

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

**SANTA CRUZ-MONTEREY-MERCED
MANAGED MEDICAL CARE COMMISSION
DBA:
CENTRAL CALIFORNIA ALLIANCE FOR HEALTH**

Contract Number: 08-85216

Audit Period: November 1, 2018
Through
October 31, 2019

Report Issued: February 10, 2020

TABLE OF CONTENTS

I. INTRODUCTION 1

II. EXECUTIVE SUMMARY 2

III. SCOPE/AUDIT PROCEDURES 4

IV. COMPLIANCE AUDIT FINDING
Category 4 – Member’s Rights 6

I. INTRODUCTION

The Santa Cruz-Monterey-Merced Managed Medical Care Commission is the governing board that oversees the Central California Alliance for Health (Plan). The Plan is a regional, non-profit health plan, established in 1996. As a County Organized Health System, the Plan serves approximately 335,627 members in Santa Cruz, Monterey, and Merced counties. The Plan's members represent about 36 percent of the population in Santa Cruz, Monterey, and Merced counties. Fifty percent of the Plan's members are children under 19 years old.

The Plan collaborates with over 7,900 providers with 73 percent of primary care physicians and 78 percent of specialists within the Plan's service area. The Plan has a delegated entity that also serves Medi-Cal members. The entity provides expanded behavioral, mental health, and substance abuse benefits for Medi-Cal Managed Care members.

As of August 2019, the Plan's enrollment for its Medi-Cal line of business was approximately 335,014 and 613 for the Alliance Care In-Home Supportive Services in Santa Cruz, Monterey, and Merced counties. Total enrollment is 335,627 members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period November 1, 2018, through October 31, 2019. The onsite review was conducted from November 4, 2019, through November 8, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel and delegated entity.

An Exit Conference with the Plan was held on January 9, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing preliminary audit findings. The Plan submitted a response after the Exit Conference. The DHCS evaluation of the Plan's response is reflected in this report. DHCS evaluated all relevant information received prior and subsequent to the Exit Conference and is reflected in this report.

The audit evaluated five categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.

The prior DHCS medical audit report issued on February 26, 2019, audit period November 1, 2017, through October 31, 2018, identified no deficiencies.

The summary of the findings by category are as follows:

Category 1 – Utilization Management

Review of prior authorization and appeal requests for appropriate and timely adjudication yielded no findings.

Delegated UM oversight review yielded no findings.

Category 2 – Case Management and Coordination of Care

Review of the Plan's case management and coordination of care, including the Whole Child Model, yielded no findings.

Category 3 – Access and Availability of Care

Review of the Plan's access and availability of care yielded no findings.

Review of the Plan's claims payment system yielded no findings.

Category 4 – Member’s Rights

The Plan did not provide members with fully translated grievance and appeal resolution letters in their identified threshold or concentration languages.

Category 5 – Quality Management

Review of the Plan’s program to train newly contracted providers yielded no findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Medical Review Branch, conducted this audit to ascertain medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State County Organized Health System Contract.

PROCEDURE

The onsite review was conducted from November 4, 2019, through November 8, 2019. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. DHCS reviewed documents and interviewed Plan administrators, staff, and network providers.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 35 medical and 21 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Process: 21 medical and 20 pharmacy prior authorization appeal requests were reviewed for appropriate and timely adjudication.

Delegated UM Oversight: Ten Behavioral Health Treatment (BHT) medical records for delegated UM oversight.

Category 2 – Case Management and Coordination of Care

California Children's Services: The Plan implemented the Whole Child Model as of July 2018. Twenty medical records were reviewed for coordination of care within the Plan.

Behavioral Health Treatment: Ten BHT medical records were reviewed for compliance with BHT provision requirements.

Non-Emergency Medical Transportation (NEMT)/Non-Medical Transportation (NMT): Ten NEMT and ten NMT records were reviewed for compliance with transportation provision requirements.

Continuity of Care: Ten medical records were reviewed to determine continuity of care to members transitioning care and services.

Category 3 – Access and Availability of Care

Appointment Availability: 15 contracted providers from the Provider's Directory were reviewed for appointment availability regarding primary care providers, urgent care, and specialists. The Provider's Directory was also reviewed for accuracy and completeness of listings.

