DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF CONTRA COSTA HEALTH PLAN FISCAL YEAR 2024-25

Contract Numbers: 04-36067 and 23-30219

Audit Period: August 1, 2023 — July 31, 2024

Dates of Audit: August 19, 2024 — August 30, 2024

Report Issued: February 14, 2025

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I. INTRODUCTION

Since 1984, Contra Costa Health Plan (Plan) has contracted with the State of California to provide health care services to Medi-Cal members in Contra Costa County. The Plan is a county sponsored Health Maintenance Organization. The Plan is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act. The Contra Costa County Board of Supervisors exercises oversight of the Plan through a Joint Conference Committee (JCC).

In October 1996, the State of California contracted with the County of Contra Costa as the Local Initiative under the Two-Plan model to provide managed care services to Medi-Cal members under the provisions of California Welfare and Institutions Code section 14087.3. The Plan received approval from the State of California to begin operations and commenced enrollment as the Local Initiative for Contra Costa County on February 1, 1997.

Effective January 1, 2024, Contra Costa County changed the Medi-Cal managed care model from a Two-Plan model to a Single-Plan model.

The Plan contracts with Contra Costa Regional Medical Center, as well as other network providers, to arrange for Medi-Cal covered services.

As of July 31, 2024, the Plan had 265,419 members. Of these 258,846 were Medi-Cal, including 16,735 Seniors and Persons with Disabilities members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of August 1, 2023, through July 31, 2024. The audit was conducted from August 19, 2024, through August 30, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on January 30, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On February 13, 2025, the Plan submitted a response following the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: (1) Utilization Management (UM); (2) Case Management and Coordination of Care; (3) Access and Availability of Care; (4) Member's Rights; (5) Quality Management; and (6) Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of July 1, 2022, through June 30, 2023, was issued on February 6, 2024. This audit evaluated the Plan's compliance with its contract with the DHCS and assessed the implementation of the 2023 Corrective Action Plan.

Prior to the start of the audit, DHCS became aware of publicly reported information citing concerns with the Plan's ECM program. As a result, DHCS expanded the scope of its audit to include additional procedures to examine the Plan's ECM program.

DHCS' ECM program is designed to address both the clinical and non-clinical needs of members by coordinating all aspects of their care, including physical and behavioral health services, for those who opt into the program. ECM provides comprehensive, whole person care management for high-need, high-cost members. The program aims to improve care coordination, integrate services, facilitate access to community resources, address social determinants of health, improve health outcomes, and reduce inappropriate utilization and service duplication. Findings related to ECM are included under Category 2, Case Management and Coordination of Care.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to include in the Notice of Action (NOA) a clear explanation of the decision based on medical necessity. The NOA must explicitly state how the member's condition does not meet the applicable criteria or guidelines. Finding 1.2.1: The Plan did not explicitly state in NOA letters how the member's condition did not meet the applicable clinical criteria or guidelines.

The Plan is required to ensure that the person making the final decision for an appeal resolution did not participate in any prior decisions related to the appeal. Finding 1.3.1: The Plan did not ensure that the person making the final decision for appeal resolutions did not participate in any prior decisions related to the appeals.

The Plan is required to send an NOA when making an authorization decision that impacts a member's ability to obtain covered services or other benefits under the Contract. The Plan must utilize the DHCS standardized NOA and "Your Rights" templates, which include Nondiscrimination Notice (NDN) and Language Assistance Taglines (LAT). Finding 1.5.1: The Plan did not ensure that Contra Costa Behavioral Health (CCBH), Plan delegate, sent NOAs and accompanying "Your Rights" information, along with the NDN and LAT notices for prior authorization denial decisions, as required.

Category 2 – Case Management and Coordination of Care

The Plan is required to cover and ensure the provision of an Initial Health Appointment (IHA), which consists of a comprehensive history and physical examination, within 120 calendar days following the date of enrollment. Finding 2.1.1: The Plan did not ensure that providers documented all required components of an IHA.

The Plan is required to cover and ensure the provision of blood lead screening tests to members under 6 years of age. The Plan must ensure a signed statement of voluntary refusal by the member is documented or the refusal of the member to sign the voluntary statement must be documented in the medical record. Finding 2.1.2: The Plan did not ensure that providers documented the completion of a blood lead screening tests.

The Plan is required to ensure the member's parent or guardian is provided anticipatory guidance at 6 months of age and continuing until 72 months of age, that at minimum, includes information that children can be harmed by exposure to lead. Finding 2.1.3: The

Plan did not ensure the provision of oral or written blood lead anticipatory guidance to the parent(s) or guardian(s) of members starting at six months to six years of age.

The Plan is required to take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost members in distinct Populations of Focus through systematic coordination of services and comprehensive care management. Finding 2.6.1: The Plan did not ensure the provision of comprehensive care management and coordination of care for the clinical needs relevant to members enrolled in the ECM program.

The Plan is required to administer ECM and provide seven core ECM services to eligible members in applicable ECM Populations of Focus. The core ECM services must include, but are not limited to, the following: Comprehensive Assessment and Care Management Plan, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, and Member and Family Supports. Finding 2.6.2: The Plan did not ensure that all members received all seven ECM core service components.

The Plan is required to ensure that the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, have a copy of the member's Care Management Plan and information about how to request updates. Finding 2.6.3: The Plan did not ensure that ECM members and their authorized support persons received a copy of the members' Care Management Plan, along with information about how to request updates.

Category 3 – Access and Availability of Care

There were no findings noted for this category during the audit period.

Category 4 – Member's Rights

The Plan is required to ensure all medical Quality of Care (QOC) grievances are immediately submitted to the Medical Director for action. Finding 4.1.1: The Plan did not have policies and procedures to ensure medical QOC grievances were immediately submitted to the Medical Director for action.

The Plan is required to forward all grievances alleging discrimination to the DHCS within ten calendar days of mailing a Discrimination Grievance resolution letter. The Plan must provide to the DHCS the original grievance, the accused party's response, member correspondence, investigation results, corrective action, and contact information for the member, accused party, and staff who investigated the grievance, and any other relevant information. Finding 4.1.2: The Plan did not submit grievances alleging

discrimination, along with detailed information regarding the grievances to the DHCS as required.

The Plan is required to maintain policies and procedures for compiling, aggregating, and reviewing grievance and appeal data for use in the Plan's Quality Improvement Strategy (QIS). The Plan's member grievance procedures shall provide for the review and analysis, on at least a quarterly basis, of all recorded grievances related to access to care, QOC and denial of services, and take appropriate action to remedy any problems identified in such reviews. Finding 4.1.3: The Plan did not ensure all grievances, including exempt grievances, were reviewed and analyzed on at least a quarterly basis.

Category 5 – Quality Management

The Plan is required to report provider preventable conditions (PPC) to the DHCS and ensure that all network providers, subcontractors, and downstream subcontractors also report PPCs. The Plan must use the DHCS' secure online reporting portal to report PPCs to the DHCS. Finding 5.1.1: The Plan did not report all PPCs to the DHCS as required.

The Plan is required to ensure members are notified in writing of any changes in the availability or location of covered services, of any termination of a network provider, subcontractor, or downstream subcontractor either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer. Finding 5.3.1: The Plan did not provide written notices to all impacted members for terminations of network providers, subcontractors, or downstream subcontractors.

Category 6 – Administrative and Organizational Capacity

The Plan is required to designate a Compliance Officer who is responsible for developing, implementing, and ensuring compliance with the requirements and standards under the Contract and who reports directly to the Chief Executive Officer (CEO) and the Board of Directors. The Compliance Officer must be a full-time employee and must be independent, which means they must not serve in both a compliance and operational role. Finding 6.2.1: The Plan did not ensure the designated Compliance Officer did not also serve in an operational role or capacity.

Plan policies and procedures are required to include the criteria for selecting a Compliance Officer and a job description, including responsibilities and the authority of this position. Finding 6.2.2: The Plan did not have policies and procedures that included

criteria for selecting a Compliance Officer or a job description outlining the responsibilities and authority of the position.

The Plan is required to have a compliance program that includes, at a minimum, the following: an outline of the key elements of the compliance program; references to the standards of conduct or code of conduct; provisions that allow the compliance program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance; details how it will implement and maintain elements of the compliance program; includes the compliance reporting structure, positions of key personnel involved in ensuring compliance, and identification of the Compliance Officer; references the delegation reporting and compliance plan; references policies and procedures operationalizing the compliance program; compliance plan review and approval by the Board of Director's Compliance and Oversight Committee routinely, but not less than annually; and is publicly posted on the Plan's website. Finding 6.2.3: The Plan did not maintain a compliance program which included all required elements of a compliance plan.

