CONTRACT AND ENROLLMENT REVIEW – NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Contra Costa Health Plan

2022

Contract Number:	04-36067
Audit Period:	July 1, 2021 Through May 31, 2022
Dates of Audit:	July 18, 2022 Through July 29, 2022
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I. INTRODUCTION

Since 1984, Contra Costa Health Plan (Plan) has contracted with the State of California to provide health care services to Medi-Cal beneficiaries in Contra Costa County. The Plan is a county sponsored Health Maintenance Organization. The Plan is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act. The Contra Costa County Board of Supervisors exercises oversight of the Plan through a Joint Conference Committee (JCC).

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. The Plan 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 individual network providers, Contra Costa Regional Medical Center, and Kaiser Permanente to provide or arrange comprehensive health care services. The Plan provides health care for public and private employee groups, private individuals, Medi-Cal and Medicare beneficiaries, and low-income county residents.

As of May 31, 2022, the Plan had 235,071 members of which 227,787 were Medi-Cal including 15,182 Seniors and Persons with Disabilities (SPD) members. The Plan also covers 4,997 county employees, 2,185 commercial members, and 102 uninsured recipients.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of July 1, 2021 through May 31, 2022. The audit was conducted from July 18, 2022 through July 29, 2022. The audit consisted of document review, verification studies, and interviews with Plan and delegated entity representatives.

An Exit Conference with the Plan was held on December 15, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are 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 Improvement (QI).

The prior DHCS medical audit for the period of July 1, 2020 through June 30, 2021, was issued on November 24, 2021. This audit examined documentation for compliance and to determine to what extent the Plan has implemented their Corrective Action Plan (CAP).

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 includes procedures and requirements for the Plan's UM program, including delegation of UM, prior authorization review and the appeal process.

The Plan is required to render routine authorizations 14 calendar days from receipt of the request and within 72 hours for expedited authorization requests. The Plan did not render decisions for routine prior authorization requests within 14 calendar days and expedited prior authorizations within 72 hours of receipt.

The Plan is required to send a written notice to the member and provider using the DHCS standardized Notice of Action (NOA) "delay" template if the Plan requires an extension, up to an additional 14 calendar days. The Plan did not send written notices of the delay to the provider and member for routine and expedited prior authorization requests not resolved within required timeframes.

The Plan is required to ensure decisions regarding prior authorization are explained in the NOA letters, and that for medical necessity denials, include a clinical reason for the denial and explicitly state how the member's condition did not meet the criteria or guidelines. The Plan's NOA letters did not explicitly state how the member's condition did not meet criteria or guidelines for adverse benefit determinations based on medical necessity.

The Plan is required to send, for adverse benefit determinations based in whole or in part on medical necessity, a written NOA letter to the provider, which includes the name and direct telephone number or extension of the decision maker. The Plan's NOA letters for providers did not include the direct telephone number of the decision maker for adverse benefit determinations based on medical necessity.

The Plan is required to resolve standard appeals within 30 calendar days and expedited appeals within 72 hours from the date the Plan receives the request for an appeal. The Plan did not resolve standard and expedited appeals cases within the required timeframes.

The Plan is required to provide written acknowledgment to the member within five calendar days of receipt of a standard appeal. The Plan did not send acknowledgement letters to members within the required five calendar days after receipt for standard appeals.

The Plan is required to have its governing body, the public policy body, and an officer of the Plan or designee periodically review the written record of grievances and appeals. The Plan's governing body and public policy body did not periodically review and thoroughly document written appeals reports.

The Plan is required to use nondiscrimination notices (NDN) and language assistance taglines (LAT) that are compliant with All Plan Letter (APL) 21-004. The Plan is accountable for all functions and responsibilities that are delegated. The Plan did not ensure its delegate sent updated NDN and LAT information to members with all written notices pertaining to rights or benefits.

The Plan is required to provide members with a written notice of an adverse benefit determination using the appropriate DHCS standardized NOA template and the DHCS standardized NOA "Your Rights" template. The Plan is accountable for all functions and responsibilities that are delegated. The Plan did not ensure a delegate sent updated NOA "Your Rights" attachment from APL 21-011 for adverse benefit determinations.

The Plan is required to provide fully translated NOA letters to members who speak an identified threshold language. The Plan is accountable for all functions and responsibilities that are delegated. The Plan did not ensure a delegate provided fully translated written member information, including the NOA letter, to a member whose primary language was an identified threshold language.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to provide Health Risk Assessments (HRA), Initial Health Assessments (IHA), and Continuity of Care (COC).

The Plan is required to cover and ensure the provision of an IHA, which consists of a comprehensive history and physical examination, preventive services, and the Individual Health Education Behavioral Assessment (IHEBA) and must be documented in the member's medical record. The Plan did not ensure that providers documented all required components of an IHA.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding access to care, Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for medically necessary services, and the adjudication of claims for emergency room and family planning services.

The Plan is required to forward all misdirected emergency service claims and any non-contracted claim to the appropriate capitated provider within ten working days of receipt by the Plan. The Plan did not forward all misdirected claims within ten working days of receipt.

The Plan is required to pay qualified family planning providers a fixed add-on amount for certain family planning services within 90 calendar days of receiving clean claims or accepted encounters as required by APL 20-013. The Plan did not distribute add-on payments for specified family planning service claims as required.

Category 4 – Member's Rights

Category 4 includes the requirements for handling of grievances and Protected Health Information (PHI).

The Plan is required to provide a written notice of resolution to the member within 30 calendar days from the date the Plan receives the grievance. The Plan did not provide written notice of resolution to members within 30 calendar days from the date of receipt of standard grievances.

The Plan is required to conduct a thorough background screening, prior to granting access to DHCS PHI, to ensure that employees given access to DHCS PHI do not pose a risk for theft of confidential data. The Plan did not ensure that all employees with PHI access had complete background checks.

Category 5 – Quality Management

Category 5 includes requirements to maintain an effective Quality Improvement System (QIS), including delegation of quality improvement and provider training.

The Plan is required to collect and review the subcontractors' ownership and control disclosure information. The Plan did not ensure completion of ownership and control disclosure forms.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The audit was conducted from July 18, 2022 through July 29, 2022. 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, staff, and delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

Service requests: A total of 35 clinical service request cases were reviewed for timeliness, consistent application of criteria, and appropriate review. 31 were prior authorization requests and four were concurrent review requests.

Appeal Procedures: 25 medical cases were reviewed for appropriate and timely adjudication.

Delegated Prior Authorization requests: 14 prior authorization requests for mental health services were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Health Risk Assessment (HRA): 20 files were reviewed to confirm coordination of care and fulfillment of HRA requirements.

Continuity of Care (COC): 11 member files were reviewed to confirm COC and fulfillment of requirements.

