

MEDICAL REVIEW – NORTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

CALIFORNIA HEALTH AND WELLNESS PLAN

Contract Numbers: 13-90157 and 13-90161

Audit Period: December 1, 2017
Through
November 30, 2018

Report Issued: June 12, 2019

TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	EXECUTIVE SUMMARY	2
III.	SCOPE/AUDIT PROCEDURES	4
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 2 – Case Management and Coordination of Care	6
	Category 3 – Access and Availability of Care	9
	Category 4 – Member’s Rights	12
	Category 5 – Quality Management	14

I. INTRODUCTION

The California Legislature awarded California Health and Wellness Plan (Plan) a contract by the California Department of Health Care Services 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 (RE) program. The expansion program included members eligible for Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP).

California Health and Wellness' provider network includes independent providers practicing as individuals, small and large group practices, and community clinics.

During the audit period, the Plan served 193,492 Medi-Cal members in the following counties: Alpine 91; Amador 1,082; Butte 39,497; Calaveras 5,210; Colusa 3,038; El Dorado 18,226; Glenn 6,757; Imperial 60,705; Inyo 1,680; Mariposa 855; Mono 992; Nevada 8,614; Placer 8,896; Plumas 2,370; Sierra 229; Sutter 10,189; Tehama 11,113; Tuolumne 5,330; Yuba 8,618.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of December 1, 2017 through November 30, 2018. The onsite review was conducted February 11, 2019 through February 22, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on May 8, 2019 with the Plan. 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 did not submit a response after the exit conference.

The effectiveness of the prior year Corrective Action Plan (CAP) was evaluated. The Plan improved its procedures to pay out-of-network claims timely and include interest if paid late. New providers are receiving Medi-Cal Managed Care program training within the Contract timeframes.

The reduced scope 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 Management (QM). The Summary of the Findings by category follows:

Category 2 – Case Management and Coordination of Care

The contract requires the Plan to make reasonable attempts to contact a member and schedule an Initial Health Assessment (IHA). All attempts must be documented. The Plan did not document completion of a member's IHA within 120 calendar days of enrollment into the Plan.

Category 3 – Access and Availability of Care

Members do not require prior authorization for family planning services. The Plan improperly denied family planning claims for not having prior authorization. The Plan's claims processing system did not follow the Contract to ensure that family planning claims were processed without prior authorization.

Category 4 – Member's Rights

The Plan did not implement and maintain oversight procedures to monitor the member's grievance resolution system. Member Grievance resolution closure letters were sent out prior to the closure of the grievance review. The audit found instances where grievance resolution dates were either not entered into the Plan's grievance tracking system or entered late.

The Plan delegates transportation services to a subcontractor. The subcontractor dispatches member service calls and processes provider payments. In the 3rd quarter, the

Plan decided to delegate the processing of the exempt grievances to the subcontractor. The audit was unable to confirm whether delegation of the exempt grievances resulted in improving the transportation process.

Category 5 – Quality Management

The Plan must monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering service on its behalf. The Plan did not implement an effective Quality Improvement system in accordance with the Contract. In addition, the Plan did not monitor the required elements for IHA completion within 120 days of enrolling into the Plan.

The Plan's transportation provider had a significant number of exempt grievances during the audit period. In the 4th quarter of the year, the Plan delegated the exempt grievance process to the transportation sub-contractor as a solution. Plan must monitor and exercise oversight of sub-contractor to ensure member services grievances are addressed.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) 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 onsite review was conducted from February 11, 2019 through February 22, 2019. 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 staff. To ensure consistency in service, the verification study included Seniors and Persons with Disabilities (SPD), non-SPD, and Rural Expansion (RE) counties in member samples.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Review Requirements: 20 medical (sample includes five SPD and RE) and 16 pharmacy (sample includes five SPD and RE) prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Prior Authorization Appeal Process: 11 medical (sample includes five SPD and RE) and 11 pharmacy (sample includes five SPD and RE) prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services: ten member records were reviewed to ensure the Plan's adherence to policies and procedures for identifying and referring members with CCS eligible conditions and to ensure that the Plan is in compliance with contract requirements for monitoring the coordination of care for members.

Initial Health Assessment: ten member records were reviewed to ensure IHA were provided to members and attempts documented in member medical records.

Complex Case Management: ten (sample includes three SPD) medical records were reviewed for evidence of continuous tracking, monitoring, and coordination of resources to members who received complex case management services.

Behavior Health Therapy: ten (sample includes five SPD) files were reviewed for

completeness and the Plan's compliance with the contract and MOU.

Non-Medical Transportation and Non-Emergency Medical Transportation: 16 member records were reviewed for completeness and compliance to the Contract. In addition, determine if the Plan has a process to provide transportation to members.

