DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
RANCHO CUCAMONGA

REPORT ON THE MEDICAL AUDIT OF

CALIFORNIA HEALTH AND WELLNESS

2023

Contract Number:	13-90157 and 13-90161
Audit Period:	July 1, 2022 Through June 30, 2023
Dates of Audit:	July 17, 2023 Through July 28, 2023
Report Issued:	November 13, 2023

TABLE OF CONTENTS

I. INTRODUCTION

The California Legislature awarded California Health and Wellness (Plan) a contract by the California Department of Health Care Services (DHCS) to provide Medi-Cal services in 19 counties as of September 23, 2023. 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 (479) and specialists (3,669) as well as hospitals (27) and ancillary providers (257).

As of June 30, 2023, the Plan served 273,136 Medi-Cal members in the following counties: Alpine (81), Amador (2,095), Butte (54,672), Calaveras (6,427), Colusa (4,867), El Dorado (21,694), Glenn (10,297), Imperial (83,216), Inyo (2,423), Mariposa (1,310), Mono (1,165), Nevada (11,334), Placer (16,411), Plumas (3,045), Sierra (348), Sutter (16,021), Tehama (17,188), Tuolumne (6,997), and Yuba (13,545).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period July 1, 2022 through June 30, 2023. The audit was conducted from July 17, 2023 through July 28, 2023. The audit consisted of document reviews, verification studies, and interviews with Plan representatives and a delegate entity.

An Exit Conference was held on October 16, 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. On October 31, 2023, the Plan submitted a response to address the audit findings. The results of the DHCS evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, 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 report issued on February 8, 2023, for the audit period of May 1, 2021 through June 30, 2022, identified deficiencies incorporated into the Corrective Action Plan (CAP). The prior year CAP was not completely closed at the time of the audit. The Plan is working with the Managed Care Quality and Monitoring Division to correct the deficiencies in the CAP.

The summary of findings by category follows:

Category 1 – Utilization Management

The Plan is required to implement and maintain procedures to allow members to file a grievance when they disagree with the Plan's decision for an expedited appeal. The Plan did not inform members of their right to file a grievance after denial of a request for an expedited resolution of an appeal.

Category 2 – Case Management and Coordination of Care

Review of the Plan's Case Management and Coordination of Care yielded no findings.

Category 3 – Access and Availability of Care

Review of the Plan's Access and Availability of Care yielded no findings.

Category 4 – Member's Rights

The Plan is required to immediately submit medical Quality of Care (QOC) grievances to the Plan's Medical Director for action. The Plan did not immediately submit QOC grievances to the Plan's Medical Director for action.

Category 5 – Quality Management

Review of the Plan's quality improvement system yielded no findings.

Category 6 – Administrative and Organizational Capacity

Review of the Plan's organizational capacity to guard against fraud and abuse yielded no findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted this audit to ascertain that medical services provided to Plan members complied with federal and state laws, Medi-Cal regulations and guidelines, and the state County Organized Health Systems contract.

PROCEDURE

The audit period was July 1, 2022 through June 30, 2023. The audit was conducted from July 17, 2023 through July 28, 2023. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. Documents were reviewed and interviews were conducted with Plan representatives and a delegated network provider.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization (PA) Requests: 22 medical (12 standard and ten urgent), 19 pharmacy, 11 dental anesthesia, and seven applied behavior analysis PA requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Process: Six Seniors and Persons with Disabilities and 20 non-Seniors and Persons with Disabilities PA appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children’s Services (CCS): 20 medical records were reviewed for appropriate CCS identification, referral to the CCS program, and coordination of care for non-eligible CCS conditions.

Behavioral Health Treatment: 12 new member medical records were reviewed for compliance with behavioral health treatment requirements and 11 medical records were reviewed for continuity of care for established behavioral health treatment patients.

Category 3 – Access and Availability of Care

Emergency Service and Family Planning Claims: 22 emergency service claims and 21

family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation: Ten records were reviewed to confirm compliance with Non-Emergency Medical Transportation requirements.

Non-Medical Transportation: Ten records were reviewed to confirm compliance with Non-Medical Transportation requirements.