Initial Health Assessment (IHA): 16 members were reviewed to confirm the performance of the assessment.

Category 3 – Access and Availability of Care

Claims: 25 emergency services and 25 family planning claims were reviewed for appropriate and timely adjudication.

NEMT: Contracted NEMT providers were reviewed for Medi-Cal enrollment.

Category 4 – Member's Rights

Grievances: 54 standard grievances, 15 exempt grievances, five expedited grievances, and 20 call inquiries were reviewed for timely resolution, appropriate classification, response to complainant, and submission to the appropriate level for review. The 54 standard grievance cases included 29 quality of service and 25 quality of care grievances.

Confidentiality Rights: Ten Health Insurance Portability and Accountability Act/PHI breach and security incidents were reviewed for processing and timeliness requirements.

Background Check Verification: 14 samples were reviewed to determine if appropriate procedures were performed.

Category 5 – Quality Management

Potential Quality Incidents (PQI): Ten PQI cases were reviewed for timely evaluation and effective action taken to address needed improvements.

Provider Training: 30 new provider training records were reviewed for the timeliness of 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: Contra Costa Health Plan
AUDIT PERIOD: July 1, 2021 through May 31, 2022 **DATES OF AUDIT: July 18, 2022 through July 29, 2022**

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Timeliness of Prior Authorization Decisions

The Plan must render decisions for routine authorizations within five working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from receipt of the request. For requests in which a provider indicates or the Plan determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Plan must make an expedited decision no later than 72 hours after receipt of the request. For routine and expedited requests, the decision can be deferred and the time limit extended an additional 14 calendar days. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. (*Contract, Exhibit A, Attachment 5(3) (G and H))*

Plan policy *UM 15.015a Timeliness of the Utilization Review Decision and Communication (revised 5/20/22)* stated that upon receipt of all necessary information to make a decision, the Plan must make decisions affecting routine care within five business days but not to exceed 14 calendar days from the date the Plan receives the request, unless a timeframe extension is required. The Plan shall make decisions affecting requests for urgent care no later than 72 hours from the time the necessary information is received by the Plan.

Finding: The Plan did not render decisions for routine prior authorization requests within 14 calendar days and expedited prior authorizations within 72 hours of receipt.

A verification study revealed that in eight of 31 prior authorization requests, the Plan did not render decisions within the required timeframes.

- In seven of 28 routine prior authorization requests, the Plan did not render a decision within 14 calendar days and did not extend decision timeframes. The Plan rendered denial and authorization decisions between 24 and 95 calendar days after receipt of providers' requests.

- In one of three expedited prior authorization requests, the Plan did not render a decision within 72 hours, did not extend the decision timeframe, and did not downgrade the provider's expedited request to a routine timeframe. The Plan rendered the denial decision 117 calendar days after receipt of the expedited request.

The Plan's Behavioral Health Authorization Unit (BHAU) processed seven of eight deficient cases.

During interviews, the Plan acknowledged that BHAU staff were not aware of and did not follow the Plan's Utilization Management (UM) department's policies and procedures, two experienced BHAU staff left the Plan during the audit period, and the BHAU lacked direct UM oversight.

Subsequent to the Exit Conference, the Plan submitted BHAU monitoring reports outside the audit period, which included turnaround times for authorizations and common reasons for not meeting timeframe requirements. Common reasons for not meeting timeframe requirements included plan staff inaction, staffing shortages, or staff incorrectly processing authorization requests. Plan monitoring reports show staff continued to not follow UM policies and procedures.

When the Plan does not follow timeframe requirements for prior authorization decisions, medically necessary services may be delayed or not provided, which may adversely impact members' health.

Recommendation: Implement policies and procedures to ensure that the Plan renders prior authorization decisions within the required timeframes.

1.2.2 Member and Provider Notification for Delayed Decisions

The Plan must render decisions for routine authorizations no longer than 14 calendar days from the receipt of the request. For requests in which a provider indicates or the Plan determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Plan must make an expedited decision no later than 72 hours after receipt of the request. For routine and expedited requests, the decision can be deferred and the time limit extended an additional 14 calendar days only when the member or provider requests an extension, or the Plan justifies 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. (*Contract, Exhibit A, Attachment 5(3) (G and H))*

If the Plan requires an extension, the Plan must either deny the request or immediately send written notice to the member and provider using the DHCS-developed, standardized Notice of Action (NOA) "delay" template. The Plan's written notice must specify the additional information that the Plan needs but did not receive, whether an expert reviewer should be consulted, and additional examinations or tests required before the service can be approved or denied. The Plan must also include the anticipated date when its decision will be made and advise the member of the right to file a grievance to dispute the delay. The NOA "delay" template informs members of their appeal rights through the included "Your Rights" attachment. The Plan must send its written notice within the required timeframes or as soon as the Plan becomes aware that it will not meet the initial authorization timeframe, whichever is earlier. *(APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, and 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates)*

Plan policy *UM 15.015a Timeliness of the Utilization Review Decision and Communication (revised 5/20/22)* stated that the Plan can extend routine request timeframes to a total of 28 calendar days from receipt of requests for the following reasons: the Plan is not in receipt of all necessary and requested information and it is in the member's best interest, the Plan requires expert consult, or the Plan wants the member to obtain an additional test or exam. The Plan can extend urgent request timeframes up to an additional 14 calendar days when the Plan is not in receipt of all information reasonably necessary to make a decision and the extension is in the member's best interest. To extend decision timeframes, the Plan must notify the provider and member of the need for an extension in writing through a deferral letter within 14 calendar days from the receipt of the request. In the written communication, the Plan will indicate when the decision will be made and specify what information is needed, such as consult notes and test or procedure results.

Finding: The Plan did not send written notice of the delay to the provider and member for routine and expedited prior authorization requests not resolved within required timeframes.

A verification study of 31 prior authorization requests demonstrated that in seven routine and one expedited case, the Plan did not extend timeframes by sending notification to the member and provider of the delay and did not process the delayed cases as denials once the initial timeframes were not met. All eight cases showed the following deficiencies:

- The Plan did not send to the member and provider a written NOA delay letter that informed them of the delay, provided the expected date of decision (based on extension of the decision timeframe by an additional 14 calendar days), or requested specific additional information needed to make the decision. In four cases, the decision-maker documented that additional information was required to make a decision; however, the Plan did not request needed information from providers.

- The Plan did not inform members of the right to file a grievance or appeal to dispute the delay through a "Your Rights" attachment.

The Plan's Behavioral Health Authorization Unit (BHAU) processed seven of eight deficient cases.

During interviews, the Plan acknowledged that BHAU staff were not aware of and did not follow the Plan's Utilization Management (UM) department's policies and procedures, two experienced BHAU staff left the Plan during the audit period, and the BHAU lacked direct UM oversight.