Continuity of Care: four case files were reviewed to ensure that the Plan members received continuity of care services as outlined in the contract.

Category 3 – Access and Availability of Care

Appointment Availability: 15 contracted providers from the Provider's directory were reviewed to determine if appointments were accurate, complete, and available. Three appointments were requested. The third next available appointment was used to measure access to care.

Claims: 7 Emergency Services and 6 Family Planning service claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance System: 31 grievances (16 quality of care and 15 quality of service and 10 cases that included SPD and RE) were reviewed for timely resolution, response to complaint, and submission to the appropriate level for review.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	BASIC CASE MANAGEMENT/ CALIFORNIA CHILDREN’S SERVICES (CCS)/ EARLY INTERVENTION/DEVELOPMENTAL DISABILITIES/ INITIAL HEALTH ASSESSMENT
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Provision of IHA for Members under Age 21

For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

- 1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
- 2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
 - a) blood pressure,
 - b) height and weight,
 - c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
 - d) clinical breast examination for women over 40,
 - e) mammogram for women age 50 and over,
 - f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
 - g) chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
 - h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
 - i) health education behavioral risk assessment.

2-Plan Contract A.10.6

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

2.1	BASIC CASE MANAGEMENT/ CALIFORNIA CHILDREN'S SERVICES (CCS)/ EARLY INTERVENTION/ DEVELOPMENTAL DISABILITIES/ INITIAL HEALTH ASSESSMENT
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Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.
2-Plan Contract A.10.3.D

SUMMARY OF FINDING(S):

2.1.1 The Plan does not have a methodology to monitor the completion of a member's Initial Health Assessment (IHA) within the required timeframe.

The scope of services available to Medi-Cal members shall include: (1) An initial health assessment, unless the member's primary care physician determines that the member's medical record contains complete information, updated within the previous 12 months, consistent with the assessment requirements...CCR, Title 22, Section 53851(b)

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule and IHA shall be considered evidence in meeting this requirement. 2-Plan Contract A.10.3.D

Plan must ensure that subcontracted provider organizations selected or assigned to a member receive timely notification of member's effective date of enrollment to allow scheduling and completion of the IHA within the required time frame. Plans may assist providers in contacting new members for scheduling the IHA appointment. In addition, the Plan must have an appropriate monitoring system.
MMCD Policy Letter 08-003

The IHA is a comprehensive assessment and must be documented in the member's medical record. The IHA enables the member's PCP to assess and manage acute, chronic, and preventive needs of the member. All new plan members must have a complete IHA within 120 calendar days of enrollment.

Policy number CA.QI.29, states that the Plan monitors and conducts quality oversight of IHA and Individual Health Education Behavioral Assessment (IHEBA). The Plan's policy states the Plan must track the three IHA attempts monthly and analyze annually to demonstrate compliance with IHA timeliness.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

The Plan used Field Service Review (FSR) and encounter claims to determine IHA timeliness. The Plan also used medical records reviews conducted during the FSR to document the completion of the IHA. The FSR's are performed once every three years.

In addition, the Plan captured encounter claims data to determine if the IHAs were completed. If procedure codes 99201 through 99205 were billed in the 120 day period, the Plan considered that an IHA had been performed.

The Plan lacked documentation that their tracking method ensured completion of IHAs within 120 calendar days of enrollment into the Plan. The Contract states that the Plan must make reasonable attempts to contact a member and schedule an IHA. All attempts are to be documented. Documented attempts which demonstrate the Plan's unsuccessful efforts to contact a member and schedule an IHA are considered as evidence of meeting the IHA timeliness requirement.

The Plan has a written policy to track the three IHA attempts, and analyze on a monthly and annual basis. However, the Plan did not follow their policy. The Plan did not provide any documentation of reasonable attempts to contact the member to schedule an IHA. No reasoning was given for the lack of documentation.

Based on the Plan's IHA completion chart, the timely IHA completion rate range from .05 percent to 3.1 percent for the quarter. The average IHA completion rate for the first quarter 2018 was two percent. The Plan has a rate of sixty six percent for welcome packets sent and nine percent for welcome calls completed.

The Plan does not document oversight of its IHA completion within the required timeframes. There is no documentation of member outreach to schedule IHA. The Plan lacked documentation that it made three attempts to contact the member to notify and schedule the IHA.

Non-timely completion of an IHA may lead to poor health outcomes related to lack of identification of health problems leading to non-treatment and lack of care coordination.

RECOMMENDATION:

2.1.1 Develop and implement a system to perform IHA activities within the required timeframe. Monitor Plan activities related to IHA.

❖ **COMPLIANCE AUDIT FINDINGS (CAF)** ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.3

EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims):

Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the plan.

