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

CONTRA COSTA HEALTH PLAN

Contract Number: **04-36067 A09**

Audit Period: March 1, 2014
Through
February 28, 2015

Report Issued: November 13, 2015

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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 February 2015, CCHP had 169,999 Members of which 154,932 were Medi-Cal Members. The Plan also covers Medicare (444), County Employees (9,420), Commercial (2,063), and Uninsured Recipients (3,140).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of March 1, 2014 through February 28, 2015. The onsite review was conducted from June 1, 2015 through June 12, 2015. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on September 29, 2015 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the preliminary audit report findings. The Plan submitted supplemental information after the Exit Conference 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 (QI), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan did not produce accurate reports for trending and analysis of Utilization Management data and therefore, could not properly monitor under and over-utilization of services.

The Plan did not consistently process medical prior authorization requests within the required time frames.

The Plan did not ensure the person making the final decision for the proposed resolution of an appeal/grievance has not participated in prior decisions related to the same appeal/grievance.

The Plan did not have documentation that an annual oversight evaluation of the Pharmacy Benefit Management Company (PBM) occurred during the audit period.

Category 2 – Case Management and Coordination of Care

The Plan did not ensure Initial Health Assessments (IHAs) were fully completed within 120 calendar days of enrollment for new members.

Category 3 – Access and Availability of Care

The Plan did not monitor that the first prenatal visit for a pregnant member is available within two weeks upon request.

The Plan did not comply with the telephone answer time and abandonment rate access

standards.

The Plan did not ensure that emergency room claims incorrectly sent to the Plan were redirected to the appropriate capitated provider within 10 working days of receipt of the claim.

The Plan did not monitor the provision of drugs prescribed in emergency circumstances in amounts sufficient to last, until the member can reasonably be expected to have the prescription filled.

Category 4 – Member's Rights

The Plan did not ensure that all grievances are resolved within the required time frame.

Category 5 – Quality Management

The Plan did not continuously monitor, evaluate, and approve entities with delegated functions. During the audit period, there was no annual delegation audit report for the Pharmacy Benefit Management Company (PBM).

Category 6 – Administrative and Organizational Capacity

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 1, 2015 through June 12, 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: Twenty (20) medical and 22 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Prior Authorization Appeal Process: Ten (10) prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): Three (3) medical records were reviewed for evidence of coordination of care between the Plan and CCS Providers.

Individual Health Assessment: Twenty-six (26) medical records were reviewed for completeness and timely completion.

Complex Case Management: Three (3) medical records were reviewed for evidence of continuous tracking and monitoring of members who received complex case management services.

Category 3 – Access and Availability of Care

Appointment Availability: Five (5) contracted providers from the Provider Directories were reviewed for accuracy, completeness, and appointment availability.

Emergency Service Claims: Twenty-three (23) 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: Fifty-eight (58) grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: Three (3) cases were reviewed for proper reporting of all suspected and actual breaches to the appropriate entities within the required timeframe.

Category 5 – Quality Management

New Provider Training: Nine (9) new contracted providers were reviewed for evidence of training and timely completion.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: Six (6) cases were reviewed for proper reporting of all suspected fraud and/or abuse to the appropriate entities within the required timeframes.

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: March 1, 2014 through February 28, 2015	DATE OF AUDIT: June 1, 2015 through June 12, 2015

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM

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

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

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

SUMMARY OF FINDINGS:

The Contract requires the Plan to continuously update and improve its Utilization Management (UM) program. The UM program shall ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services.

Policy and Procedure (P&P) UM15.008: *Under/Over-Utilization* states reports generated from Plan's computerized system will be reviewed by the UM Workgroup to identify trends affecting inpatient bed days, outpatient visit days, Emergency Department (ED) usage, and provider usage. Trends identified will be reported to Quality Council (QC) and identified issues will be forwarded to the responsible party to address and/or develop action plans. The QC oversees the UM Workgroup and Clinical Leadership Group activities and acts as the Utilization Management Committee. The Medical Director (MD), along with input from QC committee members, provides medical oversight and guidance to the UM Department as it carries out UM activities and functions.

