DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SANTA ANA SECTION

REPORT ON THE MEDICAL AUDIT OF SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSION DBA CENTRAL CALIFORNIA ALLIANCE FOR HEALTH FISCAL YEAR 2024-25

Contract Number: 08-85216

Audit Period: November 1, 2023 — October 31, 2024

Dates of Audit: January 21, 2025 — January 31, 2025

Report Issued: June 5, 2025

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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 members in Santa Cruz, Monterey, Merced, San Benito, and Mariposa counties. The Plan's members represent about 51 percent of the population in Merced County, 40 percent in Monterey County, 33 percent in Mariposa County, 30 percent in San Benito County, and 29 percent in Santa Cruz County. Forty-seven percent of the Plan's members are under 20 years old, and about 70 percent are Hispanic.

As of the first quarter of 2025, the Plan's enrollment for its Medi-Cal line of business is approximately 442,007 members in Santa Cruz, Monterey, Merced, San Benito, and Mariposa Counties.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of November 1, 2023, through October 31, 2024. The audit was conducted from January 21, 2025, through January 31, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on May 15, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On May 29, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Population Health Management and Coordination of Care, Network and Access to Care, Member's Rights, Quality Improvement and Health Equity Transformation, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of November 1, 2022, through October 31, 2023, was issued on May 14, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year 2023, Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management

There were no findings noted for this category during the audit period.

Category 2 – Population Health Management and Coordination of Care

There were no findings noted for this category during the audit period.

Category 3 – Network and Access to Care

The prior year audit found that the Plan did not ensure that family planning claims were paid to providers within 45 working days.

There were no findings noted for this category during the audit period.

Category 4 – Member Rights

The Plan is required to comply with the State's established timeframe of 30 calendar days for grievance resolution. The Plan did not ensure QOS grievance resolution within 30 calendar days of grievance receipt.

The Plan is required to establish and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints. The Plan did not ensure to address all member complaints and issues in resolving grievances.

Category 5 – Quality Improvement and Health Equity Transformation

There were no findings noted for this category during the audit period.

Category 6 – Administrative and Organizational Capacity

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that 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

DHCS conducted an audit of the Plan from January 21, 2025, through January 31, 2025, for the audit period of November 1, 2023, through October 31, 2024. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, 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 representatives.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: Twenty medical prior authorization records were reviewed for timely decision making, consistent application of criteria, and appropriate review.

Appeals: Ten medical appeal records were reviewed for appropriateness and timely adjudication.

Category 2 – Population Health Management and Coordination of Care

Continuity of Care: Ten medical records were reviewed to evaluate the timeliness and appropriateness of continuity of care request determination.

Enhanced Care Management (ECM): Ten medical records were reviewed for care coordination, completeness, and compliance with ECM service requirements.

Category 3 – Network and Access to Care

Emergency Room: Twenty-six Emergency Room claims (18 approved, one modified, and seven denied) were reviewed for claim timeliness and reason for denial, modification, or deferral.

Family Planning: Twenty-three family planning claims were reviewed for timeliness, reason for denial, modification, and deferral.

Non-Emergency Medical Transportation: Sixteen records were reviewed for timeliness and compliance with Non-Emergency Medical Transportation requirements.

Non-Medical Transportation: Sixteen records were reviewed for timeliness and compliance with Non-Medical Transportation requirements.

Category 4 – Member Rights

Call-Inquiry: Ten call-inquiry cases were requested to review. All call-inquiry cases were grievances (six exempt grievances and four QOS grievances).

Exempt Grievances: Fifteen exempt grievance cases were reviewed to verify the classification, reporting timeframes, investigation process, and appropriate resolution.

QOS Grievances: Fourteen QOS grievance cases were reviewed for timely investigation process and appropriate resolution.

QOC Grievances: Twenty QOC grievance cases were reviewed for timely process, clear response to members, and appropriate level of review.

Category 5 – Quality Improvement and Health Equity Transformation

Potential Quality Issues: Twelve potential quality issues cases were reviewed for timely evaluation and effective action taken to address needed improvements.