2-Plan Contract A.8.13.A

Contractor shall pay for emergency services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge....

2-Plan Contract A.8.13.C

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

2-Plan Contract A.8.13.D

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D). 3

2-Plan Contract A.8.13.E

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.

2-Plan Contract A.9.7.A

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

3.3

EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Family Planning (Claims):

Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate....(as required by Contract)

2-Plan Contract A.8.9

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section...Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.

2-Plan Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDING(S):

3.3.1 Family Planning Prior Authorization

Members have the right to access family planning services through any family planning provider without prior authorization. (Contract, Exhibit A, Attachment 9(9)(A)).

The Plan will inform its Members, in its Member Services guide, of their right to access any qualified family planning provider without authorization. Policy CA.CLMS.02.

Plan members have the right to access any qualified family planning provider without prior authorization in and out of network. However, the Plan improperly denied two of the six family planning claims reviewed in the verification study. The reason for the denial listed was that prior authorization was required. One of the two denials was disputed by the provider and overturned.

The Plan's report entitled Tracking Report for Procedure Codes that Require Prior Authorization contains five family planning codes that require prior authorization: J7307, 11981, 11976, 99203 and 99213. The Plan stated the report title is a misnomer and the codes do not require prior authorization to receive payment.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

In addition, The Plan discovered the following family planning diagnosis codes, Z30.46, Z30.015, and Z30.45, were denied for lack of prior authorization. The Plan initiated edits into the claims processing system in May of 2018 to include these diagnosis codes as family planning codes.

The Plan stated the codes did not contain the proper edits to go around the prior authorization prerequisite. The Plan added edits to the claims prior authorization process. The edits were supposed to allow claims with a valid family planning diagnosis and procedure code to be paid without a prior authorization.

During the onsite, the Plan conducted an audit of the claims universe for family planning claims denied for authorizations. The Plan identified 1,341 claims that were denied for lack of prior authorization. Only 76 of the 1,341 claims were improperly denied. The Plan stated all improperly denied claims were prior to the May 2018 update. However, the Denied Family Planning and State Supported Services Claims report shows 24 of the 76 claims were processed after May 2018

No documentation was submitted to confirm payment of the improperly denied claims. The Plan stated that they are in the process of correcting the edits so that prior authorization is not required for family planning claims.

Requiring prior authorization for family planning services may delay care to a member and payment to providers.

RECOMMENDATION(S):

3.3.1 Ensure all family planning procedure and diagnosis codes do not require prior authorization. Train clinical and claims staff to process family planning authorization requests and claims properly. Process family planning claims according to Contract requirements. Pay all improperly denied claims with applicable interest.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

CATEGORY 4 – MEMBER’S RIGHTS

4.1

GRIEVANCE SYSTEM

Member Grievance System and Oversight:

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member’s grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858....(as required by Contract)
2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
2-Plan Contract A.14.3.A

SUMMARY OF FINDING(S):

4.1.1 Grievance Resolutions

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan Contract A.14.1

The Contract requires the Plan to implement and maintain procedures to monitor the Member’s grievance system. The Plan did not demonstrate adequate oversight of the grievance resolution process. Members received grievance resolution letters prior to the administrative closure of the grievance file in the Plan’s grievance tracking system. Resolution letters are to be sent out only after the administrative closure of the grievance.

The Contract requires the Plan to continuously review the operation of the grievance system. Title 22, section 53858 requires the Plan’s member grievance procedure provide the date of notification of a proposed resolution. Grievance cases without closure dates or incorrect closure date in the member’s record can cause the Plan to be

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

out of compliance with the Contract.

The Plan stated the oversight of the grievance resolution process consist of reviewing two to five charts monthly per employee. If the Plan had followed their procedures, the lack of administrative closure of grievance files would have been detected.

The Plan is in the process of transitioning to a new computer grievance tracking system. The new system is designed to prevent issuance of a resolution closure letter prior to closing the grievance chart.

RECOMMENDATION(S):

4.1.1 Establish a new grievance tracking system to ensure the issuance of all resolution of grievances is properly documented.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

CATEGORY 5 – QUALITY MANAGEMENT

5.1

QUALITY IMPROVEMENT SYSTEM/ DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

General Requirements:

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

2-Plan Contract A.4.1

Written Description: Contractor shall implement and maintain a written description of its QIS [Quality Improvement System]...(as required by Contract)

2-Plan Contract A.4.7.A-I

Accountability: Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted physicians and contracted providers in the process of QIS development and performance review. Participation of non-contracting providers is discretionary.

2-Plan Contract A.4.2

Governing Body: Contractor shall implement and maintain policies that specify the responsibilities of the governing...(as required by Contract)

2-Plan Contract A.4.3.A-D

Provider Participation: Contractor shall ensure that contracting physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.

