DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT DIVISION

REPORT ON THE MEDICAL AUDIT OF COMMUNITY HEALTH GROUP FOUNDATION DBA: COMMUNITY HEALTH GROUP PARTNERSHIP PLAN FISCAL YEAR 2023-24

Contract Numbers: 09-86155 and 23-30217

Audit Period: June 1, 2023 – May 31, 2024

Dates of Audit: May 20, 2024 – May 31, 2024

Report Issued: November 4, 2024

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I. INTRODUCTION

Background

Community Health Group Foundation dba Community Health Group Partnership Plan (Plan) was incorporated in 1986 and contracted with the Department of Health Care Services (DHCS) to provide services to Medi-Cal members. In 2005, the Plan obtained a Knox Keene license from the California Department of Managed Health Care to serve Medi-Cal members.

The Plan currently contracts with DHCS to provide services to Medi-Cal members under the Geographic Managed Care program in San Diego County. The Plan provides health care services through contracts with its provider network including private physicians, group practices, Federal Licensed Community Health Centers, Indian Health Services, all hospitals in its service area, an array of ancillary providers, and pharmacy services through Medi-Cal Rx.

The Plan is accredited by the National Committee for Quality Assurance as a Medicaid Health Maintenance Organization from September 25, 2023, through September 25, 2026, and for Health Equity from August 17, 2023, through August 17, 2026.

As of May 31, 2024, the Plan served a total of 409,544 members through the following programs: Medi-Cal, 402,355; Dual Special Needs Plan, 7,055; and Chronic Condition Special Needs Plan, 134.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the audit period of June 1, 2023, through May 31, 2024. The audit was conducted from May 20, 2024, through May 31, 2024. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference was held with the Plan on October 17, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On November 04, 2024, the Plan submitted a response to address the audit findings. The findings in this report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

Two prior year audit periods' Corrective Action Plans (CAP) were reviewed due to prolonged open CAPs.

The DHCS medical audit for the period of June 1, 2021, through May 31, 2022, was issued on February 15, 2023. The Plan's CAP closed on April 24, 2024. DHCS reviewed the Plan's CAP response due to the prolonged CAP closure that fell within the current audit period of June 1, 2023, through May 31, 2024. The review yielded no findings related to the six deficiencies identified during the period of June 1, 2021, through May 31, 2022.

Additionally, the prior year DHCS medical audit for the period of June 1, 2022, through May 31, 2023, was issued on November 28, 2023. Eight deficiencies were identified and incorporated into a CAP. The prior year CAP remained open as of July 22, 2024. The Plan is working with the Managed Care Quality and Monitoring Division to implement the CAP and correct the deficiencies identified in the DHCS audit report.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan's Notice of Action (NOA) must include the name and direct telephone number or extension of the decision maker. The Plan did not include the decision maker's name and direct phone number in the NOA communication to providers for Prior Authorization (PA) decisions.

The Plan must ensure that delegated entities comply with all state and federal laws and regulations, Contract requirements, and All Plan Letters (APL), including translating information to the identified threshold language. The Plan did not ensure the delegated entity provided fully translated information in the identified threshold language.

Category 2 – Case Management and Coordination of Care

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

Category 3 – Access and Availability of Care

The Plan requires members to have an approved Physician Certification Statement (PCS) form from their provider for Non-Emergency Medical Transportation (NEMT) services. The Plan did not obtain an approved PCS from for NEMT services provided.

Category 4 – Member's Rights

The Plan is required to fully translate written member information, including all grievance and appeal notices in the member's required language. The Plan did not provide translated NOA/Notice of Appeal Resolution (NAR) information in the members' required language.

Category 5 – Quality Management

The Plan is required to maintain the qualifications of staff responsible for Quality Improvement (QI) activities in the Quality Improvement and Health Equity Transformation Program (QIHETP). The Plan did not maintain policies and procedures and a written description that included qualifications of staff responsible for QI activities.

The Plan is required to begin training within ten working days after a newly contracted network provider is placed on active status. The Plan did not train newly contracted providers within ten working days after being placed on active status.

Category 6 –Administrative and Organization Capacity

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

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The audit was conducted from May 20, 2024, through May 31, 2024, for the audit period of June 1, 2023, through May 31, 2024. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. Documents were reviewed and interviews were conducted with Plan representatives.