During the onsite interview, the Plan discussed the challenges of updating and removing unnecessary data to produce accurate reports for trending and analysis of UM data. Since the Plan is unable to produce accurate UM data reports they are unable to properly monitor over and under-utilization of services.

RECOMMENDATION:

Improve the mechanism to monitor under and over-utilization of services by resolving the challenges of uploading and removing unnecessary data to produce accurate reports for trending and analysis of UM data.

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

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

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

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

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

Denial, Deferral, or Modification of Prior Authorization Requests:
Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 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.
2-Plan Contract A.13.8.A

SUMMARY OF FINDINGS:

The Contract requires the Plan to process routine prior authorization requests for medical services 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 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. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

Policy and Procedure (P&P) UM15.015.a: *Timeliness of the Utilization Review Decision and Communication* states upon receipt of all necessary information, decisions affecting routine care shall be made within five business days or within a time frame appropriate for the enrollee's condition. Decisions can be no later than five business days for commercial and 14 calendar days for Medi-Cal and Medicare enrollees from the date the Health Plan receives the request.

During the interview, the Plan stated there were delays in processing of medical prior authorization requests during the audit period. The majority of the delays were due to the Plan not receiving requested information in a timely

manner from providers in order to render a decision on the prior authorization requests. Additionally, issues with retention and recruitment of the Plan's Utilization Management staff contributed to a delay in the processing of prior authorizations.

The verification study showed 12 prior authorization requests for medical services did not meet the required time frame for processing of routine prior authorization requests. **This is a repeat finding.**

RECOMMENDATION:

Adhere to the required time frames to ensure processing of routine prior authorization requests for medical services are met.

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:

The Contract requires the Plan to have procedures to ensure the person making the final decision for the proposed resolution of an appeal/grievance has not participated in any prior decisions related to the appeal/grievance. Policy and Procedure UM15.009: Clinical Research of Medi-Cal Member Appeals states upon receipt of an appeal from the Member Services (MS) Department, the Utilization Management (UM) Department's Appeal Liaison assigns the case to a UM nurse reviewer who was not involved in the original determination. The UM nurse researches the case facts, findings, and performs a clinical review that's presented to a physician reviewer who normally participates in the original determination.

Member Services policy MS 8.018-*Request for Reconsiderations (Appeal Process) and Independent Medical Review Process states* original case findings and additional supporting information received during the appeal process are compiled, reviewed, and presented to the original physician reviewer (the same person who participated in the prior authorization decision). These procedures do not comply with the above Contract requirement.

RECOMMENDATION:

Revise Policy and Procedure MS 8.018 to adhere to the Contract and ensure the person making the final decision for the proposed resolution of an appeal/grievance has not participated in any prior decisions related to the appeal/grievance.

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:

The Contract requires the Plan to be accountable for all Quality Improvement (QI) functions and responsibilities (e.g. Utilization Management, Credentialing, and Site Review) that are delegated to subcontractors. If the Plan delegates QI functions, the Plan and delegated entity (subcontractor) shall include in their Subcontract, QI responsibilities, specific delegated functions and activities; the Plan's oversight, monitoring, and evaluation processes and the subcontractor's agreement to such processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the QI activities at least quarterly; and the Plan's actions/remedies if subcontractor's obligations are not met.

Policy and Procedure (P&P) QM14.301: *Delegation Oversight Process* states the Plan is responsible for assuring that quality care and service are administered to Plan members when services are delegated to contracted providers. Delegation arrangements are also part of the contracting process. On an annual basis, the Plan monitors delegation via routine reporting and/or by onsite audits of delegated providers; the frequency of audits may be more often if needed and if identified as part of a Corrective Action Plan (CAP).

Review of documents show the Plan performs annual UM delegation audits of its delegated entities and reports any findings/deficiencies by issuing a site visit report and recommending a CAP. During the audit period, the Plan performed an oversight evaluation of Contra Costa Regional Medical Center's (CCRMC) Utilization Management (UM) activities with a well-documented CAP for detected deficiencies.

