MEDICAL REVIEW – SOUTHERN SECTION V
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE CAL MEDICONNECT AUDIT OF

SANTA CLARA FAMILY HEALTH PLAN

Contract Number: 13-90491
Medicare Plan ID Number: H7890

Audit Period: April 1, 2018
Through
February 28, 2019

Report Issued: July 11, 2019

TABLE OF CONTENTS

I. INTRODUCTION

In 1995, the Santa Clara County Board of Supervisors established the Santa Clara County Health Authority under the authority granted by Welfare and Institutions Code Section 14087.36.

In collaboration with the Centers for Medicare and Medicaid Services (CMS), the State of California Department of Health Care Services (DHCS) operates a program to integrate care for beneficiaries who are eligible for both Medicare and Medi-Cal, called Cal MediConnect (CMC). The program is an alternative effort under the Coordinated Care Initiative. The goal of the CMC program is to provide enrolled beneficiaries with a more coordinated, person-centered care experience, along with access to new services.

The Cal MediConnect contract is a three-way contract between CMS, DHCS, and Medicare-Medicaid health plans to coordinate the delivery of care for covered Medicare and Medicaid services for CMC members.

Members enrolled in the Cal MediConnect Plan receive all Medicare and Medi-Cal benefits, including medical care, behavioral health services, and Long-Term Services and Supports (LTSS). They also receive Home-and Community-Based Services, such as In-Home Support Services, Community Based Adult Services, and Multipurpose Senior Services Program, in addition to non-emergency transportation services and care in nursing facilities.

In 2015, Santa Clara Family Health Plan (the Plan) launched Cal MediConnect to serve people in Santa Clara County who are eligible for both Medicare and Medi-Cal. As of December 2018, Santa Clara Family Health Plan had 7,695 Cal MediConnect members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit, for the period of April 1, 2018 through February 28, 2019. The onsite review was conducted from March 18, 2019 through March 29, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on June 13, 2019 with Santa Clara Family Health Plan (the Plan). The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings.

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

The prior Department of Managed Health Care (DMHC) medical survey (for the period of April 1, 2015 through March 31, 2016) was issued on December 16, 2016. The Plan was required to provide a Corrective Action Plan (CAP) and respond to all documented deficiencies. The corrective action plan (CAP) was closed on March 27, 2017.

A summary of the findings by category are as follows:

Category 1 – Utilization Management

The Contract requires the Plan to monitor its delegated entities' performance to ensure that their operations comply with all contractual and regulatory requirements. Plan shall notify the requesting Network Provider, either orally or in writing, and give the enrollee written notice of any decision by the Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

The Plan did not ensure prior authorization decisions were consistently communicated to the requesting providers. The Plan's delegated entity and the Plan itself did not have an alternative method in handling provider notification when facsimile communication of the notification failed.

The Contract requires the Plan to comply with all applicable provisions of federal and state laws. Welfare and Institutions Code, Section 14103.6 states prior authorization for pharmaceutical services may be determined by California-licensed pharmacists. Furthermore, California Business and Profession Code, Section 4036 defines "Pharmacist" as a natural person to whom a license has been issued by the [California] board [of pharmacy].

The Plan failed to monitor its delegated entity's performance complied with contractual and regulatory requirements. The Plan did not ensure that pharmacy prior authorization decisions were made by California-licensed pharmacists or other qualified health care professionals.

Category 2 – Case Management and Coordination of Care

The Contract requires the Plan to monitor its delegated entities' performance to ensure that their operations comply with contractual and regulatory requirements. The Plan shall ensure enrollees continue to have access to medically necessary items, services, and medical and Long-Term Services and Supports providers in accordance with applicable Duals Plan Letters.

The Plan has not established oversight procedures for delegated transportation providers. In addition, the Plan denied requests for continuity of care with out-of-network providers for qualified enrollees.

Category 3 – Access and Availability of Care

No findings were noted for the audit period.

