CONTRACT & ENROLLMENT REVIEW
DIVISION – SOUTH SAN DIEGO
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Community Health Group Partnership Plan

2022

Contract Number:	09-86155
Audit Period:	June 1, 2021 Through May 31, 2022
Dates of Audit:	July 11, 2022 Through July 22, 2022
Report Issued:	February 15, 2023

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I. INTRODUCTION

Incorporated in 1982, Community Health Group Partnership Plan (Plan) first contracted with the Department of Health Care Services (DHCS), formerly known as the Department of Health Services, in 1986 to provide services to Medi-Cal members. In 2005, the Plan obtained a Knox-Keene license from the California Department of Managed Health Care to service its Medi-Cal members.

The Plan currently contracts with DHCS to provide services to Medi-Cal beneficiaries under the Geographic Managed Care program in San Diego County. The Plan provides health care services through contracts with community clinics, medical groups, and individual physicians. The Plan provides pharmacy services through a contract with Pharmacy Benefits Manager, MedImpact Healthcare Systems, Inc.

As of May 2022, the Plan served 323,601 members through the following programs: Medi-Cal 316,632 and Cal MediConnect 6,969.

II. EXECUTIVE SUMMARY

This report presents the results of the medical audit for the audit period of June 1, 2021 through May 31, 2022. DHCS conducted an audit of the Plan from July 11, 2022 through July 22, 2022. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on January 11, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in this report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

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

The prior DHCS medical audit issued on October 19, 2021, for the audit period of June 1, 2019 through May 31, 2021, identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP was closed on June 17, 2022.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 covers the requirements and procedures for the UM program, including Medical Director and medical decisions and delegation of UM.

The Plan is required to maintain a Medical Director whose responsibilities shall include ensuring that medical decisions are not influenced by administrative management considerations. The audit found that the Plan did not ensure that its Chief Medical Officer's (CMO's) medical decisions were not influenced by administrative management considerations.

The Plan is required to maintain a Medical Director whose responsibilities shall include ensuring that medical decisions are rendered by qualified medical personnel. The audit found that the Plan did not ensure that medical decisions were rendered by qualified medical personnel and that medical protocols were followed.

The Plan is required to collect and review subcontractors' ownership and control disclosure information, including the name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity. The audit found the Plan did not collect all required information and did not review subcontractors' ownership and control disclosure forms for completeness.

Category 2 – Case Management and Coordination of Care

Category 2 includes the requirements and procedures for Complex Case Management (CCM).

The Plan is required to ensure that CCM services are provided in collaboration with the primary care provider and shall include the development of care plans specific to individual needs. The Plan did not ensure the development and implementation of individualized care plans in the provision of CCM.

Category 3 – Access and Availability of Care

Category 3 includes the requirements and procedures to provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for medically necessary services.

Member's provider must prescribe the mode of transportation by submitting a Physician Certification Statement (PCS) form prior to the Plan providing NEMT services. The audit found the Plan did not ensure that members' providers prescribed the mode of transportation by submitting a PCS form prior to the Plan providing NEMT services.

All PCS forms must include function limitations justification. The audit found the Plan did not ensure all PCS forms included function limitations justification.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS, Contract & Enrollment Review Division (formerly Medical Review Branch) to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the state Contract.

PROCEDURE

The review was conducted from July 11, 2022 through July 22, 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 those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 20 medical, 20 pharmaceutical, and ten delegated prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 28 appeals of denied medical and pharmaceutical prior authorizations were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment (IHA): 20 medical records were reviewed for timeliness and completeness of IHA requirements.

CCM: 11 medical records were reviewed for evidence of care coordination between the Plan and providers.

Behavioral Health Treatment: 32 medical records were reviewed to confirm care coordination and fulfillment of behavioral health requirements.

Category 3 – Access and Availability of Care

NEMT and NMT: 30 records (15 NEMT and 15 NMT) were reviewed to confirm compliance with transportation requirements for timeliness and appropriate adjudication.

Category 4 – Member's Rights

Grievance Procedures: 40 standard grievances (20 quality of care and 20 quality of service) were reviewed for timely resolution, response to the complainant, submission to the appropriate level for review, and translation in member's preferred language (if applicable).

Category 5 – Quality Management

Potential Quality Issue: 17 files were reviewed for evaluation and to determine if effective action was taken to address needed improvement.

Provider Qualifications: Ten new network provider training records were reviewed for timeliness of Medi-Cal Managed Care program training. The Plan was accredited with the National Committee Quality Assurance effective September 2, 2020 through September 2, 2023.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Nine fraud and abuse cases were reviewed for processing and reporting requirements.