The Plan is required to file a preliminary report with the DHCS' Program Integrity Unit detailing any suspected fraud, waste, or abuse identified within ten working days of the Plan's discovery or notification of such fraud, waste, or abuse. Finding 6.2.4: The Plan did not report all suspected fraud cases to the DHCS within ten working days.

The Plan is required to have a fraud prevention program that includes policies and procedures to promptly notify the DHCS when the Plan receives information about changes in a member's circumstances that may affect the member's eligibility including, changes in the member's residence, income, insurance status, and death. Finding 6.2.5: The Plan did not have policies and procedures to promptly notify the DHCS upon receipt of information about changes in a member's circumstances for income and death.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain whether the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

The DHCS conducted an audit of the Plan from August 19, 2024, through August 30, 2024, for the audit period of August 1, 2023, through July 31, 2024. The audit included a review of the Plan's Contract with the DHCS, policies and procedures for providing services, 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

Service Requests: A total of 30 clinical service request cases were reviewed for timeliness, consistent application of criteria, and appropriate review. Nineteen were prior authorization requests, six were concurrent review requests, and five were retrospective review requests.

Appeal Procedures: Twenty medical cases were reviewed for appropriate and timely adjudication.

Delegated Prior Authorization Requests: Sixteen prior authorization requests for non-specialty mental health services were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Appointment (IHA): Fifteen files were reviewed to confirm the performance of the appointment.

California Children's Services (CCS): Ten files were reviewed for evidence of care coordination between the Plan and CCS providers.

Complex Case Management: Ten files were reviewed to confirm the performance of services.

Enhanced Care Management (ECM): Twenty-two files were reviewed to confirm coordination of care and compliance with ECM requirements.

Category 3 – Access and Availability of Care

Claims: Twenty emergency services and 20 family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation: Fifteen claims were reviewed for timeliness and appropriate adjudication.

Non-Medical Transportation: Fifteen claims were reviewed for timeliness and appropriate adjudication.

Category 4 – Member's Rights

Grievances: Fifty standard grievances, 20 exempt grievances, 5 expedited grievances, and 20 call inquiries were reviewed for timely resolution, appropriate classification, response to complainant, and submission to the appropriate level for review. The 50 standard grievance cases included 25 quality of service and 25 QOC grievances.

Confidentiality Rights: Eight Health Insurance Portability and Accountability Act/Protected Health Information breach and security incidents were reviewed for processing and timeliness requirements.

Category 5 – Quality Management

Potential Quality Issues (PQI): Twelve PQI cases were reviewed for timely evaluation and effective action taken to address needed improvements.

Provider Training: Fifteen new provider training records were reviewed for the timeliness of Medi-Cal managed care program training.

Category 6 – Administrative and Organizational Capacity

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

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Clinical Reasons for Prior Authorization Denials

An NOA must include the action the Plan has taken or intends to take and the reason for the action. *(2023 Contract, Exhibit A, Attachment 14(4)(B)(1) and (2))*

The Plan is required to comply with All Plan Letters (APLs) issued by the DHCS. *(2023 Contract, Exhibit E, Attachment 2(1)(D))*

The NOA is required to include a clear and concise explanation of the Plan's action, including the clinical rationale for the decision. *(2024 Contract, Exhibit A, Attachment III, 4.6.4(E)(1))*

The Plan is required to comply with all DHCS guidance, including APLs. *(2024 Contract, Exhibit E, 1.1.2))*

The NOA is required to include the clinical reasons for decisions based on medical necessity. The Plan must explicitly state how the member's condition does not meet the criteria or guidelines. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan desktop procedure, *APL Process* (updated 1/9/24), stated the Compliance Department will review APLs for information and action items to be disseminated, updated, or created.

Plan policy, *UM15.003, Policy for Prior Authorization* (approved 4/2024), stated within two business days of an authorization denial or modification, a written notification is sent to the member and provider, which includes a clear and concise explanation of the reason for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decision regarding medical necessity.

Finding: The Plan did not explicitly state in NOA letters how the member's condition did not meet the applicable clinical criteria or guidelines.

A verification study revealed two of two NOA letters for denied prior authorization requests based on medical necessity did not explicitly state how the member's condition did not meet the applicable clinical criteria or guidelines. The NOA letters documented the following:

- A provider requested a Positron Emission Tomography (PET) scan for a 57-year-old male for evaluation of lung nodules. The NOA stated the scan was not medically indicated and cited Plan policy, *UM15.002: Utilization Review Criteria and Guidelines* (revised 12/23), and National Comprehensive Cancer Network (NCCN) guidelines. However, the NOA did not explicitly state how the member's condition did not meet the clinical criteria or guidelines.
- A provider requested a PET scan for a 46-year-old female with weight loss and a history of breast cancer. The NOA stated the scan was not medically indicated and cited Plan policy, *UM15.002: Utilization Review Criteria and Guidelines* (revised 12/23) and NCCN guidelines. However, the NOA did not explicitly state how the member's condition did not meet the clinical criteria or guidelines.

In an interview, the Plan acknowledged the specific reason a member did not meet criteria was not included in the two NOA letters reviewed. In addition, the Plan did not explain why the explicit reason a member's condition did not meet applicable criteria or guidelines and was not included in the NOA letters. Plan policy UM15.003 did not include the Plan's process or identify the staff responsible for ensuring that the reason a member did not meet criteria or guidelines was included in the NOA letters.

When NOA letters do not explicitly state how the member's condition did not meet the clinical criteria or guidelines, the member may not understand why services were denied, which could adversely affect their ability to make informed healthcare decisions.

Recommendation: Revise and implement policies and procedures to ensure NOA letters explicitly state how the member's condition did not meet the applicable clinical criteria or guidelines.

1.3 PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Appeal Resolution Decision-Maker

The Plan is required to ensure that the person making the final decision for an appeal resolution did not participate in any prior decisions related to the appeal. *(2023 Contract, Exhibit A, Attachment 14(1)(D); 2024 Contract, Exhibit A, Attachment III, 4.6.1(D); APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, *AGD 20.005: Medi-Cal Member Appeal Policy* (revised 5/23), stated a physician, not associated with the original decision, must make all determinations for appeals involving medical necessity.

Finding: The Plan did not ensure that the person making the final decision for appeal resolutions did not participate in any prior decisions related to the appeals.

A verification study revealed that in 3 of 20 appeals (2 modified and 1 denial) the final decision-maker for the appeal resolutions participated in prior decisions related to the appeals. The Notice of Appeal Resolution letters were signed by the same physician who reviewed, agreed with, signed the NOA letters, and made the final status decisions regarding the prior authorization requests.

In a written response, the Plan stated the appeals coordinator is responsible for identifying the decision maker on the prior authorization request and assigning the appeal to a different decision maker. However, the Plan did not explain why this responsibility was not properly carried out by the appeals coordinator. Additionally, the appeals decision-maker did not identify themselves as the final decision maker for the prior authorization request when deciding on the appeal. Plan policy AGD 20.005 does not document the responsibility of the appeals coordinator, or any other staff, to ensure that the final decision-maker for appeal resolutions did not participate in any prior decisions related to the appeals.

When the final decision-maker in appeal resolutions has participated in prior decisions related to the appeals, members' healthcare rights could be compromised, as the appeals may not be adjudicated impartially.

Recommendation: Implement policies and procedures to ensure the final decision-maker for appeal resolutions has not participated in any prior decisions related to the appeals.

