

CONTRACT AND ENROLLMENT REVIEW  
DIVISION - SOUTH LOS ANGELES  
AUDITS AND INVESTIGATIONS  
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

**SANTA CLARA COUNTY HEALTH AUTHORITY  
dba SANTA CLARA FAMILY HEALTH PLAN**

**2022**

Contract Number: 04-35398

Audit Period: March 1, 2021  
Through  
February 28, 2022

Dates of Audit: March 7, 2022  
Through  
March 18, 2022

Report Issued: January 18, 2023

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## 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 which include of primary care providers (seven delegate groups), specialists, hospitals (including all hospitals in Santa Clara County), pharmacies, long term service supports and allied providers.

As of December 31, 2021, the Plan had 291,097 members of which 280,666 (96.4 percent) were Medi-Cal members and 10,431 (3.6 percent) were Cal Medi-Connect members.

The Plan is accredited with National Committee for Quality Assurance for the Medicare line of business for consumer protection and quality improvement.

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of March 1, 2021 through February 28, 2022. The audit was conducted from March 7, 2022 through March 18, 2022. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on November 29, 2022. 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 December 14, 2022, 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 six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of March 1, 2020 through February 28, 2021 was issued on July 16, 2021. This audit examined the Plan's compliance with its DHCS Contract and assessed implementation of its prior year's Corrective Action Plan.

The summary of the findings by category follows:

### **Category 1 – Utilization Management**

Category 1 includes procedures and requirements of the Plan's UM program, including the appeal process and delegation of UM.

The Plan is required to have an established specialty referral system to track and monitor referrals requiring prior authorization through the Plan. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. The Plan's referral tracking system did not track and monitor the referral types for authorized, denied, deferred, or modified, and timeliness of the referrals.

The written record of appeals is required to be reviewed periodically by the governing body of the Plan, public policy body, and an officer. The Plan's governing body, public policy body, and an officer of the Plan did not review the written record of appeals on a periodic basis.

The prior authorization requirements shall not be applied to preventive services. The Plan's delegate incorrectly required prior authorization for preventive services.

The Plan is required to have an established specialty referral system to track and monitor referrals requiring prior authorization and to ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures. The

Plan did not oversee its delegates' specialty referral system to track and monitor referrals requiring prior authorization and ensure they were compliant.

The Plan is required to include within the UM program mechanisms to detect both under-and over-utilization of health care services. The Plan did not oversee its delegates' internal system to detect and report under-and over-utilization of health care services and did not ensure that its delegates were compliant.

## **Category 2 – Case Management and Coordination of Care**

Category 2 includes procedures and requirements related to Behavioral Health Treatment (BHT) and Continuity of Care (COC).

The Plan's approved behavioral treatment plan must include care coordination that involves the parents or caregivers, school, state disability programs, and other programs and institutions. The Plan's behavioral treatment plan did not document the provision of case management and care coordination of BHT services.

The Plan is required to notify members' of approved COC services within seven calendar days and 30 calendar days before the end of the COC period. The Plan did not notify members of COC approval and 30 days before the end of the COC period.

## **Category 3 – Access and Availability of Care**

Category 3 includes procedures and requirements for access and availability of appointments, provider directory and access to Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services.

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times to obtain various types of appointments. The required types include routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult Initial Health Assessments (IHA). The Plan did not monitor wait times to obtain appointments for all the required types of services.

The Plan is required to ensure its NEMT and NMT providers are enrolled in the Med-Cal program. The Plan did not ensure NEMT and NMT providers were enrolled in the Medi-Cal program.

## **Category 4 – Member's Rights**

Category 4 includes procedures and requirements related to handling grievances.

The Plan is required to develop, implement, and maintain a Member Grievance System. It must resolve each grievance and provide notice, as expeditiously as the member's health condition requires, within state established time frames. The Plan is required to

resolve grievances and send resolution letters and notifications to members within state established time frames.

The Plan is required to provide subscribers and members with written responses to grievances, with a clear and concise explanation of the reason for the Plan's decision. The Plan did not send grievance resolution letters with a clear and concise explanation of its decisions to members.

All grievances and appeals related to medical Quality of Care (QOC) issues are required to be immediately submitted to the Plan's Medical Director for action. The Plan did not involve the Medical Director in review of the QOC and expedited grievances.