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

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.4	MEDICAL DIRECTOR AND MEDICAL DECISIONS

1.4.1 Medical Decisions

The Plan shall maintain a full-time physician as Medical Director to ensure that medical decisions are not unduly influenced by administrative management considerations and that the medical care provided meets the standards for acceptable medical care. *(Contract, Exhibit A, Attachment 1 (6) A (2) B))*

The decision-maker shall be a health care professional with clinical expertise in treating a beneficiary's condition or disease. *(All Plan Letter (APL) 17-006, Grievance and Appeals Requirements)*

Health care services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury are covered by the Medi-Cal program. *(California Code of Regulations (CCR), Title 22, section 51303, Health Care Services General Provisions*))

The Plan's policy 7251.8a, *Review of Requests for Health Care Services* (Revised 5/4/2021), states that any UM decisions determined not to meet medical necessity must be reviewed by a physician. Administrative denials that are not a covered benefit and lack appropriate clinical documentation may be processed by a Registered Nurse (RN).

The Plan's policy 7281a, *Technology Review and Assessment* (Revised 5/4/2021), states that requests for new technology should be referred to the CMO who undertakes the review in a timely manner, conflicts of interest will be avoided, technologies will be reviewed against the following objective criteria: demonstrated improvement in health outcomes, the extent of health risk, health benefit, documented indications and contraindications, alternatives, and cost.

Finding: The Plan did not ensure that its CMO's medical decisions were not influenced by administrative management considerations.

Medical Directors' and the CMO's authorizations were influenced by non-physician managers in at least two requests (Sacral Nerve Stimulator and Bone Anchored Hearing Apparatus) during the audit period. Both met the medically necessity

requirements of CCR, Title 22, section 51303. The reason for the Chief Operating Officer (COO) and Senior Director of Healthcare Services (SDHCS) involvement was that the services were "not a Medi-Cal benefit" despite evidence that no other acceptable therapy was available to alleviate the members' serious conditions and after outside medical opinions were sought.

Prior Authorizations for "new technology" services, that are approved by the Medical Directors and the CMO, must go for final approval by non-physician managers (SDHCS and COO). The Plan's process allows for non-physician managers to make decisions on medically necessary services that have already been approved by the CMO and may delay services. Eventually the two services (Sacral Nerve Stimulator and Bone Anchored Hearing Apparatus) were provided.

Administrative management involvement in the decision-making of medically necessary services may lead to delays in members receiving care which may result in poor member health outcomes.

Recommendation: Revise and implement policies and procedures to ensure that the CMO's medical decisions are not influenced by administrative management considerations.

1.4.2 Qualified Medical Personnel

The Contract requires the Plan's Medical Director to ensure that medical decisions are rendered by qualified medical personnel and that medical protocols for Plan medical personnel are followed. *(Contract, Exhibit A, Attachment 1 (6) A(1),(C))*

No person shall engage in the practice of nursing, as defined in California Business and Professions Code section 2725, without holding an active license. *(California Business and Professions Code, section 2732)*

The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof and that require a substantial amount of scientific knowledge or technical skill, including all of the following: Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures. Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized

procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures. *(California Business and Professions Code, section 2725)*

Finding: The Plan did not ensure that medical decisions were rendered by qualified medical personnel and that medical protocols for medical personnel were followed.

The Plan employed International Medical Graduates (IMGs) as Case Managers for members with complex medical needs. IMGs are unlicensed physicians who received a medical degree from a medical school located outside the United States that is not recognized by a U.S. accrediting body. IMGs are unregulated and their scope of work should not exceed that of a Medical Assistant. They may not assess patient medical conditions, create care plans, or provide any medical advice.

In a verification study, seven of the 10 member records reviewed showed that members with multiple and complex conditions were managed by IMGs. The IMGs facilitated health risk assessments of the members, accessed the member's medical history (hospital visits, office visits, medications, diagnoses), and developed care plans for the members. CCM involves clinical skills requiring independent assessment, clinical monitoring of members with acute and chronic illness, and intense care coordination of resources based on the member's medical needs. Therefore, CCM should have been provided by licensed medical personnel, such as a RN.

The CCM care plans developed by the Case Managers are sent to the Plan's Interdisciplinary Care Team (ICT) daily for quality review and approval. The ICT includes either of the two Medical Directors. However, the CMO is not involved in the ICT or supervision of the Case Managers. The care plans in the verification study were reviewed and approved by the ICT without modifications or additions.

In an interview, the Plan's CMO stated that both IMGs and RNs have the same job description, training, and case load of up to 250 cases for each Case Manager. Due to the difficulty in hiring bilingual nurses, the Plan increased its hiring of IMGs who are bilingual.

When the Plan does not ensure that medical decisions are rendered by qualified medical personnel and medical protocols are followed, it may lead to inadequate care plans, poor health outcomes, or missed services for members.

Recommendation: Develop and implement policies and procedures to ensure that medical decisions are rendered by qualified medical personnel and that medical protocols for medical personnel are followed.