When the Plan does not inform members and providers of delays to prior authorization decisions, treatment plans may be impacted and members may not be aware of their grievance and appeal rights.

Recommendation: Revise and implement policies and procedures to ensure that the Plan sends a NOA delay letter to the member and provider for routine and expedited prior authorization decisions that were not resolved within required timeframes.

1.2.3 Explicit Clinical Reason in NOA Letters

The Plan must comply with all existing All Plan Letters (APLs) issued by DHCS. (*Contract, Exhibit E, Attachment 2(1) (D))*

Adverse benefit determinations include denials, terminations, reductions, and limited authorization of requested services. For adverse benefit determinations based in whole or in part on medical necessity, the written Notice of Action (NOA) must contain a description of the criteria or guidelines used, which includes a reference to the specific regulation or authorization procedure that supports the decision as well as an explanation of the criteria or guideline; and the clinical reasons for the decision. The Plan must explicitly state how the member's condition does not meet the criteria or guidelines. *(APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, and 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates)*

Plan policy *UM 15.015a Timeliness of the Utilization Review Decision and Communication (revised 5/20/22)* stated that for denials, delays, or modification of requests, written notices to members must contain reference to the criteria, guidelines, or benefit provision used as well as the clinical reason for medical necessity denials.

Finding: The Plan's NOA letters did not explicitly state how the member's condition did not meet criteria or guidelines for adverse benefit determinations based on medical necessity.

A verification study of 35 clinical service requests revealed that in four adverse benefit determinations based on medical necessity, the Plan did not explicitly state how the member's condition did not meet criteria in NOA letters sent to members. In each of the following cases, the Plan did not describe how member's clinical symptoms, laboratory and radiological test results, and hospital course did not meet clinical criteria sets:

- In one case, the NOA letter stated the member did not meet InterQual guidelines for gastrointestinal bleeding.

- In another case, the NOA letter stated the member did not need to be in the hospital for the requested days, the admission was inappropriate and lacked "severity of illness and intensity of service criteria", and the member did not meet InterQual Criteria for complex urinary tract infection.

- In another case, the NOA letter stated the member did not need to be in the hospital for the requested days, the hospital stay lacked "severity of illness and intensity of service criteria", and the member did not meet InterQual Criteria for high blood pressure.

- In another case, the NOA letter stated the member did not meet clinical guidelines for medical necessity for autism services based on the Plan's behavioral health policy, Apollo criteria, Diagnostic and Statistical Manual of Mental Disorders-5 criteria, and Medi-Cal Early and Periodic Screening Diagnostic and Treatment guidelines. The letter also stated the member had academic and reading problems, with otherwise age-appropriate behaviors, which were best addressed through the school or the mental health delegate.

During interviews, the Plan stated that clinical reasons for denial of inpatient days were communicated to members through facility notification letters containing checkboxes with prepopulated general reasons for denials. The Plan acknowledged it did not explain details of InterQual hospitalization criteria in facility notification letters due to the complexity of the language. Three of four deficient cases involved denial of inpatient hospital days.

Subsequent to the Exit Conference, the Plan stated it conducted additional UM staff training in August 2022 on providing clinical reasons in denial letters and also submitted monthly internal audit results for denial letters. However, DHCS did not evaluate verification study cases resolved after August 2022, which was outside the audit period, and therefore could not confirm resolution of the deficiency.

When the Plan does not provide an explicit reason why the member's condition did not meet criteria, providers and members may not receive enough clinical information to make future treatment plan decisions.

Recommendation: Revise and implement policies and procedures to ensure NOA letters for adverse benefit determinations based on medical necessity explicitly state how the member's condition did not meet criteria or guidelines.

1.2.4 Decision Maker's Phone Number in NOA Letters

The Plan must comply with all existing All Plan Letters (APLs) issued by DHCS. (*Contract, Exhibit E, Attachment 2(1) (D))*

For adverse benefit determinations based in whole or in part on medical necessity, the written Notice of Action (NOA) letter to the provider must contain the name and direct telephone number or extension of the decision maker. If the Plan can substantiate through documentation that effective processes are in place to allow the provider to contact the decision maker easily through means other than a direct phone number, then the phone number or extension is not required. The Plan must conduct ongoing oversight to monitor the effectiveness of this process. *(APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, and APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates)*

Plan policy *UM 15.015a Timeliness of the Utilization Review Decision and Communication (revised 5/20/22)* stated that any written communication to a provider of a denial or modification will have a sticker affixed to the notice or the following information provided in the letter: the name, telephone number and availability of a physician reviewer or other appropriate reviewer who can discuss the decision.

Finding: The Plan's NOA letters for providers did not include the direct telephone number of the decision maker for adverse benefit determinations based on medical necessity.

A verification study of 35 clinical service requests showed that in eight adverse benefit determinations based on medical necessity, the Plan did not include the decision maker's direct phone number in the written NOA letter that was sent to the requesting provider.

- Two cases were processed by the Plan's Utilization Management (UM) Department.
- Six cases were processed by the Plan's Behavioral Health Authorization Unit (BHAU).

In a written response, the Plan explained that UM Department staff placed a sticker containing the decision-maker's direct phone number on NOA letters that were mailed to requesting providers; Plan staff documented the completion of the sticker process in the case file. In response to the two deficient cases, the Plan acknowledged that there was no documentation that the sticker was attached.

In written statements, the Plan acknowledged that BHAU staff did not place stickers with the BHAU decision maker's direct phone number on NOA letters. The BHAU relied on the Plan's provider services phone number that was listed at the top of the NOA letter. The Plan stated this alternative process allowed providers to reach the on-call Plan physician to discuss the decision. The Plan did not submit evidence that the provider call center was monitored for effectiveness to ensure that requesting providers could easily speak with the BHAU decision maker. This alternative process was not documented in the Plan's policies or procedures.

Subsequent to the Exit Conference, the Plan provided an inbound call center log, which included call type and number of calls. The Plan stated it regularly monitors the call type; however, documentation does not show the log was monitored for the effectiveness of the stated alternative process. The Plan stated it updated all NOA letter templates to include the decision-maker's direct phone number; however, the Plan did not submit evidence that the BHAU's NOA letters contained a clear explanation of how to reach the decision-maker and the verification study did not confirm the change was made.

When the Plan does not follow requirements to provide the decision maker's phone number, requesting providers may not have access to peer-to-peer explanations from the decision maker, which may affect members' care.

Recommendation: Revise and implement policies and procedures to ensure NOA letters sent to providers for adverse benefit determinations based on medical necessity contain the direct phone number of the decision maker. When an alternative process is used other than the decision maker's direct phone number, develop and implement policies and procedures to monitor the effectiveness of the process to ensure that requesting providers can easily contact the decision maker.

