CONTRACT AND ENROLLMENT REVIEW
DIVISION – SOUTH LOS ANGELES
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

CALIFORNIA HEALTH AND WELLNESS PLAN

2022

Contract Number:	13-90157
Audit Period:	May 1, 2021 Through June 30, 2022
Dates of Audit:	July 18, 2022 Through July 29, 2022
Report Issued:	February 8, 2023

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I. INTRODUCTION

The California Legislature awarded California Health and Wellness Plan (Plan) a contract by the California Department of Health Care Services (DHCS) to provide Medi-Cal services in 19 counties as of November 1, 2013. The Plan is a wholly-owned subsidiary of Centene Corporation, a publicly-traded company that serves as a major intermediary for both government-sponsored and privately-insured health care programs.

This contract was implemented under the State's Medi-Cal Managed Care Rural Expansion program. The expansion program included members eligible for Temporary Assistance for Needy Families and Children's Health Insurance Program.

The Plan's provider network includes independent providers practicing as individuals, small and large group practices, and community clinics. The Plan's provider network includes independent providers comprised of primary care physicians (450) and specialists (3,423) as well as hospitals (78) and ancillary providers (263).

As of June 30, 2022, the Plan served 235,073 Medi-Cal members in the following counties: Alpine 74, Amador 1,575, Butte 47,461, Calaveras 5,619, Colusa 4,090, El Dorado 19,364, Glenn 9,203, Imperial 72,190, Inyo 2,086, Mariposa 1,044, Mono 1,021, Nevada 9,876, Placer 12,791, Plumas 2,725, Sierra 262, Sutter 13,514, Tehama 14,782, Tuolumne 5,834, and Yuba 11,562.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS medical audit for the period of May 1, 2021 through June 30, 2022. The onsite review was conducted from July 18, 2022 through July 29, 2022. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on January 6, 2023, the Plan was allowed 15-calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On January 20, 2023, the Plan submitted a response. The results of our evaluation of the Plan's response are reflected in this report.

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.

DHCS issued the prior medical audit (for the period of December 1, 2019 through April 30, 2021) on November 22, 2021. This audit examined the Plan's compliance with its DHCS Contract and assessed implementation of its prior year Corrective Action Plan (CAP). The CAP closed on November 21, 2022.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. The Plan did not integrate reports reviewing the number and types of appeals, denials, deferrals, and modifications for dental services into the Plan's Quality Improvement (QI) process, including referral to the appropriate Quality Improvement System (QIS) staff for further analysis.

The Plan is required to ensure that qualified health care professionals review its UM program, such as prior authorization review procedures. A qualified pharmacist, holding a valid certificate issued by the California Board of Pharmacy, may approve, defer, modify, or deny prior authorizations for pharmaceutical services. The Plan's pharmacy UM activities were reviewed, approved, or denied by pharmacists that did not hold a current or valid license issued by the California Board of Pharmacy.

Category 2 – Case Management and Coordination of Care

The Plan is required to execute a Memorandum of Understanding (MOU) with the local California Children's Services (CCS) program. The Plan did not execute a MOU with the local CCS program for the coordination of CCS services to members.

The Plan is required, in accordance with the MOU, to participate, at a minimum, in quarterly meetings with the CCS Program. The Plan did not execute all provisions of the MOU that required participating in quarterly meetings with all CCS Program counties it covers.

The Plan is required, in accordance with the MOU, to designate a liaison to the CCS Program to coordinate and track referrals with the CCS Program to ensure ongoing communication, resolve operational and administrative problems, and identify policy issues needing resolution at the management level. The Plan did not execute all provisions of the MOU that included designating a liaison to the CCS Program.

The Plan is required to develop and implement systems to identify and refer children who may be eligible to receive services from the Early Start program and provide case management and care coordination to members with primary care provider participation. The Plan did not implement its policies and procedures to utilize its systems to identify children who may be eligible to receive services from the Early Start program and notify Primary Care Providers (PCPs).

The Plan shall ensure that Behavioral Health Treatment (BHT) services are medically necessary and includes recommendation from a licensed physician. The Plan did not ensure that BHT services are medically necessary and recommended by a licensed physician, surgeon, or psychologist.

The Plan must ensure that a BHT plan must be reviewed, revised, and modified no less than once every six months by the provider of BHT services. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary. The Plan did not follow the treatment plan and decreased the amount of BHT service hours.