The Plan's written record of grievances is required to be reviewed periodically by the governing body, the public policy body, and by an officer of the Plan or designee. The Plan's governing body, public policy body, and an officer of the Plan did not review the written record of grievances on a periodic basis.

The Plan and its subcontractors are prohibited from billing Medi-Cal beneficiaries for services provided under the Contract. The Plan providers billed fully eligible Medi-Cal members for services which were covered under the Contract.

The Plan's grievance system is required to capture and process all expressions of dissatisfaction as grievances. The Plan did not capture, process, and resolve all billing complaints as grievances.

### **Category 5 – Quality Management**

Category 5 includes procedures and requirements related implementation of the quality improvement process.

The Plan's Quality Improvement System (QIS) is required to have a process to document problems that are being identified and effective action is taken to improve care where deficiencies are identified. The Plan did not take effective action to address any needed improvements in the QOC based on its identified issues related to medical services, access to appointments and timeliness of referrals.

### **Category 6 – Administrative and Organizational Capacity**

Category 6 includes procedures and requirements related to Fraud, Waste, and Abuse (FWA), and reporting of overpayments.

The Plan is required to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members on a regular basis. The Plan did not have a process to verify that services that have been represented have been delivered and the application of the verification process on a regular basis.

The Plan is required to report annually to the State on their recoveries of overpayments. The Plan did not account and report all overpayments identified during the audit period to DHCS.

### **III. SCOPE/AUDIT PROCEDURES**

#### **SCOPE**

The DHCS Contract and Enrollment Review Division 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 an audit of the Plan from March 7, 2022 through March 18, 2022. 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 interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

#### **Category 1 – Utilization Management**

Prior Authorization Requests: 74 medical and 17 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to providers and members.

Appeal Procedures: 45 appeals relating to both medical and pharmacy services were reviewed for appropriateness and timeliness of decision-making.

#### **Category 2 – Case Management and Coordination of Care**

California Children Services (CCS): Ten medical records were reviewed to evaluate the performance of services.

CCS grievance: Two medical records were reviewed to evaluate the performance of services.

Coordination of Care and IHA: 31 medical records were reviewed to confirm coordination of care and fulfillment of IHA/Individual Health Education Behavior Assessment (IHEBA) requirements.

Complex Case Management: Seven medical records were reviewed to evaluate the performance of services.

BHT: 14 medical records were reviewed for coordination, completeness, and compliance with BHT provision requirements.



COC: 14 medical records were reviewed to evaluate process used for COC approval and notification of services.

### **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.

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

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

### **Category 4 – Member’s Rights**

Grievance Procedures: 89 grievances (24 QOC, 25 quality of service, 13 exempt and 27 expedited) were reviewed for timely resolutions, response to complainants, appropriate level of review and medical decision-making.

Confidentiality Rights: 12 Health Insurance Portability and Accountability Act cases were reviewed for proper reporting of all suspected and actual breaches to the appropriate DHCS individuals within the required timeframe for processing.

### **Category 5 – Quality Management**

Credentialing and Recredentialing: 15 initial and recredentialing providers were reviewed for licensing and qualifications.

Provider Training: 20 newly contracted providers were reviewed for timely Medi-Cal Managed Care program training.

Potential QOC Issues: 14 cases were reviewed for reporting, investigation, and remediation.

### **Category 6 – Administrative and Organizational Capacity**

FWA Reporting: Seven cases were reviewed for proper reporting of any potential FWA to DHCS within the required time frames.

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

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

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**CATEGORY 1 - UTILIZATION MANAGEMENT**

<b>1.1</b>	<b>UTILIZATION MANAGEMENT PROGRAM REFERRAL TRACKING SYSTEM</b>
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**1.1.1 Referral Tracking System**

The Plan is required to have an established specialty referral system to track and monitor referrals requiring prior authorization through the Plan. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers. The Plan is required to ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures. *(Contract Exhibit A, Attachment 5, (1) (F))*

The Plan is required to ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the Plan and/or delegated providers. *(California Code of Regulations (CCR), Title 28, section 1300.70 (2)(G)(5))*

The Plan is required to ensure the provision of acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2.2. In addition, the Plan shall communicate, enforce, and monitor network providers' compliance with these standards:

**B. Standards for timely appointments:**

Members must be offered appointments within the following timeframes:

- Appointment with a specialist – within 15 business days of request;
- Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

*(Contract, Exhibit A, Attachment 9, 4(B)(2))*

The Plan's Policy, HS.01.02 *Referral Tracking System* (Approved: 12/31/2020), described the process for tracking referrals to their completion and drive improvements through the monitoring of provider referral and specialist care patterns of practice. The Plan tracks all authorizations, for completion of the "authorization to claims paid" cycle. To identify opportunities for improvements, the Plan tracks all authorization types for the purpose of ensuring authorizations are completed timely. Approved authorizations are tracked to completion of the service by reviewing the date of the service on the

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submitted claim. A quarterly analysis is provided to the UM Committee for review and recommendations.

**Finding:** The Plan's referral tracking system did not track and monitor the referral types for authorized, denied, deferred, or modified and timeliness of the referrals.

The Plan's Policy HS.01.02, stated that the Plan tracks all authorizations for completion of the "authorization to claims paid" cycle in order to identify opportunities for improvements and tracks all authorization types for the purpose of ensuring authorizations are completed timely. However, the Plan reports (Q1, Q2 and Q3 for 2021) did not track the referral types (authorized, approved, denied, deferred, or modified). Timeliness of the referrals were tracked only through paid claims and untimely delivery of good and services could not be identified through its process. This process did not differentiate if the member received the services promptly or at the end of 90 day window.

In addition, the Plan's process combined specialist appointments and ancillary referrals for its referral tracking system. Specialist appointments and ancillary services were not tracked within the 15 business days of the referral to ensure timeliness. The Plan only used paid claims report to determine timeliness within the 90 day window. However, this process did not address if the member received timely medically necessary services according to timeliness standards.

A review of quarterly reports (Q1, Q2 and Q3 2021) indicated that the total of authorization services not rendered within 90 days were 35.9, 37.4 and 45.2 percent, respectively. Higher percentage of services not rendered were noted under the durable medical equipment, outpatient hospital services and transportation categories. These reports were submitted to the UM Committee on a quarterly basis. The Plan did not analyze referral tracking data for the services that were not rendered and did not consider a rising trend for potential underutilization and no interventions were documented based on these reports.

During the interview the Plan acknowledged that it did not have an effective referral tracking system to monitor referral types and timeliness. The Plan acknowledged that the system needs improvement.

The Plan's lack of an effective referral tracking system may lead to inefficiencies in delivering healthcare services and/or goods in a timely manner to members.

**Recommendation:** Revise and implement policy and procedure to track and monitor the referral types for authorized, denied, deferred, or modified and timeliness of the referrals.

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### 1.3

### PRIOR AUTHORIZATION APPEAL PROCESS

#### 1.3.1 Appeal Records Oversight

The Plan is required to comply with all existing final Policy Letters and All Plan Letters (APL) issued by DHCS. (*Contract Exhibit E, Attachment 2*)

The Plan is required to implement and maintain policies that specify the responsibilities of the governing body, including at a minimum, the following: Routinely receives written progress reports from the Quality Improvement Committee describing actions taken, progress in meeting QIS objectives, and improvements made; Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up. (*Contract Exhibit A, Attachment 4 3C and D*)

The written record of grievances and appeals shall be reviewed periodically by the governing body of the Plan, the public policy body created pursuant to section 1300.69, and by an officer of the Plan or his designee. This review shall be thoroughly documented. (*CCR, Title 28, section 1300.68 (b) (5)*)

The grievance and appeal system is required to operate in accordance with all applicable federal regulations, state laws, and state regulations. The written record of appeals is required to be reviewed periodically by the governing body of the Plan, the public policy body, and by an officer of the Plan or designee. The review is required to be thoroughly documented. (*APLs 17-006 and 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

The Plan's Policy, GA.08 v2: *Medi-Cal Appeals* (undated and unsigned)

The Grievance and Appeals Management is responsible for the following:

- Oversight of the appeals system of the Plan, which includes, but is not limited to: Reviewing the overall operations of the system and identifying trends or patterns; Maintaining a system that shows aging appeals that are pending and unresolved for 30 calendar days; Ensuring that delegated entities comply with state and federal requirements for grievances and appeals.

**Finding:** The Plan's governing body, public policy body, and an officer of the Plan did not review the written record of appeals on a periodic basis.

