MEDICAL REVIEW BRANCH – RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Santa Cruz-Monterey-Merced Managed Medical Care Commission Dba Central California Alliance for Health

Contract Number:	08-85216 A17
Audit Period:	November 1, 2016 Through October 31, 2017
Report Issued:	May 18, 2018

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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 354,346 members in Santa Cruz, Monterey, and Merced counties. The Plan's members represent about 36 percent of the population in Santa Cruz, Monterey, and Merced counties.

The Plan collaborates with 7,746 providers with 77 percent of primary care physicians and 79 percent of service area specialists. The Plan has two delegated entities that also serve Medi-Cal Members, Beacon/College Health IPA (CHIPA) and Vision Services Plan (VSP). Beacon provides expanded behavioral health benefits for Medi-Cal Managed Care Members. VSP provides routine vision services for Members.

As of August 31, 2017, the Plan's enrollment totals for each line of business is as follows:

Medi-Cal	353,785
Alliance Care IHSS in Monterey County	561
Total	354,346

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, 2016 through October 31, 2017. The on-site review was conducted from November 6, 2017 through November 17, 2017.

An exit conference was held on March 28, 2018 with the Plan. 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 Plan submitted supplemental information after the Exit Conference and it is reflected in this report.

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, Administrative and Organizational Capacity, and State Supported Services.

The summary of the findings by category are as follows:

Category 1 – Utilization Management

The Plan sent member Notice of Action (NOA) letters that contained complex language, did not specifically identify the reasons for its decisions, contained misstatements, and were lengthy.

The Plan's deferred prior authorization policy contained errors and inconsistencies in describing the extension and deferral process.

The Plan's policy and practices did not describe withdrawn and void processes for adverse determinations; the Plan applied the void and withdrawal process to cases involving medical necessity.

The Plan's appeal resolution letters contained complicated and unclear language and did not explain the reasons for overturned appeals.

The Plan did not send acknowledgement letters to providers who had written permission from members to appeal adverse authorization decisions for them.

The Plan did not notify members in writing that it downgraded urgent appeals to routine status and of their right to contest the action.

Category 2 – Case Management and Coordination of Care

No findings were noted during this audit period.

Category 3 – Access and Availability of Care

No findings were noted during this audit period.

Category 4 – Member's Rights

The Plan did not reach a final conclusion about member grievances, date medical director grievance reviews, or document medical director grievance reviews in grievance case files.

The Plan did not refer all clinical grievances to a medical director for resolution.

The Plan's grievance resolution letters sent to members contained incomplete and inaccurate explanations of decisions in clinical quality of care grievances.

Category 5 – Quality Management

No findings were noted during this audit period.

Category 6 – Administrative and Organizational Capacity

No findings were noted during this audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS), Medical Review Branch to ascertain medical services provided to Plan members comply with Federal and State laws, Medi-Cal regulations and guidelines, and the State COHS contract.

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. In addition, the Plan's Senior, Persons with Disabilities (SPD) population was included in this review period.

PROCEDURE

The on-site review was conducted from November 6, 2017 through November 17, 2017. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 29 medical (including three SPD) and 23 pharmacy (including three SPD) prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeals Process: 24 (three SPD, 21 Medi-Cal (eight pharmacy)) prior authorization appeal requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Complex Case Management: Five (including two SPD) medical records were reviewed for evidence of continuous tracking, monitoring, and coordination of resources to members who received complex case management services.

Early Intervention Services and Developmental Disabilities: 10 medical records were reviewed for evidence of coordination of care between the Plan and Regional Centers.

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

Behavioral Health Treatment (BHT): 10 behavioral health charts were reviewed for compliance with BHT provision requirements.

Initial Health Assessment: 15 (including three SPD) medical records were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Appointment Availability: 15 contracted providers from the Provider's Directory were reviewed to determine if appointments were accurate, complete, and available. The third next available appointment was used to measure access to care.

Emergency Services and Family Planning Claims: 10 (including three SPD) emergency service claims, and 12 (including two SPD) family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 16 quality of service and 21 quality of care (including three SPD) grievances were reviewed for timely resolution, response to complaint, and submission to the appropriate level for review.