Category 3 – Access and Availability of Care

No findings were noted during the audit period.

Category 4 – Member's Rights

No findings were noted during the audit period.

Category 5 – Quality Management

No findings were noted during the audit period.

Category 6 – Administrative and Organizational Capacity

No findings were noted during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

DHCS conducted the audit of the Plan 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 and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 22 medical and 11 pharmacy prior authorization requests (including denied or modified) were reviewed for timely decision making, consistent application of criteria, and appropriate review.

Appeals: 11 medical and six pharmacy upheld, overturned, or withdrawn appeals were reviewed for appropriateness and timely adjudication.

Delegated prior authorization requests: Ten medical prior authorization requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

CCS: Six medical records were reviewed for appropriate CCS identification, referral to the CCS program, and coordination of care for non-eligible CCS conditions.

Initial Health Assessment (IHA): 18 medical records were reviewed for appropriate documentation, timely completion, and fulfillment of all required IHA components.

Complex case management: Seven medical records were reviewed for continuous tracking, monitoring, and coordination of services.

BHT: 15 medical records were reviewed for coordination, completeness, and compliance with BHT provision requirements.

Continuity of care: 13 medical records were reviewed to evaluate timeliness and appropriateness of continuity of care request determination.

Category 3 – Access and Availability of Care

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

Non-Emergency Medical Transportation (NEMT): Ten claims were reviewed for timeliness and compliance with NEMT requirements.

Non-Medical Transportation (NMT): Ten claims were reviewed for timeliness and compliance with NMT requirements.

Category 4 – Member's Rights

Grievance procedures: 47 grievances, including 22 quality of service, 15 quality of care, three expedited, and seven exempt, were reviewed for timely resolution, response to complainant, and appropriate level of review and medical decision-making.

Confidentiality rights: Ten Health Insurance Portability and Accountability Act cases were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

Provider training: Ten newly contracted providers were reviewed for timely program training.

Potential quality issues: Five cases were reviewed for timely evaluation and effective action taken to address improvements.

Category 6 – Administrative and Organizational Capacity

Fraud and abuse: Ten fraud and abuse cases were reviewed for processing and appropriate reporting.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: California Health and Wellness
AUDIT PERIOD: May 1, 2021 through June 30, 2022 **DATES OF AUDIT:** July 18, 2022 through July 29, 2022

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM REFERRAL TRACKING SYSTEM

1.1.1 Integration of Utilization Management Activities

The Plan is accountable for all QI functions and responsibilities (e.g. UM, Credentialing, and Site Review) that are delegated to subcontractors. If the Plan delegates UM activities, it is required to comply with requirements for Delegation of QI Activities. *(Contract, Exhibit A, Attachments 4 (6) and Attachment 5 (5))*

The Plan is required to develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. The Plan is responsible to ensure that the UM program includes the integration of UM activities into the QIS, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. *(Contract, Exhibit A, Attachment 5 (1)(G))*

The Plan must provide Prior Authorization for IV sedation and general anesthesia for dental services and must assist providers and beneficiaries with the prior authorization process as a form of care coordination to avoid situations where services are unduly delayed. The Plan is responsible to ensure that their subcontractors adhere to the policy. *(All Plan Letters (APL) 15-012, Dental Services-Intravenous Sedation and General Anesthesia Coverage)*

The Plan maintains the responsibility of ensuring that delegates are, and continue to be, in compliance with all applicable Medi-Cal, state and federal laws, and contractual requirements. *(APL 17-004, Subcontractual Relationships and Delegation)*

The Plan's policy, *CA.UM.63V3*, *Dental Service and IV Sedation and General Anesthesia* (Reviewed 04/04/2020*)*, stated that the Plan covers medically necessary IV Sedation and General Anesthesia services administered in connection with non-covered dental services, when such services are not provided by dentists or dental anesthesiologists. The Plan will produce IV Sedation and General Anesthesia Prior Authorization reports as described and directed by the Department**.**

The Plan's policy, *CHW-2022-DO-103*, *Delegated Entity Evaluation* (Reviewed 11/22/2021), stated that the Plan may delegate to certain contracted entities the responsibility including, but not limited to, UM activities. The Plan retains accountability for all care and service delivered to members.

Finding: The Plan did not integrate UM activity data for all services into the QIS, including reports reviewing the number and types of appeals, denials, deferrals, and modifications, and did not refer this to the appropriate QIS staff.