The following verification studies were conducted:

Category 1 – Utilization Management

PA Requests: 24 standard and 7 expedited PA requests. Of the 31 authorizations, 17 denied and 14 approved PA requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to providers and members.

Appeal Procedures: 17 PA appeals were reviewed for appropriate and timely adjudication.

Delegation of UM: 15 PA requests from Rady Children's Specialists of San Diego were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Complex Case Management: 11 medical records were reviewed for care coordination and completeness to evaluate the performance of services.

Behavioral Health Treatment: Ten member files were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

Category 3 – Access and Availability of Care

NEMT: 15 records were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): 15 records were reviewed to confirm compliance with NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: 23 Quality of Care (QOC), 26 Quality of Service (QOS), 6 expedited, and 4 exempt grievance cases were reviewed for timely resolution, appropriate response to complainant, submission to the appropriate level for review, and translation in the member's preferred language. In addition, 15 member calls from the inquiry log were reviewed for appropriate classification and processing.

Category 5 – Quality Management

Quality Improvement System (QIS): Seven potential quality issue files were reviewed for proper decision-making and effective actions taken to address QI.

Provider Qualifications: 15 new provider training records were reviewed for timeliness.

Category 6 – Administrative and Organization Capacity

Fraud and Abuse Reporting: Three fraud and abuse cases were reviewed for appropriate reporting of suspected fraud, waste, or abuse to DHCS within the required time frame.

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

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 Prior Authorization Review Requirements

1.2.1 Decision Maker Written Communication

Any written communication to a provider regarding a denial, delay, or modification of a request must include the name and telephone number of the responsible Plan's health care professional. *(Contract, Exhibit A, Attachment III)*

The written NOA must include the name and direct telephone number or extension of the decision maker. The provider must first be notified by telephone or facsimile, followed by written confirmation, except for retrospective decisions. *APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request must include the name and telephone number of the health care professional responsible for the decision. The telephone number provided shall be a direct number or an extension to allow the physician or health care provider the ability to easily contact the professional responsible for the denial, delay, or modification. (*Health and Safety Code, section 13607.01(h)(4)*)

The Plan's policy, *7224a Denial Review Process* (revised 05/04/2022), outlined the Plan's process for review of cases by the Chief Medical Officer (CMO) and Medical Director when a denial is being recommended. The process ensures when a case is denied that a licensed physician reviews appropriate medical records and that the denial letter contains the required information, i.e., phone number and name of decision maker.

Finding: The Plan did not include the decision maker's name and direct phone number in the NOA communication to providers for PA decisions.

Although the Plan's policy 7224a stated the CMO and Medical Director reviews the medical records and the denial letters to ensure it contains the required information, the Plan did not follow their process for providing the decision maker's name and direct phone number in their communication to providers for PA decisions. The Plan's process

is to provide a screenshot of the authorization request details in the online provider portal instructing the physician to call the direct phone number to the CMO's assistant.

The verification study revealed the Plan did not include the decision maker's direct phone number in 31 out of 31 PA requests. Additionally, in 13 out of 31 requests, the Plan did not include the decision maker's name.

During the interview, the Plan stated the phone number to reach the Medical Director who is the decision maker, is present in the online provider portal. However, according to APL 21-011, the Plan is required to include the name and direct telephone number or extension of the decision maker in the NOA written communication. Therefore, due to an inadequate policy and procedure, the Plan did not include the decision maker's name and direct phone number in the NOA written communication to providers.

Without the medical decision maker's name and direct phone number in the Plan's NOA written communication, providers are unable to directly communicate with the appropriate decision maker, which may hinder timely resolution of authorization issues, and peer-to-peer discussions. This can delay patient care and potentially affect treatment outcomes and overall patient satisfaction.

Recommendation: Revise policy and procedures to include the name and direct telephone number of the decision maker in the NOA communication to providers for PA.