1.5	DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Delegated Entity's Disclosure Statement

The Plan is required to collect and review subcontractors' ownership and control disclosure information as set forth in Code of Federal Regulations (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. (*APL 17-004*, *Subcontractual Relationships and Delegation*)

The Plan is required to comply with CFR, Title 42, section 455.104, Disclosure by providers: Information related to business transactions. *(Contract, Exhibit E, Attachment 2(32)(B))*

The Plan must require that disclosing entities provide the name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity. *(CFR, Title 42, section 455.104 (b)(4))*

"Managing Employee" means a General Manager, Business Manager, Administrator, Director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an applicant or provider. *(CCR, Title 22, section 51000.12)*

Finding: The Plan did not collect all required information and did not review the subcontractor's Disclosure Statement for completeness.

A review of the Plan's delegated entity's Disclosure Statement revealed that the Plan did not collect the name, address, date of birth, and Social Security Number of all Directors.

The Plan's policies and procedures did not specifically address a process to review the completeness of subcontractors' ownership and control disclosure information. Instead, the Plan had a, *Best Practice Guide (BPG): Ownership and Control Disclosure,* that addressed monitoring of disclosure forms. The Plan updated its *BPG* on July 13, 2022, to include that the Plan will review delegated entity disclosure forms at the time of new contract or renewal.

When the Plan does not collect and review the subcontractors' ownership and control disclosure information, it cannot ensure that the subcontractors' owners and individuals with controlling interest are eligible for program participation. There is also a risk that a conflict of interest exists.

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RECOMMENDATION: Implement policy and procedures to ensure all required subcontractor disclosure information is collected and reviewed for completeness.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.2	COMPLEX CASE MANAGEMENT

2.2.1 Individualized Care Plans in Complex Case Management

The Plan shall ensure the provision of Comprehensive Medical Case Management to each member and maintain procedures for monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside the Plan's Provider Network. These services are provided through either Basic or CCM activities based on the medical needs of the member. CCM services are provided by the Plan, in collaboration with the primary care provider, and shall include, at a minimum: 1) Basic Case Management Services; 2) Management of acute or chronic illness, including emotional and social support issues by a Multidisciplinary Case Management Team; 3) Intense coordination of resources to ensure member regains optimal health or improved functionality; 4) With member and primary care provider input, development of care plans specific to individual needs, and updating of these plans at least annually. *(Contract, Exhibit A, Attachment 11(1)(B))*

The Plan's policy, *HCS 7255.1.a, Complex Case Management* (revised 11/01/2021), stated that in accordance with regulatory requirements, the Plan will coordinate services for members that require case management/or have complex conditions. This involves a comprehensive assessment of the member's condition, management of acute or chronic illness, including behavioral and social support issues by a Multidisciplinary Case Management Team; development and implementation of an individualized case management plan with performance goals, monitoring, and follow-up to ensure member regains optimal health or improved functionality.

Finding: The Plan did not ensure the development and implementation of individualized care plans in the provision of CCM services.

In a verification study, all ten member records reviewed showed that the Plan's Clinical Care Management Department did not develop care plans that were individualized. Of the ten care plans reviewed, seven were developed by IMGs. While the members were ranked as high-risk with complex co-morbidities (having three to seven diagnoses), the care plans did not provide specific information related to their condition or diagnoses. In addition, health education appropriate for the members' diagnoses were not documented or addressed.

The Plan stated that the ICT, led by a medical doctor, monitors the quality of CCM care plans through its daily review and approval process. The Plan did not provide an explanation why these daily reviews did not result in care plan modifications based on members' individual needs.

In the provision of CCM, care plans that are not individualized based on the member's medical needs can lead to a lack of coordinated care, non-progression toward health goals, and poor health outcomes.

Recommendation: Implement policies and procedures to ensure the development and implementation of individualized care plans in the provision of CCM services.

3.8	**NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICALTRANSPORTATION**

3.8.1 PCS Forms for Skilled Nursing Facility (SNF) Members

The member's provider must submit the PCS form to the Plan for the approval of NEMT services and the Plan must use the PCS form to provide the appropriate mode of NEMT to members. A member or provider is not required to obtain prior authorization for NEMT services if the member is being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a SNF. *(APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses*)

The Plan's Policy 6059, *Non-Emergency Medical Transportation and Non-Medical Transportation* (Revised 1/27/2022), also stated "Member's treating physician must prescribe the form of transportation by submitting a NEMT PCS form prior to the Plan providing NEMT services."

Finding: The Plan did not ensure that the member's provider prescribed the mode of transportation by submitting a PCS form prior to the Plan providing NEMT services.

A total of 15 NEMT services were reviewed for completeness of documentation. Six of the services did not have a PCS form on file. Documentation received from the Plan stated, "No PCS form in file. Member was admitted to SNF."