Category 4 – Enrollee Rights

The Contract and Title 42 of the Code of Federal Regulations, Section 438.408, Subpart F preclude grievances from progressing to the level of a state fair hearing. Enrollees must exhaust the appeal process with the Plan before they can request a state fair hearing. The APL 17-006 and Title 42 of the Code of Federal Regulations, Section 438.400(b)(7) define the terms "Grievance" and "Appeal" separately. A Managed Care Organization (MCO) enrollee has the option of requesting an appeal following receipt of an adverse benefit determination. In contrast, a grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination.

The Plan provided the option of a state fair hearing in grievance resolution letters to CMC enrollees. This was incorrect and misleading. A state fair hearing may only be requested if the Plan's internal appeal process has been exhausted and a Notice of Appeal Resolution (NAR) has been issued.

Category 5 – Quality Management

The Contract requires the Plan to ensure that Network Providers training relates to Cal MediConnect services, policies, procedures and any modifications to existing services, policies or procedures. The Plan shall maintain policies and procedures and educate its network providers concerning its policies and procedures.

The Plan could not provide Cal MediConnect policies and procedures related to new provider orientation and provider training and communication; therefore, it could not demonstrate compliance.

Category 6 – Administrative and Organizational Capacity

No findings were noted for the audit period.

III. AUDIT SCOPE/PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch to ascertain that services provided to Cal MediConnect enrollees comply with federal and state laws, applicable guidelines, and the Cal MediConnect Three-Way Contract.

PROCEDURES

DHCS conducted an onsite audit of the Plan from March 18, 2019 through March 29, 2019. The audit included a review of the Plan's contract with DHCS, its policies for providing services, the 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

Prior Authorization Requests: 25 medical and eight pharmacy prior authorization files were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to enrollees and providers.

Appeal Procedures: Seven standard and six expedited appeal files were reviewed for timely resolution, response to complainant, and appropriate medical decision making.

Category 2 – Case Management and Coordination of Care

Health Risk Assessment and Individualized Care Plan: 18 files were reviewed for compliance in procedures and timeliness.

Category 3 – Access and Availability of Care

No verification study was conducted for this section for the audit period.

Category 4 – Enrollee Rights

Grievance Procedures: 26 standard grievances (13 Quality of Care & 13 Quality of Service), and 10 exempt inquiry files were reviewed for timely resolution, response to complainant, and appropriate medical decision making.

Health Insurance Portability and Accountability Act (HIPAA): 14 files were reviewed for compliance in timeliness requirements.

Category 5 – Quality Management

Provider training: Verification files were requested. There were no new providers during the audit period. Therefore, no verification study was conducted for this section.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse reporting related to the providers: Seven fraud and abuse cases were reviewed during the audit period for appropriate reporting and processing.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: April 1, 2018 through February 28, 2019
DATE OF ONSITE AUDIT: March 18, 2019 through March 29, 2019

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures
The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment.

A qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Contractor's medical director, in collaboration with the Contractor's pharmacy and therapeutics committee or its equivalent.
(Cal MediConnect Three-Way Contract § 2.11.5 and 2.11.6)

Delegation Oversight
Contractor shall provide ongoing delegation oversight of the structures, processes, and outcomes of First Tier, Downstream, and Related Entities operations.

Contractor shall continually assess its First Tier, Downstream, and Related Entities' ability to perform delegated activities through initial reviews, on-going monitoring, performance reviews, analysis of data, and utilization of available benchmarks, if available.

Contractor shall provide delegation oversight of its First Tier, Downstream, and Related Entities that includes the following:

- Desktop and annual on-site revises;
- Monitoring; and
- Continuous improvement activities.

(Cal MediConnect Three-Way Contract § 2.2.4)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: April 1, 2018 through February 28, 2019
DATE OF ONSITE AUDIT: March 18, 2019 through March 29, 2019

Compliance
The Contractor must, to the satisfaction of CMS and DHCS:

- Comply with all provisions set forth in this contract.
- Comply with all applicable provisions of federal and state laws, the CFAM-MOU, regulations, guidance, waivers, Demonstration terms and conditions, including the implementation of a compliance plan.