The Plan collected statistical data from its internal network and the delegated network regarding the provision of dental anesthesia services subject to the prior authorization process. However, there was no process for the integration of this UM activity data into the QIS provided by the Plan which would enable further analysis regarding the appropriate provision of this service.

The Plan's policy, *CA.UM.63V3*, *Dental Service and IV Sedation and General Anesthesia* (Reviewed 04/04/2020) did not reference specific QI activity or aggregated data analysis to further monitor and evaluate the provision of these specific services for appropriate compliance or systemic quality improvement. No mention was made of requirement for corrective action by delegated network groups were indicated if deficiency was determined in provision of this service for members. The Plan did not supply documentation of specific audit and oversight activities directly related to dental anesthesia within its internal or delegated networks.

During the interview, the Plan stated that there was oversight of this service via the prior authorization process and cases were reviewed and monitored on a case-by-case basis through prior authorization procedures. The Plan also emphasized that they collected the statistical data from their networks regarding this service as required by the APL. These processes, however, were not a formal approach to more comprehensive data analysis for system QIs regarding dental anesthesia services. The Plan did not provide specific documentation of monitoring and oversight activities related to their audit processes regarding provision of dental anesthesia services.

If the Plan does not effectively oversee the process and procedures of their internal and delegated networks for dental anesthesia, this may adversely impact the provision of medically necessary dental services received by members.

Recommendation: Revise and implement policy and procedures to integrate reports reviewing the number and types of appeals, denials, deferrals, and modifications for dental anesthesia services into the Plan's QI process, including referral to the appropriate QIS staff for further analysis.

1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Pharmacist License

The Plan may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. The Plan is required to ensure that all Subcontracts shall be in accordance with applicable federal and state laws and regulations. *(Contract, Exhibit A, Attachment 6(14)(A))*

The Plan is required to ensure that its UM program, such as prior authorization review procedures, are reviewed by qualified health care professionals to supervise review decisions and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity. A qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services. *(Contract, Exhibit A, Attachment 5(2)(C))*

Policy Letter (PL) provides clarification to the Contract regarding the allowable scope of practice in California licensed pharmacist performing pharmacy UM activities on behalf of the Plan. A licensed pharmacist may approve, defer, modify, approve as modified, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan Medical Director, in collaboration with the Plan Pharmacy and Therapeutics Committee or its equivalent. *(PL 08-013, Pharmacy Prior Authorization Requests by California Licensed Pharmacists)*

The Plan's policy, *CA.CC.PHAR.08*, *Pharmacy Prior Authorization and Medical Necessity Criteria 2021-01* (Reviewed 01/2021), stated that initial prior authorization and medical necessity requests will be reviewed by a Pharmacy Technician or a licensed Clinical Pharmacist for a determination of meeting criteria. For requests that meet initial screening criteria, an authorization for approval will be entered in the prior authorization application and the prescriber will be notified that approval has been granted. When a request does not meet criteria, it will be forwarded to a licensed Clinical Pharmacist for a final determination. Clinical Pharmacists will review all denials.

Finding: The Plan did not ensure that pharmacy prior authorization requests were reviewed, approved, or denied by California licensed pharmacists.

The verification study prior authorization review demonstrated that Pharmacy prior authorization decisions were delegated to Plan's contracted Pharmacy Benefit Manager (PBM) until 1/1/2022 when this process was "carved out" to the California Drug Medi-Cal Pharmacy Program.

The verification study from 2021 revealed that two prior authorizations were denied by pharmacists that did not hold a valid or current license issued by California State Board of Pharmacy.

In an interview, the Plan explained that it prefers but does not require the use of California licensed pharmacists to perform pharmacy prior authorization review and approval. When non-California licensed pharmacists are utilized, such individuals are trained to review pharmacy benefits for the California Medi-Cal Plan.

When the Plan's PBM uses non-California licensed pharmacists to perform prior authorization denials and approvals, the Plan cannot ensure that the staff has sufficient knowledge to comply with all California requirements for medications approved or denied for members.

Recommendation: Revise and implement policies and procedures to ensure that California licensed pharmacists review, approve, defer, modify, or deny pharmacy prior authorizations.

2.1.1 Memorandum of Understanding

The Plan shall execute a MOU with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to Members. *(Contract, Exhibit A, Attachment 11 (9)(B))*

Plan's policy, *CA.LTSS.40*, *California Children's Services (CCS)* (Effective 08/24/2021), stated that its County Relations Department negotiates and executes the Memorandum of Understanding (MOU) between the Plan and the CCS Program. The MOU is consistent with the Plan's Contract requirements and delineates the responsibilities of both the Plan and the CCS Program.