1.5 DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Notice of Action letters, Nondiscrimination Notice and Language Assistance Taglines

The Plan is accountable for all delegated functions and responsibilities, including UM. The Plan is required to maintain a system to ensure accountability for delegated activities that, at a minimum, ensures a delegate meets standards set forth by the Plan and the DHCS. *(2023 Contract, Exhibit A, Attachment 4(6)(A and B))*

The Plan is accountable for all Quality Improvement (QI) functions that are delegated. The Plan is required to maintain adequate oversight procedures to ensure delegate compliance with all QI activities. *(2024 Contract, Exhibit A, Attachment III, 2.2.5(A) and (B)(2))*

The Plan is required to send within five business days from receipt of the information an NOA in a format approved by the DHCS, for the denial or limited authorization of a requested covered service. *(2023 Contract Exhibit A, Attachment 14(4)(1))*

The Plan is required to send an NOA when making an authorization decision that impacts a member's ability to obtain a covered service or other benefits required under the Contract. The Plan must approve, deny, or modify the request and send the written NOA within the shortest applicable timeframe that is appropriate for the nature of the member's condition, but no longer than five working days from receipt for standard authorization requests. *(2024 Contract, Exhibit A, Attachment III, 4.6.4(A)(3))*

The Plan is required to render a decision on the provider's request for authorization of health care services for a member, and notify the provider and the member using the appropriate NOA template within the shortest applicable timeframe that is appropriate for the members condition, but no longer than five business days from receipt for standard requests. The Plan must ensure that the NOA provides a clear and concise explanation of the reasons for the decision. The NOA is comprised of two components: the appropriate DHCS standardized NOA template and the DHCS standardized NOA "Your Rights" template. The Plan is required to send these documents together any time an NOA is issued. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan must comply with all of the nondiscrimination requirements set forth under federal and state law, and by DHCS. This includes posting of the NDN and LAT in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. DHCS does not require plans to use the DHCS-provided templates verbatim as long as all notices and associated taglines are compliant with federal and state law, and the requirements contained in this APL. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan policy, *UM15.007, Utilization Management Delegation* (revised February 2023), stated the Plan reviews the delegate's practices for compliance with contractual obligations through an annual audit, which includes file reviews.

Plan policy, *UM 15.015a, Timeliness of the Utilization Review Decision and Communication* (revised 2/28/24), stated for all authorization types, members will be notified in a timely manner according to the appropriate correspondence notification type, including authorizations and NOAs. Member correspondence regarding all UM

determinations will be accompanied by State required attachments including NDN, "Your Rights" information, and LAT guidelines.

The Plan delegated UM functions to CCBH. CCBH policy, *CMU Authorization Policy* (revised 12/10/21), stated if medical necessity criteria is not met, the Care Management Unit (CMU) clinician is responsible for completing an NOA. For Medi-Cal members , the clinician is responsible for notifying the provider and member in writing within three business days from the date of the decision.

Finding: The Plan did not ensure that CCBH, Plan delegate, sent NOAs and accompanying "Your Rights" information, along with the NDN and LAT notices for prior authorization denial decisions, as required.

CCBH's CMU Authorization Policy did not include requirements to send NDN and LAT written communications to members, including for approval, modification, or denial decisions.

A verification study revealed that in six of seven denied prior authorization requests, CCBH did not send an NOA or the required "Your Rights" attachments. In five of seven denied prior authorization requests, CCBH did not send the required NDN or LAT. Instead, CCBH issued a Denial of Authorization Service letter without any of the required attachments.

CCBH issued only administrative denials and no medical necessity denials for the audit period. For all administrative denials of prior authorization, CCBH issued a "Denial of Authorization Service" letter rather than an NOA. These administrative denials included members whose insurance expired or did not have active coverage with the Plan, or members who had other healthcare coverage where Medi-Cal was secondary health coverage, or the provider refused to contract with the Plan.

In an interview, CCBH stated that it does not issue NOAs with "Your Rights" attachments for any administrative denials. CCBH did acknowledge that NDN and LAT should have been included with the member denial letters.

In an interview, the Plan stated for administrative denials, specifically where the Plan is the secondary payer, an NOA is not issued. Instead, a denial letter is sent informing the member of the secondary payer status. The Plan acknowledged that the "Your Rights" attachment, NDN, and LAT should have been included with the member denial letters.

When the Plan does not ensure members receive the information necessary to understand UM decisions, members may be unable to exercise their rights.

Recommendation: Revise and implement policies and procedures to ensure delegates send required member information with prior authorization denials, including NOAs, "Your Rights" attachments, and NDN and LAT for all prior authorization denials as required.

COMPLIANCE AUDIT FINDINGS

Category 2 – Case Management and Coordination of Care

2.1 INITIAL HEALTH APPOINTMENT

2.1.1 Required Components of the Initial Health Appointment

The Plan is required to cover and ensure the provision of an IHA to each new member within 120 calendar days of enrollment. An IHA consists of a comprehensive history and physical examination, and preventive services which must be documented in the member's medical record.

The Plan is required to make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate the Plan's unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting the requirement. *(2023 Contract, Exhibit A, Attachment 10(3) and (6))*

The Plan is required to ensure the provision of an IHA in accordance with CCR, Title 22, sections 53851(b)(1) and 53910.5(a)(1), and APL 22-030, *Initial Health Appointment*. An IHA at a minimum must include: a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the member's primary care provider determines that the member's medical record contains complete information, updated within the previous 12 months, consistent with the assessment requirements.

The Plan must ensure an IHA is performed within 120 calendar days of enrollment. An IHA must be completed for all members and periodically re-administered according to requirements in the Population Health Management (PHM) Policy Guide and Contract requirements. An IHA:

- Must be performed by a provider within the primary care medical setting.
- Is not necessary if the member's primary care physician determines that the member's medical record contains complete information that was updated within the previous 12 months.
- Must be provided in a way that is culturally and linguistically appropriate for the member.

- Must be documented in the member's medical record.

An IHA must include all of the following: a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services, health education, and the diagnosis and plan for treatment of any diseases. *(2024 Contract, Exhibit A, Attachment III 5.3.3 and 5.3.4; APL 22-030, Initial Health Appointment)*

Plan policy, *QM14.701, Initial Health Appointment* (approved 2/13/2024), stated that an IHA should be completed on all new members within 120 days of enrollment with the Plan. An IHA consists of a comprehensive history of the member's physical and mental health, identification of risks, assessment of the need for preventive screens or services, health education, diagnoses, as needed, a plan of care, which must include all follow-up activities that reflect the findings or risk factors discovered during the IHA and preventive services.

Finding: The Plan did not ensure that providers documented all required components of an IHA.

A verification study of members aged 21 years and older revealed in three of seven cases the Plan did not ensure that the provider documented compliance with IHA timeliness requirements, the completion of a history of the member's physical and mental health, or the completion of a physical examination. A review of medical records showed:

- In three samples, an IHA was not completed within 120 calendar days of enrollment as required.
- In two samples, a history of the member's physical and mental health, and a physical examination were not completed.

In an interview, the Plan stated that providers are sent a list of assigned new members informing them which members are due for an IHA. The Plan stated IHA elements and preventive services screenings are monitored during facility site reviews and medical record reviews. However, the Plan's existing process has not ensured the provision of complete IHAs for new members.

The Plan conducted education with providers on IHA required components and clinical practice guidelines. The Plan also created an IHA audit tool utilized to verify that all IHA components were completed by providers. However, this audit identified non-compliance.

When the Plan does not ensure the provision of a complete IHA, members may not receive important behavioral and medical health screenings that can help identify and prevent illnesses.

Recommendation: Implement policies and procedures to ensure the completion and documentation of all required components of an IHA.

2.1.2 Blood Lead Screening

The Plan is required to cover and ensure the provision of a blood lead screening test to members at ages and intervals specified in CCR, Title 17, sections 37000, et. seq., and in accordance with APL 20-016, *Blood Lead Screening of Young Children*. The Plan is required to document and appropriately follow up on blood lead screening test results. The Plan is required to make reasonable attempts to ensure that the blood lead screen test is provided and document attempts to provide the test. If the member refuses the blood lead screen test, the Plan must ensure a signed statement of voluntary refusal by the member is documented, or the refusal of the member to sign the voluntary statement must be documented in the medical record. *(2023 Contract, Exhibit A, Attachment 10(5)(D); 2024 Contract, Exhibit A, Attachment III 5.3.4(D))*

The Plan is required to ensure its network providers follow the Childhood Lead Position Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local health department. *(2024 Contract, Exhibit A, Attachment III 5.3.4(D))*

The Plan is required to ensure that network providers order or perform blood lead screenings tests on all child members in accordance with the following:

- At 12 months and at 24 months of age.
- When the network provider performing a PHA becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
- When the network provider performing a PHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
- At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
- If requested by the parent or guardian

(APL 20-016, Blood Lead Screening of Young Children)

Plan policy, *QM14.701, Initial Health Appointment* (approved 2/13/2024), stated the Plan monitors for the completion of blood lead screenings or the documentation of the refusal through its Medical Record Review.