Category 4 – Member's Rights

Grievance Procedures: Ten standard Quality of Service (QOS), ten Seniors and Persons with Disabilities QOS, 21 standard QOC, and five Seniors and Persons with Disabilities QOC grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review. 20 inquiry calls were reviewed for proper classification and routing to the appropriate level for review.

Category 5 – Quality Management

Quality Improvement System: 18 potential quality issue cases were reviewed for timely evaluation and effective action taken to address improvements.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: Ten fraud and abuse cases were reviewed for proper reporting of suspected fraud, waste, or abuse to DHCS within the required timeframe.

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

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: California Health and Wellness
AUDIT PERIOD: July 1, 2022, through June 30, 2023 **DATES OF AUDIT:** July 17, 2023, through July 28, 2023

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM REFERRAL TRACKING SYSTEM

1.3.1 Members' Right to File a Grievance

The Plan shall implement and maintain procedures to allow members to file a grievance when they disagree with the Plan's decision to extend the timeframe for resolution of an appeal or an expedited appeal. *(Contract, Exhibit A, Attachment 14(2))*

If the Plan denies a request for an expedited resolution of an appeal, it must follow the requirements in Code of Federal Regulations (CFR), Title 42, section 438.408(c)(2). *(CFR, Title 42, section 438.410(c)(2))*

If the Plan extends the timeframe of an appeal, it must give the member written notice of the reason for that decision and inform the member of their right to file a grievance if they disagree. *(CFR, Title 42, section 438.408(c)(2)(ii))*

The Member Handbook must contain information that enables members to effectively use the managed care program. This includes grievance, appeal, fair hearing requirements, procedures, and timeframes. The right to file grievances and appeals must be included. *(CFR, Title 42, section 438.10(g)(2)(xi)(A) and (B))*

Plan policy *CA.QI.11*, *Member Appeals and Grievances System Description (approved 6/9/2022),* states the Plan will maintain an expedited review process that at any time, for appeals when the members request or the provider indicates that the service involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.

Finding: The Plan did not inform members of their right to file a grievance after denial of a request for an expedited resolution of an appeal.

The verification study revealed that 4 out of 26 appeals were requests for an expedited resolution. The Plan denied all four requests without informing members of their right to file a grievance if they disagreed with the decision.

The Plan's policies lacked procedures to inform members of their right to file a grievance after denial of a request for an expedited resolution of an appeal. The Plan's written notices must include the reason for the decision and inform members of their right to file a grievance if they disagree. However, the Plan's written notices did not inform members of their right to file a

grievance if they disagreed with the Plan's decision.

The Member Handbook also did not contain information to advise members of their right to file a grievance if the Plan denied their request for an expedited resolution of an appeal.

During the interview, the Plan stated that the Contract is reviewed annually; however, the Plan was unaware of the requirement to inform members of their right to file a grievance after denial of a request for an expedited resolution of an appeal. Therefore, the Plan did not have an effective process to ensure members were informed of their right to file a grievance after denial for an expedited resolution of an appeal.

When members are not fully advised of their rights, they cannot make well-informed decisions about their healthcare. This could potentially cause a delay in receiving necessary care, and potentially result in patient harm.

Recommendation: Revise and implement policies, procedures, the Member Handbook, and informing templates to ensure members are informed of their right to file a grievance after denial of a request for an expedited resolution of an appeal.

4.1.1 Quality of Care Grievances

Grievances related to medical QOC issues shall be referred to the Plan's Medical Director. *(Contract, Exhibit A, Attachment 14 (2)(D))*

Grievances related to medical QOC issues must be immediately submitted to the Plan's Medical Director for action. The Plan must ensure the person making the final decision for the proposed resolution of a grievance is a health care professional with clinical expertise in treating a member's condition or disease on any grievance involving clinical issues. *(All Plan Letter 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy *CA.QI.11*, *Member Appeals and Grievances System Description (approved 6/9/2022)*, states the content and substance of a grievance, including all clinical care aspects, will be fully investigated, and documented according to applicable statutory, regulatory, and contractual provisions. All QOC grievances will be leveled for severity by a Medical Director. Additionally, the Plan will ensure that decision makers on grievances are health care professionals with clinical expertise in treating the member's condition when deciding grievances involving clinical issues.