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Timeliness of Appeals Resolution

The Plan must ensure timely acknowledgement for a request for an appeal and provide a notice of resolution to the member as quickly as the member's health condition requires, within 30 calendar dates from the date the Plan receives the request for an appeal. The Plan must provide oral notice of the resolution of an expedited review within 72 hours. *(Contract, Exhibit A, Attachment 14(1) (B) and (H))*

On September 17, 2018, DHCS informed all Plans to remove any reference to the 14-day extension provision language from their appeal policies and procedures, and any notification template letters. Federal regulations are not in alignment with the Knox Keene Act, which does not allow 14-day extensions beyond 30 calendar days to resolve standard appeals or expedited appeals. *(DHCS All Plan Correspondence)*

Plan policy *AGD 20.005 Medi-Cal Member Appeal Policy (revised 05/2022)* stated the Plan may extend the resolution for standard appeals by up to 14 calendar days if the member requests the extension or the Plan feels there is need for additional information in the interest of the member. The Plan may extend the resolution for expedited appeals by up to 10 calendar days if additional information is needed and is in the best interest of the member.

Finding: The Plan did not resolve standard and expedited appeals cases within the required timeframes.

A verification study revealed that in one of 17 standard appeals, the Plan did not resolve the appeal within 30 days. In two of eight expedited appeals, the Plan did not resolve the appeals within 72 hours. In all three deficient samples, the Plan utilized a 14-day extension and notified the members in writing of the delayed resolution:

- In the standard appeal, the Plan resolved the case 38 days after receipt.
- In one expedited appeal, the Plan resolved the case five days after receipt.
- In another expedited appeal, the Plan resolved the case 76 hours after receipt.

In an interview, the Plan stated it was unaware of the removal of the 14-day extension for appeals.

Subsequent to the Exit Conference, the Plan revised policy AGD 20.005 to remove the 14-day extension of appeals and submitted a report showing the timeliness of appeals determinations. However, DHCS did not re-evaluate verification study cases resolved after July 2022, which was outside the audit period, and therefore could not confirm resolution of the deficiency.

When the Plan does not resolve appeals in a timely manner, this may lead to delays in care and potential adverse health outcomes.

Recommendation: Revise and implement Plan policies and procedures to ensure appeals are resolved within the required timeframes.

1.3.2 Appeals Acknowledgment Letters

The Plan must provide a timely acknowledgement for receiving appeal requests. *(Contract, Exhibit A, Attachment 14(1) (B))*

The Plan must provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of the standard appeal. The acknowledgment letter must advise the member that the standard appeal has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the appeal. *(APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, and 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates)*

Plan policy *AGD 20.005 Medi-Cal Member Appeal Policy (revised 05/2022)* stated a member who files a standard appeal will receive an acknowledgment letter within five calendar days in their preferred language.

Finding: The Plan did not send acknowledgement letters to members within the required five calendar days after receipt for standard appeals.

A verification study revealed that in three of 17 standard appeals, the Plan sent late acknowledgement letters or did not send an acknowledgement letter.

- In two cases, the Plan sent acknowledgement letters six and nine days after receipt of the appeals. In one case, a different Plan department received the appeal and did not forward it to the appeals team in a timely manner.

- In one case, the Plan did not send an acknowledgement letter.

In an interview, the Plan stated it was unsure why acknowledgement letters were sent late. The Plan noted that there was a vacancy in the position responsible for acknowledgement letters and staff in other positions provided coverage.

Subsequent to the Exit Conference, the Plan submitted a statement that it hired new appeals staff, and it would be performing monthly audits over the next year to ensure acknowledgement letters are sent. However, DHCS did not re-evaluate verification study cases resolved after July 2022, which was outside the audit period, and therefore could not confirm resolution of the deficiency.

When acknowledgment letters are not sent in a timely manner, Members may not be informed of the appeals process and their ability to participate in decisions regarding their care.

Recommendation: Implement policies and procedures to ensure timely processing of appeal acknowledgement letters.

1.3.3 Governing Body Appeals Oversight

The written record of grievances and appeals must be reviewed periodically by the governing body of the Plan, the public policy body, and by an officer of the Plan or designee. The review must be thoroughly documented. *(APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, and 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates; Title 28, California Code of Regulations (CCR), section 1300.68(b)(5))*

Plan policy *AGD 20.005 Medi-Cal Member Appeal Policy (revised 05/2022)* stated the manager of the appeal, grievance, and dispute team monitors the performance of appeals processes and presents quarterly reports to Quality Council, Managed Care Commission (MCC), and Joint Conference Committee (JCC).

The *JCC Charter (06/29/2021)* stated the Board of Supervisors is the governing body of the Plan. The JCC is the entity through which the Board of Supervisors exercises oversight of the Plan. The JCC is responsible for receiving and reviewing quarterly reports regarding Appeals Committee activity. The MCC is the principal public advisory board to the Plan.

Finding: The Plan's governing body and public policy body did not periodically review and thoroughly document written appeals reports.

A review of MCC meeting minutes did not demonstrate discussion of appeals reports and information.

A review of quarterly meeting minutes demonstrated the JCC did not review appeals reports or analyze the appeals system; the JCC reviewed the following limited information: number of member appeals and appeals per 1000 members.

In an interview, the Plan stated it presents appeals information to the JCC. However, the JCC meeting minutes do not show a thorough review of appeals.

Subsequent to the Exit Conference, the Plan submitted quarterly reports and a statement that the JCC reviewed quarterly reports for appeals as a part of its "operational dashboard". However, review of the reports showed information only on the number of member appeals and appeals per 1000 members. Documentation did not demonstrate a thorough review of the appeals system by the governing board.

When the Plan's governing body and public policy body do not review appeals reports, potential issues and opportunities for improvement may be overlooked.

Recommendation: Implement policies and procedures to ensure the governing and public policy bodies review appeals reports periodically and thoroughly document its review.

1.5	DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Nondiscrimination Notice and Language Assistance Taglines

The Plan is accountable for all functions and responsibilities, including Utilization Management (UM), that are delegated. The Plan is required to maintain a system to ensure accountability for delegated activities that at a minimum ensures a delegate meets standards set forth by the Plan and DHCS. (*Contract, Exhibit A, Attachment 4(6) (A and B))*

DHCS updated its templates for nondiscrimination notice (NDN) to include additional characteristics protected under state nondiscrimination laws as well as contact information for members to file a discrimination grievance directly with the DHCS Office of Civil Rights (OCR). DHCS also updated its language assistance taglines (LAT) template to conform to federal law and to include additional top California languages (Mien and Ukrainian). The NDN and LAT must be posted in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. Although DHCS does not require Plans to use the DHCS-provided templates verbatim, notices must be compliant with requirements in this APL and with information in the DHCS-provided templates. The implementation date for required information in full-sized NDN and LAT was October 5, 2021. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan Policy *QM14.301 Delegation Oversight Process (revised 4/28/22)* stated that the Plan monitors delegated functions through routine reporting and annual audits, which include file reviews.