(Cal MediConnect Three-Way Contract § 2.1.5)

Code of Federal Regulations 42 CFR, Section 438.210 Coverage and Authorization of Services
(c) Notice of adverse benefit determination. Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
MCPs shall comply with all other existing state laws and regulations in determining whether to approve, modify, or deny requests by providers prospectively, concurrently, or retrospectively. For decisions based in whole or in part on medical necessity, the written NOA shall contain all of the following:

e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions shall be communicated to the beneficiary in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing. Decisions rendered retrospectively only need to be communicated to providers in writing.

(APL 17-006, Section II (C)(1)(e))

SUMMARY OF FINDINGS:

1.2.1 Written Notification to Prescribing Providers

The Contract requires the Plan to monitor its delegated entities' performance to ensure that their operations comply with contracts and applicable regulations. The Plan shall notify the requesting Network Provider, either orally or in writing, and give the enrollee written notice of any decision by the Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. [Cal MediConnect Three-Way Contract Sections 2.1.5, 2.11.5 and 2.2.4]

Title 42 of the Code of Federal Regulations, Section 438.210 Coverage and Authorization of Services states, "Each contract must provide for the CMO, PIHP, or

PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorized a service in an amount, duration, or scope that is less than request."

California Health & Safety Code, Section 1367.01(h)(3) and (4) states, "Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision… Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated … to providers initially by telephone or facsimile… and then in writing…"

All Plan Letter 17-006 states, "decisions shall be communicated to the provider initially be telephone or facsimile, and then in writing."

The Plan's procedure No. HS.01.01-Prior Authorization Process states, "Notification to the requesting practitioner or provider (1) Routine standard decisions are sent to the requesting provider via fax, (2) Expedited and urgent decisions are communicated to the individual or provider submitting the requested service via phone followed by a written notification within 3 calendar days."

The Plan's Procedure PH.03.01 Prior Authorization Notification section states, "All decisions shall be communicated to the requesting prescriber by telephone, facsimile, or electronic mail within 24 hours of the decision followed by written notification."

The Plan did not notify the provider of a pharmacy prior authorization decision within 24 hours of the decision. The verification study identified that the Plan did not consistently provide notification to the requesting providers in a timely manner. Neither the Plan's or the delegated entity's policies and procedures address proper handling of unsuccessful facsimile communication to the requesting providers.

The Plan did not have adequate quality assurance or oversight and supervision in monitoring the Pharmacy Benefit Manager (PBM) delegate's performance and compliance with contract requirements, state laws and contract or delegation agreements.

Unsuccessful or inefficient transmission of information from the Plan to Providers concerning enrollees' prior authorization denials can lead to inadvertent omission, or delay in receipt of medically necessary services and thus result in potentially adverse outcomes.

1.2.2 California-Licensed Pharmacist to Approve, Defer, Modify, or Deny Prior Authorization Requests for Pharmaceutical Services

The Contract requires the Plan to comply with all applicable provisions of federal and state laws. The Contract states for decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease. A qualified physician or pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services.
[Cal MediConnect Three-Way Contract Sections 2.1.5, 2.11.6 and 2.2.4]

Medi-Cal Managed Care Division Policy Letter 08-013 clarifies that a California-licensed pharmacist may approve, defer, modify, approve as modified, or deny prior authorization requests for pharmacy services pursuant to Health and Safety Code, Section 1367.01(c) and (e), Welfare and Institutions Code, Section 14103.6 and Business and Professions Code, Section 4000.

Welfare and Institutions Code, Section 14103.6 states prior authorization for pharmaceutical services may be determined by California-licensed pharmacists. Furthermore, California Business and Profession Code, Section 4036 defines "Pharmacist" as a natural person to whom a license has been issued by the [California] board [of pharmacy].