The Plan's Policy, *GA.08 v2 and Procedure GA.08.01 v5: Medi-Cal Appeals*, did not include the process of a review of the written record of appeals by the governing body, public policy body, and an officer of the Plan. Both policy and procedure were undated and not approved (unsigned) by the Plan.

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The Plan's Policy GA.08 v2, stated that the Plan would perform oversight of its appeals system. The policy did not document that the Plan would follow and comply with the federal and state regulations but it required its delegates to comply with these requirements.

The Plan did not have documentation to support the review of the written records of appeals and was unaware of the APLs 17-006 and 21-011 requirements. The Plan did not ensure that the APLs, federal, and state requirements were incorporated into the policy and procedure.

When the written record of appeals is not reviewed by the governing body, public policy body, and by an officer of the Plan or designee, this may result in missed opportunities to implement quality improvements.

**Recommendation:** Revise and implement policy and procedure to ensure periodic review of the written record of appeals is conducted by the governing body, public policy body, and designated officer.

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1.5

### DELEGATION OF UTILIZATION MANAGEMENT

#### 1.5.1 Preventive Services

Prior authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing. (*Contract Exhibit A, Attachment 5, 2H*)

In addition, the Contract requires all preventive services identified as U.S. Preventive Services Task Force “A” and “B” recommendations must be provided by the Plan. (*Contract Exhibit A, Attachment 10, 6(B)*)

Plans are ultimately responsible for ensuring that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; Contract requirements; reporting requirements; and other DHCS guidance including, but not limited to APLs. Plans must have in place policies and procedures to communicate these requirements to all subcontractor and delegated entities. (*APL 17-004: Subcontracted Relationships and Delegation*)

The Plan’s Policy, HS.01: *Prior Authorization* (Approved: 03/11/2121), stated prior authorization is not required for emergency services (including emergency behavioral health services), urgent care, consent services for a member who is a minor under 18 years of age, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

**Finding:** The Plan’s delegate incorrectly required prior authorization for preventive services.

A review of the documents provided by the delegate demonstrated that it required prior authorization for 13 lung cancer screening during the audit period.

During the interview, the Plan was asked if it was aware that one of its delegates was requiring prior authorization for the preventive services. The Plan informed the team that it was unaware of the issue. The Plan did not ensure that its delegate was compliant with the Plan’s policy and procedure along with the Contract requirements.

When the Plan’s delegate requires prior authorization for preventive services, this may cause a delay and possible denial in the member receiving preventive services in a timely manner.

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**Recommendation:** Develop and implement a process to ensure that prior authorization is not required for preventive services by the Plan's delegates.

### 1.5.2 Delegation Referral Tracking System Oversight

The Plan is accountable for all quality improvement functions and responsibilities (e.g. UM, credentialing, and site review) that are delegated to subcontractors. If the Plan delegates UM activities, it is required to comply with requirements for Delegation of Quality Improvement Activities. (*Contract Exhibit A, Attachments 4 (6) and Attachment 5 (5)*)

The Plan is required to submit policies and procedures to show how delegated activities will be regularly evaluated for compliance with the Contract requirements and, that any issues identified through the UM program are appropriately resolved; and that UM activities are properly documented and reported. (*Contract Exhibit A, Attachment 18, 5G*)

The Plan is required to have an established specialty referral system to track and monitor referrals requiring prior authorization through the Plan. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers. The Plan is required to ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures. (*Contract Exhibit A, Attachment 5, (1) (F)*)

The Plan maintains the responsibility of ensuring that delegates are and continue to be in compliance with all applicable Medi-Cal, state and federal laws, and contractual requirements. (*APL 17-004: Subcontractual Relationships and Delegation*)

The Plan's Policy, HS.01.02 *Referral Tracking System* (Approved: 12/31/2020), described the process for tracking referrals to their completion and drive improvements through the monitoring of provider referral and specialist care patterns of practice. The Plan tracks all authorizations, for completion of the "authorization to claims paid" cycle. To identify opportunities for improvements, the Plan tracks all authorization types for the purpose of ensuring authorizations are completed timely. Approved authorizations are tracked to completion of the service by reviewing the date of the service on the submitted claim. A quarterly analysis will be provided to the UM Committee for review and recommendations.

