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

CALIFORNIA HEALTH AND WELLNESS PLAN

Contract Number: 13-90157 AND 13-90161

Audit Period: December 1, 2016
Through
November 30, 2017

Report Issued: October 2, 2018

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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 to provide Medi-Cal services in 19 counties, as of November 1, 2013. The Plan is a wholly-owned subsidiary of Centene, a publicly-traded company that serves as a major intermediary for both government-sponsored and privately-insured health care programs.

The contracts were implemented under the State's Medi-Cal Managed Care Rural Expansion 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 191,733 Medi-Cal members in the following counties: Alpine 107; Amador 1,045; Butte 37,089; Calaveras 5,618; Colusa 2,635; El Dorado 19,298; Glenn 6,291; Imperial 60,624; Inyo 1,881; Mariposa 846; Mono 959; Nevada 8,343; Placer 9,053; Plumas 2,407; Sierra 217; Sutter 9,862; Tehama 11,101; Tuolumne 5,670; Yuba 8,687

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, 2016 through November 30, 2017. The onsite review was conducted December 4, 2017 through December 15, 2017. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on August 28, 2018 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 submitted a response after the exit conference. 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, Quality Management (QI), and Administrative and Organization Capacity. The Summary of the findings by category follows:

Category 3 – Access and Availability of Care

The contract requires that the Plan reimburse each complete claim as soon as possible, but no later than 45 working days after the receipt of the claim. For claims paid after 45 working days the Plan must pay interest on the claim. The Plan's claims processing system did not pay all claims timely and with interest when paid late.

Category 5 – Quality Management

The contract requires that the Plan ensure that all providers receive training regarding the Medi-Cal Managed Care program within ten working days of being placed on an active status. Once a provider becomes a new provider, the Plan calls and informs the provider of new provider training. The provider is informed of the various options to take the training, and after the training is taken, the provider becomes active and is eligible to provide services to the Plan's members. The Plan lacked evidence that providers received training ten working days after being placed on the Plan's active provider status.

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 December 4, 2017 through December 15, 2017. 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.

The following verification studies were conducted:

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): Eight claims were reviewed to determine 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.

Behavior Health Therapy (BHT): 11 claims were reviewed to determine the Plan's compliance with BHT eligibility and treatment plan requirements included in the contract and APL 15-025.

Category 3 – Access and Availability of Care

Emergency Services Claims: 21 emergency service claims were reviewed for appropriate time adjudication and correct payment.

Category 5 – Quality Management

Provider Qualifications: 16 provider qualification cases were reviewed to determine if the Plan maintained policies and procedures related to initial credentialing and re-credentialing of providers of services under the Plan as well as determine if the Plan is in compliance with the Medi-Cal contract and their policies and procedures related to credentialing.

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

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3.5	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

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

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3.5	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

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 FINDINGS:

3.5.1 Timely Payment of Out-of-Network Claims

California Health and Safety Code, Section 1371.35(b) requires the managed care plan to reimburse each complete claim, or portion of no later than 45 working days after receipt of the complete claim.

Furthermore, the Contract 13-90157 A.8.5 , states that the Plan shall pay all claims submitted by a contracting provider unless the Plan and the contracting provider have an alternate payment schedule in writing. No such contract is in effect. Therefore, the Plan is subject to interest payment for all claims received in excess of 45 working days after receipt.

At the time of the audit, the Plan was merging with another entity and the Policy & Procedure for Emergency Services Compensation for the review period was in draft form. The previous policies addressing Emergency Services Compensation were not reviewed or submitted by the Plan.

The Plan submitted a draft policy entitled Emergency Services Compensation as a policy for the review period; however, the policy submitted does not have an effective date, does not have a prior policy number, and has not been approved by the Department. In addition, the policy does not address timeliness and interest payments on late claims.

A total of 1,186 out of network emergency claims were not paid within the contractual timeframe. Of the 1,186 claims a total of 224 were denied and 962 were paid by the Plan in excess of 45 working days after the date of the receipt of the complete claim. Payments for 39 of the 962 claims included the interest as required by California Health and Safety Code, Section 1371.35(b).

Based on the results of the verification study, the Plan's claims payment procedures did not follow California Health and Safety Code, Section 1371.35(b) or the Contract, which requires the Plan to pay interest when a claim is paid beyond 45 days after receipt.

The Plan was in a dispute regarding the party responsible for payment of a number of emergency room out of network claims. As a result, the Plan set the claims in dispute aside which led to the untimely payment of the claims. The Plan's payment systems and procedures did not identify all the claims that required to be paid with interest. The Plan stated they are in the process of amending the current policies to comply with the appropriate criteria and contract requirements.

The policies and procedures must contain the proper language to ensure that the out-of-network providers are compensated timely and properly for services rendered to Plan Members. Late and improper payment amount to out-of-network claims may lead to fewer out-of-network providers willing to see Plan Members.

RECOMMENDATIONS:

3.5.1 Comply with contract time for reimbursements to ensure timely payment of out-of-network emergency claims. Implement procedures that identify late claims and calculates and adds the required interest to the payment.

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CATEGORY 5 – QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status….
2-Plan Contract A.7.*5*

SUMMARY OF FINDINGS:

5.2.1 Provider Training

Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations." … "Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status. (California Health and Wellness Plan Contract Exhibit A, Attachment 7, 5.)

Prior to 2017, no record or logs were kept to document the completion of new provider training. The 2017 new provider training log does not include accurate information on dates of completion. Also missing from the 2017 logs was documentation from the providers to verify new provider training was completed within ten days of being placed on the Plan's active status as required by the contract. The Plan stated that in October 2017, changes were made to the Provider training completion report to include a contact log and required that the provider submit a signed attestation to document that new provider training was completed within ten days of being placed on the active list. However, the new provider training log did not contain dates of contact and dates of completion.

The Plan had added new providers after October 2017. However, documentation submitted by the Plan did not document training was completed by providers added after

October 2017.

The Plan must maintain policies and procedures that outline the contract requirements for the timeliness and completion of new provider training. In addition, the Plan must maintain a system that documents the completion of new provider training to document compliance to the ten day requirement.

In December 2017, a draft of the policy was submitted to the audit team to confirm the changes. However, the policy has not been approved by Managed Care Quality Management Division (MCQMD). The draft policy includes the correct ten day time requirement, but it does not reference the attestation or any detail of what is to be included in the log. The policy in effect prior to the October 2017 changes was not submitted for review.

The Plan did not ensure that its network providers received training related to the Medi-Cal Managed Care program. If new providers do not receive training they may not be aware of current programs and services that could benefit members. In addition, the Plan is not in compliance with the requirements of the Medi-Cal contract.

RECOMMENDATIONS:

5.2.1 Maintain and implement policy and procedures to ensure that new providers receive training within the ten working day requirement. Document when and if new providers complete training. Adhere to the Contract and policies and procedures and ensure that all Plan providers are eligible to participate in the Medi-Cal program.

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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, 2016 Through November 30, 2017
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INTRODUCTION

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

The onsite audit was conducted from December 1, 2017 through December 15, 2017. The audit period is December 1, 2016 through November 30, 2017 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

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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))

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

However, there is no age restriction or parental consent requirement in the Plan's policy number C.UM.01.01 Covered Benefits & Services or in the Plan's provider manual. The restrictive language in the Member Handbook may cause members to misunderstand the extent to which parental consent for abortion services is needed.

RECOMMENDATION:

SSS.1 Revise the EOC Member Handbook and all distributed material to be in compliance with the American Academy of Pediatrics v. Lungren 16 Cal.4th 307 (1997).