The Plan's policy No. PH03 – Prior Authorization, effective March 15, 2018, defines how prior authorization procedures and processes address the adoption or review, application of criteria, turn-around times, requirements of prior authorization denial notifications to members and requesting provider and practitioners. The policy failed to address the need for California-licensed pharmacists in rendering pharmacy prior authorization decisions.

The Plan's policy No. PH.04.03 – Medicare Coverage Determination Oversight, effective January 24, 2019, states, "The Director of Pharmacy or designee will audit coverage determinations monthly using the Medicare Coverage Determination Oversight Procedure PA (Prior Authorization) Audit Report (Appendix A)…". The policy failed to identify reviewer's licensure as part of the monthly inter-rater reliability (IRR) oversight process.

A review of pharmacy prior authorizations revealed that decisions delegated to the PBM were made by non-California-licensed pharmacists.

The Plan delegated prior authorization decisions to its PBM; however, it did not ensure that those decisions were made by California-licensed pharmacists or other qualified health care professionals.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: April 1, 2018 through February 28, 2019
DATE OF ONSITE AUDIT: March 18, 2019 through March 29, 2019

The Plan did not comply with the contract requirements and California state law by allowing non-California-licensed pharmacists to approve, defer, modify, prior authorization requests for Medi-Cal pharmacy services.

RECOMMENDATIONS:

1.2.1 Develop and implement procedures to ensure timely notification of prior authorization decisions.

1.2.2 Develop and implement procedures to ensure prior authorization decisions are made by California-licensed pharmacists or other qualified health care professionals.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: April 1, 2018 through February 28, 2019
DATE OF ONSITE AUDIT: March 18, 2019 through March 29, 2019

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4	NON-EMERGENCY MEDICAL TRANSPORTATION/ NON-MEDICALTRANSPORTATION

Non-Medical Transportation and Non-Emergency Medical Transportation Benefits:

- Contractors must provide transportation services to beneficiaries for Medically Necessary Services.
- Contractors must provide transportation services pursuant to this Contract, applicable law including but not limited to Welfare & Institutions Code 14132(ad) and the requirements in applicable current and future DPLs.

(Cal MediConnect Three-Way Contract § A.3.2)

Delegation Oversight:
Contractor shall provide ongoing delegation oversight of the structures, processes, and outcomes of First Tier, Downstream, and Related Entities operations.

Contractor shall continually assess its First Tier, Downstream, and Related Entities' ability to perform delegated activities through initial reviews, on-going monitoring, performance reviews, analysis of data, and utilization of available benchmarks, if available.

Contractor shall provide delegation oversight of its First Tier, Downstream, and Related Entities that includes the following:

- Desktop and annual on-site revises;
- Monitoring; and
- Continuous improvement activities.

(Cal MediConnect Three-Way Contract § 2.2.4)

Compliance
The Contractor must, to the satisfaction of CMS and DHCS:

- Comply with all provisions set forth in this contract.
- Comply with all applicable provisions of federal and state laws, the CFAM-MOU, regulations, guidance, waivers, Demonstration terms and conditions, including the implementation of a compliance plan.

(Cal MediConnect Three-Way Contract § 2.1.5)

SUMMARY OF FINDINGS:

2.4.1 Non-Emergency Medical Transportation (NEMT) / Non-Medical Transportation (NMT) Delegation Oversight

The Contract requires the Plan to monitor and ensure that their delegated entities comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including Duals Plan Letters.
[Cal MediConnect Three-Way Contract Sections A.3.2, 2.1.5 and 2.2.4]

The Plan's procedure No. HS.01.08 – Transportation Services states:

1. "Emergency medical transportation does not require prior authorization."
2. "Non-emergency medical transportation is covered when the member's medical condition does not allow the patient to travel by bus, car, taxi or another form of public or private transportation and the service the member is going to obtain is a covered benefit and within Santa Clara County."
3. "SCFHP monitors compliance such as driver attitude, timeliness and riding experience through grievance tracking and the Member Satisfaction process…"

The Plan delegated its transportation services to NEMT/NMT providers. The Plan failed to monitor and ensure that their delegated entities comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including Duals Plan Letters. The Plan did not perform audits or other oversight activities of its delegates.