During the interview, the Plan stated that it does not require a PCS form for members in an inpatient setting, including members living in a SNF. However, this is not one of the exceptions stated in APL 22-008. The six services in the verification study were for transportation of members residing in a SNF to their medical appointments and not for their initial transfer to the SNF.

The Plan later acknowledged that NEMT requests from providers, including SNFs, must include a PCS form. Effective August 1, 2022, all NEMT requests processed by the Plan will include the PCS form.

According to the Plan, it did not require a PCS form for NEMT requests from SNFs as the form creates an administrative burden for the provider and may delay appropriate medically necessary care to members.

If the Plan does not utilize the PCS form, the transportation provider would not be aware of what mode of transportation is prescribed by the treating physician and needed by the member. Members' health may be at risk when their transportation providers are unaware of their limitations. Members are at risk for falls and inadequate monitoring of their medical condition without the PCS form.

Recommendation: Execute policies and procedures to ensure a PCS form is obtained for all NEMT services, including SNF residents. Implement monitoring procedures to ensure a PCS form is obtained for all NEMT services, including SNF residents.

3.8.2 Incomplete PCS Forms

The member's provider must submit the PCS form to the Plan for the approval of NEMT services and the Plan must use the PCS form to provide the appropriate mode of NEMT to members. For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles. *(APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)*

The Plan's Policy 6059, *Non-Emergency Medical Transportation and Non-Medical Transportation,* stated the member's treating physician must prescribe the form of transportation by submitting a NEMT PCS, which includes function limitations justification.

Finding: The Plan did not ensure all PCS forms included function limitations justification.

A total of 15 NEMT services were reviewed for completeness. Nine of the 15 records contained PCS forms. Four of the nine PCS forms reviewed were incomplete. For the Justification Reason, the documentation only stated the diagnosis and ICD 10 code (e.g., ESRD N18.6). The PCS forms did not provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.

During the interview, the Plan stated that function limitations justification documentation should include explanations such as unable to ambulate, impairment, supervision needed, or patient has no other transportation. However, if the physician signed the form, the Plan considered it valid, as the Plan did not want to go against medical advice. The Plan stated that a diagnosis code would be sufficient for the function limitations justification.

In a written statement, the Plan indicated that all four member cases with incomplete PCS forms had a diagnosis of end stage renal disease, which required dialysis treatment. The Plan stated that all members with this diagnosis needed NEMT services and as such, the services were approved.

The Plan's Policy 6059 stated that a PCS form must include function limitations justification. During training, providers were informed to complete the function limitations justification section of the PCS form. However, the Plan does not monitor whether the function limitations justification is included on PCS forms.

If transportation providers are unaware of the function limitations of the members being transported, members are at risk for falling or inadequate monitoring of their medical condition.

Recommendation: Implement policies and procedures to ensure PCS forms are complete, including the function limitations portion. Implement monitoring procedures to ensure PCS forms are complete, including the function limitations justification.

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2022

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I. INTRODUCTION

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

The audit period is from June 1, 2021 through May 31, 2022. The review was conducted from July 11, 2022 through July 22, 2022, and consisted of a document review, verification study, and interview with the Plan.

The prior DHCS medical audit issued on October 19, 2021, for the audit period of June 1, 2019 through May 31, 2021, identified a deficiency addressed in a Corrective Action Plan (CAP). As of June 17, 2022, the CAP is closed.

The audit reviewed 18 State Supported Services claims for appropriate and timely adjudication.

There were no deficiencies found for the review period on the Plan's State Supported Services.

An Exit Conference with the Plan was held on January 11, 2023.

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STATE SUPPORTED SERVICES

The Contract requires the Plan to provide or arrange to provide eligible members the following State Supported Services: Current Procedural Coding System Codes 59840 through 59857 and Health Care Financing Administration Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336.

The Plan's Policy 7809a, *Claims for Abortion Services* (revised July 1, 2021), states that the Plan covers abortions performed as a physician service. Abortion is a covered benefit regardless of the gestational age of the fetus. Medical justification and authorization for abortion are not required for outpatient care.

Members may obtain abortion services from providers and facilities in and outside the Plan's contracted network. Minors of any age may consent to the performance of an abortion. The Plan covers Current Procedural Terminology (CPT) codes 59840-59857 and HCPCS codes X1516, X1518, X7724, X7726, and Z0336.

The Plan informs members and providers about abortion services through the Evidence of Coverage (Member Handbook) and the Provider Manual, which are available on the Plan's website. Members may also call the Plan's Member Services Call Center for more information.

The Plan's Claims Payment System contains all the required pregnancy termination billing codes. The Plan automatically adjudicates the claims in the Plan's system without prior authorization.

The audit found no exceptions to the contractual requirements.

Recommendations: None.