Finding: The Plan did not ensure QOC grievances were immediately submitted to the Plan's Medical Director for action.

The verification study revealed 26 out of 26 QOC grievances were not immediately reviewed by the Medical Director. The following are examples of the deficiencies:

- On September 6, 2022, a member who was experiencing nausea, filed a QOC grievance against a provider who refused to lower medication dosage. The case was initially reviewed by a Registered Nurse (RN) and subsequently referred to the Medical Director on September 29, 2022. It took 23 days from the time of the grievance receipt date until the Medical Director referral date. This case was de-escalated from an expedited grievance to a standard grievance by the RN prior to the Medical Director's review.

- On October 24, 2022, a member having difficulty obtaining approval for the medication to complete chemotherapy filed a grievance against a provider. The case was initially reviewed by an RN and subsequently referred to the Medical Director on

November 17, 2022. It took 24 days from the time of the grievance receipt date until the Medical Director referral date. This case was de-escalated from an expedited grievance to a standard grievance by the RN prior to the MD's review.

- On March 4, 2023, a member with presumed pseudo tumor cerebri filed a QOC grievance. The case was initially reviewed by an RN and subsequently referred to the MD on March 24, 2023. It took 20 days from the time of the grievance receipt date until the Medical Director referral date. This case was de-escalated from an expedited grievance to a standard grievance by the RN prior to the Medical Director's review.

According to the Plan's grievance process flow chart, when a member files a grievance, the Appeals and Grievances Triage Team reviews, classifies, and documents receipt of the grievance in the Plan's electronic record keeping system. The grievance is then assigned to an Appeals and Grievances Case Coordinator for research and submitted to a Medical Director for review and resolution. However, the Plan's flow chart did not include a documented step for the immediate review by a Medical Director.

Although Plan policy *CA.QI.11* stated that clinical care grievances will be fully documented according to contractual provisions, the Plan's policy and their grievance process flow chart did not include steps for the immediate submission of QOC grievances to their Medical Director for action.

During the interview, the Plan stated that their Medical Director determines the severity of QOC cases within 30 days. However, the Plan could not substantiate that the Medical Director was immediately involved in the review process. Therefore, the Plan did not have an adequate process in place to ensure QOC grievances were immediately reviewed by their Medical Director.

Lack of the Medical Director's immediate action and involvement in QOC grievances could result in substandard care by providers and potentially cause medical harm to members.

Recommendation: Revise and implement policies and procedures to ensure QOC grievances are immediately submitted to the Plan's Medical Director for action.

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REPORT ON THE MEDICAL AUDIT OF

CALIFORNIA HEALTH AND WELLNESS

2023

Contract Number:	13-90158 and 13-90162 State Supported Services
Audit Period:	July 1, 2022 Through June 30, 2023
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TABLE OF CONTENTS

I. INTRODUCTION

This report presents the audit results 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 covered the audit period from July 1, 2022 through June 30, 2023. The audit was conducted from July 17, 2023 through July 28, 2023. The audit consisted of document reviews, verification study, and interviews with Plan staff.

An Exit Conference with the Plan was held on October 16, 2023. There were no deficiencies identified for the audit of the Plan's State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: California Health and Wellness

AUDIT PERIOD: July 1, 2022, through June 30, 2023
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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, and Z0336. These codes are subject to change upon the Department of Health Care Service's implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. *(State Supported Services Contract, 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 provides Medi-Cal members timely access to abortion services from any qualified provider without prior authorization. The Plan's Member Handbook stated that if members are under 18 years of age, they can go to a doctor without permission from their parents or guardian for family planning and abortion services.

The doctor or clinic does not have to be part of the Plan's network. The member can choose any Medi-Cal provider and go to them without a referral or prior authorization for these services.

The verification study revealed the Plan appropriately processed abortion service claims for payment. Based on the review of the Plan's documents, there were no deficiencies noted for the audit period.

Recommendation: None.