Manager provided a nonspecific response within 30 days. The response excluded pertinent details specific to the grievance. The resolution signed by the Chief Medical Officer (CMO) which contained the relevant details exceeded the 30 day time frame. The Plan was not in compliance with the grievance resolution time frame requirements.

4.1.3 Grievance Clinical Oversight

The Plan must implement and maintain procedures to ensure that the grievance submitted is reported to an appropriate level and the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Plan's Medical Director. [*Contract, Exhibit A, Attachment 14 (2)(D) and (E)*]

No oversight was conducted by clinical personnel to ensure proper identification of clinical/quality of care grievances.

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The Member Services Call Center receives member grievances. Member Services Representatives, non-clinical employees, review the grievances to classify as administrative versus clinical care. The Plan lacked clinical oversight and failed to monitor grievances appropriately.

The Member Services Representative forwards clinical grievances to the Grievance and Appeals Manager. The Grievance and Appeals Manager logs the cases as QOC grievances. The Grievance and Appeals Manager routes the cases to the CMO via the Director of Corporate Quality (a Registered Nurse) for research and resolution.

As part of the pre-audit document submission, the Plan's Call Tracking Log 2014-2015 identified 82 *exempt* QOC grievances processed through the Member Services Call Center. Subsequent to submission, the Plan's Director of Corporate Quality reviewed the QOC grievances and reclassified 46 grievances as QOS; 36 remained classified as QOC.

The audit identified Member Services Representatives processed 36 medical quality of care *exempt* grievances during the audit period. As a result, the grievances were not routed to the Grievance and Appeals Manager to ensure the grievances were reported to the CMO. Consequently, the Grievance and Appeals Manager did not refer these clinical cases to the CMO for research and resolution. **This is a REPEAT finding.**

4.1.4 Grievance Quarterly Reports

The Plan must submit a quarterly report to the Department of Health Care Services (DHCS) describing grievances that were or are pending and unresolved for 30 days or more. [Contract, Exhibit A, Attachment 14 (1)(A)] Due to the misclassifications of grievances discussed above, the Plan sent inaccurate reports to DHCS. The Plan re-filed these reports on July 15, 2015.

RECOMMENDATIONS:

- 4.1.1 Send grievance written acknowledgment letters to members within five calendar days and resolution letters within 30 calendar days.
- 4.1.2 Resolve grievances within 30 calendar days.
- 4.1.3 Develop and implement a process for monitoring and reviewing grievances designated as administrative versus clinical to ensure quality of care issues are not missed or unresolved by the CMO.
- 4.1.4 Ensure the accuracy of the grievance quarterly reports sent to DHCS.

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4.2

CULTURAL AND LINGUISTIC SERVICES

Cultural and Linguistic Program:

Contractor shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes 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 requirements... (as stated in the Contract) GMC Contract A.9.13

Contractor will assess, identify and track the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical).

GMC 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.

GMC Contract A.9.13.E

Linguistic Services:

Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 USC 2000d, 45 CFR Part 80) that prohibit recipients of Federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

GMC Contract A.9.12

Contractor shall comply with 42 CFR 438.10(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact...either through interpreters, telephone language services, or any electronic communication options...

GMC Contract A.9.14.B

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.
- 2) Fully translated written informing materials...
- 3) Referrals to culturally and linguistically appropriate community service programs.
- 4) Telecommunications Device for the Deaf (TDD).
- 5) Telecommunications Relay Service (711)

GMC Contract A.9.14.C

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.

GMC Contract A.9.14.E

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PLAN: Community Health Group Partnership Plan

AUDIT PERIOD: April 1, 2014 through March 31, 2015

DATE OF AUDIT: June 22, 2015 through July 3, 2015

SUMMARY OF FINDINGS:

4.2.1 Linguistic Capability of Interpreters

The Plan shall implement and maintain a written description of its Cultural and Linguistic Services Program, which shall include qualifications of staff. *[Contract, Exhibit A, Attachment 9 (13)(A)]*

The Plan has a process to assess, identify, and track the linguistic capability of interpreters. However, the method to measure proficiency and monitor linguistic capability is not described in the Plan's policies and procedures.

According to the Plan, approximately 70% of Plan staff are bilingual and adequately proficient to provide translation and interpretation services. Staff language proficiency is self-reported. In employment interviews, the Plan internally evaluates conversational and/or medical terminology proficiency. For specific translators, the Plan administers the *Berlitz* language test to measure proficiency in speaking, listening, reading, and writing a language. However, the Plan does not have a policy that includes these procedures.

RECOMMENDATION:

- 4.2.1 Update the Plan's policies and procedures to include the Plan's process to assess, identify, and track the linguistic capability of interpreters.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Community Health Group Partnership Plan

AUDIT PERIOD: April 1, 2014 through March 31, 2015

DATE OF AUDIT: June 22, 2015 through July 3, 2015

4.3

CONFIDENTIALITY RIGHTS

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 PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR 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 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316....

GMC 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 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 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 ...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.

GMC Contract G.III.J

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Community Health Group Partnership Plan

AUDIT PERIOD: April 1, 2014 through March 31, 2015

DATE OF AUDIT: June 22, 2015 through July 3, 2015

SUMMARY OF FINDINGS:

4.3.1 Breach Incident Reporting

Upon discovery of any breach or security incident, the Plan is required to notify the Department of Health Care Services (DHCS) Privacy Officer, the Managed Care Operations Division (MCO) Contracting Officer, and the DHCS Information Security Officer. *[Contract, Exhibit G, Attachment 3 (H)]*

During the audit period, six (6) breach cases were reported only to the DHCS Privacy Officer within the required time frame but not to the MCO Contracting Officer and the DHCS Information Security Officer. **This is a REPEAT finding.**

RECOMMENDATION:

- 4.3.1 Notify and report breach incidents to the DHCS Privacy Officer, MCO Contracting Officer, and the DHCS Information Security Officer.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Community Health Group Partnership Plan

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CATEGORY 5 – QUALITY MANAGEMENT

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.