**Finding:** The Plan did not oversee its delegates' specialty referral system to track and monitor referrals requiring prior authorization. It did not ensure that its delegates were compliant with Contract requirements.

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The Plan's Delegation Agreement stated that the delegate was responsible for the performance of the following delegated activities: UM, credentialing, re-credentialing, and processing and payment of all claims for payment of services provided to the Plan members who were assigned to the delegate. In addition, the agreement outlined the Plan's responsibilities which included annual review of the delegate's UM program, evaluation of regularly scheduled reports by the Plan's Medical Director, UM Director and UM Committee and ongoing monitoring of the delegate's compliance with its UM work plan by the Plan's UM Committee.

The Plan did not provide any documentation to demonstrate tracking of its delegates' specialty referral system. These authorizations (authorized, denied, deferred, modified referrals) and the timeliness of the referrals were not documented on a quarterly basis.

During the interview, the Plan stated that they did not require its delegates to submit a referral tracking report on a quarterly basis. The Plan only reviewed the delegates' appointment availability survey reports and policies on an annual basis. As a result, the Plan did not monitor referral types and timeliness, and which did not enable to implement quality improvements.

The Plan's Policy, HS.01.02 *Referral Tracking System*, did not outline how delegated activities would be regularly evaluated for compliance with the Contract requirements. According to APL 17-004 the Plan remains responsible for monitoring the performance of the delegated duties.

If the Plan fails to monitor a delegate's referral tracking system this may lead to inefficiencies in delivering healthcare services in a timely manner to its members.

**Recommendation:** Implement a delegation agreement to ensure delegated activities are regularly evaluated for compliance with Contract requirements.

### 1.5.3 Plan Oversight of Delegated Over and Under-Utilization of Medical Services

The Plan is required to include within the UM program mechanisms to detect both under-and over-utilization of health care services. The Plan's internal reporting mechanisms used to detect member utilization patterns shall be reported to DHCS upon request. (*Contract Exhibit A, Attachment 5 (4)*)

The Plan is accountable for all quality improvement functions and responsibilities (e.g. UM, credentialing, and site review) that are delegated to subcontractors. If the Plan delegates UM activities, it is required to comply with requirements for Delegation of Quality Improvement Activities. (*Contract Exhibit A, Attachments 4 (6) and Attachment 5*)



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(5)

The Plan is required to submit policies and procedures to show how delegated activities will be regularly evaluated for compliance with the Contract requirements and, that any issues identified through the UM program are appropriately resolved; and that UM activities are properly documented and reported. (*Contract Exhibit A, Attachment 18, 5G*)

Plans are required to maintain the responsibility of ensuring that delegates continue to be in compliance with all applicable Medi-Cal, state and federal laws, and contractual requirements. (*APL 17-004: Subcontractual Relationships and Delegation*)

Plan Procedure, HS.01.15: *Over and Under Utilization of Medical Services* (Approved: 12/31/2020), stated the Plan monitors the utilization of medical services and corrects under-or over-utilization to achieve optimal use of services. Also, the Plan collects and analyzes medical services utilization data routinely and reports the results to the UM Committee for evaluation. The Utilization Data Report (delegates) is issued quarterly by the delegated provider groups performing UM activities: report includes over-and under-utilization data.

**Finding:** The Plan did not oversee its delegates' internal system to detect and report under-and over-utilization of health care services. It did not ensure that its delegates were compliant with Contract requirements.

The Plan's Delegation Agreement stated that the delegate was responsible for the performance of the following delegated activities: UM, credentialing, re-credentialing, and processing and payment of all claims for payment of services provided to the Plan members who were assigned to the delegate. In addition, the agreement outlined the Plan's responsibilities which included annual review of the delegate's UM program, evaluation of regularly scheduled reports by the Plan's Medical Director, UM Director and UM Committee and ongoing monitoring of the delegate's compliance with its UM work plan by the Plan's UM Committee.

Industry Collaborative Efforts reports submitted had omissions in the sections on the over and under-utilization of health care services. The UM Committee meeting minutes did not document any over-and under-utilization reports from its delegates. The Plan did not provide an analysis of its delegated UM activities in regard to over-and under-utilization of services and goods.

During the interview, the Plan confirmed that it did not report over-and under-utilization of health care services from its delegates "quarterly to UM and Quality Improvement Committees".