Finding: The Plan did not submit documents to support that a review was conducted to ensure compliance with executing MOUs for all of its counties.

The Plan executed MOUs with 18 of the 19 counties that it covers.

In an interview, the Plan stated that it has made several attempts but failed to successfully execute an MOU with Tehama County.

The Plan has no dedicated CCS liaison to follow up with executing an MOU with Tehama County.

If an MOU is not executed, this can lead to unclear delineation of the responsibilities of both the Plan and the CCS Program and may result in ineffective coordination of care for CCS services.

Recommendation: Revise and implement policies and procedures to ensure that an MOU is executed between the Plan and the local CCS program for the coordination of CCS services.

2.1.2 Joint Quarterly Meetings with CCS

The Plan shall execute a MOU with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to Members. *(Contract, Exhibit A, Attachment 11 (9)(B))*

In accordance with the MOU, the Plan shall participate, at a minimum, in quarterly meetings with the CCS Program to conduct the following: update policies and procedures as appropriate, maintain ongoing communication, resolve operational and administrative problems, and identify policy issues needing resolution at management level. (*MOU, CCS Program Attachment (F)(2)*)

The Plan's policy, *CA.LTSS.40*, *California Children's Services (CCS)* (Effective 08/24/2021), stated that its County Relations Department negotiates and executes the Memorandum of Understanding (MOU) between the Plan and the CCS Program. The MOU is consistent with the Plan's Contract requirements and delineates the responsibilities of both the Plan and the CCS Program.

Finding: The Plan did not execute all provisions of the MOU that requires participating, at minimum, in quarterly meetings with all CCS Program counties it covers.

The Plan provided a list of the joint meetings between the Plan and the counties respective CCS liaisons. Per review of documentation, the Plan did not consistently hold, at a minimum, joint quarterly meetings with CCS for all 19 counties within its network. The Plan's policy *CA.LTSS.40* did not delineate this requirement.

During the interview, the Plan explained that it did not have procedures on how to conduct periodic joint meetings with CCS for all counties within its network. The Plan did not have an established process of conducting quarterly meetings with all 19 CCS counties. Although the Plan explained that priority was given to meet with counties that were more populated and had more CCS members, these meetings were not always held quarterly. All 19 counties were given access to reach out and request a meeting with the Plan on an ad hoc basis. Additionally, the Plan acknowledged that no CCS meetings were held between the Plan and certain counties during the audit period.

If the Plan does not conduct periodic joint quarterly meetings with CCS Program counties as specified in the MOU, it cannot ensure that members are receiving appropriate care and that any issues with coordination of care are being resolved.

Recommendation: Revise and implement policies and procedures to ensure that, at a minimum, joint quarterly meetings are held with CCS program for all counties in the Plan's network.

2.1.3 CCS Liaison

The Plan shall execute a MOU with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to Members. *(Contract, Exhibit A, Attachment 11 (9)(B))*

In accordance with the MOU, the Plan shall designate a liaison to the CCS Program to do the following: coordinate and track referrals, meet, at a minimum, quarterly, with the CCS Program to ensure ongoing communication, resolve operational and administrative problems, and identify policy issues needing resolution at the management level. (*MOU, CCS Program Attachment (A)(1-2))*

The Plan's policy, *CA.LTSS.40*, *California Children's Services (CCS)* (Effective 08/24/2021), stated that its County Relations Department negotiates and executes the Memorandum of Understanding (MOU) between the Plan and the CCS Program. Furthermore, Public Programs Department collaborates with CCS liaisons as needed. Some of the Public Programs Department's responsibilities include communicating with County CCS programs to facilitate care coordination; provide CCS reports to the Plan's Internal Departments and Committees, as requested; and work to resolve problems on a local level.

Finding: The Plan did not execute all provisions of the MOU that included designating a liaison to the CCS Program.

The Plan's organizational chart did not list a CCS liaison. The Plan's policy *CA.LTSS.40* did not designate its own CCS liaison, as required in the MOU.

The Plan did not execute duties that the CCS liaison is responsible for such as conducting quarterly meetings with CCS and ensuring adherence to operational requirements by executing an MOU with all 19 counties served by the Plan. The Plan did not submit meeting minutes demonstrating that it conducted quarterly meetings with the CCS Program for all counties in the Plan's network.

