State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

February 18, 2022

Tyler Haskell
Interim Compliance Officer
Santa Clara Family Health Plan
6201 San Ignacio Avenue
San Jose, CA 95119

RE: Department of Health Care Services Cal MediConnect Audit

Dear Mr. Haskell:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Cal MediConnect Audit of Santa Clara Family Health Plan, a Medicare-Medicaid Plan (MMP), from March 18, 2019 through March 29, 2019. The audit covered the period of April 1, 2018 through February 28, 2019.

On September 30, 2021, the MMP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on July 11, 2019.

All items have been evaluated and DHCS accepts the MMP's submitted CAP. The CAP is hereby closed. Overall effectiveness of the CAP will continue to be assessed, as well as, to what extent the MCP has operationalized proposed corrective actions on the subsequent audit. The enclosed report will serve as DHCS' final response to the MCP's CAP.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

If you have any questions, feel free to contact me at (916) 345-7825 or Diana O'Neal at (916) 345-8668.

Sincerely,

[Singnature on file]

Lyubov Poonka, Chief
Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Enclosures: Attachment A, CAP Response Form

cc: Jennifer Maryland, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Santa Clara Family Health Plan **Review Period: 04/01/18 - 02/28/19**

Audit Type: Cal MediConnect Audit **Onsite Review: 03/18/19 - 03/29/19**

MMPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MMPs are required to submit the CAP in word format that will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that require long-term corrective action or a period longer than 30 calendar days for implementation, the MMP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MMP will be required to include the date when full compliance is expected to be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MMP's Contract Manager for review and approval in accordance with existing requirements.**

DHCS will maintain close communication with the MMP throughout the CAP process and provide technical assistance to ensure the MMP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MMP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.21Written Notification to Prescribing Providers	SCFHP's Pharmacy Benefit Manager (PBM), MedImpact, has updated the failed fax process to prevent future issues. The cases previously	• Failed Faxes 2019.pef • FF Training Sign off.pdf	March 19, 2019	**08/13/19** – The following documentation supports the MMP's efforts to correct this deficiency: - Updated P&P PH.03.01v5 "Medi-

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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	identified with unsuccessful faxes were manually mailed out to the physicians. MedImpact will now attempt to refax the request twice. If after 2 attempts the fax is still unsuccessful, MedImpact will reach out to the physician office for a valid mailing address and mail the letter manually to the physician.			Call/Health Kids Prior Authorization" (revised 02/13/19) demonstrates a written procedure and monitoring mechanism in place to ensure successful fax transmission to providers. (Page 2, F. Notification) - "Pharmacy Failed Fax Training" (02/15/19) with sign-in sheets as evidence that the staff received training. The training material addresses facsimile failure and quality assurance process in monitoring for unsuccessful provider notification. **This finding is closed.**

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compliance with contract requirements, state laws and contract or delegation agreements.				

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1.2.2 California-Licensed Pharmacist to Approve, Defer, Modify, or Deny Prior Authorization Requests for Pharmaceutical Services The Plan delegated prior authorization decisions to its PBM; however, it did not ensure that those decisions were made by California-licensed pharmacists. The Plan did not comply with the contract requirements and California state law by having non-California-licensed pharmacists to approve, defer, modify, prior authorization requests for Medi-Cal pharmacy services.	SCFHP's PBM, MedImpact, will comply with the contract requirements and California state law by utilizing California-licensed pharmacists to approve, defer, and/or modify prior authorization requests for Medi-Cal pharmacy services.		September 1, 2019	**9/16/21** – The following documentation supports the MMP's efforts to correct this finding: The following documentation supports the MMP's efforts to correct this finding. The MMP updated policies and procedures to ensure prior authorization decisions are made by California-licensed pharmacists or other qualified health care professionals. Supporting Documentation: • Updated Policies and Procedures PH03 "Prior Authorization" and PH.04.03 "Medicare Coverage Determination Oversight" has been revised to reflect the revisions requested by DHCS. Updated Policies now specify the required use of California licensed pharmacists. • Revised Policy PH.04.03 demonstrates the oversight process by requiring an annual review of delegated prior authorization requests to ensure decisions to deny, modify or defer were made by