During the interview, the Plan stated that some of their UM functions are delegated to the Pharmacy Benefit Management Company (PBM). However, there was no documentation to support that an annual oversight evaluation of the PBM occurred during the audit period. **This is a repeat finding.**

RECOMMENDATION:

Ensure annual oversight evaluations are conducted on the Plan's PBM.

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 (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.
2-Plan Contract A.10.3.A

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

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

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

2-Plan Contract A.10.6

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

SUMMARY OF FINDINGS:

The Contract requires the Plan to ensure that an Initial Health Assessment (IHA) is performed within 60 calendar days of enrollment for new members under the age of 18 months, and within 120 calendar days for new members 18 months of age and older. A complete IHA consists of a history and physical examination, and an Individual Health Education Behavioral Assessment (IHEBA), which includes an age-appropriate assessment or screening on

a periodic basis. The Plan shall also document all attempts to contact and schedule an IHA with a member to demonstrate the Plan's efforts in meeting this requirement.

Policy and Procedure (P&P) QM14.701: *Preventive Services/Initial Health Assessment* states the Plan must complete an IHA within 60 calendar days of enrollment for new members less than 18 months of age, and within 120 calendar days for new members 18 months of age and older. The Plan will ensure that adult and pediatric members receive timely IHAs and comprehensive preventive services, including immunizations at intervals appropriate to their age, gender and as appropriate, health risk.

During the onsite interview, the Plan acknowledged they track completion of IHAs by monitoring a set of procedure codes that providers use to bill for services. A provider's use of these procedure codes indicate to the Plan that IHAs have been completed. The Plan also conducts Medical Record Reviews (MRRs) during Facility Site Reviews (FSRs).

The verification study showed that 18 medical records for new members were incomplete and/or lacking comprehensive clinical information such as an IHEBA (Staying Healthy Assessment) or immunization information. These medical records indicated IHAs were not fully completed within 120 calendar days of enrollment. **This is a repeat finding.**

RECOMMENDATION:

Improve the monitoring system to ensure IHAs are fully completed within 120 calendar days of enrollment.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

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

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

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

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

SUMMARY OF FINDINGS:

The Contract requires the Plan to develop, implement, and maintain procedures to monitor waiting times for members to obtain prenatal care appointments. The Contract also requires the Plan to ensure the first prenatal visit for a pregnant member will be available within two weeks upon request.

Policy and Procedure QM14.101 contains a table that outlines access standards for non-urgent care, urgent care, non-urgent specialty care, emergency care, first prenatal visit, and IHA appointments. The policy states the Plan's access standards for the first prenatal visit for a pregnant member is within two weeks upon request. The Plan utilizes a variety of methods to monitor the above health care services, which include Appointment Availability Surveys, Member Grievances, and Advice Nurse Reports.

During the onsite interview, the Plan acknowledged the 2014 Provider Appointment Availability Survey did not monitor whether the first prenatal visit for a pregnant member is available within two weeks upon request. **This is a repeat finding.**

RECOMMENDATION:

Improve monitoring systems to ensure the first prenatal visit for pregnant members is available within two weeks upon request.

3.3	TELEPHONE PROCEDURES / AFTER HOURS CALLS

Telephone Procedures:
Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.
2-Plan Contract A.9.3.D

Contractor shall maintain the capability to provide Member services to Medi-Cal Members or potential members through sufficient assigned and knowledgeable staff.
2-Plan A.13.2.A

After Hours Calls:
At a minimum, Contractor shall ensure that a physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls.
2-Plan Contract A.9.3.E

SUMMARY OF FINDINGS:

The Contract requires the Plan and its providers to maintain a procedure for triaging members' telephone calls, providing telephone medical advice, and accessing telephone interpreters.