Confidentiality Rights: Four cases were reviewed for proper reporting of all suspected and actual breaches to the appropriate entities within the required time frame.

Category 5 – Quality Management

New Provider Training: 10 new contracted providers were reviewed to determine if they received Medi-Cal Managed Care program training in a timely manner.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: 10 cases were reviewed for proper reporting of all suspected fraud and/or abuse to appropriate entities within the required time frame.

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

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:
Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements… (as required by Contract)
COHS Contract A.5.2.A, B, C, F, H, I

Exceptions to Prior Authorization:
Prior Authorization requirements are not applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
COHS Contract A.5.2.G

Timeframes for Medical Authorization
Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).
COHS Contract A.5.F

Routine authorizations: five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

COHS Contract A.5.H

Denial, Deferral, or Modification of Prior Authorization Requests:
Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative…This notification must be provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.
COHS Contract A.13.8.A

SUMMARY OF FINDINGS:

1.2.1 **Notice Of Action (NOA) Letters**

The Plan shall send members NOA letters that are clear and concise in explaining the reasons for the Plan's decisions to deny, defer, or modify requests for prior authorization. (Contract, Exhibit A, Attachment 13 (8)(A); California Health and Safety Code (CA HSC) Section 1367.01; Managed Care Quality and Monitoring Division (MCQMD) All Plan Letter (APL) 17-006 Grievance and Appeal Requirements, and Revised Notice Templates and "Your Rights" Attachments)

When the Plan defers or delays a prior authorization decision because of the following: 1) missing information 2) the member or provider requests a delay, or 3) delaying the decision is in the best interests of the member, the Plan shall include the specific reason for the delay or deferral in the NOA letter. (Contract, Exhibit A, Attachment 13 (8)(A); CA HSC Section 1367.01; MCQMD APL 17-006)

The Plan sent member NOA letters that contained complex language, did not specifically identify the reasons for its decisions, contained misstatements, and were lengthy.

Member NOA letters demonstrated complex phrasing:

- "Severity and periodicity of symptoms…concurrent drug treatment"
- "No clinical notes to suggest alternate household pillows could not serve the desired purpose"
- "Consultation expertise is beyond what is available through a provider in-network"
- "CGH genetic testing can be reconsidered in the future if accompanied by a negative Fragile X testing result"
- "MCG criteria… tonsillar hypertrophy"
- "One formulary alternative DMARD"
- "This medication is carved out from the Alliance's coverage responsibilities…"

NOA letters revealed additional deficiencies:

- Listed the 15 qualifying conditions for Hepatitis C medication approval
- Reported tonsillar hypertrophy when the physical examination showed normal tonsils

Deferral NOA letters contained errors:

- Did not identify missing information needed to make a decision
- Stated that the member or provider had requested the deferral when documentation did not support this assertion

Plan policy *404-1201 Authorization Request Process* stated that member NOA letters would conform to contractual requirements and that provider letters would contain clear and concise reasons for determinations. The Plan's documentation titled *67-NOA Process 3-7-17* showed that pharmacy services staff and medical directors reviewed NOAs for errors and if needed, returned the NOAs to authorization nurses for correction. Pharmacy services coordinators reviewed pharmacy NOAs for errors.

In interviews, the Plan reported that it was unsuccessful in its attempts to revise and simplify NOA letter language, especially clinical terms. The pharmacy department reported efforts to write two versions of NOA letters, one for providers (more detailed and complex), and one for members. The Plan has implemented the latter for hepatitis C medication-related notifications, as indicated in the Plan's memo *47-Pharmacy Letter Review.*

Complex letters and notifications that include vague or incorrect statements may lead to member and provider confusion about the authorization of requested services. This may inadvertently lead to suboptimal health care decisions by enrollees and health care practitioners.