The Delegation Agreement between the Plan and delegate *(signed 8/4/21)* stated the Notice of Action (NOA) must be consistent with the Plan's policies and procedures. The attachment to the delegation agreement stated the delegate must follow all Utilization Management (UM) policies and applicable DHCS templates for reporting. During quarterly meetings, Plan staff will cover all new policies and procedures and the delegate must update their staff of any changes.

Plan policy *UM 15.015a Timeliness of the Utilization Review Decision and Communication (revised 5/20/22)* does not mention requirements for NDN and language assistance taglines for written communications sent to members. The attachment to the policy contains a NDN and language assistance taglines with outdated information.

Finding: The Plan did not ensure its delegate sent updated NDN and LAT information to members with all written notices pertaining to rights or benefits in accordance with APL 21-004.

A verification study demonstrated that in 12 of 18 mental health service requests (four continuity of care and 14 prior authorization requests), the delegate did not send current NDN and LAT information in its written notices.

- In two denial letters sent to members for continuity of care requests, the delegate did not submit a NDN and sent an outdated LAT, which did not contain Ukrainian and Mien languages.

- In ten notification letters sent to members for prior authorization approval decisions, the delegate did not submit a NDN or LAT.

A review of the delegate's Medi-Cal NOA letter templates showed the following deficiencies:

- The following templates had outdated NDN, which did not contain all non-discrimination characteristics and DHCS' OCR information:

    - Denial in Spanish, Delay in Spanish, Modify in Spanish, Carve Out in Spanish, Carve Out in English, and Terminate in Spanish

- The following templates did not have a NDN:

    - Denial in English, Delay in English, Modify in English, Terminate in English, Authorization in English, and Authorization in Spanish

- The following templates had outdated LAT, which did not contain Ukrainian and Mien languages:

    - Denial in Spanish, Denial in English, Delay in Spanish, Delay in English, Modify in Spanish, Modify in English, Carve Out in Spanish, and Terminate in Spanish

- The following templates did not have LAT:

    - Terminate in English, Authorization in English, and Authorization in Spanish

In interviews and written statements, the delegate acknowledged it did not update information in NDN and LAT templates because it was not aware of APL 21-004 requirements. In addition, the delegate admitted that the NDN was inadvertently deleted from its system for some notification letter templates in September 2021. The delegate was not aware of a requirement to include the NDN and LAT with authorization letters.

In interviews, the Plan stated its compliance department had a process to email relevant APLs and Medi-Cal requirements to the delegate. However, the Plan did not submit evidence that it informed the delegate on the use of updated NDN and LAT.

Subsequent to the Exit Conference, the Plan stated it created new oversight processes and ensured the delegate's NDN and LAT templates were updated in August 2022. However, DHCS did not evaluate verification study cases resolved after August 2022, which was outside the audit period, and therefore could not confirm resolution of the deficiency.

When the delegate does not follow new requirements set forth by DHCS, members may not receive information necessary to exercise their rights.

Recommendation: Implement policies and procedures to ensure that delegated entities follow updated DHCS requirements.

1.5.2 NOA "Your Rights" Attachment

The Plan is accountable for all functions and responsibilities, including Utilization Management (UM), that are delegated. The Plan is required to maintain a system to ensure accountability for delegated activities that at a minimum ensures a delegate meets standards set forth by the Plan and DHCS. (*Contract, Exhibit A, Attachment 4(6) (A and B))*

The Plan must provide members with written notice of an adverse benefit determination using the appropriate DHCS standardized Notice of Action (NOA) template and the DHCS standardized NOA "Your Rights" template. DHCS updated the Knox-Keene NOA "Your Rights" attachment template with additional information on deemed exhaustion (exceptions when a member can file a state hearing), Aid Paid Pending (continuation of treatment), and new contact information for California Department of Social Services (CDSS) and Department of Managed Health Care (DMHC). Knox-Keene licensed Plans must use the Knox-Keene "Your Rights" attachment template attached to this APL. Plans are not permitted to make changes to NOA or "Your Rights" templates without prior review and approval from DHCS, except to insert information specific to the member as required. The implementation date of the templates was February 28, 2022. *(APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates)*

Plan policy *QM14.301 Delegation Oversight Process (revised 4/28/22)* stated that the Plan monitors delegated functions through routine reporting and annual audits, which include file reviews.

The Delegation Agreement between the Plan and delegate *(signed 8/4/21)* stated the NOA must be consistent with the Plan's policies and procedures. The attachment to the delegation agreement stated the delegate must follow all UM policies and applicable DHCS templates for reporting. During quarterly meetings, Plan staff will cover all new policies and procedures and the delegate must update their staff of any changes.

Plan policy *UM 15.015a Timeliness of the Utilization Review Decision and Communication (revised 5/20/22)* stated that for denial, delay, and modification of requests, the Plan must send "Your Rights" in written notices to members. The "Your Rights" attachment, which was attached to the policy, was outdated and did not align with APL 21-011.

Finding: The Plan did not ensure a delegate used the updated NOA "Your Rights" attachment from APL 21-011 for adverse benefit determinations.

A review of the delegate's Medi-Cal NOA letter templates at the time of the DHCS audit revealed deficiencies. The Plan's denial, delay, modify, carve out, and terminate NOA templates in Spanish contained outdated "Your Rights" attachments without required information on deemed exhaustion, Aid Paid Pending, and updated contact information for CDSS and DMHC.

During interviews and in written responses, the delegate confirmed it received email guidance from the Plan in September 2021 requiring implementation of new templates from APL 21-011. The delegate stated it updated "Your Rights" templates and began sending them to members on September 20, 2021. However, the delegate acknowledged that it mistakenly overlooked the Spanish language templates and did not update them.

Subsequent to the Exit Conference, the Plan stated it created new oversight processes and ensured the delegate's Your Rights Attachment templates were updated in August 2022. However, DHCS did not evaluate verification study cases resolved after August 2022, which was outside the audit period, and therefore could not confirm resolution of the deficiency.

When the delegate does not follow current requirements set forth by DHCS, such as member notification templates, members may not receive information necessary to exercise their rights.

Recommendation: Implement policies and procedures to ensure that delegates follow updated requirements set forth by DHCS.

