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

REPORT ON THE MEDICAL AUDIT OF

SANTA CLARA FAMILY HEALTH PLAN

2021

Contract Number: 04-35398

Audit Period: March 1, 2020
Through
February 28, 2021

Report Issued: July 20, 2021

TABLE OF CONTENTS

I. INTRODUCTION

In 1995, the Santa Clara County Board of Supervisors established the Santa Clara County Health Authority (SCCHA) under the authority granted by Welfare and Institutions Code section 14087.36. The SCCHA distinct from the County was given the mission to develop a community-based health plan, Santa Clara Family Health Plan (Plan), to provide coverage to Medi-Cal Managed Care recipients.

The Plan is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act of 1996. Since 1997, the Plan has contracted with the State of California Department of Health Care Services (DHCS) as the local initiative for Santa Clara County under the Two-Plan Medi-Cal Managed Care model.

The Plan delivers services to members through delegated groups and vendors. The Plan partners with over 4,000 providers, including all hospitals in Santa Clara County.

As of February 2021, the Plan had 274,988 members of which 265,095 were Medi-Cal members and 9,893 Cal Medi-Connect members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of March 1, 2020 through February 28, 2021. The onsite review was conducted from March 9, 2021 through March 19, 2021. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on June 25, 2021. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On July 9, 2021, the Plan submitted a response after the Exit Conference. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated five performance categories: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights and Quality Management.

The prior DHCS medical audit for the period of March 1, 2019 through February 29, 2020 was issued on August 18, 2020. This audit examined the Plan's compliance with its DHCS contract and assessed implementation of its closed prior year's Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to issue a Provider Manual that includes information and updates regarding the member Appeal process. The Plan's Provider Manual did not comply with contractual and All Plan Letter (APL) requirements. The Manual contained inaccurate information about the Appeal process.

The Plan is required to maintain policies and procedures to ensure that subcontractors fully comply with all terms and conditions of the Contract. Subcontractors are required to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. The Plan did not ensure the policy and procedures of its subcontractor complied with the Contract requirements. The delegate's policies and procedures were not updated and contained incorrect information.

Category 2 – Case Management and Coordination of Care

No findings were noted for the audit period.

Category 3 – Access and Availability of Care

The Plan is required to ensure its Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) providers are enrolled in the Medi-Cal

Program. The Plan did not ensure its NMT and NEMT providers were enrolled in the Medi-Cal Program.

Category 4 – Member's Rights

No findings were noted for the audit period.

Category 5 – Quality Management

No findings were noted for the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Medical Review Branch conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State contract.

PROCEDURE

DHCS conducted a virtual audit of the Plan from March 9, 2021 through March 19, 2021. The audit included a review of the Plan's Contract with DHCS, its policies and procedures for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. DHCS reviewed the Plan's documents and conducted interviews with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 19 medical and 18 pharmacy prior authorization requests, including eight medical and eight pharmacy Seniors and Persons with Disabilities (SPD) cases, were reviewed for timeliness, consistent application of criteria, and appropriateness of review.

Prior authorization Appeal procedure: 22 Appeals including 13 SPD cases related to both medical and pharmacy services were reviewed for appropriateness and timeliness of decision-making.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment (IHA): 25 medical records including two SPD records were reviewed for appropriate documentation, timely completion, and fulfillment of all required IHA components.

Behavioral Health Treatment (BHT): Ten medical records were reviewed for coordination, completeness, and compliance with BHT provision requirements.

Category 3 – Access and Availability of Care

Emergency services and family planning claims: Ten emergency service claims and ten family planning claims were reviewed for appropriate and timely adjudication.

NMT: 20 records were reviewed to confirm compliance with NMT requirements.

NEMT: 18 records were reviewed to confirm compliance with NEMT requirements.

Category 4 – Member's Rights

Grievance procedures: 47 Grievances including 25 quality of care, 20 quality of service, and two expedited were reviewed for timely resolution, response to complainant, and appropriate level of review and medical decision-making. Twenty-two Grievances were for SPD members.