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The Plan's lack of oversight of over and under-utilization of health care services performed by its delegates may lead to fraud, unnecessary services, and potential member harm, along with "delayed or suboptimal treatment of medical conditions".

**Recommendation:** Implement delegation agreement and procedure to ensure delegated activities are regularly evaluated for compliance with Contract requirements.

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**CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE**

**2.3 BEHAVIORAL HEALTH TREATMENT**

**2.3.1 Coordination of Care**

The Plan is required to provide or arrange and pay for Early and Periodic Screening, Diagnostic and Treatment services for members under the age or 21, including case management services. (*Contract Exhibit A, Attachment 10, 5F*)

The approved behavioral treatment plan must also meet the following criteria: Include care coordination that involves the parents or caregiver(s), school, state disability programs, and other programs and institutions, as applicable. (*APL 19-014: Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21*)

The Plan's BHT Program, described the Plan's expectations for the treatment plan including care coordination that involves parents or caregiver(s), school, state disability and other programs.

**Finding:** The Plan's behavioral treatment plan did not document the provision of case management and care coordination of BHT services.

The Plan's unsigned Policy, QI.17 v2: Behavioral Health Coordination, and the BHT program addressed APL 19-014 requirements for coordination of care; however, review of verification studies demonstrated that eight of 14 behavioral treatment plans and case management notes did not include documented care coordination with either the provider, school and/or other programs and institutions for the following services: individual education plan, speech therapy, and audiology testing.

During the interview, the Plan stated it did not have a process for its Case Managers to document external services received by the members.

Without care coordination of services members may not receive the treatment.

**Recommendation:** Develop and implement process to ensure care coordination and case management for BHT services.

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### 2.4 CONTINUITY OF CARE (COC)

#### 2.4.1 Continuity of Care Notification

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. (*Contract Exhibit E, Attachment 2, D*)

The Plan is required to notify members' of approved COC services within seven calendar days and 30 calendar days before the end of the COC period about the process that will occur to transition the member's care to an in network provider. (*Revised APL 18-008: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care*)

The Plan's Policy, HS.01.05: *Continuity of Care* (Approved: 12/21/2020), stated the Plan's notification process includes the following: The request determination; the duration of the COC arrangement; the notification to the member at least 30 calendar days before the end of the COC period about the process that will occur to transition care. This includes coordination with the member and provider.

**Finding:** The Plan did not notify members of COC approval and 30 days before the end of COC period.

A review of the *Policy HS.01.05* indicated that the Plan had process of notification to COC members of approval and the end of COC services. However, the policy was not followed by the Plan.

The verification files identified the following:

- Eight of ten files for approved cases did not include notification information to members.
- One file had no notification of the end of COC services.

During the interview the Plan acknowledged that it did not notify members 30 days before the end of COC services.

Without confirmation and notification of COC services, member may not be aware of the duration of the benefit, and the transition process at the end of COC period.

**Recommendation:** Implement COC policy and procedure on members' initial approval and 30 days notification before the end of COC period.

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**CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE**

<b>3.1</b>	<b>APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES</b>
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**3.1.1 Scheduling Appointment**

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in network providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments. The required types include routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult IHA. (*Contract Exhibit A, Attachment 9 (3) (C)*)

The Plan's Policy, *PN.02: Accessibility of Services defined Appointment Waiting Time* (Revised: 12/19/2020), stated the time from the initial request for health care services by a member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the Plan or subcontracted networks and completing any other condition or requirement of the Plan or its contracting providers.

The Plan's Procedure, *PN.02.01: Monitoring Timely Access* (Revised: 11/7/2018), stated monitoring provider network's compliance with timely access regulations are measured by assessing and surveying access on, at least, an annual basis.

**Finding:** The Plan did not monitor wait time to obtain appointments for all the required types of services.

A review of policy and procedure, assessment reports on annual surveys, and the interview revealed there was no evidence that the Plan monitored times for the following services: prenatal care, children's preventive care health assessment, and adult IHA.

The Plan monitoring focused on meeting access standards for timely appointments for member accessing primary care physicians, specialists, urgent, and non-urgent services through assessment of annual Plan survey results.

The Plan confirmed that they did not monitor wait times for prenatal care, children's preventive care health assessment, and adult IHA appointments.