Policy and Procedure (P&P) AN17.004.1: *Answer Time* Standards states the Plan shall assure that callers have prompt and efficient access to the Advice Nurse Service. Only Advice Nurses shall answer calls for inbound patient queues and keep their telephones logged in to the Automated Call Distribution (ACD) system. A live person from the Advice Nurse Unit should answer calls with an average speed of 30 seconds or less and an average abandonment rate of 5% or less.

The February 4, 2015 *"Managed Care Commission Meeting - Advice Nurse Unit Report"* disclosed the Plan's average speed to answer a call was 94 seconds in the 3rd Quarter of 2014 and 88 seconds in the 4th Quarter of 2014. The Plan's abandonment rate was 8% in the 3rd Quarter of 2014 and 9% in the 4th Quarter of 2014. Although the Plan has taken actions to reduce telephone answer times and abandonment rates, the Plan did not comply with the telephone answer time and abandonment rate access standards. **This is a repeat finding.**

RECOMMENDATION:

Ensure the Plan complies with the telephone answer time and abandonment rate access standards.

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

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 FINDINGS:

California Code of Regulations, Title 28, section 1300.71(b)(A), states the Plan shall forward emergency service claims to the appropriate capitated provider within 10 working days of receipt of the claim that was incorrectly sent to

the Plan.

Policy and Procedure CLM 4.536: *Kaiser Member Claims* states if a claim is incorrectly sent to the Plan and the member is enrolled in Kaiser, it is the responsibility of the Plan to direct the claims accordingly. The Plan shall forward Kaiser claims to Kaiser within 10 working days of receipt of the claim.

The verification study revealed three emergency room claims that were incorrectly sent to the Plan were not sent to the appropriate capitated provider within 10 working days of receipt of the claim. **This is a repeat finding.**

RECOMMENDATION:

Ensure emergency room claims incorrectly sent to the Plan are redirected to the appropriate capitated provider within 10 working days of receipt of the claim.

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...

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.
2-Plan Contract A.10.8.G.1

SUMMARY OF FINDINGS:

The Contract requires the Plan to cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. At a minimum, the Plan shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the member can reasonably be expected to have the prescription filled.

Policy and Procedure PM6.010: *Pharmacy Services* requires the Plan to monitor that members have access to a sufficient supply of medications in emergency situations to last until the member can reasonably be expected to have a prescription filled. If warranted, the Plan will randomly select and review Emergency Department claims to determine if prescribed medications were dispensed in sufficient quantities.

During the onsite interview, the Plan presented a report labeled *HCV Meds Adherence (TAP3409)* and a prescription dispensing report to show that Emergency Room (ER) data is monitored. However, the Plan could not demonstrate how the data is used to track and verify that members received sufficient supplies of medication when discharged from the ER. The Plan did not monitor Emergency Departments at contracted hospitals to ensure members have access to a sufficient supply of medications in emergency situations to last until the member can reasonably be expected to have a prescription filled. **This is a repeat finding.**

RECOMMENDATION:

Monitor Emergency Departments at contracted hospitals to ensure members have access to a sufficient supply of medications in emergency situations to last until the member can reasonably be expected to have a prescription filled.

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 Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan 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)
2-Plan Contract A.14.2

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

SUMMARY OF FINDINGS:

The Contact requires the Plan to implement and maintain a Member Grievance System. The Plan shall implement and maintain procedures to monitor the member's grievance system and the expedited review of grievances. The Contract also requires the Plan to resolve each grievance and provide notice to the member within 30 calendar days from the date the Plan receives the grievance.

Policy and Procedure MS 8.001: *Handling of Complaints and Grievances* describes the Plan's grievance system to provide members with a process for voicing and promptly resolving complaints and grievances; to facilitate the investigation and resolution of all complaints and grievances, and to provide avenues of appeal. A member who files a grievance will be sent a written acknowledgement letter within five days that will include the time frame in which a resolution letter will be sent. The written disposition of the complaint is mailed to the member within 30 days of receipt of the complaint/grievance by the Plan. In the event a resolution is not reached within 30 days, the member shall be notified in writing by the Plan of the status of the grievance and provided with an estimated completion date of resolution.