GMC Contract A.4.12

Provider Qualifications:

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and 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.

GMC Contract A.4.12.A

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 10 working days after the Contractor places a newly contracted provider on active status...Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or DHCS.

GMC 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...

GMC Contract A.4.12.B

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.

GMC Contract A.4.12.D

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Community Health Group Partnership Plan

AUDIT PERIOD: April 1, 2014 through March 31, 2015

DATE OF AUDIT: June 22, 2015 through July 3, 2015

SUMMARY OF FINDINGS:

5.2.1 Provider Training Completion

The Plan must ensure that all providers receive training. *[Contract, Exhibit A, Attachment 7, (5)]*

The Plan did not conduct provider training for all providers. The review found six new providers did not receive training as required by the Contract. The providers were part of an existing physicians group currently active in the network. The Plan does not have any follow-up procedures in place to ensure new providers added to an existing network provider group have received training. The Plan stated these providers only received a welcome letter with a username and password to access the Plan's provider manual and information online. This did not constitute training. The Plan was responsible for all new provider training.

5.2.2 Provider Training Time Frame

The Plan is required to conduct training for all newly contracted providers within 10 working days after they are placed on active status. *[Contract, Exhibit A, Attachment 7, (5)]*

The Plan did not complete new provider training timely. During the audit period, two providers received training beyond the 10 working day time frame. They received training 11 and 22 days after they were placed on active status.

RECOMMENDATION:

5.2.1 Ensure that all providers receive training.

5.2.2 Ensure that all new providers are trained within 10 working days after being placed on active status.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Community Health Group Partnership Plan

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3

FRAUD AND ABUSE

Fraud and Abuse Reporting

Contractor shall meet the requirements set forth in 42 CFR 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 42 CFR 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....

GMC Contract E.2.25.B

SUMMARY OF FINDINGS:

6.3.1 Fraud and Abuse Policy

The Plan is required to establish an Anti-Fraud and Abuse Program that 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. [*Contract, Exhibit E, Attachment 2 (25)(B)(1)*]

The Plan's policies and procedures, *Managing Incidents of Suspected Fraud and Corrective Action Policy*, excluded the 10 day reporting time frame requirements. Additionally, the *Corrective Action Policy* omitted the requirement to confirm suspended providers no longer receive Medi-Cal payments.

The Plan established guidelines for investigating and reporting suspected fraud. The Plan revised *Policy 5509.2, Managing Incidents of Suspected Fraud*, as part of its *corrective action plan* (CAP) for the previous audit findings. The revision reflected the 10 working day reporting time frame to DHCS. (Revision Approval by Managed Care Quality and Monitoring Division (MCQMD) Date: March 2013). The Plan stated the 10 working day reporting time frame to DHCS is reflected in the Medi-Cal Compliance Plan. However, the policy's latest version excludes this language. **This is a REPEAT finding.**

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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The Plan's *Policy 7701, Corrective Action Policy*, states that the Plan shall terminate the participation of a suspended or excluded provider. However, the policy excluded language to report the termination within 10 state working days to the Medi-Cal Managed Care Program/Program Integrity Unit and for the Plan to confirm that the provider is no longer receiving payments in connection with the Medicaid program.

The audit did not find any evidence that these omissions resulted in the Plan to considerably exceed the time frame or allow suspended providers to receive Medi-Cal payments.

6.3.2 Fraud and Abuse Reporting Time Frame

The Plan is required to report to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date it first becomes aware of, or is on notice of, such activity. *[Contract, Exhibit E, Attachment 2 (25)(B)(4)]*

The Plan failed to report a suspected fraud and abuse case to DHCS within the required time frame.

During the audit period, the Plan reported four fraud and abuse cases to DHCS. The Plan reported one case beyond the 10 working day time frame; the Plan reported it 14 working days from the incident date.

RECOMMENDATIONS:

- 6.3.1 Update the Plan's policies and procedures to include language for the 10 working day time frame and the requirement for the Plan to confirm suspended providers no longer receive Medi-Cal payments.
- 6.3.2 Ensure fraud cases are reported to DHCS within the required 10 working day time frame.

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: April 1, 2014
Through
March 31, 2015

Report Issued: December 14, 2015

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INTRODUCTION

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

The on-site audit was conducted from June 22, 2015 through July 3, 2015. The audit period is April 1, 2014 through March 31, 2015 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

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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 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 *Policy Claims-7809, Claims for Abortion Services*, states that the Plan provides abortion services and supplies to members without prior authorization. Abortions are required to be provided in accordance with State and Federal law and are considered by the California Department of Health Care Services to be a "sensitive service".

The Plan provides Medi-Cal members timely access to abortion services from any qualified contracting or non-contracting Provider without prior authorization. Minors do not need an adult's consent or referral to access pregnancy termination services.

The Plan's Staff Supported Services billing code sheet includes Current Procedural Terminology codes 59840 through 59857 and Healthcare Common Procedure Coding System codes A4649-U1, A4649-U2, S0190, S0191, S0199 (formerly known as codes X1516, X1518, X7724, X7726, Z0336) as billable pregnancy termination services as required by the Contract.

The Plan is in compliance with contractual requirements.