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

Category 4 – Member's Rights

Grievance Procedures: 20 quality of service and 20 quality of care grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

Provider Qualifications: 30 contracted providers were reviewed to determine if they received Medi-Cal Managed Care program training within the required timeframe.

A description of the applicable finding is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Central California Alliance for Health

AUDIT PERIOD: November 1, 2018 – October 31, 2019

DATE OF AUDIT: November 4, 2019 – November 8, 2019

4.1	MEMBER'S RIGHTS
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4.1.1 Fully Translated Written Informing Materials

The Plan shall provide fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, if applicable, and form letters including Notice of Action letters and grievance acknowledgement and resolution letters. The Plan shall provide translated written informing materials to all monolingual or limited English proficiency members that speak the identified threshold or concentration standard languages. (*Contract, Exhibit A, Attachment 9, Provision 13 (C)(2)*)

All Plan Letter (APL) 17-006 states, the Plan shall address the linguistic and cultural needs of its members. The Plan shall ensure all members have access to, and can fully participate, in the Grievance and Appeal System by assisting those with limited English proficiency, with a visual impairment, or other communicative impairment. Such assistance shall include translations of grievances and appeals procedures, forms, and Plan responses to grievances and appeals. (*APL 17-006 VII.J*)

Plan Policy 405-3102, Translation of Alliance Documents, states all written member information materials to be distributed to members will be available in English, Plan's threshold languages, and concentration languages.

Finding: The Plan did not provide members with fully translated grievance and appeal resolution letters in their identified threshold or concentration languages.

Plan Policy 405-3102, was not effectively implemented to provide members with fully translated written informing materials in their grievance and appeal resolution letters. The Plan did not have a monitoring system to ensure members received the full translation of grievance and appeal resolution letters in their identified threshold and concentration languages.

The verification study and onsite interview confirmed the Plan did not translate the decision and clinical rationale for six quality of care grievances, nine medical appeals, and three pharmacy appeals into the member's primary language of Spanish or Hmong.

Without providing fully translated written informing materials to members in their identified threshold or concentration language on grievance and appeal resolution letters, there could be a misunderstanding of the Plan's decision, the inability of the member to make an informed health decision, and delays in receiving medically needed services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Central California Alliance for Health

AUDIT PERIOD: November 1, 2018 – October 31, 2019

DATE OF AUDIT: November 4, 2019 – November 8, 2019

Recommendation: Implement a monitoring system of the requirements in the Plan's policies and procedures to ensure that members receive fully translated grievance and appeal resolution letters in their identified threshold and concentration languages.

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

**SANTA CRUZ-MONTEREY-MERCED
MANAGED MEDICAL CARE COMMISSION
DBA:
CENTRAL CALIFORNIA ALLIANCE FOR HEALTH**

Contract Number: 08-85223
State Supported Services

Audit Period: November 1, 2018
Through
October 31, 2019

Report Issued: February 10, 2020

TABLE OF CONTENTS

I. INTRODUCTION1

II. COMPLIANCE AUDIT FINDINGS2

INTRODUCTION

This report represents our recent audit of the Santa Cruz-Monterey-Merced Managed Medical Care Commission dba Central California Alliance for Health (Plan) State Supported Services Contract No. 08-85223. The State Supported Services contract covers contracted abortion services with the Plan.

The audit period was November 1, 2018, through October 31, 2019. The onsite audit was conducted from November 4, 2019, through November 8, 2019.

An Exit Conference with the Plan was held on January 9, 2020.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Central California Alliance for Health

AUDIT PERIOD: November 1, 2018 – October 31, 2019

DATE OF AUDIT: November 4, 2019 – November 8, 2019

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

SUMMARY OF FINDING:

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Coding System Codes: 59840 through 59857 and Health Care Financing Administration Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract. (*Contract, Exhibit A, (4)*)

According to Plan *Policy 404-1309, Member Access to Self-Referred Services* and *Policy 404-1702, Provision of Family Planning Services to Members*, Medi-Cal members may access sensitive services from any qualified family planning provider, in- or outside the Plan's network without a referral from the member's primary care provider and without authorization from the Plan for abortion services.

Review of the Plan's State Supported Services claims processing system and abortion services billing procedure codes yielded no findings for this year's audit.

RECOMMENDATION:

None