1.5.1 Delegation Oversight

The Plan must ensure delegates meet all Contract requirements for the functions undertaken. The Plan remains fully responsible for all delegated duties and obligations. To ensure compliance, the Plan must monitor and oversee all delegated functions. *(Contract, Exhibit A, Attachment III, 3.1.1(B)(4))*

The Plan must have the capacity to provide fully translated member information, including member rights information, form letters and notices, NOA letters, all grievance and appeal notices, and any other materials required by APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services. *(Contract, Exhibit A, Attachment III, 5.2.10(B)(3)(b))*

Member information is essential information regarding access to and usage of Plan services, including documents that are vital or critical to obtaining services and/or

benefits. The Plan must provide translated written member information to Medi-Cal members who speak identified threshold and concentration languages. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

The Plan must ensure that delegated entities comply with all state and federal laws and regulations, Contract requirements, and APLs. *(APL 23-006, Delegation and Subcontractor Network Certification)*

Regardless of the relationship with the delegated entity, the Plan is ultimately responsible for adhering to and fully complying with all Contract terms and conditions. *(Code of Federal Regulations (CFR), Title 42, section 438.230(b)(1))*

The Plan's policy, *7271a Delegated Utilization Management* (revised 08/01/2023), stated that the Plan shall provide copies of standardized templates to members and providers correspondence including letters that are in compliance with all applicable state and federal laws and regulations and National Committee for Quality Assurance standards. Furthermore, adopt the Plan's templates or provide copies of translated member correspondence in designated threshold languages to the Plan for approval. Oversight of delegated UM by the Plan will include annual review and approval of delegate's UM program, policies and procedures, UM work plan, member correspondence templates, Plan's member files, and quarterly and ad hoc UM reports.

Finding: The Plan did not ensure the delegate, Rady Children's Specialists of San Diego, provided fully translated information in the identified threshold language.

Although the Plan's policy 7271a stated the Plan shall provide translated member correspondence in designated threshold languages, the Plan did not provide translated information in the identified threshold language.

The verification study revealed seven out of seven PA files where information to the member was not translated in the member's identified threshold language.

During the interview, the Plan acknowledged that they were not aware the delegate was out of compliance with translating information in the member's identified language. The Plan's delegated UM review tool did not verify translation requirements during the annual audit. The Plan stated this error was attributed to lack of oversight and quality control.

When the Plan does not ensure an effective delegation oversight it can result in missed opportunities to identify and correct deficiencies. Additionally, not providing fully translated information restricts members' rights and may negatively impact their ability to make informed healthcare decisions.

Recommendation: Revise and implement policies and procedures to ensure an effective oversight process for the delegated entity to provide fully translated information in the identified threshold language.

COMPLIANCE AUDIT FINDINGS

Category 3 – Access and Availability of Care

3.8 Non-Emergency Medical Transportation and Non-Medical Transportation

3.8.1 Non-Emergency Medical Transportation Services Requiring Physician Certification Statement Forms

NEMT is for members whose medical and physical conditions prevent them using regular public or private transportation for medical care. NMT services do not cover transportation by ambulances, litter vans, or wheelchair vans for sick, injured, or incapacitated members. (*Contract, Exhibit A, Attachment I*)

The Plan requires members to have an approved PCS form from their provider before NEMT services can be authorized. (*Contract, Exhibit A, Attachment III*)

The Plan must offer four NEMT modalities: ambulance services, litter van services, wheelchair van services, and air transport. NEMT must be available for members who cannot stand or walk without assistance, including those using walkers or crutches. *(APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)*

The Plan's policy, *6059 Non-Emergency Medical Transportation & Non-Medical Transportation* (revised 02/13/2023), stated the member's provider must submit the PCS form to the Plan for approval of NEMT services. The Plan uses the PCS form to determine the appropriate mode of NEMT service for the members.

The Plan's, *Desktop Process Transportation, NMT and NEMT* (revised 06/09/2023), outlined the two transportation services available for members. NMT services include bus, trolley or LIFT passes, and mileage reimbursement. NEMT services include a wheelchair van, litter van, ambulance, and air transport, all of which require an approval from the UM Department with a PCS form.

Finding: The Plan did not obtain an approved PCS form for rendered NEMT services.

Although the Plan's policy 6059 stated PCS forms must be submitted to the Plan for approval of NEMT services, the Plan did not follow the policy.

The verification study revealed 5 out of 15 NMT samples were misclassified as NMT.