During the interview, the Plan acknowledged that it had not established oversight procedures for delegated transportation providers. The Plan did not perform oversight activities such as conducting audits of its delegates. The Plan monitored NEMT/NMT services through grievance tracking and the member satisfaction process. The Plan relied on the delegates to perform its responsibilities in accordance with the terms of the written agreement and applicable state and federal laws without validating compliance as required by contract.

When the Plan does not oversee its transportation delegated entities, the transportation providers may not comply with all applicable state and federal laws and regulations governing NEMT/NMT vehicles and drivers.

RECOMMENDATIONS:

2.4.1 Develop and implement procedures to monitor the delegated entities for compliance with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including Duals Plan Letters.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: April 1, 2018 through February 28, 2019
DATE OF ONSITE AUDIT: March 18, 2019 through March 29, 2019

2.5	CONTINUITY OF CARE

Continuity of Care
Contractor shall ensure Enrollees continue to have access to medically necessary items, services, and medical and LTSS providers and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

Contractor must allow Enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for Medi-Cal services if all of the following criteria are met under Welfare and Institutions Code section 14182.17(d)(5)(G):

- Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network provider at least twice within the previous twelve (12) months from the date of enrollment. The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medi-Cal FFS claims, treatment authorization request data or Medi-Cal managed care Encounter Data provided by the state or by documentation from the provider or Enrollee.
- Provider is willing to accept payment from the Contractor based on the Contractor's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and
- Contractor would not otherwise exclude the provider from their Provider Network due to documented quality of care concerns or state or federal exclusion requirements.

(Cal MediConnect Three-Way Contract §2.8.4)

Revised Duals Plan Letter 16-002: Continuity of Care
Upon beneficiary request, or other authorized person as noted below, MMPs must offer continuity of care with out-of-network providers to all Cal MediConnect beneficiaries if all of the following circumstances exist:

- A beneficiary has an existing relationship with a primary or specialty care provider. An existing relationship means the beneficiary has seen an out-of network primary care provider (PCP) or a specialty care provider at least once during the 12 months prior to the date of his or her initial enrollment in the MMP for a non-emergency visit;
- The provider is willing to accept, at a minimum, payment from the MMP based on the current Medicare or Medi-Cal fee schedule, as applicable; and
- The provider does not have any documented quality of care concerns that would cause the MMP to exclude the provider from its network.

SUMMARY OF FINDINGS:

2.5.1 Continuity of Care with Out-Of-Network Provider

The Contract states, "Contractor shall ensure Enrollees continue to have access to medically necessary items, services, and medical and LTSS providers and in accordance with applicable DPL(s) as indicated in Section 2.1.5."
[Cal MediConnect Three-Way Contract Section 2.8.4]

The revised Duals Letter 16-002 states that upon beneficiary request, or other authorized person as noted below, Medicare-Medicaid Plans (MMP) must offer continuity of care with out-of-network providers to all Cal MediConnect beneficiaries if all of the following circumstances exist: (1) a beneficiary has an existing relationship with a primary or specialty care provider, (2) the provider is willing to accept, at a minimum, payment from the MMP based on the current Medicare or Medi-Cal fee schedule, (3) the provider does not have any documented quality of care concerns that would cause the MMP to exclude the provider from its network.

The Plan's procedure No. HS.01.05 states:

Continuity of care services may be authorized through the Utilization Management or Case Management processes for the following:

1. When a contracted provider leaves the Plan either through voluntary or involuntary termination or by death.
2. When a newly enrolled member is in a current episode of treatment with a non-participating provider for the following:
    a. Acute episode of care
    b. Care for defined chronic condition
    c. Terminal illness
    d. Newborn care ages birth to 36 months for up to 12 months after first enrolled
    e. Surgeries
3. A new member is receiving services covered under a medical exemption (MER) from Managed Care Plan enrollment.
4. Medical, behavior health and long term services and supports with defined conditions.