Category 5 – Quality Management

Provider training: 15 newly contracted providers were reviewed for timely Medi-Cal Managed Care Program training.

Potential quality of care issues: 14 cases were reviewed for reporting, investigation, and remediation.

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: March 1, 2020 through February 28, 2021 **DATE OF AUDIT: March 9, 2021 through March 19, 2021**

CATEGORY 1 - UTILIZATION MANAGEMENT

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Provider Manual Accuracy

The Plan is required to issue a Provider Manual to the contracting and subcontracting providers of health care services that includes information and updates regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access, special requirements, and the member Grievance, Appeal, and State Fair Hearing process. The Provider Manual must include the following Member Rights information: Member's Right to file Grievances and Appeals and their requirements and timeframes for filing; availability of assistance in filing; toll-free numbers to file oral Grievances and Appeals; and Member's Right to request continuation of benefits during an Appeal or State Fair Hearing. *(Contract, Exhibit A, Attachment 7)*

APL-17-006, Grievance and Appeal Requirements (05/09/2017), requires beneficiaries to file an Appeal within 60 calendar days from the date of the Notice of Adverse Benefit Determination (NOA). Managed Care Plans (MCPs) shall adopt the 60-calendar day timeframe in accordance with federal regulations.

Finding: The Plan's Provider Manual contained inaccurate filing timeframes and omitted Appeal assistance and Member Rights information.

- The Provider Manual guidance on how to file an Appeal incorrectly provided two timeframes for filing an Appeal, 60 days and 90 days. The correct timeframe should be 60 days for filing an Appeal.

- The Provider Manual omitted instructions and contact information about the Plan's availability of assistance in filing an Appeal and the member's right to request continuation of benefits during an Appeal or State Fair Hearing.

In the review of the Provider Manual, the Plan did not revise the Provider Manual to include APL requirements. The Provider Manual provided was not current with the last revision date of April 2018.

Misinformation regarding the Appeal process may prevent providers from assisting members in making informed decisions about their health care.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Santa Clara Family Health Plan
AUDIT PERIOD: March 1, 2020 through February 28, 2021 **DATE OF AUDIT: March 9, 2021 through March 19, 2021**

Recommendation: Develop and implement policies and procedures to update Provider Manual to reflect accurate information about Appeal assistance, member rights, and filing timeframes.

1.5	DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Compliance with Medi-Cal, State, and Federal Laws

The Plan is required to maintain policies and procedures, approved by DHCS, to ensure that subcontractors fully comply with all terms and conditions of the Contract. The Plan shall oversee and remain responsible and accountable for any functions and responsibilities delegated and must meet the subcontracting requirements as stated in Code of Federal Regulations 42, APL 17-004, and the Contract. *(Contract, Exhibit A, Attachment 6)*

APL 17-004, *Subcontractual Relationships and Delegation (04/18/2017)*, requires subcontractors to agree to comply with all applicable Medicaid laws and regulations as well as applicable State and federal laws. The Plan maintains the responsibility of ensuring that subcontractors are and continue to comply with all applicable Medi-Cal, State and federal laws, and contractual requirements.

APL 20-004, Emergency State Fair Hearing Timeframe Change – Managed Care (08/18/2020), extended the timeframe allowing an additional 120 days to request a State Fair Hearing.

The Plan's Delegation Agreement requires the Plan to oversee the delegate's performance of delegated activities by conducting an annual oversight audit, which includes ongoing review of policies as they are revised.

Finding: The Plan did not ensure that the delegate's policies and procedures accurately described the NOA process, contained updated guidelines for medical necessity determination, and provided correct information about the Appeal process.