During the interview, the Plan stated that it did not have an official or a dedicated position for a CCS liaison to ensure all MOU requirements are met. For the review period, the Plan's Director of UM and Manager of Program Operations served as points of contact for CCS-related issues. The county CCS liaison can reach out to the Plan to arrange for meetings when concerns arise. However, the Plan acknowledged that it did

not have an established protocol to hold quarterly meetings with CCS for all counties served by the Plan.

If the Plan does not designate a liaison to the CCS program, this may lead to poor coordination of care for CCS services due to non-identification of issues and subsequent failure to resolve problems.

Recommendation: Revise and implement policies and procedures to designate a Plan CCS liaison, as required in the MOU.

2.1.4 Coordination of Care for Early Intervention Services

The Plan shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program and provide case management and care coordination to the Member with Primary Care Provider participation. *(Contract, Exhibit A, Attachment 11 (11))*

In accordance with the MOU, the Plan shall assist and guide PCPs in identification and referral of potentially eligible Regional Center (RC)/Early Start members and facilitate exchange of medical information between the Plan's PCPs and RC/Early Start program providers. (*MOU, CCS Program Attachments (B)(2) and (C)(4)*)

The Plan's policy, *CA.LTSS.44*, *Early Start Program* (Revised 08/17/2021), stated that the Plan and contracted PCP's identify children who may be eligible to receive services from the Early Start program and refer them to local Regional Centers for evaluation. In addition, the Plan's Public Programs Department notifies PCPs of their patients accessing Early Start services.

The Plan's policy, *CA LTSS.49*, *Regional Centers Coordination* (Revised 08/17/2021), delineates when the Plan identifies a member who is potentially eligible for Regional Center services and has not been referred to the Regional Center, the Plan facilitates the referral in coordination with the PCP or Specialist Provider. If a member had been previously referred or accepted into the Regional Center and it is unknown to the PCP or Specialist, the Plan contacts the PCP or Specialist Provider to facilitate care coordination activities with the Regional Center (RC) and the member.

Finding: The Plan did not utilize its systems to identify children who may be eligible to receive services from the Early Start program and notify PCPs.

The Plan's policy, *CA.LTSS.44* clearly delineated the Plan's responsibility to notify PCP of their patients accessing Early Start services. When a member is referred into the Regional Center and it is unknown to the PCP, the Plan contacts the PCP to facilitate care coordination activities. The Plan did not follow its policies and procedures.

During the interview, the Plan confirmed that it did not have a process in place to identify and notify providers or PCPs of members receiving EIDD services. The Plan stated that the process is being developed and past the “planning stage”. The Plan is working in collaboration with the Information Technology (IT) Department to start sending notification letters to providers to keep them informed about their members. Simultaneously, some providers may communicate directly with the RC and fail to involve the Plan.

Without the Plan’s identification and notification to PCPs of members receiving Early Start services, the Plan is unable to facilitate care coordination activities between PCP’s and RC/Early Start program providers.

Recommendation: Implement policy and procedures to identify and notify PCPs of members accessing Early Start program services.

2.3 BEHAVIORAL HEALTH TREATMENT

2.3.1 BHT Medical Necessity Recommendation

The Plan is required to comply with all existing final PLs and APLs issued by DHCS. All PLs and APLs issued by DHCS subsequent to the effective date and during the term of the Contract shall provide clarification of the Plan's obligations pursuant to the Contract, and may include instructions regarding implementation of mandated obligations pursuant to changes in state or federal statutes, regulations, or pursuant to judicial interpretation. (*Contract, Exhibit E, Attachment 2(1)(D)*)

Criteria for BHT services for members under the age of 21 includes recommendation from a licensed physician, surgeon or psychologist that evidence based BHT services are medically necessary. (*APL 19-014*, *Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21)*

Plan's policy, *MHN.UM.01*, *Administration of Applied Behavioral Analysis (ABA) Benefit* (Revised 12/08/2021), delineated the criteria for ABA services for members under the age of 21 includes a recommendation from a licensed physician, surgeon, or psychologist that evidence based BHT services are medically necessary.

Finding: The Plan did not ensure that BHT services are medically necessary and recommended by a licensed physician, surgeon, or psychologist.

Verification study revealed that three of 15 files did not contain a medical necessity recommendation, by a licensed physician, surgeon, or psychologist. Additionally, one of 15 medical records contained the medical necessity statement, completed by a nurse practitioner, and not by a licensed physician, surgeon, or psychologist.