1.5.3 Translation into Threshold Language

The Plan is accountable for all functions and responsibilities, including Utilization Management (UM), that are delegated. The Plan is required to maintain a system to ensure accountability for delegated activities that at a minimum ensures a delegate meets standards set forth by the Plan and DHCS. (*Contract, Exhibit A, Attachment 4(6) (A and B))*

The Plan must comply with 42 Code of Federal Regulations 438.10(d)(4) and provide, at minimum, fully translated member information including but not limited to form letters including Notice of Action (NOA) letters. The Plan must provide translated written informing materials to all monolingual or Limited English-Proficient (LEP) members that speak the identified threshold or concentration language. (*Contract, Exhibit A, Attachment 9(14) (B))*

Plans are required to provide translated written member information to population groups who indicate their primary language as other than English and that meet certain numeric thresholds or concentration standards. Threshold languages for Contra Costa County included English and Spanish. (*APL 17-011, Standards for Determining Threshold Languages and Requirements for section 1557 of the Affordable Care Act, and APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan policy *QM14.301 Delegation Oversight Process (revised 4/28/22)* stated that the Plan monitors delegated functions through routine reporting and annual audits, which include file reviews.

The Delegation Agreement between the Plan and delegate *(signed 8/4/21)* stated the NOA must be consistent with the Plan's policies and procedures.

Plan policy *CL20.003 Materials Translation and Alternative Formats CCHP (revised 6/1/22)* stated that the Plan must translate materials free of charge to members. The translation must be appropriate to the targeted non-English speaking and/or LEP members. Plan materials that must be translated include NOA letters, information/form letters regarding the use of services, and information on fair hearing process and member rights.

Finding: The Plan did not ensure a delegate provided fully translated written member information, including the NOA letter, to a member whose primary language was an identified threshold language.

A verification study of 14 prior authorization requests was conducted. In one of two cases requiring translation of member notices, the delegate did not translate written notices into the threshold language.

In the single prior authorization case with a deficiency, the member's preferred written and spoken language was Spanish. The delegate sent the following notices to the member entirely in English and did not translate them into Spanish: NOA delay letter for a timeframe extension, NOA denial letter, "Your Rights" attachment, and nondiscrimination notice.

During interviews, the delegate stated its workflow required staff to check the member's preferred written language in its system, use available Spanish templates, and submit the templates to Spanish-speaking staff for further translation of inserted information.

The delegate's system did not have a flag that alerted staff to send notices in threshold and concentration languages. In response to the deficient sample, the delegate acknowledged a staff member did not follow procedures to use the required Spanish templates.

The Plan stated it checked for translation of notices during the annual delegation audit. However, the Plan's delegation audit did not review any Spanish-language cases to verify the delegate's compliance with translations.

Subsequent to the Exit Conference, the Plan stated it created new oversight processes and ensured the delegate corrected the translation issue as of July 2022. However, since this change was outside the audit period, DHCS could not confirm resolution of the deficiency.

When the delegate does not translate NOA letters and attachments into threshold and concentration languages, members may not receive important information on outcome of UM decisions; how to seek assistance and legal help; and members' rights to file appeals, state fair hearings, grievances, and independent medical reviews.

Recommendation: Implement a process to ensure that delegates fully translate written member information, including NOA letters, into threshold and concentration languages.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Required Components of the Initial Health Assessment

The Plan is required to cover and ensure the provision of an Initial Health Assessment (IHA) to each new member within 120 calendar days of enrollment. (*Contract, Exhibit A, Attachment 10(5) (A) and (6) (A).*

An IHA consists of a comprehensive history and physical examination, preventive services, and the Individual Health Education Behavioral Assessment (IHEBA) and must be documented in the member's medical record. The Plan shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate the Plan's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement. *(Contract, Exhibit A, Attachment 10(3) and Medi-Cal Managed Care Division (MMCD) Policy Letter 08-003)*

The Plan is required to follow the latest edition of the Guide to Clinical Preventive Services published by the United States Preventive Services Task Force (USPSTF) to provide preventive services to asymptomatic, healthy adult members. All preventive services identified as USPSTF "A" and "B" recommendations must be provided and the status must be documented. *(Contract, Exhibit A, Attachment 10(6) (B) (1) and MMCD Policy Letter 08-003)*

DHCS temporarily suspended requirements for the Plan to complete the IHA within the required timeframes and allowed the Plan to defer completion of these IHAs until further notice. Starting October 1, 2021, the Plan must begin resumption of IHA activities that they suspended during the period of December 1, 2019 – September 30, 2021. The Plan is required to identify all members who were newly enrolled since December 1, 2019; have not received an IHA since enrollment; and for whom an IHA or portions of an IHA are currently appropriate. The Plan is required to outreach to members identified and coordinate access to providers as needed. *(APL 20-004, Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19)*

Plan policy *QM14.701 Initial Health Assessment (approved 02/08/2022)* stated providers are required to complete the IHA within 120 days of enrollment with the Plan for new members. The IHA consists of:

- Staying Healthy Assessment (SHA), which is the Plan's IHEBA
- A comprehensive history and physical, and mental exam
- Diagnoses, as needed
- A plan of care, which must include all follow up activities that reflect the findings or risk factors discovered during the IHA and SHA
- Provision of any needed preventive care

Finding: The Plan did not ensure that providers documented all required components of an IHA.

A verification study revealed that in nine of 16 samples, providers did not document all required components of an IHA or document member outreach to schedule an IHA. A review of medical records showed:

- Six of nine samples did not have a completed SHA.
- Eight of nine samples did not have a comprehensive history and physical.
- Four of nine samples did not have documentation of applicable immunizations.
- Four of nine samples did not have documentation of tobacco cessation screenings.

In a written response, the Plan stated it did not suspend the requirements to complete the IHA during the period of December 1, 2019 – September 30, 2021 and there was no gap in service to its IHA program.

This was a finding in 2020. As part of its corrective action plan, the Plan conducted medical record reviews, reported IHA completion rates to the Plan's Quality Committee, sent monthly member lists of outstanding IHAs to providers, and conducted provider education. However, the Plan's corrective action did not resolve 2020's finding. For the audit period covered by the 2021 audit, APL 20-004 suspended the IHA requirements; therefore, this finding was not applicable.

Subsequent to the Exit Conference, the Plan disputed three samples stating a member declined completing a SHA, outreach attempts to conduct an IHA were made, and that member history and physicals were completed. However, additional documentation was not provided to support the Plan's statements.

This is a repeat of the 2020 finding, 2.1.7 (2020) Required Components of the Initial Health Assessment.

Without the provision of a complete IHA, providers may not be able to comprehensively assess and manage the healthcare needs of the member.