New Provider Training: Fourteen new provider training cases were reviewed for completeness and timeliness.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: Twelve cases were reviewed for investigation process and timely reporting to DHCS.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member Rights

4.1 GRIEVANCE SYSTEM

4.1.1 Quality of Service Grievance Resolution

The Plan must have in place a Member Grievance and Appeal system that complies with 42 CFR sections 438.228 and 438.400 – 424, 28 CCR sections 1300.68 and 1300.68.01, and 22 CCR section 53858 for Covered Services including Contractor's selected Community Supports under 42 CFR section 438.3(e)(2). Contractor must follow Grievance and Appeal requirements set forth in, and use all notice templates included in, All Plan Letter (APL) 21-011. *(Contract, Exhibit A, Attachment III 4.6.1)*

Timeframes for resolving grievances and sending a written resolution to the member are delineated in federal and state law. The State's established timeframe is 30 calendar days. Managed Care Plans (MCP) must comply with the State's established timeframe of 30 calendar days for grievance resolution. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated in state regulations. The MCPs written resolution must contain a clear and concise explanation of the MCPs decision. *(APL 21-011, Grievance and Appeal Requirements)*

The Plan's policy, *200-9002 Member Grievance and Appeal System* (revised 07/10/2024), states that "resolved" means the grievance or appeal has reached a final conclusion with respect to the member's submitted grievance. The Plan has multiple internal levels and subject matter experts used to investigate and resolve a grievance or appeal. All levels and processes required to determine resolution are completed within 30 calendar days of the Plan's receipt of the grievance, including clinical grievances which are reviewed and resolved by a Medical Director within 30 calendar days. The Plan ensures cases are resolved by reaching a final conclusion with respect to the member's submitted grievance or appeal. The results are documented.

Finding: The Plan did not ensure QOS grievance resolution within 30 calendar days of grievance receipt.

In a verification study, the Plan sent grievance resolutions letters related to three of 14 QOS grievance cases. These three cases were not resolved since no final conclusion was reached to address each member's submitted grievance.

For example:

- In the QOS grievance case on October 21, 2024, the member called and stated that they were currently in Long-Term Care facility and planned to participate in an outdoor activity on October 21, 2024. The member was upset because they were informed that they would receive a letter on or around October 21, 2024, regarding the care, which would instead be evaluated in-person. She was looking forward to participating in outdoor activities for her mental health issues but was upset all weekend that she could not. The Plan's resolution letter dated on November 18, 2024, stated, "Your complain was escalated to our Care Management and Enhanced Care Management for review."
- In another QOS grievance case on August 13, 2024, the member stated that they would like to file a grievance against the health plan as they requested for an ECM housing provider change on August 7, 2024, from MCCAA to Sierra Saving Grace and the change was not yet made. The Plan's resolution letter dated on September 10, 2024, stated, "Additional review by our ECM Department was necessary to resolve your complaint. Your case has been referred to our CM team for assistance with your healthcare needs."

In both cases, following the Plan's initial review, the grievances were escalated to ECM Department to review within the Plan for further investigation. Pending the full resolution of these cases, the Plan incorrectly sent resolution letters to members. Therefore, the Plan did not implement their policy, *200-9002*, which states that resolution letters are sent to members only when grievances have been resolved.

If the Plan does not ensure timely and complete grievance resolution, this can lead to delay of proper care for members.

Recommendation: Develop and implement a process to ensure QOS grievances are completely resolved before sending the resolution letter.

4.1.2 Quality of Care Grievance Resolution Letters

The Plan must have in place a Member Grievance and Appeal system that complies with 42 CFR sections 438.228 and 438.400 – 424, 28 CCR sections 1300.68 and 1300.68.01, and 22 CCR section 53858 for Covered Services including Contractor's selected Community Supports under 42 CFR section 438.3(e)(2). Contractor must follow Grievance and Appeal requirements set forth in, and use all notice templates included in, All Plan Letter (APL) 21-011. *(Contract, Exhibit A, Attachment III 4.6.1)*

The Plan is required to establish and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints. *(CCR, Title 22, section 53858(a))*

The Plan must establish, implement, maintain, and oversee a Grievance and Appeal System to ensure the receipt, review, and resolution of grievances and appeals. The Grievance and Appeal System must operate in accordance with all applicable federal and state laws. The Plan must ensure adequate consideration of grievances, appeals, and rectification when appropriate. If multiple issues are presented by the member, the Plan must ensure that each issue is addressed and resolved. (*APL 21-011, Grievance and Appeal Requirements)*

The Plan's policy, *200-9002 Member Grievance and Appeal System* (revised 07/10/2024), states that the Plan will ensure adequate consideration of grievance, appeals, and rectification when appropriate. If multiple issues are presented by the member, the Plan ensures that each issue is addressed and resolved.