The Plan's *2024 Provider Manual* stated that providers must order or perform blood lead screening tests on all child members at 12 months and at 24 months of age, and when the network provider performing a well visit becomes aware that a child member has no documented evidence of a blood lead screening test taken.

Finding: The Plan did not ensure that providers documented the completion of a blood lead screening tests.

A verification study revealed in four of eight members under 6 years of age, who required a blood lead screening, the provider did not document performing a blood lead screening.

In an interview, the Plan stated it monitors claims data to identify members under 6 years of age to ensure they received the required blood level screenings at 12 and 24 months. The Plan also indicated that it monitored compliance through Facility Site Reviews, and provided education through newsletters and training, which included information on blood lead screening guidelines and outreach responsibilities. However, the Plan's monitoring processes were not effective in ensuring all members under 6 years of age received blood lead screenings.

When the Plan does not ensure the provision of a complete blood lead screening, members may remain unaware of their exposure to or the associated risks, which can result in behavioral and physical impairment.

Recommendation: Revise and implement policies and procedures to ensure documentation and completion of all blood lead screening tests as required.

2.1.3 Blood Lead Anticipatory Guidance

The Plan is required to cover and ensure the provision of a blood lead screening test to members at ages and intervals specified in CCR, Title 17, sections 37000, et. seq., and in accordance with APL 20-016, *Blood Lead Screening of Young Children*. *(2023 Contract, Exhibit A, Attachment 10(5)(D); 2024 Contract, Exhibit A, Attachment III 5.3.4(D))*

The Plan is required to identify, at least quarterly, all members less than six years of age with no record of receiving a required blood lead screening. The Plan must notify

network providers responsible for members with no record of receiving the required blood lead screening of the requirement to test the member and to provide the written or oral anticipatory guidance as required. *(2024 Contract, Exhibit A, Attachment III 5.3.4(D)(2))*

The Plan is required to provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child that at a minimum, includes information that children can be harmed by exposure to lead. This anticipatory guidance must be provided parent or guardian at each PHA, starting at 6 months of age and continuing until six years (i.e. 72 months). *(APL 20-016, Blood Lead Screening of Young Children)*

The Plan's 2024 Provider Manual stated that providers must provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member. The anticipatory guidance must be provided to the parent or guardian at each well visit, starting at 6 months of age and continuing until 72 months of age.

Plan policy, *QM14.701, Initial Health Appointment* (approved 2/13/2024), stated the Plan monitors for the completion of blood lead screenings or the documentation of the refusal through its Medical Record Review.

Finding: The Plan did not ensure the provision of oral or written blood lead anticipatory guidance to the parent(s) or guardian(s) of members starting at six months to six years of age.

The Plan's policy did not include information on the provision of blood lead anticipatory guidance.

A verification study revealed in five of eight members under 6 years of age, the provider did not document the provision of blood lead anticipatory guidance.

In an interview, the Plan stated it monitors claims data to identify members under 6 years of age to ensure they received the required blood level screenings at 12 and 24 months. The Plan also indicated that it monitored compliance through Facility Site Reviews, and provided education through newsletters and training, which included information on blood lead screening guidelines and outreach responsibilities. However, the Plan's monitoring processes did not include monitoring for blood lead anticipatory guidance for members starting at six months to six years of age.

When the Plan does not provide blood lead anticipatory guidance, members may remain unaware of the exposure to or the associated risks, which can result in behavioral and physical impairment.

Recommendation: Develop and implement policies and procedures to ensure oral and written blood lead anticipatory guidance is provided to the members parent(s) or guardian(s) starting at six months to six years of age.

2.6 ENHANCED CARE MANAGEMENT

2.6.1 Comprehensive Enhanced Care Management Program

The Plan is required to take a whole-person, interdisciplinary approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost members in distinct Populations of Focus through systematic coordination of services and comprehensive care management. *(2024 Contract, Exhibit A, Attachment III, 4.4.1 (A), (B) and(C))*

The Plan is required to identify necessary clinical and non-clinical resources that may be needed to appropriately assess a member's health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan. *(APL 23-032, Enhanced Care Management Requirements)*

The Plan is required to perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the Contract, the DHCS' policies and guidance, APLs, and the Plan's Model of Care. *(2024 Contract, Exhibit A, Attachment III, 4.4.13)*

Plan policy, *ADMIN 1.048, ECM Engagement, Operations, and Evaluation* (revised 04/2024), stated that ECM providers must complete and maintain through regular updates, a Comprehensive Assessment and Care Management Plan. The ECM provider shall identify and ensure that they have available the necessary clinical and non-clinical resources that may be needed to appropriately assess a member's health status and gaps in care. ECM providers shall assess member risks, needs, goals, and preferences to develop a comprehensive, individualized, and person-centered care plan in collaboration with the member, multi-disciplinary care team, and caregivers or support persons. The policy did not include an oversight process to ensure that the Plan's ECM providers implemented a comprehensive ECM program to address a member's clinical needs.

The Contra Costa County Public Health Department's (CCCPHD), an ECM network provider, *Public Health Nurse (PHN) New Client Assessment Workflow* (undated), stated all new clients in ECM are assigned to PHNs to assess if clients are medically complex and if case management should be provided by a PHN, or if another discipline is more appropriate. The workflow stated that client consents, review of systems, vital signs, and medication reconciliation should be completed first. Then if the PHN determines after

completing the review of systems, vital signs, and medication reconciliation that a PHN will continue with the client as the Lead Care Manager (LCM), the Long Term Services and Supports needs assessment can be completed during the next visit.

Finding: The Plan did not ensure the provision of comprehensive care management and coordination of care for the clinical needs relevant to members enrolled in the ECM program.

A verification study of 11 of 19 (CCCPHD) and 1 of 3 non-county ECM providers (Omatochi) members' medical records revealed that member clinical needs were not assessed or reviewed by a clinical case manager:

- In ten samples, there was documentation that non-clinical needs were addressed, but there was no record of a clinical case manager's assessment to determine clinical needs. In one case, the member had a history of ischemic cardiomyopathy, high blood pressure, heart failure, peptic ulcer disease, and Stage 3 chronic kidney disease. However, documentation did not show that the ECM provider made an assessment to identify and address gaps in care or health care concerns related to the member's health history.
- In two samples, although the ECM provider addressed the member's non-clinical needs, neither the comprehensive PHN initial clinical needs assessment or the Long Term Services and Supports needs assessment was completed. In one case that lacked a PHN's initial clinical needs assessment, the member's diagnoses included abnormal renal function, anxiety, drug use, history of panic attacks, auditory hallucinations, schizophrenia spectrum disorder with psychotic disorder, depression, chronic low back pain, tension headaches, arm paresthesia (tingling, numbness, prickling, or pins and needles), and leukemia. Furthermore, in one of the cases, the need for Long Term Services and Supports was not incorporated into the member's care management plan.

In an interview, CCCPHD acknowledged that prior to August 2023, ECM members were not assessed by a clinical case manager. In August 2023, CCCPHD implemented the PHN New Client Assessment Workflow requiring all patients to receive an assessment by a PHN. The workflow instructs CCCPHD staff to complete an assessment which includes a review of symptoms, vital signs, medication reconciliation, social determinants of health, and Long Term Services and Supports. In June 2023, the Plan provided training to its ECM providers to ensure that all members receive an initial assessment by a PHN case manager. However, the Plan does not have an oversight process of its ECM providers, such as routine periodic audits, to ensure compliance with ECM requirements.

The Plan conducted an ad hoc audit of CCCPHD, including a review of 200 ECM member records. Issued on July 1, 2024, the Plan's audit report identified a lack of clinical oversight on the completion of member comprehensive assessments. Furthermore, there was inconsistent use of ECM-related flowsheets and screenings to determine clinical and non-clinical needs of members.

ECM members are those individuals with the most complex medical and social needs. When the Plan does not implement a comprehensive ECM program and/or ensure that its ECM providers perform complete and appropriate needs assessments, critical clinical needs may go unidentified and unaddressed, leading to member neglect and adverse health outcomes.

Recommendation: Revise policies and procedures to ensure the implementation of a comprehensive ECM program that effectively assesses and addresses the clinical needs of the Plan's ECM population.