Recommendation: Implement policies and procedures to ensure the provision of all required components of an IHA.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.6	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

3.6.1 Emergency Services and Family Planning Misdirected Claims

The Plan is required to maintain sufficient claims processing/tracking/payment systems capability to comply with applicable State and Federal law, regulations, and Contract requirements. *(Contract, Exhibit A, Attachment 8(5) (D))*

The Plan is required to forward all misdirected emergency service claims and any non-contracted claim to the appropriate capitated provider within ten working days of receipt by the Plan. (*CCR, Title 28, section 1300.71(b) (2))*

Plan policy *CLM 4.007e Claims Determination Timeliness Internal Monitoring (revised 4/11/2022)* stated the Plan is required to meet the established requirement of working within a specific timeframe for payment of claims, claims denial, and contesting of claims.

Finding: The Plan did not forward all misdirected claims within ten working days of receipt.

A verification study revealed that the Plan did not forward four of four misdirected emergency services claims and three of three misdirected family planning claims within ten working days. All seven claims were submitted by non-contracted providers, which were the responsibility of the Plan's delegate. The Plan notified providers that the claims should be directed to the responsible delegated entity, but did not forward the claims to the delegated entity for processing in a timely manner. The Plan forwarded the claims between 67 to 188 days after receipt.

During the interview, the Plan stated misdirected claims were manually processed by the claims team, which caused the delay in forwarding the claims to the Plan's delegate.

Subsequent to the Exit Conference, the Plan stated that misdirected claims are now automatically forwarded within ten business days to the delegated contractor. However, the automation process was not in effect during the audit period.

When the Plan does not forward misdirected claims, providers may not be reimbursed for services rendered and may be discouraged from treating members.

Recommendation: Revise policies and procedures to ensure forwarding of misdirected claims within ten working days.

3.6.2 Proposition 56 Family Planning Payments

The Plan is required to maintain sufficient claims processing/tracking/payment systems capability to comply with applicable State and Federal law, regulations, and Contract requirements. *(Contract, Exhibit A, Attachment 8(5) (D))*

The Plan must comply with all existing All Plan Letters (APLs) issued by DHCS. *(Contract, Exhibit E, Attachment 2(1) (D))*

The Plan is required to directly, or through their delegated entities, pay qualified family planning providers a fixed add-on amount for specified family planning services listed in APL 20-013 using Proposition 56 appropriated funds. This payment obligation applies to contracted and non-contracted providers. The uniform dollar add-on amounts for the services listed are in addition to whatever other payments eligible providers would normally receive from the Plan. For clean claims or accepted encounters with dates of service between July 1, 2019, and the date the Plan receives payment from DHCS, the Plan must ensure that payments required by this APL are made within 90 calendar days. *(APL 20-013, Proposition 56 Directed Payments for Family Planning Services)*

Finding: The Plan did not distribute add-on payments for specified family planning service claims as required by APL 20-013.

A verification study revealed nine of 25 family planning claims were related to codes that were listed in the APL that must be paid additional add-on reimbursement. In three of the nine claims, the Plan did not distribute add-on payments:

- In one sample, the Plan did not make the add-on payment.

- In two samples, the Plan did not make the add-on payment because the member's primary insurance paid in excess of the required Medi-Cal rate.

This was a finding in 2021. As part of its CAP, the Plan stated the county finance department would review all claims eligible for add-on payments and distribute the payments. The Plan performed quarterly reviews of family planning claims to verify Proposition 56 payments were issued. In the interview, the Plan stated the quarterly review did not address denied claims. The Plan's corrective action did not fully address the prior year's finding; the Plan did not identify denied claims eligible for add-on payments.

Subsequent to the Exit Conference, the Plan stated it updated its process to include Medicare-denied claims that are eligible for Proposition 56 Family Planning Payments on September 21, 2022. However, the updated process was not in effect during the audit period.

This is a repeat of prior year's finding, 3.6 (2021) Proposition 56 Family Planning Payments.

When the Plan does not distribute payments within the required timeframe, it may discourage providers from participating with the Plan and limit members' access to care.

Recommendation: Revise and implement procedures to distribute family planning service add-on payments within 90 calendar days of receiving a clean claim or accepted encounter.

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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Timeliness of Resolution for Standard Grievances

The Plan is required to provide a written notice of resolution to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. (*Contract, Exhibit A, Attachment 14(1) (B))*

The Plan is required to comply with the State's established timeframe of 30 calendar days for standard grievance resolution. A federal regulation allowance for 14-calendar day extension of appeals, based on 42 CFR 438.408 (c) does not apply to grievances. (*APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, and APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates)*

Plan policy *AGD20.002 Handling of Complaints and Grievances (revised 03/2022)* stated that standard grievance resolution letters should be mailed within 30 calendar days of receipt of the grievance. In the event the resolution of a grievance does not occur within 30 calendar days as required, the Plan will notify the member in writing of the status of the grievance and the estimated date of resolution.

Finding: The Plan did not provide written notice of resolution to members within 30 calendar days from the date of receipt of standard grievances.

A verification study revealed that in seven of 54 standard grievances, the Plan sent resolution letters to members between 36 to 43 calendar days after the date of receipt. In five of seven delayed grievances, the reason for delay was untimely provider responses to grievance inquiries.

The Plan's quarterly grievance reports described grievance procedures and stated that standard grievances should be closed within 30 calendar days of receipt. However, if it is in the best interest of the member, an interim letter can be sent to the member to extend the grievance an additional 14 calendar days.

In a written statement, the Plan acknowledged it allowed 14-day extensions during the audit period when a 30-day resolution could not be achieved. In quarterly grievance reports and in written responses, the Plan stated that grievance staffing shortages and untimely provider responses caused delayed resolution.

Subsequent to the Exit Conference, the Plan stated it conducted a process and policy change to remove 14-day extensions for grievances, increased weekly review of grievances, and provided additional oversight of grievance staff. However, the corrective actions were completed after the audit period, and therefore, DHCS could not confirm resolution of the deficiency through the verification study.

When the Plan does not resolve grievances timely, there may be missed opportunities for improved health care delivery and adverse health outcomes may occur.

Recommendation: Implement policies and revise procedures to ensure that the Plan provides written notice of resolutions to members within 30 calendar days from the date of receipt for standard grievances.

4.3	CONFIDENTIALITY RIGHTS

4.3.1 Background Check

The Plan is required to conduct a thorough background check of a worker before any member of the workforce may access DHCS protected health information (PHI) and evaluate the results to assure there is no indication that the worker may present a risk for theft of confidential data. The Plan is required to maintain each workforce member's background check documentation for a period of three years after the employee contract is terminated. *(Contract, Exhibit G Attachment A(I) (D))*

DHCS requires that a background check must be conducted for all employees who will have access to DHCS PHI. *(APL 09-014, Exhibit G, Health Insurance Portability and Accountability Act (HIPAA), and CFR, Title 45, section 164.530)*

Plan policy *Contra Costa County Administrative Bulletin Number 415 Pre-Employment Screening (dated 4/1/18)* stated as a conditional offer of employment, potential hires (full time, part time, temporary, contractor) are required to successfully pass pre-employment background investigation, fingerprint check, drug screening, and potential verification of licenses and certificates.