In the absence of monitoring wait times to obtain prenatal care, children's preventive care health assessment, and adult IHA appointments, members' access to the related

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health care services may potentially be delayed.

**Recommendation:** Revise and implement policy and procedure to include monitoring wait times to obtain prenatal care, children’s preventive care health assessment, and adult IHA appointments.

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<b>3.8</b>	<b>NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICAL TRANSPORTATION</b>
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### **3.8.1 Medi-Cal Enrollment of NEMT and NMT Providers**

The Plan is required to comply with all existing final Policy Letters issued by DHCS and All Policy Letters issued by DHCS. (*Contract Exhibit E, Attachment 2(1)(D)*)

The Plan's 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. The Plans have the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL, or the Plan may direct their network providers to enroll through a state-level enrollment pathway. If the Plan 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. (*APL 19-004: Provider Credentialing / Re-credentialing and Screening / Enrollment*)

**Finding:** The Plan did not ensure that contracted NEMT and NMT providers in its network were enrolled in the Medi-Cal program during the audit period.

The Plan did not have a screening and enrollment process for its NEMT and NMT providers.

A review of 20 paid claims for NEMT and NMT providers, disclosed that three out of eight transportation providers were not enrolled in the Medi-Cal program during the audit period when services were rendered.

The Plan disclosed that the three transportation vendors resubmitted Medi-Cal applications during the review period after being denied into the Medi-Cal program at least one time prior. There was regular communication with the vendors to monitor their Medi-Cal application status and participation in Joint Operation Committee meetings which included discussions of Medi-Cal application updates. The Plan stated that the transportation vendors are waiting for an onsite audit or to be notified of their audit outcome. The Plan has given the transportation vendors multiple opportunities to enroll in the Medi-Cal program.

Medi-Cal members may be subject to inadequate and unsafe transportation conditions if unscreened transportation providers do not meet the Medi-Cal program requirements.

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**This is a repeat of prior year finding 3.8.1 Medi-Cal Enrollment of NEMT and NMT Providers.**

**Recommendation:** Develop and implement screening and enrollment process to ensure all NEMT and NMT transportation providers are enrolled in the Medi-Cal program.



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**CATEGORY 4 – MEMBER’S RIGHTS**

<b>4.1</b>	<b>GRIEVANCE SYSTEM</b>
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**4.1.1 Grievances Resolution Timeframes**

The Plan is required to develop, implement, and maintain a Member Grievance System in accordance with CCR, Title 28, sections 1300.68, and 1300.68.01, and CCR, Title 22, section 53858. (*Contract Exhibit A, Attachment 14 (1)*).

The Plan must resolve each grievance and provide notice, as expeditiously as the member’s health condition requires, within state established time frames. (*Code of Federal Regulation (CFR), Title 42, section 438.408 Resolution and Notification*)

The Plan is required to establish a grievance system that tracks, and monitors grievances received by the Plan, or any entity with delegated authority to receive or respond to grievances. The system shall monitor the number of grievances received and resolved; and the number of grievances pending over 30 calendar days. (*CCR, Title 28, section 1300.68 (e)*)

The Plan’s is required to provide a written response to the grievance to be sent to the complainant within 30 calendar days of receipt. (*CCR, Title 28, section 1300.68 (d)(3)*)

The Plan is required to resolve grievance and send written resolution to the members within 30 calendar days. In the event that resolution of a standard grievance is not reached within 30 calendar days, the Plan is required to notify the beneficiary in writing of the status of the grievance and the estimated date of resolution, which shall not exceed 14 calendar days. (*APLs 17-006 and 21-011: Grievance and Appeal Requirements, Notice and “Your Rights” Templates*)

**Finding:** The Plan did not resolve grievances, send resolution letters and notifications to members within State established time frames.

The Plan’s undated Procedure, GA.03.01 v4: *Medi-Cal Grievances*, stated that the Grievance Coordinator reviews each grievance to ensure the categorization is accurate and is responsible for the following: Coordinating and or sending an acknowledgment letter to the member/representative within five calendar days; Mailing the letter within 30 calendar days or 44 calendar days for standard grievances, if extended and 72 hours for expedited grievances. The Plan did not follow its procedure.

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A review of 25 verification files for quality of service grievances revealed that four files were late with delays ranging from 34 to 219 days. In addition, the Plan provided analysis for the third quarter which indicated that the Plan was late in sending grievance resolution letter for additional 13 cases beside the four above cases.