The Plan provided five wheelchair transportation services. These five services should have been classified as NEMT services. However, the Plan classified these as NMT services but billed them as NEMT services. The Plan did not obtain PCS forms for these NEMT billed services.

During the interview, the Plan stated that a PCS form was not required for NMT trips using wheelchair vans. However, the Contract states NMT services do not cover wheelchair vans. NEMT services using wheelchair vans require a PCS form. Therefore, the Plan did not implement their policy and procedure to ensure providers submit a PCS form prior to rendering the misclassified NEMT services.

Without obtaining a PCS form, the Plan cannot ensure Medi-Cal members receive appropriate transportation services. This could lead to potentially patient harm from inadequate transportation services.

Recommendation: Implement policies and procedures to ensure PCS forms are obtained before providing NEMT services.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 Grievance System

4.1.1 Translated Member Information in Member's Required Language

The Plan must ensure all NOA are written in a language that meets the standards of CFR, Title 42, sections 438.10, 438.404, and 438.408; Welfare and Institutions Code section 14029.91; California Code of Regulations, Title 22, section 53876; Exhibit A, Attachment III, Subsection 5.1.3 (Member Information), and APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services. *(Contract, Exhibit A, Attachment III, 4.6.4 Notice of Action (E))*

Plans must provide translated written member information in both paper and electronic form. At a minimum, written translations must be in the member's threshold and concentration languages. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination requirements, and Language Assistance Services)*

The Plan must fully translate and provide written member information, including all grievance and appeals notices, in a member's required language. This includes translating NOA/NAR and the clinical rationale for the Plan's decision. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan's policy, *5510A Member Grievance and Appeal Policy* (revised 01/09/2024), stated all members can fully participate in the grievance and appeal system, and the Plan will assist those with limited English proficiency or communicative impairments. This includes translating grievance and appeal procedures, forms, responses, and providing written member information in the required languages.

Finding: The Plan did not provide translated NOA/NAR information in the members' required language.

The Plan's policy 5510A stated the Plan will translate grievance and appeal procedures, forms, responses, and provide written member information in the required languages. Additionally, in a written statement, the Plan indicated that notification letters are initially drafted in English and then translated into a member's primary language if it

meets one of their threshold languages. However, the Plan did not provide translated NAR information in the members' threshold languages.

The verification study revealed the Plan did not provide a translated NAR attachment in the member's threshold language for 10 out of 25 QOC grievance notices and for 8 out of 34 QOS grievance notices.

During the interview, the Plan stated that letters and attachments were previously fully translated into members' threshold languages. However, the Plan was unaware that the letters and attachments were no longer fully translated. The Plan acknowledged this oversight, citing inadequate oversight and quality control.

If members' NOA/NAR attachments are not translated into their threshold language, they may not be able to read the attachment and/or exercise their rights, leading to possible adverse health outcomes and improper service maintenance by the Plan.

Recommendation: Implement policy and procedures to ensure NOA/NAR information is translated in the members' required language.

COMPLIANCE AUDIT FINDINGS

Category 5 – Quality Management

5.1 Quality Management and Improvement

5.1.1 Qualifications of Staff Responsible for Quality Improvement

The Plan shall implement and maintain a written description of its QIS that shall include qualifications of staff responsible for QI studies and activities, including education, experience, and training. *(Contract # 09-86155*, Exhibit A, Attachment 4(7)(C))*
**Superseded by Contract #23-30217, effective January 1, 2024*

The Plan must develop, implement, and periodically update its QIHETP policies and procedures that include the qualifications and identification of staff responsible for QI and health equity activities. *(Contract #23-30217, Exhibit A, Attachment III, 2.2.6(C))*

The Plan's policy, *7618.2a Quality Program, Annual Evaluation and Documentation* (revised 08/10/2023), provided a general outline of the QIHETP description.

Finding: The Plan did not include the qualifications (education, experience, and training) of staff responsible for QI activities in the QIHETP written description or policies and procedures.

Although the Plan's policy 7618.2a stated a general outline of the QIHETP description, it did not include the qualifications of staff responsible for QI activities, nor did it specify that QI staff responsible qualifications should be included in the Plan's QIHETP written description.