The Plan has policies and procedures in place that outline that the Plan must ensure that BHT services are medically necessary and recommended by a licensed physician, surgeon, or psychologist. However, during the interview, the Plan stated that they maintained separate records in which medical records are kept with the PCP while BHT records are kept with BHT provider. Regardless of who maintains the records, these records were requested, and no documentation was provided to support that the BHT services are medically necessary and recommended by a licensed professional as stated in the contract.

Without medical necessity determinations, members may not meet the criteria to receive BHT services.

Recommendation: Implement policies and procedures to ensure medical necessity determinations are included or documented in members' medical records.

2.3.2 BHT Plan

The Plan shall cover and ensure the provision of screening, preventive and medically necessary diagnostic, and treatment services for members under 21 years of age including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services. (Contract, *Exhibit A, Attachment 10*)

BHT services must be provided, observed, and directed under the Plan's approved behavioral treatment plan. The BHT plan must be person-centered and based on individualized, measure goals and objective over a specific timeline for the specific member being treated. The BHT plan must be reviewed, revised, and modified no less than once every six months by the provider of BHT services. The BHT plan may be modified or discontinued only if it is determined that the services are no longer medically necessary under the EPSDT medical necessity standard. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary. *(APL 19-014, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21)*

Plan's policy, MHN.UM.01, *Administration of Applied Behavioral Analysis (ABA) Benefit,* (Revised 12/08/2021) also stated that a behavioral treatment plan may be modified or discontinued only if it is determined that services are no longer medically necessary under the EPSDT medically necessity standard. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary.

Finding: The Plan did not follow the treatment plan and decreased the amount of BHT service hours.

In a verification study, two of 15 BHT files revealed that the Plan decreased the amount of service hours contrary to the medical necessity-based recommendations in the BHT plan. The reason noted for the reduction in hours was due to ABA network inadequacy and not due to a lack of medical necessity. The files had been reviewed by mental health subcontractor with no action taken.

During the interview, the Plan explained that treatment hours had been reduced due to an ABA provider shortage, which the BHT community was experiencing as a whole. Even though the Plan provided several courses of action regarding the shortage of staff that could have been done, in addition to initiating a quality of care concern. There was no indication in the files that any action was taken. Furthermore, the Plan stated that there is a process to elevate to the medical director for the best course of action, however there is not a standard process.

Without following the BHT plan, the Plan is not able to ensure that medically necessary behavioral health services are provided to members.

Recommendation: Implement Plan policy and procedure to ensure that BHT plans are modified or discontinued only if services are no longer medically necessary based on EPSDT medical necessity standards.

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2022

Contract Number:	13-90161 State Supported Services
Audit Period:	May 1, 2021 Through June 30, 2022
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I. INTRODUCTION

This report presents the audit of California Health and Wellness (Plan) compliance and implementation of the State Supported Services contract with the State of California. The Contract covers abortion services for the Plan.

The audit was conducted from July 18, 2022 through July 29, 2022. The audit covered the audit period from May 1, 2021 through June 30, 2022. It consisted of document reviews and interviews with the Plan's staff.

An Exit Conference with the Plan was held on January 6, 2023. There were no deficiencies found for the audit period of the Plan's State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: California Health and Wellness

AUDIT PERIOD: May 1, 2021 through June 30, 2022
DATES OF AUDIT: July 18, 2022 through July 29, 2022

STATE SUPPORTED SERVICES

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology Codes 59840 through 59857 and the Centers for Medicare and Medicaid Services Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. *(State Supported Services Contracts, Exhibit A, (1))*

Plan Policy and Procedure, *CA.CLMS.SS.01, California Health and Wellness Sensitive Services (Revised 06/04/21)*, described the process by which Medi-Cal members may access and obtain abortion services. The policy stated that abortion services and supplies are covered by the Plan. The Plan provides members timely access to abortion services from any qualified provider, or non-contracted provider, without prior authorization.

The Plan provided information on covered services to new members through the Evidence of Coverage. The information stated that abortion services are available to members without referral or authorization and doctor or clinic does not have to be part of the Plan.

The verification study revealed the Plan appropriately processed abortion claims for payment and did not demonstrate any deficiencies related to State Supported Services.

Based on the review of the Plan's documents, there were no deficiencies noted for the audit period.

Recommendation: None.