2.6.2 ECM Core Service Components

The Plan is required to ensure that all members receive all seven ECM core service components: Outreach and Engagement, Comprehensive Assessment and Care Management Plan, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Member and Family Supports, and Coordination of and Referral to Community and Social Support Services. *(2024 Contract, Exhibit A, Attachment III, 4.4.11)*

The Plan is required to perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the Contract, the DHCS' policies and guidance, APLs, and the Plan's Model of Care. *(2024 Contract, Exhibit A, Attachment III, 4.4.13)*

The Plan is required to administer ECM and provide seven core ECM services to eligible members in applicable ECM Populations of Focus. The core ECM services must include, but are not limited to, the following:

Comprehensive Assessment and Care Management Plan

- Identifying clinical and non-clinical resources that may be needed to appropriately assess member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan; and
- Developing a comprehensive, individualized, person-centered Care Management Plan with input from the member and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as

appropriate, to assess strengths, risks, needs, goals and preferences and make recommendations for service needs.

Enhanced Coordination of Care

- Maintaining regular contact with all providers that are identified as being a part of the member's multi-disciplinary care team since their input is necessary for successful implementation of the member's goals and needs; and
- Providing support to engage the member in their treatment, including coordination for medication review and reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to member engagement in treatment.

Health Promotion

- Providing services to encourage and support the member to make lifestyle choices based on healthy behavior, with the goal of supporting the member's ability to successfully monitor and manage their health; and
- Supporting the member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Comprehensive Transitional Care

- Providing the member services to reduce avoidable admissions and readmissions by evaluating the member's medical care needs, developing a treatment plan, and coordinating any support services to facilitate safe and appropriate transitions to, from, and among treatment facilities, including admissions and discharges; and
- Supporting members by tracking admissions and discharges to or from an emergency department, hospital inpatient facility, skilled nursing facility, or other treatment center and communicating with the appropriate care team members to include coordinating medication review and reconciliation; as well as providing adherence support and referral to the appropriate services.

Member and Family Supports

- Documenting and ensuring authorizations are in place to ensure effective communication between the member's authorized family members, legal

guardians, authorized representatives, caregivers, and other authorized support persons, as applicable; and.

- Providing education and identifying supports needed for the member and/or their family members, legal guardians, authorized representatives, caregivers, and/or authorized support persons, as applicable to manage the member's condition and assist them in accessing needed support services.

(APL 23-032, Enhanced Care Management Requirements)

Plan policy, *ADMIN 1.048 ECM, Engagement, Operations, and Evaluation* (revised 04/2024), detailed how ECM providers must provide all seven core services components in accordance with Contract requirements, including Health Promotion, Comprehensive Transitional Care, Member and Family Supports, and Enhanced Coordination of Care.

Finding: The Plan did not ensure that all members received all seven ECM core service components.

A verification study of twenty-two-member medical records found that 16 of 19 CCCPHD and 3 of 3 non-county ECM providers (Omotachi, Master Care Inc., and Axis Senior Resource) did not include all ECM core service components:

- In 11 samples, Health Promotion was not completed. In one case, the members medical history included: coronary artery disease, dyslipidemia, high blood pressure, diabetes, high blood sugar, chronic kidney disease, depression, back and knee pain, rotator cuff syndrome of right shoulder, amputation of the fingertip, stroke, and insomnia. There was no documentation that indicated the member was provided the tools and support that would help the member better monitor and manage their current health status.
- In four samples, Comprehensive Transitional Care was not completed. In one case, the member was a frequent user of emergency room services and unplanned hospital stays. There was no documentation that the member was provided support to safely and easily transition in and out of treatment facilities, including hospitals.
- In 13 samples, Member and Family Supports was not completed. In one case, the members medical history included: anxiety, depression, post-traumatic stress disorder, attention deficit hyperactivity disorder, breast cancer, lupus, nausea, and vomiting. There was no documentation that indicated the member's family support system was engaged or educated by the ECM provider regarding the

member's current health issues to assist the member in the management and improvement of their health conditions.

- In 13 samples, Enhanced Coordination of Care was not completed. In one case, the LCM did not engage with the member's primary care provider for input in the implementation of member goals and needs. The member also did not receive a reconciliation of their medication.

Plan policy ADMIN 1.048 did not state how the Plan will conduct oversight of ECM providers, such as routine medical record reviews, to ensure members received all ECM core service components.

In an interview, CCCPHD stated that they adhere to contractual requirements for ECM. The Plan stated that it provided ECM program training, inclusion of ECM providers in Plan committee meetings, and conducted an ad hoc oversight audit. However, the County ECM provider does not conduct routine medical record reviews to ensure members received all ECM core service components.

The Plan conducted an ad hoc audit of CCCPHD. Issued July 1, 2024, the Plan's audit report identified CCCPHD did not consistently provide all required core service components including: Comprehensive Assessment and Care Management Plans, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, and Member and Family Supports. Furthermore, CCCPHD did not have policies or procedures addressing primary care provider identification and outreach, medication reconciliation, identification and integration of Member and Family Supports, or transitional care services.

ECM members are those individuals with the most complex medical and social needs. When the Plan does not ensure that all ECM core service components are completed, members may not receive proper coordination of services and comprehensive care management, resulting in adverse health outcomes.

Recommendation: Revise and implement policies and procedures to ensure all ECM core service components are completed.

2.6.3 Care Plans for Member and Family Supports

The Plan is required to follow all provisions in the ECM Policy Guide, in addition to provisions outlined in the Contract. *(2024 Contract, Exhibit A, Attachment III, 4.4.1 and 4.4.11)*

The Plan is required to ensure that the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, have a copy of the Member's Care Management Plan and information about how to request updates. *(APL 23-032, Enhanced Care Management Requirements)*

Plan policy, *ADMIN 1.048, ECM Engagement, Operations, and Evaluation* (revised 04/2024), stated that ECM providers shall ensure that the member has a copy of his/her care plan and information about how to request updates.

Finding: The Plan did not ensure that ECM members and their authorized support persons received a copy of the members' Care Management Plan, along with information about how to request updates.

A verification study of 19 of 19 CCCPHD member medical records revealed no documentation that a copy of the Care Management Plan was provided to the member or their applicable authorized support persons.

Plan policy ADMIN 1.048 stated that the Plan shall ensure that the member has a copy of the ECM care plan and information about how to request updates. However, this policy does not state that the Plan will ensure that a care plan copy is given to the member's member or their authorized support persons.

In an interview, CCCPHD stated that members can access copies of their care plans through the member portal. CCCPHD stated that it does not have the ability to print care plan copies. The Plan did not describe an established process for instructing members on how to access their care plans and for documenting the provision of such instruction. Additionally, the Plan did not clarify whether the member's applicable authorized support persons have access to the portal.

ECM members are individuals with the most complex medical and social needs, including the elderly, those experiencing homelessness, and other members with limited access to technology. When members and their authorized support persons do not receive a copy of the Care Management Plan or information on how to request updates, it can result in a lack of knowledge needed to manage a member's condition effectively and make informed decisions.

Recommendation: Develop and implement policies and procedures to ensure that members and their authorized support persons receive a copy of the Care Management Plan, along with and information about how to request updates.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 GRIEVANCE SYSTEM

4.1.1 Quality of Care Grievances

The Plan is required to ensure that individuals with authority to require corrective action participate in the grievance process. Medical QOC grievances shall be referred to the Medical Director. *(2023 Contract, Exhibit A, Attachment 14(2)(D))*

The Plan is required to ensure all medical QOC grievances are immediately submitted to the Medical Director for action. *(2024 Contract, Exhibit A, Attachment III, 4.6.1(D))*

The Plan is required have a system in place in accordance with CCR, Title 22, section 53858, and follow grievance requirements. *(2023 Contract, Exhibit A, Attachment 14(1))*

The Plan is required to have in place a system that complies with grievance requirements set forth in CCR, Title 22, section 53858, and APL 21-011. *(2024 Contract, Exhibit A, Attachment III, 4.6.1)*

The Plan is required to ensure that, at minimum, all medical QOC grievances are submitted to the Medical Director for action. *(CCR, Title 22, section 53858(e)(2); APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, *AGD 20.002, Handling of Complaints and Grievances* (revised 5/2024), stated all grievances are reviewed by the grievance nurse and for all QOC grievances, the grievance nurse will initiate the investigation. Before grievance resolution letters are sent to members, the Chief Medical Officer (CMO) or physician medical consultant will review all QOC grievance resolution letters to confirm that all issues raised have been addressed.

The Plan's desktop procedure, *APL Process* (updated 1/9/24), stated the Compliance Department will review APLs for information and action items to be disseminated, updated, or created.