The Plan's Continuity of Care desktop resource instructed customer care representatives to inform an enrollee requesting continuity of care that he/she may continue seeing his/her out-of-network provider for a period of time if the enrollee is currently undergoing treatment for certain medical conditions. This guideline did not mention that the enrollee could continue seeing his/her current out-of-network provider for a period of 12 months as long as all of the continuity of care protections are met.

During the interview, the Plan stated that if the enrollee was not currently receiving treatment for certain medical conditions (acute, serious chronic, terminal illness, surgeries), then the Plan denied the request for continuity of care with the out-of-network provider. The Plan offered the enrollee an in-network alternative. An in-network alternative was assigned to the enrollee if the enrollee did not choose one.

When the Plan denies requests for continuity of care with out-of-network providers to all qualified enrollees, the enrollees may have poor health outcomes related to the delay or interruption of medically necessary services.

RECOMMENDATIONS:

2.5.1 Update the desktop resource and establish a process to allow continuity of care with out-of-network providers for all Cal MediConnect enrollees who meet the criteria as stated in the DPL 16-002.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: April 1, 2018 through February 28, 2019
DATE OF ONSITE AUDIT: March 18, 2019 through March 29, 2019

CATEGORY 4 – ENROLLEE RIGHTS

4.1	GRIEVANCE SYSTEM

Enrollee Grievances
Grievance Filing**:** The Contractor shall inform Enrollees that they may file a grievance through either the Contractor or Cal Medi-Connect Ombuds Program for complaints relating to Medicare and Medi-Cal covered benefits and services.

The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee grievance regarding Medicare and Medi-Cal covered benefits and services may be filed. Authorized representatives may file grievances on behalf of Enrollees to the extent allowed under applicable federal or state law.

The Contractor shall make availability to Enrollees of information about Enrollee Appeals, as described in Section 2.15, including reasonable assistance with Enrollee Grievances and Appeal in completing any forms.
(Cal MediConnect Three-Way Contract § 2.14)

Enrollee Appeals
Contractor must provide a member notice of resolution, as expeditiously as the Enrollee's health condition requires, not exceeding thirty (30) calendar days from the day Contractor receives the appeal. An Enrollee notice, at a minimum, must include the result and date of the appeal resolution. For decisions not wholly in the Enrollee's favor, Contractor, at a minimum must include:

- Enrollee's right to request a State Fair Haring;
- How to request a State Fair Hearing;
- Right to continue to receive benefits pending a State Fair Hearing;

(Cal MediConnect Three-Way Contract § 2.15.1.2)

Code of Federal Regulations 42 CFR, Section 438.408, Subpart F, Requirements for State Fair Hearing
An enrollee may request a State fair hearing only after receiving notice that the Managed Care Organization (MCO) is upholding the adverse benefit determination. In the case of an MCO that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's appeals process. The enrollee may initiate a State fair hearing.

SUMMARY OF FINDINGS:

4.1.1 Grievance Resolution Letters

The Contract precludes grievances from progressing to the level of a state fair hearing. Enrollees must exhaust the appeal process with the Plan before they can request a state fair hearing. The Plan shall implement and maintain an Internal Appeals system in accordance with all applicable federal and state laws and regulations including but not limited to Federal Medicaid regulations governing Medi-Cal Managed Care Appeals pursuant to 42 CFR, Section 438.408, Subpart F.
[Cal MediConnect Three-Way Contract Sections 2.14 and 2.15.1.2]

Title 42 of the Code of Federal Regulations, Section 438.408, Subpart F, Requirements for State Fair Hearing states an enrollee may request a State fair hearing only after receiving notice that the Managed Care Organization (MCO) is upholding the adverse benefit determination. In the case of an MCO that fails to adhere to the notice and timing requirements in Section 438.408, the enrollee is deemed to have exhausted the MCO's appeals process. The enrollee may initiate a state fair hearing.