The Plan's *Quality Improvement and Health Equity Transformation Program Description for 2023 and 2024,* stated that both the CMO and Medical Director must hold a current, unrestricted California medical license. However, the required qualifications of education, experience, and training were not included for all staff responsible for QI activities, including the Chief Operating Officer, Chief of Health Equity, and Director of Corporate Quality.

During the interview, the Plan confirmed that the qualifications of staff responsible for QI activities are not listed in the QIHETP description and could not substantiate that the requirement is integrated into policies and procedures.

Without the full qualifications of staff responsible for QI activities in the QIHETP written description, anyone reviewing the Plan's QIHETP cannot determine if the staff are qualified to provide quality healthcare services to members.

Recommendation: Revise and implement policies and procedures to ensure that the full qualifications of staff responsible for QI activities are included in the QIHETP written description.

5.3 Provider Qualifications

5.3.1 Provider Training

The Plan must begin training within 10 working days and complete it within 30 working days after a newly contracted Network Provider is placed on active status. The training can be conducted online or in-person, and records of attendance must be maintained to validate that Network Providers received training on a bi-annual basis. *(Contract, Exhibit A, Attachment III)*

The Plan's policy, *5101a New Provider Orientation and Refresher Training* (revised 01/01/2024), stated that the Plan will conduct new provider orientation training within 10 working days and complete it no later than 30 working days after a newly contracted provider is placed on active status. A refresher training will be provided at least every other year, either in person, over the phone, or via the Plan's provider web portal.

Finding: The Plan did not begin training newly contracted providers within ten working days after being placed on active status.

Although the Plan's policy 5101a stated that new provider orientation training will be provided within ten working days, the Plan misinterpreted the Contract and did not adhere to their policy and procedure.

The verification study revealed that the Plan did not conduct provider training within ten working days for 4 out of 15 newly contracted providers. The delays ranged from 22 to 28 working days from the time the contracted providers were placed on active status.

During the interview, the Plan stated that the training timeliness standards changed from 10 to 30 working days with the new Contract effective January 1, 2024. However, the Contract requires that training must begin within 10 working days and must be completed with 30 working days after a newly contracted Network Provider is placed on

active status. Therefore, the Plan misinterpreted the Contract and caused the provider to be out of contractual compliance.

Without timely training, the Plan cannot ensure providers operate in full compliance with Medi-Cal program requirements. In addition, members might receive misinformation regarding their rights, available resources, and provider's responsibilities.

Recommendation: Implement policies and procedures to ensure newly contracted providers receive training within the required timeframes.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLEMENT DIVISION

REPORT ON THE MEDICAL AUDIT OF COMMUNITY HEALTH GROUP FOUNDATION DBA: COMMUNITY HEALTH GROUP PARTNERSHIP PLAN FISCAL YEAR 2023-24

Contract Numbers: 09-86156, 22-20485, and 23-30249

Contract Type: State Supported Services

Audit Period: June 1, 2023 – May 31, 2024

Dates of Audit: May 20, 2024 – May 31, 2024

Report Issued: November 4, 2024

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I. INTRODUCTION

Background

This report presents the results of the audit of Community Health Group Foundation dba Community Health Group Partnership Plan's (Plan) compliance and implementation of the State Supported Services contract numbers 09-86156, 22-20485, and 23-30249 with the State of California. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of June 1, 2023, through May 31, 2024. The review was conducted from May 20, 2024, through May 31, 2024, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on October 17, 2024. No deficiencies were noted during the review of the State Supported Services Contracts.

COMPLIANCE AUDIT FINDINGS

State Supported Services

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

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)*

The Plan's policy, *7809a Claims for Abortion Services* (revised 04/01/2024), stated that the Plan covers abortions performed as a physician service. Abortion is a covered benefit regardless of the gestational age of the fetus. Medical justification and authorization for abortion are not required for outpatient care. However, inpatient hospitalization requires prior authorization under the same criteria as other medical procedures. The Plan covers CPT codes 59840, 59841, 59850 through 59852, 59855 through 59857, and Healthcare Common Procedures Coding System codes A4649, S0190, S0191, and S0199.

The Plan informs members and providers about abortion services through the Evidence of Coverage in the Member Handbook and the Provider Manual.

A review of 12 claims demonstrated that the Plan appropriately processed, paid, or denied abortion service claims within the required time frames.

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

Recommendation: None.