Finding: The Plan did not have policies and procedures to ensure medical QOC grievances were immediately submitted to the Medical Director for action.

A verification study revealed 19 of 25 standard QOC grievances filed with a standard timeframe were not immediately submitted to the Medical Director or CMO for action.

The grievances were sent to a Medical Director between 14 and 30 days from the Plan's receipt of a grievance. Examples of deficient grievances include:

- In one case, a member filed a grievance that their provider did not perform a physical exam. The CMO reviewed the case 27 days after the grievance was received.
- In another case, a member's mother filed a grievance after it took ten days to be informed that her son had a fractured arm following the completing of x-rays. The CMO reviewed the case 26 days after the grievance was received.
- In another case, a member's mother filed a grievance alleging that her son was restrained for more than two hours and neglected by emergency room staff. A Medical Director reviewed the case 30 days after the grievance was received.

In an interview, the Plan stated that the timeframe for physician review of QOC grievances is variable, as nurses may consult with a physician at any time and informal discussions occur. However, these consultations and discussions are not documented. Additionally, the Plan was unable to explain why the requirement that QOC grievances be immediately submitted to the Medical Director for action was not incorporated into its policies and procedures. While the Compliance Department is responsible for identifying APL requirements, the Plan could not demonstrate that the requirement was identified during the review of APL 21-011. Plan policy ADG 20.002 does not include procedures for the immediate submission of all QOC grievances to the Medical Director.

Lack of immediate involvement by the Medical Director in the QOC grievance process may delay provider corrective actions and contribute to preventable substandard care, potentially resulting in adverse health outcomes for members.

Recommendation: Develop and implement policies and procedures to ensure that medical QOC grievances are immediately submitted to the Medical Director for action.

4.1.2 Grievances Alleging Discrimination

The Plan is required to comply with APLs issued by the DHCS. *(2023 Contract, Exhibit E, Attachment 2(1)(D))*

The Plan is required to comply with all DHCS guidance, including APLs. *(2024 Contract, Exhibit E, 1.1.2))*

The Plan is required to forward all grievances alleging discrimination against members to the DHCS for review and appropriate action. *(2023 Contract, Exhibit E, Attachment 2(28)(C))*

The Plan is required to process discrimination grievances as required by federal and state nondiscrimination law and DHCS policy, as outlined in APL 21-004, *Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*. Within ten calendar days of mailing a Discrimination Grievance resolution letter, the Plan is required to submit the information regarding the discrimination grievance to the DHCS' Office of Civil Rights (OCR) as specified in APL 21-004. *(2024 Contract, Exhibit A, Attachment III, 4.6.3)*

The Plan is required to forward all grievances alleging discrimination to the DHCS within ten calendar days of mailing a Discrimination Grievance resolution letter. The Plan must submit the following detailed information to the DHCS: the original grievance, the accused party's response, member correspondence, investigation results, corrective action, and contact information for the member, accused party, and the staff who investigated the grievance, and any other relevant information. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan policy, *AGD 20.002, Handling of Complaints and Grievances* (revised 5/2024), stated when a grievance includes a complaint of discrimination, the grievance will be forwarded to the Plan's Civil Right Coordinator for review. Within ten days of mailing a Discrimination Grievance resolution letter, detailed information regarding the grievance is submitted to the DHCS' OCR.

Finding: The Plan did not submit grievances alleging discrimination, along with detailed information regarding the grievances to the DHCS as required.

A verification study revealed in two of two QOC grievances alleging discrimination, the grievance and required detailed information was not submitted to the DHCS:

- In one grievance alleging racial discrimination, a provider declined to refill a member's medication. The grievance resolution letter was mailed, but the grievance was not submitted to the DHCS. In a written response, the Plan confirmed the grievance clerk was notified that the discrimination grievance had been closed and to submit the required documentation to the DHCS; however, the clerk did not submit the grievance to the DHCS.

- In another grievance, the Plan's Health Equity Office was responsible for submitting discrimination grievances to the DHCS starting in December 2023. In the grievance, a mother alleged that her son was restrained for more than two hours and neglected by emergency room staff. She alleged discrimination based on age and race. The grievance resolution letter was mailed, but the grievance was not submitted to the DHCS.

In an interview, the Plan stated that as of December 2023, grievance discrimination reporting transitioned from the Grievance Department to the Health Equity Office. The Plan explained that there were communication issues between grievance staff and Health Equity staff during the handover, which contributed to the failure to submit discrimination complaints to the DHCS. The Plan also stated that an investigation into the racial discrimination grievance found no evidence of provider discrimination against the member, and as a result the grievance was not report to the DHCS. The Plan applied more restrictive criteria for reporting discrimination grievances, leading to non-compliant reporting of discrimination grievances. The Plan is required to report all member discrimination grievances based solely on a member's allegation, not verification of actual discrimination.

When the Plan does not submit all grievances alleging discrimination to the DHCS, members may be prevented from fully exercising their full rights and could lead to adverse health outcomes.

Recommendation: Implement policies and procedures to ensure grievances alleging discrimination, along with detailed information regarding the grievances are submitted to the DHCS.

4.1.3 Grievance Tracking and Trending

The Plan is required to have in place a system in accordance with CCR, Title 28, sections 1300.68 and 1300.68.01, CCR, Title 22, section 53858; and Code of Federal Regulations (CFR), Title 42, sections 438.402 – 424. *(2023 Contract, Exhibit A, Attachment 14(1))*

The Plan is required to have in place a member grievance and appeal system for covered services that complies with CFR, Title 42, sections 438.228 and 438.400 – 424; CCR, Title 28, sections 1300.68 and 1300.68.01, and CCR, Title 22, section 53858. *(2024 Contract, Exhibit A, Attachment III, 4.6.1))*

The Plan is required to maintain policies and procedures for compiling, aggregating, and reviewing grievance and appeal data for use in the Plan's QIS. The Plan must regularly analyze grievance and appeal data to identify, investigate, report, and act upon systemic

patterns of improper service denials and other trends impacting health care access and delivery to members. (2024 *Contract, Exhibit A, Attachment II, 4.6.1)(J))*

The Plan's member grievance procedures must provide for the review and analysis, on at least a quarterly basis, of all recorded grievances related to access to care, QOC, and denial of services, and take appropriate action to remedy any problems identified in such reviews. *(CCR, Title 22, section 53858 (e)(4))*

Plan Policy, *AGD 20.002, Handling of Complaints and Grievance* (revised 05/2024), stated that all exempt, expedited, and standard grievances will be included in the quarterly summary reports of grievance for monitoring, tracking, and reporting purposes.

Finding: The Plan did not ensure all grievances, including exempt grievances, were reviewed and analyzed on at least a quarterly basis.

The Plan submitted quarterly grievance tracking and trending analyses to the JCC and Quality Council Committee. The grievance tracking and trending analyses included aggregate data for standard grievances received during the quarter by topics: Access, Other Issues, QOC or Quality of Service, and subtopics such as Provider/Office Staff Services, Communication Issues, Transportation Punctuality, and more. The analyses did not include a review of any exempt grievance data.

In an interview and written response, the Plan acknowledged that the quarterly grievance tracking and trending did not include exempt grievances in the aggregate data due to the limitation of data reporting.

When the Plan does not review and analyze all grievances, it cannot identify, investigate, and act upon the trends that are impacting health care access and delivery to members.

Recommendation: Implement policies and procedures to include review and analysis of all grievances in the grievance quarterly track and trend monitoring report.

COMPLIANCE AUDIT FINDINGS

Category 5 – Quality Management

5.1 QUALITY MANAGEMENT

5.1.1 Reporting of Provider Preventable Conditions to Department of Health Care Services

The Plan must not pay any provider claims or reimburse a provider for PPCs in accordance with CFR, Title 42, section 438.3(g). The Plan is also required to report, ensure all it its providers report PPCs in the form and frequency required by APL 17-009, *Reporting Requirements Related to Provider Preventable Conditions*. *(2023 Contract, Exhibit A, Attachment 8(4); 2024 Contract, Exhibit A, Attachment III, 3.3.17))*

The Plan is required to comply with the requirements mandating provider identification of PPCs as a condition of payment, as well as the prohibition against payment for PPCs. The Plan must report all identified PPCs in a form and frequency as specified by the State. *(CFR, Title 42, section 438.3(g))*

CFR, Title 42, section 438.3(g) requires the Plan to report PPC-related encounters "in a form and frequency as specified by the State." Accordingly, the Plan is required on a monthly basis to screen the encounter data, including data received from network providers, for the presence of PPCs. PPCs include, but are not limited to, deep vein thrombosis/pulmonary embolism, falls or trauma resulting in fractures, Stage III or IV pressure ulcers, surgical site infections, and vascular catheter-associated infections. The Plan must use the DHCS' secure online reporting portal to report PPCs to the DHCS. *(APL 17-009, Reporting Requirements Related to Provider Preventable Conditions)*

Plan policy, *QM14.805, Reporting Provider Preventable Conditions* (revised 10/30/23), stated the Plan is responsible for identifying and reporting PPCs to the DHCS. The Plan maintains a log of PPCs identified through monthly monitoring of encounter data. PPCs are investigated as PQIs and are considered potential PPCs until the investigation concludes. The PQI nurse and PQI Committee will review all relevant information gathered through the investigation to determine whether the case is a confirmed PPC.