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				California-license pharmacist or other qualified health care professionals. • Med-Impacts CA licensed SAC process (RN13.b1) specifies the use of California licensed pharmacists for Pas. • Med-Impact PA & UM Part D Meeting agenda (8/19/21) demonstrate staff was trained on RN13.b1. **9/30/21** – The following additional documentation supports the MMP's efforts to correct this finding: • Screen shot from MedImpact License Check demonstrates the MMP is monitoring the use of California licensed pharmacists for PA requests. • The revised service agreement indicates that all personnel must be licensed or certified by their respective board or agency, where required by law. **This finding is closed.**

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2. Case Management and Coordination of Care				
2.4.1Non-Emergency Medical Transportation (NEMT} / Non-Medical Transportation (NMT) Delegation Oversight 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 of its delegates for delegation oversight as the contractual	SCFHP provides ongoing monitoring and oversight of the transportation providers in a variety of methods. Please see NEMT/NMT Narrative for details. The Risk Assessment and Auditing process for transportation providers is detailed in the NMT/NEMT narrative. See also, Compliance Policy CP.17 "Risk Assessment."	• NEMT/NMT Narrative • HS.13.01 "NEMT Services" • CP.17 "Risk Assessment Policy"	August 5, 2019	**08/13/19** – The following documentation supports the MMP's efforts to correct this finding: - NEMT/NMT Transportation Oversight Narrative that expresses the MMPs efforts of monitoring and oversight of the transportation providers to comply with all applicable state and federal laws and regulations, contractual requirements and other requirements set forth by DHCS guidance and dual plan letters. The MMP has several methods of monitoring transportation providers such as monthly NMT/NEMT processing claims, data mining activities with Fraud, Waste, and Abuse (FWA) vendor, T&M Protection Resources, UM monitoring prior authorization process for Transportation services, grievance and appeal tracking system, and customer service support. The MMP established oversight procedures at least bi-

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requirements.				annually. MMP reviews transportation utilization reports to determine the transportation service providers with the highest utilization. Meetings with Joint Operations Committee (JOC) are scheduled twice a year with transportation service providers and provide an opportunity to share information and have discussions regarding operations, contracts, and compliance related topics. Issues with transportation providers are also discussed monthly in the Delegation Oversight Committee and Quarterly in the Compliance Committee. - P&P, "CP.17 v1: Risk Assessments" (03/28/2019) as evidence that the MMP implemented a system for assessing operational risks, contractual and regulatory risks that designs to prioritize monitoring and auditing activities according to specified risk categorizations. High volume

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				transportation service providers will be audited for the Medi-Cal line of business in 2020. - Joint Operation Committee (JOC) meeting minutes with transportation service providers Yellow Cab (05/29/19), Ken's Transportation (06/05/19), Green Cab (06/09/19), which provide evidence of documented review and discussion that MMP are meeting to share information and discuss compliance related issues. **This finding is closed.**
2.5.1 Continuity of Care with Out-Of-Network Provider The Plan stated that if the enrollee was not currently receiving treatment for certain medical conditions (acute, serious chronic,	SCFHP has updated the UM procedure (HS.01.05) in accordance to the continuity of care criteria of continuation of care through the post-partum period for members in their second or third trimester of pregnancy as stated in DPL 16-002.	• HS.01.05 "Continuity of Care"	August 5, 2019	**02/06/20** – The following additional documentation submitted supports the MMP's subsequent efforts to correct this finding: - Updated P&P, "HS.01.05: Continuity of Care" (08/26/19) which has been amended to allow continuity of care with out of network providers. The policy states that SCFHP allows newly enrolled Cal MediConnect

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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 does not allow 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				members to maintain existing prior relationships with their current Medicare providers for a period up to 12 months for primary and specialty services. - Updated Provider Manual (08/26/19), under the Continuity of Care from a Terminating Physician or a Non-Contracted Provider section, the MMP states that, to ensure that medically necessary, in-progress, covered medical services are not interrupted due to the termination of a provider's contract, we assure continuity of care for our members, as well as for those newly enrolled individuals who have been receiving covered services from a non-contracted provider. Continued care for a newly enrolled member may not exceed 12 months from the initial effective date of coverage (page 38). **This finding is closed.**