1.2.2 Deferred Prior Authorizations (PAs)

The Plan shall resolve requests for PA within five business days but no more than the 14 calendar days after receipt of the amount of information reasonably needed to make a decision. It may defer requests beyond the first 14 calendar days for up to a total of 28 days when the member or provider requests a delay, or if the Plan can demonstrate that it needs additional information and the delay is in the member's best interest. (Contract, Exhibit A, Attachment 5 (3)(H))

The Plan deferred decisions about PA requests in order to redirect care to in-area providers. Verification study showed that the Plan delayed PA requests for authorization of visits to out-of-area providers while it awaited the requesting provider's decision about whether the Plan could instead redirect the member to an in-area provider.

Case review indicated that PA nurses extended and then deferred service requests before sending them for medical director review in order to obtain the requesting providers' responses to a request for redirection.

Deferral letters to providers sent at five business days and 14 calendar days after the Plan received the requests asked if it could redirect care in-network, and asked for additional information. Letters to members stated the Plan was waiting for more information from the requesting provider.

Plan policy *404- 1310 Out of Network Authorizations* stated that referrals to out-of-area specialists required prior authorization, but that in-service area-specialist referrals for Medi-Cal members required no approval. Merced, Monterey, and Santa Cruz counties comprised the Plan's Medi-Cal service area.

The Plan confirmed in interviews that letters requesting deferrals implied, if they did not directly state, that it required additional information supporting referral to an out-of-area provider.

Prolonging a prior authorization decision up to 14 calendar days after receipt of the request while awaiting needed information complies with contractual requirements. However, delaying the decision initially and then deferring it yet an additional 14 calendar days after the initial extension for administrative reasons such as obtaining a provider's approval to redirect the member to an in-area provider does not. This may lead to inappropriate prolongation of service delivery, not only by an out-of-area, but also by an in-area provider.

1.2.2 **Deferred Prior Authorizations (PAs)**

The Plan shall require that a qualified physician review a request for health services that results in a denial, modification or reduction in services due to medical necessity. The Plan shall provide the member with a notice of action and appeal rights when it denies, modifies, or defers a prior authorization. (Contract, Exhibit A, Attachment 5 (2)(I) and Attachment 13 (B))

Adverse benefit determinations include denial or modification of requested services due to type or level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit, or the denial of a beneficiary's request to obtain services outside the network when the member resides in a rural area with only one managed care plan. Beneficiaries must receive written notice of Adverse Benefit Determination in a Notice of Action (NOA) letter containing appeal rights. (MCQMD APL 17-006)

The Plan asked providers to withdraw PA requests that did not meet medical necessity for out-of-area care, voided the withdrawals when providers agreed to in-area redirection, and did not notify members of the actions, when they were, in effect, adverse determinations due to lack of medical necessity.

A verification study showed that the Plan attempted to void a request for out-of-service area autism care that it could provide in-area instead. The Plan issued a denial for no medical necessity when the provider did not respond to inquiries about withdrawing the request.

Plan policy *404- 1201 Prior Authorization Request Process* noted that request

determination status included the category “void”, which it defined as an action for authorization requests due to non-membership, duplicate authorization request, no authorization required, California Children’s Services eligible condition, or insufficient or incomplete information needed to process the request. The policy did not describe the void process.

In interviews, the Plan reported that it voided authorization requests for the following:

- Missing pertinent identifying information not supplied after multiple attempts to contact the requesting provider
- Duplicates of other requests
- Withdrawn by providers
- Requests for non-members
- Requests for non-covered benefits

The Plan sent void notices to providers, but none to members. A search of the Plan’s *Provider Manual* did not produce information about voided or withdrawn prior authorizations.

The Plan confirmed that it did not send modified approvals for requests for out-of-area service that it could deliver in-area, because requests for in-area providers did not require prior authorization. The Plan confirmed that a medical director did not review withdrawals and voids, and provided a draft void notice that contained no appeal information.

If a provider withdraws a PA request for non-administrative reasons, such as not being able to support medical necessity for an out-of-area referral, and the Plan voids the authorization, the action can be seen as an adverse determination that requires a medical director review and member NOA with the right to appeal. By not issuing a formal modified approval or denial with the required member notification, the Plan deprives the member of their right to appeal. This may lead to adverse health outcomes for members.

RECOMMENDATIONS:

1.2.1 Simplify NOA letters; include specific rationale for deferrals in NOA letters, and revise the review processes to include assessment of language level and case-specific content.