The Plan's, *Quality Improvement and Health Equity Transformation Program Description 2024,* stated any department, provider, or member can identify a PQI and forward it to the Quality Department for investigation and resolution. Additionally, a quality nurse reviews a report that identifies PPCs and develops PQIs as necessary.

Finding: The Plan did not report all PPCs to the DHCS as required.

A verification study revealed in 2 of 12 PQI cases the Plan identified PPCs but did not report the incidents to the DHCS.

- In one case, the member was admitted to the Intensive Care Unit following a cardiac arrest. During their stay, the member experienced a fall, which resulted in a left femur fracture.
- In another case, after being cleared by physical therapy and awaiting discharge, the member experienced a fall that resulted in a shoulder fracture.

The Plan reported one PPC to the DHCS during the audit period. However, a review of PQI meeting minutes showed other member cases designated as PPCs that were not reported to the DHCS.

In an interview and in a written response, the Plan stated that neither of these cases were considered PPCs. The Plan stated the fracture in the first case was the result of a non-compliant member, and the fall would not have been preventable. However, the member exhibited confusion during the hospital stay and would have been considered a fall risk. In the second case, the Plan stated the fall was not preventable as the patient had been cleared by physical therapy and discharged. However, the member experienced the fall in the hospital room and had not been discharged, they were awaiting discharge and still in the hospital's care. The Plan's interpretation of reportable PPCs incorrectly included incidents where PPCs were not preventable. The Plan's policy is to identify all PPCs as a potential PPC until the conclusion of an investigation is not compliant with its contractual requirements.

Review of PQI Committee minutes and PQI documentation does not show that these incidents were re-adjudicated as non-PPCs, contrary to the Plan's statements. Additionally, the contractual requirements do not make a distinction between a preventable fall resulting in fracture versus an unpreventable fall resulting in fracture; the Plan is required to report a PPC fall resulting in a fracture regardless of the conditions that led to the fall.

When the Plan does not accurately capture and report all PPCs, it cannot hold providers accountable for the care they deliver, and providers may receive payment for services that are not reimbursable. This also can increase the risk of member harm being undetected and underreported.

Recommendation: Revise and implement policies and procedures to ensure all PPCs are reported to the DHCS.

5.3 PROVIDER QUALIFICATIONS

5.3.1 Provider Terminations

The Plan is required to ensure members are notified in writing of any changes in the availability or location of covered services, at least 30 calendar days prior to the effective date. The Plan is required in good faith to give written notice of termination of a provider within 15 calendar days of receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notification must be presented to and approved in writing by the DHCS prior to release. *(2023 Contract, Exhibit A, Attachment 13(5))*

The Plan is required to ensure members are notified in writing of any changes in the availability or location of covered services, of any termination of a network provider, subcontractor, or downstream subcontractor either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by the DHCS. The notification must be provided to each member who received primary care from, or was seen on a regular basis by, the terminated provider. This notification must also be submitted to the DHCS in writing for approval before release. *(2024 Contract Exhibit A, Attachment III, 5.2.9 (B))*

The Plan is required to meet the notification and reporting requirements for terminations by determining the overall member impact due to the termination. For all terminations, the Plan is required to mail appropriate member notifications and remain accountable for all functions and responsibilities of the terminated network provider/subcontractor to ensure that impacted members do not experience disruption in access to care.

Regardless of the number of members, the Plan is required to provide written notice to all impacted members informing them of the contract termination either 30 calendar days prior to the effective date of the contract termination or 15 calendar days after receipt or issuance of the termination notice, whichever is later, unless directed by the DHCS. If the Plan is notified of a contract termination less than 30 days prior to the effective date of the termination, the Plan must immediately notify all impacted members of the termination.

Whenever a Plan or network provider/subcontractor voluntarily terminates a contract, the Plan is required to provide notice to all impacted members. *(APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations)*

Plan policy, *CR11.004, Provider Reconsideration Process* (reviewed 12/2023), described the Plan's reconsideration process for providers to be heard in response to a recommended action by the Peer Review and Credentialing Committee.

Finding: The Plan did not provide written notices to all impacted members for terminations of network providers, subcontractors, or downstream subcontractors.

The Plan's policy did not include information regarding written member notices for provider terminations.

In an interview, the Plan stated there may have been providers who moved out of the county and left the network. Providers within a medical group may leave, and the Plan is not made aware until several months later. At that point, the Plan takes action to remove the provider from the network.

In a written statement, the Plan confirmed there were 331 provider terminations during the audit period. The Plan provided a list of inactive providers without dates for member notifications. The explanation on the list of inactive providers stated member services did not notify the member when a specialty provider left the network. If the member needed to continue services, they would be referred to a contracted specialist by the Authorization/UM unit.

If the Plan does not provide written notice to members when providers leave the network, members may experience unexpected challenges and delays when trying to obtain medically necessary health care services.

Recommendation: Develop and implement policies and procedures to ensure that all impacted members are provided written notice when the Plan, network providers, subcontractors, or downstream subcontractors terminate contracts.

COMPLIANCE AUDIT FINDINGS

Category 6 – Administrative and Organizational Capacity

6.2 FRAUD AND ABUSE

6.2.1 Compliance Officer Independence

The Plan is required to designate a Compliance Officer who is responsible for developing, implementing, and ensuring compliance with contractual requirements and standards. The Compliance Officer must report directly to the CEO and the Board of Directors. The Compliance Officer must be a full-time employee and operate independently, meaning they cannot serve in both compliance and operational roles. *(2024 Contract, Exhibit A, Attachment III, 1.3.1(E))*

The Plan's *Compliance Plan and Code of Conduct (undated)* stated the Compliance Officer reports directly to the Plan's CEO. The Contra Costa County Board of Supervisors is the designated governing body responsible for the supervision of the Plan's compliance efforts.

Finding: The Plan did not ensure the designated Compliance Officer did not also serve in an operational role or capacity.

In October 2023, the Plan hired a Deputy Executive Officer, who was later appointed as Compliance Officer in January 2024.

Review of the Compliance Officer's current resume revealed duties as Deputy Executive Director/Compliance Officer included responsibilities for developing staffing, and coordinating with supervisors and senior managers to resolve issues related to personnel actions and operating procedures.

In an interview, the Plan stated that the Compliance Officer's role mainly consists of compliance-related duties, but also includes other administrative duties, such as ad hoc and special projects, at the discretion of the CEO, beyond compliance responsibilities.

When the Plan's Compliance Officer is not independent and serves in an operational role, compliance-related activities such as investigations may be compromised, and the Plan would not be in compliance with the contractual requirements.

Recommendation: Revise and implement policies and procedures to ensure the Compliance Officer is independent and does not serve in both compliance and operational roles.

6.2.2 Compliance Officer Criteria

Plan policies and procedures are required to include the criteria for selecting a Compliance Officer and a job description, including responsibilities and the authority of the position. *(2024 Contract, Exhibit A, Attachment III, 1.3.1, E)*

The Plan's *Compliance Plan and Code of Conduct* (undated) stated the Compliance Officer reports directly to the Plan's CEO. The Contra Costa County Board of Supervisors is designated governing body responsible for the supervision of the Plan's compliance efforts.

The Plan's *Duty Statement* (undated) for the Compliance Officer included an organizational chart and listed responsibilities including, but not limited to the following: litigation matters, liaison with County Counsel, Department of Managed Health Care annual filing, coordination with legal and member services on all powers of attorney and subpoenas, oversight of compliance vendors, and coordination and investigation of all Health Insurance Portability and Accountability Act violations.