During the onsite interview, the Plan acknowledged there were issues of unresolved grievances within 30 calendar days due to timely receipt of medical records from contracted providers. The verification study revealed that 31 grievances were not resolved within 30 calendar days.

RECOMMENDATION:

Improve monitoring systems to ensure that grievances are resolved within 30 calendar days.

CATEGORY 5 – QUALITY MANAGEMENT

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 FINDINGS:

The Contract requires the Plan to maintain a system to ensure accountability for delegated Quality Improvement (QI) functions and responsibilities (e.g. Utilization Management, Credentialing, and Site Review) through continuous monitoring, evaluation, and approval of the delegated functions.

Policy and Procedure (P&P) QM14.301: *Quality Management* outlines the process and procedures for delegation and monitoring of QI activities to contracted providers. Claims review activities are monitored on an ongoing basis. Medical Records are reviewed at Facility Site Reviews. Routine reporting, generally quarterly, occurs through the Quality Council, which includes Quality Management (QM), Utilization Management, and Member Services. Pursuant to the aforementioned policy, the QM Director, QM Nurse, and/or designee, coordinate the audit process for the Plan. Upon completion of the audit a letter is sent to the contracted delegated provider informing them of the results of the audit. If opportunities for improvement have been identified, a Corrective Action Plan (CAP) request for the contracted provider will also be written and sent. The Plan monitors delegation via routine reporting and/or onsite audits of delegated providers on an annual basis.

During the onsite interview, the Plan stated that it delegates quality management functions to the Pharmacy Benefit Management Company (PBM). However, there was no annual delegation audit report found for the PBM during the audit period. **This is a repeat finding.**

RECOMMENDATION:

Ensure there is an annual delegation audit report for the PBM.

MEDICAL REVIEW - ONTARIO SECTION IV
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

CONTRA COSTA HEALTH PLAN

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

Audit Period: March 1, 2014
Through
February 28, 2015

Report Issued: November 13, 2015

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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 March 1, 2014 through February 28, 2015. The onsite audit was conducted from June 1, 2015 through June 12, 2015 and consisted of document review and onsite interviews.

An Exit Conference was held on September 29, 2015 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the preliminary audit report findings. No additional information was submitted following the Exit Conference.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Contra Costa Health Plan	
AUDIT PERIOD: March 1, 2014 through February 28, 2015	DATE OF AUDIT: June 1, 2015 through June 12, 2015

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 Contract requires the Plan to provide, or arrange to provide, abortion services to eligible members without prior authorization from any Medi-Cal Provider both within and outside the Plan's network of providers.

Policy and Procedure (P&P) CLM 4.573e: *Sensitive Services: HIV, Family Planning & Sexually Transmitted Disease* states within the Policy and Purpose section that every Medi-Cal member is assured the freedom to choose a qualified family planning provider both within and outside their network of providers. The Procedure section states that no authorization is needed if rendered by a *contracted network provider*. However, the language is not clear on whether or not a member needs prior authorization if services are rendered by a *non-contracted network provider*. The Plan's Policy and Procedure language does not fully comply with the Contract. **This is a repeat finding.**

The Contract also requires the Plan 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.

During the onsite interview, the auditor requested a complete list of the Plan's Current Procedural Coding System Codes and HCFA Common Procedure Coding System Codes for all abortion services. The Plan provided a "CCHP Sensitive Services Grid" which listed codes 59840-59857. However, codes X1516, X1518, X7724, X7726, and Z0336 (replaced by code S0199 - Effective 4/1/2011) were not included within the grid. The Plan acknowledged these codes were missing and provided screen shots of codes X1516 and X1518 being added to their system; although codes X7724, X7726, and Z0336 remained missing. The Plan did not include within their billing system all State Supported Service codes required by Contract.

RECOMMENDATIONS:

- Revise policies and procedures to comply with the Contract and remove language that place limitations or conditions for members to receive abortion services.
- Ensure the Plan includes within their billing system all State Supported Service codes required by Contract.