1.2.2 Revise Plan policy to conform with the contract. Defer requests beyond the first 14 calendar days for up to a total of 28 days when the member or provider request a delay, or if the Plan can demonstrate that it needs additional information and the delay is in the member's best interest.

1.2.3 Revise Plan policy and practices to describe the withdrawal and void processes, and limit the actions to items not considered adverse benefit determinations. Eliminate the practice of initiating provider withdrawal of prior authorizations when cases do not meet medical necessity for out-of-area care.

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1.3	PRIOR AUTHORIZATION APPEAL PROCESS
Appeal Procedures: There shall be a well-publicized appeals procedure for both providers and Members. COHS Contract A.5.2.E	

SUMMARY OF FINDINGS:

1.3.1 **Member Appeal Resolution Letters**

The Plan's appeal resolution letters shall clearly state the reasons for its decisions and include the criteria, medical policies, or benefits section of the member handbook that support the determination; this requirement also applies to resolution letters in appeals resolved in members' favor. (California Code of Regulations (CCR), Title 28, Section 1300.68 (d)(4); MCQMD APL 17-006 (IV)(F) and (G))

The Plan's appeal resolution letters did not explain the reasons for overturned appeals or contained complicated and unclear language.

Verification study revealed multiple deficiencies:

- Complicated language: "(The Plan) confirmed both modafinil and armodafinil are non-formulary medications and neither is indicated for the treatment of MS related fatigue. The Alliance prior authorization criterion for armodafinil requires a trial and failure of one formulary stimulant and preferred modafinil, which requires prior authorization" and "Information derived from whole genome sequencing has yet to be translated into effective patient-specific management."
- In other cases, the Plan did not explain why it overturned denials.
- The Plan misstated an appeal decision. The medical director wrote, "In brief, going to surgery in advance of (a complete medical evaluation) could lead to missing a serious medical problem." The resolution letter declared, "Therefore, because a complete medical evaluation has not been fully undertaken and going to surgery in advance of this may lead to a serious medical problem authorization number… will remain approved as modified."

Plan's policy *105-1002 Member Grievance System*, a Plan grievance coordinator (GC) drafted and sent appeal resolution letters that described the appeal, presented a decision and provided a clear and concise explanation of the reasons for the decision. The Plan's appeal process flow chart confirmed that GCs drafted and sent resolution letters. Verification study files showed that pharmacists and medical directors documented the reasons for their appeal decisions in case notes; these formed the basis for the "rationale" portion or appeal resolution letters written by a GC. Documentation did not describe a quality control process for appeal resolution letters.

In an interview, the Plan reported that it thought appeals resulting in overturned decisions did not require resolution letters fully explaining the reasons for the favorable results. The Plan was inconsistent sending appeal resolution letters explaining its reasons for overturned denials or sent resolution letters containing complicated and unclear language.

Unclear and complicated letters explaining Plan appeal decisions increase the risk that members will have difficulty making informed health care decisions. Poor health outcomes are the possible, although unintended, result.

1.3.2 Provider Appeal Notices

If the member agrees in writing, providers may appeal adverse utilization management determinations on a member's behalf. (Contract, Exhibit A, Attachment 14 (5)(A))

The Plan's grievance process, which includes appeals, shall follow guidelines in the CCR, Title 28, Section 1300.68. The regulation defines individuals who appeal on behalf of members as complainants; the Plan shall inform complainants with acknowledgement and resolution letters. (Contract, Exhibit A, Attachment 14 (1))

The Plan shall adopt the federal definition of appeals, but also apply all existing state regulations pertaining to appeal handling, as applicable. (MCQMD APL 17-006 (I)(D))

The Plan did not send acknowledgement letters to providers who had written permission from members to appeal adverse authorization decisions for them.

A verification study showed that providers appealed with written member permission in five of 23 reviewed cases. The Plan did not send provider acknowledgement letters in five of the five cases.

Plan's policy *105-1002 Member Grievance System*, "the Member, or a provider acting on behalf of a Member and with the Member's written consent, may file an appeal a Member Appeal". It describes the sending of acknowledgment and resolution letters to members but not to providers who have written permission to appeal for members. An undated flow chart of the grievance resolution process labeled "final" in the title, noted the sending of acknowledgement letters to members only.