Title 42 of the Code of Federal Regulations, Section 438.400(b)(7) states, "Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination. Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination."

CMS's 2016 Medicaid and Children's Health Insurance Program Managed Care Final Rule included Federal Regulations that prompted creation of APL 17-006 and were influential in the crafting of relevant 2018 Contract language. The APL states that the terms "Grievance" and "Appeal" are separately defined. An MCO member has the option of requesting an appeal following receipt of an adverse benefit determination. In contrast, a grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. A complaint is the same as a grievance.

CMS Final Rule states, "…grievances do not progress to the level of a state fair hearing… Once this single level appeal process is exhausted, the enrollee would be able to request a state fair hearing".

The Plan's policy No. GA.03 – Member Grievance and Appeals Reporting and Monitoring states, "This policy also confirms SCFHP's commitment to providing appropriate resolutions to all grievances and appeals…"

A review of 26 grievance verification study files revealed that the Plan provided the option of a state fair hearing in 23 grievance resolution letters to CMC enrollees. This was incorrect and misleading. A state fair hearing may only be requested if the Plan's

internal appeal process has been exhausted and a Notice of Appeal Resolution (NAR) has been issued.

During the interview and in a subsequent written statement, the Plan cited a key personnel limitation with a loss of a long-term Grievances and Appeals supervisor as the primary reason for untimely recognition and implementation of all grievance-related changes specified in the Contract.

A CMC enrollee's receipt of erroneous information concerning recourse beyond the Plan's determined grievance resolution can cause enrollees to file incorrect forms and misunderstand their grievance rights.

RECOMMENDATIONS:

4.1.1 Develop and implement procedures to ensure the grievance system and processes comply with requirements and provide accurate information to enrollees.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: April 1, 2018 through February 28, 2019
DATE OF ONSITE AUDIT: March 18, 2019 through March 29, 2019

5.2	PROVIDER QUALIFICATIONS

Provider Training:

- Contractor shall ensure that all Network Providers receive training regarding the MediConnect Program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations, including rights and responsibilities pertaining to Grievance and Appeals procedures and timelines under this contract.
- Contractor shall ensure that Network Provider training relates to MediConnect services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among Contractor, Network Provider, Enrollee and/or other healthcare professionals. Contractor shall conduct training for all Network Providers within thirty (30) working days after the Contractor places a newly contracted provider on active status.
- The Contractor will maintain policies and procedures on Advance Directives pursuant to 42 C.F.R. §§ 422.128, 438.3(j), and 489.102, and will educate its network providers concerning its policies and procedures on Advance Directives. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor, CMS, or DHCS.

(Cal MediConnect Three-Way Contract § 2.9.10)

SUMMARY OF FINDINGS:

5.2.1 Provider Training Policies and Procedures

The Contract requires the Plan:

- Ensure that Network Provider training relates to Cal MediConnect services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among Contractor, Network Provider, Enrollee and/or other healthcare professionals. Contractor shall conduct training for all Network Providers within thirty (30) working days after the Contractor places a newly contracted provider on active status.
- Maintain policies and procedures on Advance Directives pursuant to 42 CFR, Sections 422.128, 438.3(j), and 489.102. The Contractor will educate its network providers concerning its policies and procedures on Advance Directives. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor, CMS, or DHCS.

[Cal MediConnect Three-Way Contract Section 2.9.10]

The Plan could not provide Cal MediConnect policies and procedures related to new provider orientation, provider training and communication; therefore, it could not demonstrate compliance.

Plan staff did not know that they needed to create provider training policies and procedures for Cal MediConnect to comply with the Contract's requirements. Plan staff believed they could use its existing Medi-Cal policies and procedures for the Cal MediConnect line of business.

Failure to have policies and procedures in place for new provider training may result in members being delayed in receiving Cal MediConnect services and the Plan not being compliant with the contract requirements.

RECOMMENDATIONS:

5.2.1 Develop and implement policies and procedures for new provider training for Cal MediConnect line of business based on the Three-Way Contract, state and federal regulations.