Review of delegate's policies and procedures revealed the following deficiencies:

- Delegate Policy, *UM 50.0 Notice of Action Letters, Deferred, Denied and Modified (12/07/2020)*, did not accurately describe the NOA process. The policy included a template letter (Attachment A), which allows ten days, instead of 14 days, and did not specify the anticipated date when a decision will be rendered as required. Additionally, the "Your Rights", Attachment E, did not include accurate information on the Appeal process. The attachment did not inform members that they will need to exhaust the Plan's internal Appeal process prior to requesting a State Hearing or Independent Medical Review in accordance with *APL 17-006*.
- Delegate Policy, *UM 52.0 Review Criteria and Decision Making Process (12/4/2020)*, was not updated to include the delegate's change in the guidelines used to determine medical necessity. The delegate's policy and procedure listed

InterQual as its first criteria to determine medical necessity. The delegate utilized InterQual until December 2019; the criteria were phased out and are no longer used by the delegate as of June 2020. The delegate uses Milliman Clinical Guidelines to determine medical necessity. The delegate's policies and procedures were not updated to include the delegate's guidelines. The Plan did not ensure the delegate's policies and procedures were updated to reflect the change in the criteria and decision making process used by its delegate.

- Delegate *Utilization Management Policy and Procedure Operating Manual (02/2011)*, provided incorrect information on the Appeal process. The "Your Rights" attachment stated that a State Hearing can be initiated within 90 days of a decision. *APL-17-006* specifies that federal regulations require members to request a State Hearing within 120 calendar days from the date of the Notice of Appeal Resolution. Furthermore, *APL 20-004,* extended the timeframe allowing an additional 120 days.

The Plan did not follow the Delegation Agreement, which requires ongoing review of policies when they are revised. Furthermore, the Delegation Agreement states the Plan's oversight consist of an annual audit, which includes a review of the delegate's current policies and procedures of delegated activities. However, the delegation audit was not done last year due to sudden personnel changes in the Compliance Department (the Plan's Chief Compliance and Regulatory Affairs Officer and the Delegation Oversight (DO) Department Managers' resignations). The DO Committee disbanded and regrouped in April 2019. To prevent this key personnel inadequacy, the Plan split the Compliance and Regulatory Affairs responsibilities between two officers.

Lack of oversight of the delegate may lead to impaired delivery of needed healthcare services to members.

Recommendation: Develop and implement procedures to ensure delegate's policies are consistent with the Plan's UM policies and procedures and comply with Medi-Cal, State, and federal regulations.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Santa Clara Family Health Plan
AUDIT PERIOD: March 1, 2020 through February 28, 2021 **DATE OF AUDIT: March 9, 2021 through March 19, 2021**

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICALTRANSPORTATION

3.8.1 Medi-Cal Enrollment of NEMT and NMT Providers

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. All Policy Letters and APLs issued by DHCS subsequent to the effective date and during the term of the Contract shall provide clarification of the Plan's obligations pursuant to the Contract, and may include instructions regarding implementation of mandated obligations pursuant to changes in State or federal statutes, regulations, or pursuant to judicial interpretation. *(Contract, Exhibit E, Attachment 2(1)(D))*

APL 19-004, *Provider Credentialing/Re-credentialing and Screening/Enrollment (06/12/2019)*, states that MCPs network providers that have a state-level enrollment pathway must enroll in the Medi-Cal Program. State-level enrollment pathways are available through either the DHCS' Provider Enrollment Division (PED) or another State Department with a recognized enrollment pathway. MCPs have the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL, or MCPs may direct their network providers to enroll through a state-level enrollment pathway. DHCS' PED is the primary developer of state-level enrollment pathways for Fee-for-Service providers. If an MCP chooses to enroll a provider type into their network that does not have an enrollment pathway through PED, DHCS will recognize all other state-level enrollment pathways.

Finding: The Plan failed to monitor the transportation providers' enrollment and screening process, to ensure that all transportation providers were enrolled in the Medi-Cal Program as required by *APL 19-004*.

The Plan uses transportation providers to provide NMT and NEMT services to Medi-Cal members. Review of the Plan's paid claims revealed that four transportation providers were not enrolled in the Medi-Cal Program, yet provided services to Medi-Cal members.