The Plan explained that APL 17-006 requires the sending of acknowledgement and resolution letters to members. In response to providers inquiring about appeal outcomes, the Plan now faxes appeal resolution letters to providers who appeal for members. The verification study confirmed the new process for resolution letters but not for acknowledgement letters.

Providers appealing for members with their written permission, require notification of the Plan's decisions in order to proceed with their members' health care services. Failure to notify may lead to delay in needed treatment and possible poor health outcomes for members.

1.3.3 Expedited Appeal Notifications

As of July 1, 2017, the Plan shall adopt the formal definition of appeal as stated in federal guidelines, which also state specific requirements for these reconsideration requests. (MCQMD APL 17-006 (I)(D))

If the Plan extends the timeframe to resolve an appeal, it must attempt to notify the member promptly and verbally, and must notify the member in writing in two calendar days of the action and their right to contest the action in writing. (42 Code of Federal Regulations, (CFR) 438.408, Section c (2); Contract, Exhibit A, Attachment 14 (6)(E))

If the Plan independently downgrades an expedited or urgent member appeal to standard status, it shall follow the member notification process as in appeals with extended timeframes and notify the member of the reason for the action. (MCQMD APL 17-006 (IV)(D) and (E))

The Plan did not notify members in writing why it downgraded their urgent appeals to routine status.

A verification study showed that the Plan sent acknowledgement letters on the same day that it received urgent appeals from members; however, the Plan did not write that it had changed the case from urgent to routine, and that members could contest the action. During the onsite interview, the Plan reported that it did not notify members when it downgraded urgent appeals post the July 1, 2017 implementation date for revised appeal adjudication processes.

Policy *105-1002 Member Grievance System* noted the following: "If the Alliance denies a request for an expedited resolution of a member appeal, the case will transfer to the timeframes for standard resolutions and extensions." The policy did not state the Plan would notify the member of the change, although page nine, *Procedures, Case Extensions* noted the Plan would respond with prompt verbal and two day written notice to members when it extended appeal timeframes.

Not specifically notifying members that the Plan will process an appeal in a standard rather than an urgent manner, and that members may contest this decision, may result in missed opportunities for members to present new information about urgent requests for services or medications. This may unintentionally lead to delayed decisions about health care delivery and to poor member health outcomes.

RECOMMENDATIONS:

1.3.1 Develop and implement processes for writing clear and concise appeal resolution letters, including those for overturned favorable decisions.

1.3.2 Revise plan policy and implement processes for sending acknowledgement letters to providers who have written permission to appeal on members' behalf.

1.3.3 Revise Plan policy and implement processes for verbal and written member and/complainant notification of downgraded appeals, and of their right to contest the action.

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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance system in accordance with Title 28 CCR Section 1300.68 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph D.13, and 42 CFR 438.420(a)(b) and (c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.
COHS Contract A.14.1

Contractor shall implement and maintain procedures…to monitor the Member's Grievance system and the expedited review of grievances required under Title 28 CCR Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858…. (as required by Contract)
COHS Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
COHS Contract A.14.3.A

SUMMARY OF FINDINGS:

4.1.1 **Grievance Process**

The Plan's grievance system shall follow guidelines established in the CCR, Title 28, Section 1330.68 and Contract, Exhibit A, Attachment 14 (1). The Plan shall resolve grievances within 30 days of receipt where "resolved" means the grievance has reached a conclusion about the submitted complaint. (CCR, Title 28, Section 1330.68 (a) (4)). A health care professional with clinical expertise in treating a beneficiary's condition or disease shall resolve any grievance or appeal involving clinical issues. (MCQMD APL 17-006 (VII)(I) and (M))

The Plan did not reach a final conclusion about member grievances, date medical director grievance reviews, or document medical director grievance reviews in grievance case files.