Finding: The Plan did not ensure to address all member complaints and issues in resolving grievances.

The verification study revealed that for six of the 20 QOC Grievance cases, the Grievance Resolution letters did not address the multiple issues and complaints of members.

For example:

- In the QOC grievance case, the member stated they arrived at their clinic appointment on November 1, 2023, and while waiting in the lobby, was informed by the clinic staff that the physician refused to provide medical care because they did not follow medical orders; they did not take their seizure medication and was driving behind the wheel. The member felt the situation should have been handled in a private manner by inviting them into an exam room to discuss the issue. Instead, the staff member relayed the physician's reasons for dismissal in front of other patients waiting in the lobby. The member stated they felt angry and overwhelmed by the physician's rudeness and unprofessionalism. The Plan's resolution letter addressed the member's dismissal from service/care by the provider but failed to address the member's privacy issue that occurred in the provider's office lobby.
- In another QOC grievance case, the member stated on March 26, 2024, they went to the Salud Para La Gente clinic due to a chronic cough and was diagnosed with bronchitis. The member stated the provider prescribed Mirtazapine 5mg, which is

used for depression; however, the member does not have depression. The member further stated that, along with their child, they tried contacting the clinic to speak with the provider. However, the member was told the provider was not in and they would receive a call back. On March 29, 2024, the date the complaint was received, the member stated they had not yet received a call back. Incidentally, on April 3, 2024, the member was seen by the same provider upon their return to the clinic for a different medical reason. The Plan's resolution letter addressed the member's complaint pertaining to the medication prescribed but failed to address the member's complaint of not receiving a call back from provider.

In both cases, the Plan sent resolution letters without completely resolving the grievances. The Plan did not address all the complaints in the resolution letters.

The Plan's policy, *200-9002 Member Grievance and Appeals System,* reflects that "if multiple issues are presented by the member, the Plan ensures that each issue is addressed and resolved". Though this is documented in the policy, the procedure to ensure this is performed is not indicated. During the interview, the Plan stated that they review two files per grievance coordinator each quarter to assess the documentation of the grievance. The verification study demonstrated that six of the 20 QOC grievance cases did not ensure resolution of all the issues in the resolution letter.

When the Plan does not address all member issues and complaints, this can lead to poor health outcomes for members and missed opportunities to improve the Plan's health care delivery system.

Recommendation: Develop and implement controls to ensure that all issues are resolved and documented in the resolution letter.

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Contract Number: 08-85216

Contract Type: State Supported Services

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DHCS

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I. INTRODUCTION

This report presents the results of the audit of the Santa Cruz-Monterey-Merced Managed Medical Care Commission is the governing board that oversees the Central California Alliance for Health (Plan) compliance and implementation of the State Supported Services contract number 08-85216 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of November 1, 2023, through October 31, 2024. The audit was conducted from January 21, 2025, through January 31, 2025, which consisted of a document review and verification study with the Plan's administration and staff.

The prior Department of Health Care Services (DHCS) medical audit for the period of November 1, 2022, through October 31, 2023, was issued on May 14, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year 2023, Corrective Action Plan.

An Exit Conference with the Plan was held on May 15, 2025. No deficiencies were noted during the review of the State Supported Services Contract.

The prior year audit found that the Plan did not ensure that State Supported Services claims were paid to providers within 45 working days.

There were no findings noted for this category during the audit period.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan's policies and procedures, Provider Manual, and Member Handbook indicate that Medi-Cal members may obtain an abortion from any qualified provider without obtaining a referral or prior authorization. A qualified provider of abortion services is the member's primary care physician, an obstetrician/gynecologist, certified nurse midwife, nurse practitioner, physician assistant, family planning clinic, or a Federally Qualified Health Center.

A verification study of 27 State Supported Services claims was conducted to determine appropriate process and timely adjudication of claims. There were no material findings noted during the audit period.

Recommendation: None.