Plan policy *CR 11.016 Credentialing License CCHP Staff (revised 12/2021)* stated prior to employment at the Plan, all licensed staff (full time, part time, temporary, contractor) are required to successfully pass a pre-employment screening. Plan staff having access to PHI are subjected to a background check as a condition of any type of employment.

Finding: The Plan did not ensure that all employees with PHI access had complete background checks.

A verification study revealed that three of 14 samples did not have documentation to support complete background checks:

- In one sample, a fingerprinting check and sanction check were not documented.
- In a second sample, a sanction check was not documented.
- In a third sample, a fingerprinting check was not documented.

This was a finding in 2019, 2020, and 2021. As part of its corrective action plan, the Plan finalized an agreement with its labor unions to conduct background checks of employees hired during or prior to 2018. In an interview, the Plan stated it had completed background checks for all employees current and those hired prior to 2018. However, the Plan's corrective action did not resolve the prior year's finding.

Subsequent to the Exit Conference, the Plan provided additional documentation stating the missing documentation appeared to have been a document sharing error. However, the additional documentation did not support all missing background check information. The Plan also stated that one staff member was a consultant and credentialed provider, not an employee. However, this individual is a member of the Plan's workforce with access to member PHI which requires the completion of a background check.

This is a repeat of prior years' findings: 4.3.3 (2019), 4.3.1 (2020), and 4.3.1 (2021) Background Check.

When the Plan does not complete background checks of all individuals who have PHI access this may increase the risk of theft or unauthorized use of members' PHI.

Recommendation: Implement policies and procedures to ensure background checks are completed for all individuals prior to providing them with access to PHI.

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CATEGORY 5 – QUALITY MANAGEMENT

5.2	DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

5.2.1 Ownership and Control Disclosures of Delegates

The Plan is required to collect and review their subcontractors' ownership and control disclosure information as set forth in *CFR, Title 42, section 455.104*. The Plan must make the subcontractors' ownership and control disclosure information available, and upon request, this information is subject to audit by DHCS. *(Contract, Exhibit A, Attachment 1(2) (B) and APL 17-004, Subcontractual Relationships and Delegation)*

The Plan must require each subcontractor to disclose the following information: the name and address of each person with an ownership or control interest in the subcontractor; whether any of the persons named is related to another; and the name, address, date of birth, and social security number of any managing employee. *(CFR, Title 42, section 455.104)*

Plan policy *PA 9.830 Sub-Contractual Relationships and Delegation (reviewed 05/2022)* stated the Plan shall collect and review its subcontractors' ownership and control disclosure information as set forth in *CFR, Title 42, section 455.104*.

Finding: The Plan did not ensure completion of ownership and control disclosure forms.

In six of eight ownership and control disclosure forms, the Plan did not collect all required information:

- Three of eight did not contain the social security numbers, address, and date of birth of all individuals with control interest.

- Three of eight did not include the names of any individuals with ownership or control interest.

This was a finding in 2019, 2020, and 2021. The prior year's audit found the Plan did not ensure collection and completion of ownership and control disclosure information. As a corrective action, the Plan implemented new processes and training, including the use of a checklist to ensure all required ownership and control interest information is collected. If the collected information was not complete, the Plan stated that it would return the form to the delegates. The Plan's corrective action did not resolve the prior year's finding.

Subsequent to the Exit Conference, the Plan provided updated ownership and disclosure forms. Updated disclosure forms for two samples included all required information; however, the remaining six samples did not collect all required information.

This is a repeat of prior years' findings: 5.1.5 (2019), 5.2.1 (2020), and 5.2.1 (2021) Ownership and Control Disclosures of Delegates.

When the Plan does not collect and review ownership and control disclosure information of all delegates, it cannot ensure that the delegates' owners and controlling interest individuals are eligible for program participation.

Recommendation: Implement policies and procedures to ensure collection, completion, and review of all subcontractor's ownership and control disclosure information.

CONTRACT AND ENROLLMENT REVIEW – NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Contra Costa Health Plan

2022

Contract Number:	03-75796 State Supported Services
Audit Period:	July 1, 2021 Through May 31, 2022
Dates of Audit:	July 18, 2022 Through July 29. 2022
Report Issued:	January 18, 2023

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II. COMPLIANCE AUDIT FINDINGS 2

I. INTRODUCTION

This report presents the audit findings of Contra Costa Health Plan (Plan) State Supported Services Contract No. 03-75796. The State Supported Services Contract covers contracted abortion services with the Plan.

The audit was conducted from July 18, 2022 through July 29, 2022. The audit period was July 1, 2021 through May 31, 2022. The audit consisted of document review of materials supplied by the Plan, verification study, and interviews.

25 State Supported Services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Contra Costa Health Plan

AUDIT PERIOD: July 1, 2021 through May 31, 2022
DATES OF AUDIT: July 18, 2022 through July 29, 2022

STATE SUPPORTED SERVICES

SSS.1 Misdirected Claims

The Plan is required to maintain sufficient claims processing/tracking/payment systems capability to comply with applicable State and Federal law, regulations, and Contract requirements. *(Contract, Exhibit A, Attachment 8(5) (D))*

The Plan is required to forward all misdirected emergency service claims and any non-contracted claim to the appropriate capitated provider within ten working days of receipt by the Plan. (*California Code of Regulations (CCR), Title 28, section 1300.71(b)(2))*

Plan policy *CLM 4.007e Claims Determination Timeliness Internal Monitoring (revised 04/11/2022)* stated the Plan is required to meet the established requirement of working within a specific timeframe for payment of claims, claims denial, and contesting of claims.

Finding: The Plan did not forward all misdirected claims within ten working days of receipt.

A verification study revealed that the Plan did not forward four of four misdirected state supported services claims within ten working days. All four claims were submitted by non-contracted providers, which were the responsibility of the Plan's delegate. The Plan notified providers that the claims should be directed to the responsible delegated entity, but did not forward the claims to the delegated entity for processing in a timely manner. The Plan forwarded the claims between 42 to 75 days after receipt.

During the interview, the Plan stated misdirected claims are manually processed by the claims team, which caused the delay in forwarding the claims to the Plan's delegate.

Subsequent to the Exit Conference, the Plan stated that misdirected claims are now automatically forwarded within ten business days to the delegated contractor. However, the automation process was not in effect during the audit period.

When the Plan does not forward misdirected claims, providers may not be reimbursed for services rendered and may be discouraged from treating members.

Recommendation: Revise policies and procedures to ensure forwarding of misdirected claims within ten working days.