A verification study consisting of 18 quality of care (QOC) Medi-Cal grievances, their corresponding potential quality issue (PQI) cases, and three SPD (Seniors and Persons with Disabilities) enrollee QOC grievances demonstrated several findings:

- In six cases, the Plan resolved clinical grievances using limited information such as medication claims data, and closed grievances before medical record receipt.
- In six cases, the Plan did not resolve all of the member complaints before closing the grievances and sending resolution letters.
- Twenty-one of 21 QOC grievance files did not contain the medical directors' decisions.
- In 18 of 18 Medi-Cal cases, medical directors did not date their decisions in PQI files related to clinical grievances.

Policy *105-002 Member Grievance System* stated the Plan immediately routed potential QOC complaints to clinical staff acting on behalf of the medical director. Clinical staff then reviewed the complaint details and immediately routed medical QOC issues to a medical director.

A complaint resolution flow chart implemented January 1, 2017 outlined the grievance resolution process. According to the chart, clinical grievances were directed to the quality department for Quality Registered Nurse (QRN) review. The QRN reviewed the cases then referred those with potential QOC issues to a medical director for review.

The Plan's PQI *Dashboard- Q3 2017* stated that clinical QI staff reviewed all member complaints as of January 1, 2017, returning those cases without QOC issues to the grievances department, and opening PQI cases for QOC grievances. The Plan documented each QOC grievance investigation in a PQI file corresponding to a particular QOC grievance case.

In an interview, the Plan stated that Quality RNs reviewed all complaints sent from the grievances department to determine clinical versus non-clinical cases. The Plan stated that medical directors resolved all clinical cases after RN investigation. Examination of the clinical cases usually required medical record review; however, some cases could be resolved without this documentation. The Quality RN reported the QOC grievance closure date to the grievance department, which then entered the date in the grievance case file. The "closed" date that medical directors entered in a given case's matching PQI file might be later than the grievance closure date and resolution letter because of additional quality review after grievance resolution. If a case had outstanding non-clinical issues after resolution of the medical items, the grievance department would resolve those.

Although the Plan closed quality of care grievances timely, documentation did not demonstrate resolution of all complaints in a grievance by the time of case closure. In addition, the Plan could not support the assertion that a medical director resolved the clinical grievances because of the absence of medical director documentation in

grievance files, clear medical director documentation that he or she was closing a grievance versus a quality case investigation, and undated medical director notes in PQI files related to QOC grievances.

The contract requires the Plan resolve all of the member's complaints and secure a medical director's review of any clinical issues before closing grievances within 30 days. This ensures all complaints receive prompt, complete, and appropriate resolution. The Plan may then be prevent repeat quality errors timely.

4.1.2 **Clinical Grievance Resolution**

A health care professional with clinical expertise in treating a beneficiary's condition or disease shall resolve any grievance or appeal involving clinical issues. (MCQMD APL 17-006 (VII)(I) and (M))

The Plan did not refer all clinical grievances to a medical director for resolution.

A clinical grievance that alleged poor medical care contained an MD case summary signed and dated by a Quality RN. Although documentation named the medical director assigned to the case, it did not include notes signed by the physician.

Policy *105-002 Member Grievance System* stated the Plan immediately routed potential quality of care complaints to clinical staff acting on behalf of the medical director. According to the policy, clinical staff reviewed the complaint details and immediately routed medical quality of care issues to the medical director. Plan document *Explanation of Grievance Codes* stated the Plan used DHCS- determined characteristics to categorize grievance cases.

A complaint resolution flow chart documenting the grievance resolution process implemented January 1, 2017 showed:

- The Plan directed complaints grievance staff labeled as access and clinical quality to the quality department.
- Quality RNs investigated the cases and directed those with an underlying QOC issue to a medical director.

In an interview, the Plan reported as of October 1, 2017, that if investigation by the Quality RN showed that a QOC- labeled grievance had clinical elements but was actually more about service, the RN could then decide whether quality was at issue and could close level P0 (no quality issue) cases without medical director review. The Plan reported that it did not allow Quality RNs to determine clinical cases.

The contract designates that qualified health care professionals with clinical expertise in treating disease, such as medical directors, shall review grievances involving clinical matters to ensure an appropriate level of review. Poor member health outcomes may unintentionally result if clinical quality problems are not recognized and corrective actions prescribed.

