DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN DIEGO SECTION

REPORT ON THE MEDICAL AUDIT OF SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSION DBA CENTRAL CALIFORNIA ALLIANCE FOR HEALTH 2024

Contract Number: 08-85216

Audit Period: November 1, 2022 – October 31, 2023

Dates of Audit: January 29, 2024 – February 9, 2024

Report Issued: May 14, 2024

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I. INTRODUCTION

The Santa Cruz-Monterey-Merced Managed Medical Care Commission is the governing board that oversees the Central California Alliance for Health (Plan). The Plan is a regional, non-profit health plan, established in 1996. As a County Organized Health System (COHS), the Plan serves members in Santa Cruz, Monterey, and Merced counties. The Plan's members represent about 50 percent of the population in Merced and Monterey Counties, and about 33 percent in Santa Cruz County. Forty-seven percent of the Plan's members are under 20 years old, and 70 percent of the Plan's members are Hispanic.

The Plan collaborates with over 12,448 providers and contracts with 87 percent of Primary Care Physicians (PCP) and 85 percent of specialists within the Plan's three-county service area. The Plan also collaborates with more than 3,617 providers to deliver behavioral health and vision services.

As of December 2023, the Plan's enrollment for its Medi-Cal line of business was approximately 405,390 for Santa Cruz, Monterey, and Merced counties.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of November 1, 2022, through October 31, 2023. The audit was conducted from January 29, 2024, through February 9, 2024. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on April 24, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary 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, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit report issued on April 26, 2023, (audit period November 1, 2021, through October 31, 2022) did not identify any findings of non-compliance.

The summary of findings by category follows:

Category 1 – Utilization Management

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

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 is required to reimburse complete claims within 45 working days after the date of receipt unless the complete claim or portion thereof is contested or denied. The Plan did not ensure that family planning claims are paid to providers within 45 working days.

Category 4 – Member's Rights

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

Category 5 – Quality Management

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

Category 6 – Administrative and Organizational Capacity

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

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted this audit to ascertain that the medical services provided to Plan members complied with federal and state laws, Medi-Cal regulations and guidelines, and the state's COHS Contract.

PROCEDURE

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 the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan representatives.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization (PA) Requests: 23 medical PA requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 20 appeals of medical PAs were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Appointment (IHA): 15 medical records were reviewed for timeliness and completeness of IHA requirements.

Category 3 – Access and Availability of Care

Emergency Services and Family Planning Claims: 15 emergency and 15 family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): 41 records (25 NEMT and 16 NMT) were reviewed to confirm compliance with transportation requirements for timeliness and appropriate adjudication.

Category 4 – Member's Rights

Grievance Procedures: 39 standard grievances (20 quality of care and 19 quality of service), 15 exempt grievances, and 34 call inquiries were reviewed for timely resolution,

response to the complainant, submission to the appropriate level for review, and translation in the member's preferred language (if applicable).

Category 5 – Quality Management

Twenty potential quality issue files were reviewed for timely evaluation and effective action taken to address improvements.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: Ten fraud and abuse cases were reviewed for processing and reporting requirements.

Encounter Data: Five encounter data records were reviewed for complete, accurate, reasonable, and timely encounter data submissions.

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

COMPLIANCE AUDIT FINDINGS

Category 3 – Access and Availability of Care

3.6 FAMILY PLANNING SERVICES CLAIMS

3.6.1 Timely Payment of Claims

Members may access family planning services through any family planning provider without prior authorization. *(Contract, Amendment 38, Exhibit A, Attachment 9(8)(A))*

The Plan shall pay all claims submitted by contracting providers in accordance with United States Code, Title 42, section 1396a(a)(37) and Health and Safety Code sections 1371 through 1371.39. *(Contract, Amendment 38, Exhibit A, Attachment 8(4)(A and B))*

The Plan is required to reimburse claims or a portion of a claim no later than 45 working days after receipt of the claim unless the claim or portion thereof is contested or denied. *(Health and Safety Code, section 1371)*

The Plan's policy, *404-1702, Provision of Family Planning Services to Members (approval date March 7, 2023),* states that Plan members may access family planning services and may go to any qualified family planning provider, inside or outside the Plan's network without a referral from the member's PCP and without authorization from the Plan.

The Plan's policy, *600-1001, Claims Processing (approval date December 31, 2021),* states that the Plan will pay claims submitted by providers in a timely manner in accordance with United States Code, Title 42, section 1396a(a)(37) and Health and Safety Code sections 1371 and run weekly reports to ensure that claims are appropriately processed. When errors are identified, ad hoc reports are run to identify claims that require re-adjudication and to ensure that appropriate interest and penalties are incorporated into payments.

Finding: The Plan did not ensure that family planning claims are paid to providers within 45 working days.

The Plan's desktop procedure, *Claims 101*, describes it automates the initial claims review through its Health Solutions Plus claims system. The system checks for errors, including but not limited to, missing or incorrect modifiers and/or referral waivers for family planning diagnosis codes. When errors are detected, the claims must be resubmitted by the provider or pend for manual review by the Plan. The Plan did not implement its policy, *404-1702*, which stated that members may access family planning

services without authorization. Furthermore, the Plan did not properly pay family planning claims pended for manual review.

During the audit period, the Plan had 39,889 family planning claims, of which 19 percent were either denied or modified. A verification study of 15 family planning claims was conducted and found that the Plan improperly denied claims, which resulted in an untimely payment to providers between 27 to 207 days beyond the 45-working day timeframe.

- Two claims for an office visit and a cervical screening for human papillomavirus were improperly denied for requiring prior authorizations from the members' PCP.
- One claim for an injection was improperly denied for an incorrect modifier.

In an interview, the Plan acknowledged that its Health Solutions Plus claims system was not properly configured to waive the prior authorization requirement for family planning services. The Plan staff also did not follow the workflow procedures on claims pended for manual review.

Untimely payments may cause providers to be discouraged to provide quality service to Plan members.

Recommendation: Revise and implement procedures to ensure family planning claims are paid to providers within 45 working days.