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4. Enrollee Rights				
4.1.1 Grievance Resolution Letters 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 appeals process has been exhausted and a Notice of Appeal Resolution (NAR) has been issued	SCFHP has reviewed and revised our grievance notices to exclude the State Hearing rights. SCFHP removed the State Hearing language from the grievance resolution letters effective April 2, 2019. The letters were reprogrammed into the grievance system of record as of July 1, 2019. Additionally, the Grievance & Appeals Department is recruiting a Quality Assurance Program Manager that will be responsible for reviewing notices prior to mailing to the member. The intent of the position is to ensure our members receive the appropriate resolution, including the appropriate rights.	• Grievance and Appeals Quality Assurance Program Manager Job Description • 4.1.1 CMC Examples	Short term date: 7/1/2019. Long-term date: 9/1/2019.	**08/12/19** – The following documentation supports the MMP's efforts to correct this deficiency: - Sample of three exempt grievances, (4/9/19, 4/19/19, and 6/12/19) as evidence that the MMP's grievance resolution letters did not provide an option of a state fair hearing. **10/07/19** – The following additional documentation supports the MMP's efforts to correct this deficiency: - An email (10/7/19) which states, "The Plan promoted a Grievance & Appeals Coordinator to a G&A Quality Assurance Program Manager effective September 1, 2019. - An email dated (10/25/19) which states, "Trainings are done ad hoc based on trends found through the

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				internal Q&A process or audit-related findings. With the addition of the QA Program Manager, the Plan anticipates having more frequent formal and informal trainings based on QA findings. - PowerPoint training, “Grievance & Appeals, Santa Clara Family Health Plan” (10/22/19) and sign-in sheets as evidence that the G&A staff received training. The training materials address that New federal regulations require beneficiaries to exhaust the MMP’s internal Appeal process and receive notice that the Adverse Benefit Determination has been upheld prior to proceeding to a State Hearing. If the MMP fails to adhere to the required timeframe when resolving the Appeal, the beneficiary is deemed to have exhausted the MMP’s internal Appeal process and may request a State Hearing. - P&P, “GA.07.01: Member Grievances” (12/30/19) which explains that once a resolution letter

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				is mailed out to a member the notice does contains additional rights to an external grievance if the member disagrees with the findings and/or resolution of the SCFHP grievance. **06/16/20** – The following additional documentation submitted supports the MMP's efforts to correct this deficiency: - An email, (06/16/20) clarifying that Policy GA.07.01 does not contain State Fair Hearing information because it is the procedure for grievances. Since the Plan's finding was that grievance notices contained appeal-related information (i.e., the right to file a State Hearing) in error, the grievance procedure was updated to clarify the next steps for a member in the grievance system. The grievance procedure was not updated to include State Hearing information; doing so may further confuse staff as State Hearings only relate to the appeals system. **This finding is closed.**

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5. Quality Management				
5.2.1 Provider Training Policies and Procedures 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. The Plan did not know that they needed to create provider training policies and procedures for Cal MediConnect to comply with the	SCFHP has developed a new policy PN.04 v1 "Provider Orientation and Education" and procedure PN.04.01 v1 "New Provider Orientation" attached, to replace previous policies which includes clarification that the initial provider orientation is to occur within 10 business days after contract effective date, as well as the process for overseeing SCFHP performance and delegate performance related to this task.	• Policy PN.01 v1 • Procedure PN.04.01 v1	August 5, 2019	**09/24/19** – The following documentation supports the MMP's efforts to correct this deficiency: - Newly developed P&P, "PN.04.01 V3: New Provider Training" (drafted 09/24/19) (replaces P&P, PS025-025) which states, "The Provider Network Management Department conducts the new provider training within ten (10) business days of the effective date of the contract". **This finding is closed.**

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Contract's requirements. The Plan thought they could use its existing Medi-Cal policies and procedures for the Cal MediConnect line of business				

Submitted by: [Signature on file] **Date: 8/12/19**

Title: Christine M. Tomcala, Chief Executive Officer