4.1.3 **Grievance Resolution Letters**

The Plan's grievance system shall follow guidelines established in the CCR, Title 28, Section 1300.68 and Contract, Exhibit A, Attachment 14 (1)(3). "Resolved" means that the grievance has reached a conclusion with respect to the enrollee's submitted complaint. The written resolution shall clearly explain the plan's decision. (CCR, Title 28, Section 1330.68)

The Plan sent incomplete and inaccurate written member notifications that did not clearly explain its decisions in clinical/ QOC grievances.

Seven of 18 member resolution letters in a verification study stated:

- Summary of Investigation: the Plan's QI department reviewed the complaint, which the Clinical QI department with MD oversight will further review.
- Proposed Resolution: The Plan has resolved the complaint by escalating the issue to the clinical QI department to investigate for potential QOC issues.

In three of the seven cases, the letters contained an inaccurate description of the resolutions, as the Plan had already completed its investigations and closed the grievances. The Plan's resolutions in the cases included sending letters to and calling the providers.

A flow chart showed that the Plan directed clinical grievances to the quality department for investigation and resolution. Once that department resolved the member's grievance within 20 calendar days, it redirected the complaint to the grievance department for closing and sending of a resolution letter.

The Plan reported that it began sending the resolution letter as of January 2017 after receiving member complaints about letters that commented on actual grievance investigation results. For example, it reported that members complained when the grievance investigation showed no quality of care lapses.
The contract requires the Plan shall clearly inform its members of the outcome of complaint investigations. Transparent communication provides members with the means to make informed decisions about their health care.

RECOMMENDATIONS:

4.1.1 Revise grievance resolution processes and implement changes so it is clear that medical directors resolve clinical cases before grievance closure, and all complaints in the cases are resolved by the grievance closure date (30 days after submission). Clearly delineate additional quality investigation from the grievance resolution in case files.

4.1.2 Revise Plan processes so that qualified health care professionals with clinical expertise in treating diseases make the final determination for clinical grievances whether or not an RN investigation indicates no quality problem.

4.1.3. Revise grievance resolution letters so they contain accurate information regarding the Plan's decisions.

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INTRODUCTION

This report presents the audit findings of Central California Alliance for Health (CCAH) State Supported Services Contract No. 08-85223. The State Supported Services contract covers contracted abortion services with CCAH.

The onsite audit was conducted from November 6, 2017 through November 17, 2017. The audit period is November 1, 2016 through October 31, 2017 and consisted of review of documents supplied by the Plan and interviews conducted onsite.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Central California Alliance for Health	
AUDIT PERIOD: November 1, 2016 through October 31, 2017	DATE OF AUDIT: November 6, 2017 through November 17, 2017

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion *Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:* *Current Procedural Coding System Codes*: 59840 through 59857* *HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336* **These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.* *State Supported Services Contract Exhibit A.1*

SUMMARY OF FINDINGS:

The Contract requires the Plan to provide, or arrange to provide, to eligible Members the following State Supported Services: Current Procedural Coding System Codes*: 59840 through 59857 and HCFA Common Procedure Coding System Codes X1516, X1518, X7724, X7726, Z0336. These codes are subject to change upon the Department of Health Services' implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.

Policy *404-1309 Member Access to Self-Referred Service,* states Medi-Cal members have access to sensitive services from any Medi-Cal Provider. Minors do not need parental consent to receive sensitive services. Providers do not have to be contracted with the Plan.

Policy *404-1702 Provision of Family Planning Services to Members,* states members have access to family planning that include abortion services in or out of network without prior authorization.

The Member Handbook informs members of sensitive services (termination of pregnancy). Members under the age of eighteen do not need the consent of their parents or guardian to terminate a pregnancy. These services are confidential and no referral is needed from their primary care physician. The Plan's Provider Manual informs providers of the member's rights to sensitive services without prior authorization.

The Plan’s payment system contains the required pregnancy termination billing codes and automatically adjudicates the claims in the Plan’s system without prior authorization.

The onsite interview confirmed the Plan provided the required State Supported Services to its members. The Plan complied with contractual requirements.

RECOMMENDATIONS:

None