In an interview, the Plan stated that they considered their providers enrolled in the Medi-Cal Program since these providers submitted their application to the Provider Application and Validation for Enrollment (PAVE), PED's portal to complete and submit applications. In actuality, enrollment in the Medi-Cal Program requires an application approval following PED's evaluation of the provider's application. Furthermore, the Plan did not have a policy and procedure to ensure transportation providers were enrolled in

the Medi-Cal Program.

Medi-Cal members may be subject to inadequate and unsafe transportation conditions if a transportation provider does not undergo the enrollment process to be eligible as a Medi-Cal provider.

This is a repeat of prior year finding 2.4.2**.**

Recommendation: Develop and implement policies and procedures to monitor and ensure that NMT and NEMT providers in the Plan's network are enrolled in the Medi-Cal Program.

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

REPORT ON THE MEDICAL AUDIT OF

SANTA CLARA FAMILY HEALTH PLAN

2021

Contract Number:	03-75802 State Supported Services
Audit Period:	March 1, 2020 Through February 28, 2021
Report Issued:	July 20, 2021~~July 16, 2021~~

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the review of Santa Clara Family Health Plan's (Plan) compliance and implementation of the State Supported Services contract with the State of California. The Contract covers abortion services contracted with the Plan.

The onsite audit was conducted from March 9, 2021 through March 19, 2021. The audit covered the review period from March 1, 2020 through February 28, 2021. It consisted of document reviews and interviews with Plan staff.

An Exit Conference with the Plan was held on June 25, 2021. There were no deficiencies found for the review period in the evaluation of the Plan's State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: March 1, 2020 through February 28, 2021
DATE OF AUDIT: March 9, 2021 through March 19, 2021

STATE SUPPORTED SERVICES

The Plan agrees to provide, or arrange to provide, to eligible members the following State Supported Services based on the following codes:
● Current Procedural Terminology Coding System: 59840 through 59857
● Health Care Finance Administration Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336
(State Supported Services Contract, Exhibit A.1)

Outpatient abortion is a sensitive service covered by the Medi-Cal program without prior authorization. The Plan is required to ensure that members can access these services from in- or out-of-network providers. The Plan provides pregnancy termination procedures through any qualified provider without prior authorization, except for inpatient abortions.
(State Supported Services Contract, Exhibit A.1)

All Plan Letter (APL) 15-020, Abortion Services (09/15/2015), states that the Plan is responsible to provide members timely access to abortion services. Plans that provide physician services must not require medical justification and/or prior authorization for outpatient abortion services.

The Plan's *Medi-Cal Member Handbook (2020), Evidence of Coverage*, provides information to members regarding their right to seek family planning services from any qualified provider of family planning services, including providers outside the Plan's network. Members may seek services, such as family planning, including sensitive services, without a referral.

The Plan's *Provider Manual (04/2018)* informed providers that members have the right to family planning services, which include services to determine pregnancy, temporarily delay pregnancy, or permanently prevent pregnancy. The Provider Manual states that family planning services for members do not require prior authorization and may be obtained from any family planning provider.

The Plan's procedure *CL.22.01*, *Processing of Abortion Claims Procedures (12/31/2020)*, ensures that neither medical justification nor prior authorization for outpatient abortion services is required.

The Plan's policy *CL.22, Processing of Abortion Claims (01/06/21),* ensures processing and payment of abortion claims from contracted and non-contracted providers. The timeframes for processing the abortion claims are as follows:

Contracted Providers: The Plan will pay 95 percent of all clean claims within 45 working days of the date of receipt.

Non-Contacted Providers: The Plan will pay 95 percent of all claims within 45 working days of the date of receipt.

The Plan's claims system maintains abortion procedure and service codes that automatically adjudicate payment without prior authorization for the covered services.

Review of ten claims revealed that the Plan provided the services and processed the claims properly for payment per Contract requirements.

Based on review of the Plan's documents, no deficiencies were noted for the audit period. The Plan provided members with the required State Supported Services based on the Contract and APL 15-020 requirements.

Recommendation: None.