Finding: The Plan did not have policies and procedures that included criteria for selecting a Compliance Officer or a job description outlining the responsibilities and authority of the position.

The Plan provided a duty statement, that outlined the Compliance Officer's reporting structure and a list of responsibilities. However, the Plan's policies and procedures did not define the selection criteria for the Compliance Officer or provide a detailed job description.

Without the required policies and procedures, the Plan cannot fully demonstrate that the Compliance Officer was appropriately hired and is fulfilling all the necessary responsibilities.

Recommendation: Revise and implement policies and procedures to include criteria for selecting a Compliance Officer and a job description outlining the responsibilities and the authority of the position.

6.2.3 Compliance Plan

The Plan is required to have a compliance program that includes, at a minimum, the following elements of a compliance plan:

- Outlines the key elements of the compliance program;
- Includes reference to the standards of conduct or code of conduct;

- Allows the compliance program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance;
- Details how it will implement and maintain elements of the compliance program;
- Includes the compliance reporting structure and positions of key personnel involved in ensuring compliance, including the Compliance Officer;
- References the delegation reporting and compliance plan;
- References policies and procedures operationalizing the compliance program;
- Is reviewed and approved by the Board of Director's Compliance and Oversight Committee routinely, but not less than annually; and
- Is publicly posted on the Plan's website.

(2024 Contract, Exhibit A, Attachment III, 1.3.1(A))

The Plan's *Compliance Plan and Code of Conduct* (undated) included standards to address areas identified as a high priority for compliance oversight and ensure the Plan's commitment to ethical behavior.

Finding: The Plan did not maintain a compliance program which included all required elements of a compliance plan.

In an interview, the Plan confirmed that the Compliance Plan and Code of Conduct document was the compliance plan. However, review of the compliance plan revealed that only two required elements were included: the standards of conduct and the review and approval process by the Board of Director's Compliance and Oversight Committee. The compliance plan did not include any of the other seven required elements and cannot be found on the Plan's website.

When the Plan does not have a written compliance plan with all required information for how it will operationalize compliance operations, the Plan cannot effectively carry out the duties and fulfill its contractual requirements.

Recommendation: Revise and implement a compliance program that includes all the required compliance plan elements.

6.2.4 Fraud, Waste, or Abuse Reporting

The Plan is required to promptly refer any potential fraud, waste, or abuse that the Plan identifies to the DHCS' Audits and Investigations Intake Unit. The Plan is required to conduct, complete, and report to the DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days of the date the Plan first becomes aware of, or is on notice of, such activity. *(2023 Contract, Exhibit E, Attachment 2(26)(B)(7))*

The Plan is required to file a preliminary report with the DHCS' Program Integrity Unit detailing any suspected fraud, waste, or abuse identified within ten working days of discovery or notification of such fraud, waste, or abuse. The Plan is required to submit a preliminary report in accordance with requirements set forth in APLs or other similar instructions. Subsequent to the filing of the preliminary report, the Plan is required to promptly conduct a complete investigation of all reported or suspected fraud, waste, or abuse activities. *(2024 Contract, Exhibit A, Attachment III, 1.3.2(D)(1))*

Plan policy, *ADM1.006, CCHP Anti-Fraud Program* (revised 06/2024), stated when there is a report of a potential or suspected fraud case to the Anti-Fraud Unit, or the Anti-Fraud Compliance Officer (or designee), the Plan's Anti-Fraud Compliance Officer (or designee) must log all fraud, waste, or abuse inquiries and evaluate the reported incident for validity. Based upon the supporting documentation, the Anti-Fraud Coordinator will either close the case or refer the case for further investigation. The Plan's Anti-Fraud Officer will communicate cases referred to the DHCS Program Integrity Unit, or other appropriate government agency to the Anti-Fraud Unit, including the Health Plan CMO, Chief Operating Officer, and other members as required. The Anti-Fraud Officer will prepare a notification to the DHCS management not to exceed ten business days of the reported suspected fraud.

Finding: The Plan did not report all suspected fraud cases to the DHCS within ten working days.

A verification study revealed in four of eight samples the Plan did not send a notification to the DHCS. Quarterly, the Plan receives reports from a contracted entity, Cotiviti, responsible for analyzing claims and evidence for reasonable suspicion of fraud, waste, or abuse. All four samples were reports of suspected fraud, waste, or abuse from Cotiviti.

In an interview, the Plan stated that in February 2024, the Plan conducted an analysis of the data Cotiviti utilized and stated the data may be flawed. Therefore, the Plan did not investigate the suspect fraud reports due to the potential data concern. As of the end of

the audit period the Plan was still in process of correcting data issues with Cotiviti and has not conducted any investigations into the suspected fraud reports.

When the Plan does not notify the DHCS of suspected cases of fraud, the DHCS may not be unable to take appropriate and timely action with suspected fraud, waste, or abuse providers.

Recommendation: Implement policies and procedures to ensure all suspected cases of fraud are reported to the DHCS within ten working days.

6.2.5 Notification of Changes in Member's Circumstances

The Plan is required to establish administrative and management arrangements or procedures that provide prompt notification to the DHCS when the Plan receives information about changes in a member's circumstances that may affect the member's eligibility including, changes in the member's residence, income, and death. *(2023 Contract, Exhibit E, Attachment 2(23)(B)(3))*

The Plan is required to have a fraud prevention program that includes policies and procedures to promptly notify the DHCS when the Plan receives information about changes in a member's circumstances that may affect the member's eligibility including, changes in the member's residence, income, insurance status, and death (CFR, Title, 42 section 438.608(a)(3)). *(2024 Contract, Exhibit A, Attachment III, 1.3.2(B))*

Plan policy, *ADM1.006, CCHP Anti-Fraud Program* (revised 06/2024), and *Compliance Plan and Code of Conduct* (undated), did not include policies or procedures to promptly notify the DHCS about changes in members circumstances.

Finding: The Plan did not have policies and procedures to promptly notify the DHCS upon receipt of information about changes in a member's circumstances for income and death.

In a written statement, the Plan acknowledged there were no mechanisms to report a member's income or the death of the member. The Plan further stated they direct members to call Medi-Cal directly to inform the DHCS about changes in income or death. The Plan stated the County's Employment and Human Services Division collects member income information for Medi-Cal eligibility and the County Public Health Department reports all member deaths to the State. County Public Health's Vital Registration Department does not have access to the Plan's Medi-Cal members' files. Therefore, Contra Costa Public Health Department does not send death reports to the Plan. However, the Plan is responsible for notifying the DHCS when it receives

information about changes in member circumstances, not when another county division receives updated information. The Plan does not have any policies or procedures to report changes in member circumstances to the DHCS.

When the Plan does not notify the DHCS of changes in member's eligibility, Medi-Cal funds may not be appropriately adjudicated, and the Plan is not able to fulfill its contractual requirements.

Recommendation: Develop and implement policies and procedures to ensure changes in a member's circumstances, including income and death, are promptly report the DHCS.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF CONTRA COSTA HEALTH PLAN FISCAL YEAR 2024-25

Contract Numbers: 22-20462 and 23-30251

Contract Type: State Supported Services

Audit Period: August 1, 2023 — July 31, 2024

Dates of Audit: August 19, 2024 — August 30, 2024

Report Issued: February 14, 2025

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I. INTRODUCTION

This report presents the results of the audit of Contra Costa Health Plan's (Plan) compliance and implementation of the State Supported Services contract numbers 22-20462 and 23-30251 with the State of California. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of August 1, 2023, through July 31, 2024. The audit was conducted from August 19, 2024, through August 30, 2024, which consisted of a document review and verification study with the Plan's administration and staff.

An Exit Conference with the Plan was held on January 30, 2025. No deficiencies were noted during the review of the State Supported Services Contracts.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members enrolled under either this Contract or the Primary Contract, the following private services:

1) Current Procedure Terminology Codes 59840 through 59857
2) 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 Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code set provisions. *(2023 Hyde Contract, Exhibit A, (4) and 2024 Hyde Contract, Exhibit A, 1.2.1 and 1.2.2)*

The Plan is required to cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion consistent with the requirements in the Medi-Cal Provider Manual. The Plan, network providers, and subcontractors are prohibited from requiring medical justification, or imposing any utilization management or utilization review requirements, including prior authorization and on the coverage of outpatient abortion services. *(All Plan Letter, 24-003, Abortion Services*)

Finding: No deficiencies were identified in the audit.

Recommendation: None.