2-Plan Contract A.4.5

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

SUMMARY OF FINDING(S):

5.1.1 Initial Health Assessment Quality Improvement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor. Contract, Exhibit A, Attachment 4(1).

An IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.

A. Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

B. Contractor shall ensure that the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10) using an age appropriate DHCS approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.

C. Contractor shall ensure that Members' completed IHA and IHEBA tool are contained in the Members' medical record and available during subsequent preventive health visits.

D. Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor'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)(A-D).

Based on the Plan's policy, IHAs are tracked through encounter claims. However, the Plan did not consistently follow their policy. The Plan tracks Initial Health Assessment (IHA) completion through encounter claims and Field Service Reviews (FSR). The Plan's tracking method is retrospective since the data source is posted claims. There is a minimum of a four to six months lapse between data collection and tracking. In addition, FSRs are performed once every three years.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

Some of the individual Plan provider offices stated that once the Plan distributes the new member list there was little or no monitoring relating to which new members had contacted the provider to schedule an IHA and the members who did not. The individual provider offices did not receive any follow-up from the Plan.

According to Title 28, CCR, 1300.70, the Plan's Quality Improvement System (QIS) must document that quality of care is being reviewed, is properly identified, and that effective action is taken to improve care where deficiencies are identified. Non-timely completion of an IHA may lead to poor health outcomes related to lack of identification of health problems leading to non-treatment and lack of care coordination.

5.1.2 Transportation Quality Improvement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.
2-Plan Contract A.4.1

The Plan's Non-Emergency Medical Transportation and Non-Medical Transportation subcontractor handles 100 percent of the Plan member's transportation needs. The subcontractor functions as a dispatching service which allocates requests for transportation to providers and processes claims and payments.

The Plan processed transportation grievances for the majority of the audit period and a significant number of exempt grievances were related to transportation services. In the third quarter of 2018, 44 percent of exempt grievances were related to transportation. The Plan delegated the processing of exempt transportation grievance to the subcontractor in the fourth quarter as a solution to address the high transportation exempt grievances.

The Contract states that "Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf..."

Quarterly, the subcontractor submits grievance data to the Plan. The delegation of exempt transportation grievances began in the fourth quarter, the effectiveness of the delegation cannot be measured at this time.

The Contract requires the Plan to maintain oversight of delegated member services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CALIFORNIA HEALTH AND WELLNESS PLAN

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018
DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

Without proper oversight the Plan cannot ensure members receive timely service. Further, the Plan cannot develop a corrective action plan to properly address a member's concerns related to transportation grievances.

RECOMMENDATION(S):

5.1.1 Document and monitor IHA attempts. Implement procedures to assist PCP with scheduling IHAs.

5.1.2 Monitor transportation grievances to improve member satisfaction and ensure contract compliance.

MEDICAL REVIEW - NORTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

CALIFORNIA HEALTH AND WELLNESS PLAN

Contract Number: 13-90158 and 13-90162
State Supported Services

Audit Period: December 1, 2017
Through
November 30, 2018

Report Issued: June 12, 2019

TABLE OF CONTENTS

I. INTRODUCTION1

II. COMPLIANCE AUDIT FINDINGS2

INTRODUCTION

This report presents the audit findings of California Health and Wellness Plan (CHW) State Supported Services Contract Numbers 13-90158 and 13-90162. The State Supported Services contracts covers contracted abortion services with CHW.

The onsite audit was conducted from February 11, 2019 through February 22, 2019. The audit period is December 1, 2017 through November 30, 2018 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: California Health and Wellness Plan

AUDIT PERIOD: DECEMBER 1, 2017 THROUGH NOVEMBER 30, 2018

DATE OF AUDIT: FEBRUARY 11, 2019 THROUGH FEBRUARY 22, 2019

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion

Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:

Current Procedural Coding System Codes: 59840 through 59857*

HCFA Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336*

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*

State Supported Services Contract Exhibit A.1

SUMMARY OF FINDINGS:

SSS.1 – Minor Consent

A minor may consent to an abortion without parental consent and without court permission. (American Academy of Pediatrics v. Lungren 16 Cal.4th 307 (1997))

In the prior year the Minor Consent Services section of the Plan's Evidence of Coverage (EOC) Member Handbook stated that "Minors, age 12 years and older, can receive certain services without their parents' consent." This was not compliant with the American Academy of Pediatrics v. Lungren decision which allows members of any age to receive abortion services without parental consent.

The Plan's EOC has been changed and is in compliance with the American Academy of Pediatrics v. Lungren decision which allows members of any age to receive abortion services without parental consent.

RECOMMENDATION:

None