DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

REPORT ON THE MEDICAL AUDIT OF CALIFORNIA HEALTH AND WELLNESS PLAN FISCAL YEAR 2023-24

Contract Number: 13-90157

Audit Period: July 1, 2023 — December 31, 2023

Dates of Audit: July 16, 2024 — July 17, 2024

Report Issued: November 5, 2024

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I. INTRODUCTION

The California Legislature awarded California Health and Wellness Plan (Plan) a contract by the California Department of Health Care Services (DHCS) to provide Medi-Cal services in 19 counties as of December 31, 2023.

The Plan is a wholly owned subsidiary of Centene Corporation, a publicly traded company that is a major intermediary for government-sponsored and privately insured health care programs.

This Contract was implemented under the State's Medi-Cal Managed Care Rural Expansion program. The expansion program included members eligible for the Temporary Assistance for Needy Families program and the Children's Health Insurance program. The Plan's provider network includes independent providers practicing as individuals, small and large group practices, and community clinics. The Plan's independent providers are comprised of primary care physicians (436) and specialists (3,904), as well as hospitals (27) and ancillary providers (255).

As of December 31, 2023, the Plan served 256,104 Medi-Cal members in the following counties: Alpine (81), Amador (1,978), Butte (51,858), Calaveras (6,163), Colusa (4,537), El Dorado (18,951), Glenn (9,438), Imperial (79,764), Inyo (2,105), Mariposa (1,146), Mono (1,028), Nevada (10,740), Placer (14,867), Plumas (2,611), Sierra (310), Sutter (14,892), Tehama (16,315), Tuolumne (6,726), and Yuba (12,594).

II. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The review was conducted from July 16, 2024, through July 17, 2024, for the audit period of July 1, 2023, through December 31, 2023. The audit included a review of the Plan's contract with the DHCS, the policies for providing services, the procedures used to implement the policies, and the verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization (PA) Review: 20 medical PA requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to providers and members.

Category 4 – Member's Rights

Grievance Procedures: 20 Quality of Care (QOC) grievances were reviewed for timely resolutions, appropriate response to complainants, and submission to the appropriate level for review.

III. COMPLIANCE AUDIT FINDINGS

This report presents the audit findings of the DHCS medical audit for the period of July 1, 2023, through December 31, 2023. The audit was conducted from July 16, 2024, through July 17, 2024. The audit consisted of document reviews, verification studies, and interviews with the Plan representatives.

An Exit Conference with the Plan was offered on October 22, 2024. The Plan declined to hold an Exit Conference, as no areas of non-compliance were found in this audit.

The audit evaluated two categories of performance: Utilization Management and Member's Rights. This report is a summary without findings or recommendations due to the Plan's Corrective Action Plan (CAP) being closed with the Managed Care Quality and Monitoring Division (MCQMD).

Implementation of Prior Year Audit Recommendations

The prior DHCS medical audit identified deficiencies for the period of July 1, 2022, through June 30, 2023. The Plan addressed the deficiencies in a CAP. The CAP was closed as of July 24, 2024.

The following sections below present the prior audit findings and the corrective actions the Plan has implemented to resolve those deficiencies.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

Member's Right to File a Grievance

The prior year's audit found that the Plan did not inform members of their right to file a grievance after the denial of a request for an expedited resolution of an appeal.

During the audit period, the Plan did not have policies and procedures to inform members of their right to file a grievance after denial of a request for an expedited resolution of an appeal. In an interview, the Plan stated that the Contract was reviewed annually; however, the Plan was unaware of the requirement to inform members of their right to file a grievance after denial of a request for an expedited resolution of an appeal. The Plan has worked with the MCQMD to close the deficiency addressed in the CAP.

The Plan revised and implemented policies and procedures to ensure members are informed of their right to file a grievance after denial of a request for an expedited resolution of an appeal.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

Quality of Care Grievances

The prior year's audit found that the Plan did not immediately submit QOC grievances to the Plan's Medical Director for action.

During the audit period, the Plan did not have policies and procedures to ensure QOC grievances were immediately submitted to the Plan's Medical Director for action. The Plan's flow chart did not include a documented step for the immediate review by a Medical Director. In an interview with the Plan personnel, the Plan could not substantiate that the Medical Director was immediately involved in the review process.

The Plan has worked with the MCQMD to close the deficiency addressed in the CAP.

The Plan revised and implemented policies and procedures to ensure QOC grievances were immediately submitted to the Plan's Medical Director for action.