During the interview, the Plan stated the Plan's failure to provide members with timely notifications of written resolution letter was due to the following reasons: high workload, turnover of the staff in the Grievance Department, and managerial staff's failure to effectively monitor the Grievance Department's resources to ensure notification letter timelines.

The Plan's failure to adhere to the required time frames for resolving grievances may potentially lead to delay in care and treatment of members.

**Recommendation:** Develop and implement a procedure to ensure that grievance resolution letters and notification of status are sent within the required time frames.

### 4.1.2 Resolution Letter Decision

The Plan is required to develop, implement, and maintain a Member Grievance System in accordance with CCR, Title 28, sections 1300.68, and 1300.68.01 and CCR, Title 22, section 53858. (*Contract Exhibit A, Attachment 14 (1)*).

The Plan is required to establish and maintain written procedures for the submittal, processing, and resolution of all member grievance and complaints. The Plan's grievance procedure shall at minimum provide for a description of the action taken by the Plan or provider to investigate and resolve the grievance and the proposed resolution by the Plan or provider. (*CCR, Title 22, section 53858 (a)*)

The Plan is required to provide subscribers and members with written responses to grievances, with a clear and concise explanation of the reason for the Plan's decision. The Plan's response shall describe the criteria used and clinical reasons for its decision including all criteria and clinical reasons related to medical necessity. (*Health and Safety Code, section 1368 (5)*)

The Plan's written resolution letter shall contain a clear and concise explanation of the Plan's decision. (*APLs 17-006 and 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Template*)

**Finding:** The Plan did not send grievance resolution letters with a clear and concise explanation of its decision to members.

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The Plan's undated Procedure, GA.11.01 v2: *Grievance and Appeal Resolution Monitoring*, stated that the purpose is to outline the monitoring process to notify members, authorized representatives and/or providers of the resolution relate to grievances to ensure accuracy, completeness, and thoroughness of the case. The Plan did not follow its procedure.

A review of 49 standard grievance files revealed that 22 grievance resolution letters did not have a clear and concise explanation of the decision; for example, the letters included the following statements:

- Your grievance is being referred to the QOC team for improvement.
- Your grievance is being referred to the QOC team and due to privacy concerns member will not receive any further information.
- No final decision statement was provided to address the member's complaint.

During the interview, the Plan acknowledged that the existing language in grievance resolution letter was not appropriate in all cases and did not always address the member's concerns.

Lack of a clear and concise explanation of the Plan's decision in the grievance resolution letter may result in unnecessary delay in the delivery of medically necessary services for members.

**Recommendation:** Develop and implement a process to ensure that grievance resolution letters include a clear and concise explanation of the Plan's decision.

### 4.1.3 Medical Director Involvement

The Plan is required to implement and maintain procedures based on the following regulations 42 CFR 438.402, 406, and 408 and CCR, Title 28, section 1300.68 and 1300.68.01 and CCR, Title 22, section 53858 as follows: The Plan is required to ensure the participation of individual with authority to require corrective action. Grievances related to medical QOC issues shall be referred to the Plan's Medical Director. (*Contract Exhibit A, Attachment 14 2D*)

The member grievance procedures shall at a minimum provide for: the immediate submittal of all medical QOC grievances to the Medical Director for action. (*CCR, Title 22, section 53858 2(e)*)

The Plan is required to establish, implement, and maintain a Grievance and Appeal System to ensure the receipt, review, and resolution of grievances and appeals. The Grievance and Appeal System shall operate in accordance with all applicable federal regulations, state laws, and state regulations: All grievances and appeals related to

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medical QOC issues are required to be immediately submitted to the Plan's Medical Director for action. (*APLs 17-006 and 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Template*)

**Finding:** The Plan did not involve the Medical Director in the review of the QOC and expedited grievances.

The Plan's undated and unsigned Procedure, *GA.03.01 v4: Medi-Cal Grievances*, stated that Grievance Coordinator performs the following: verbally acknowledges the grievance within 24 hours, explaining that the grievance will be reviewed by a Medical Director or licensed healthcare professional; the Medical Director will review the grievance and all available supporting documentation. The Plan's process did not include correct Contract and APL requirements.

A review of 24 QOC and 27 expedited verification files revealed that there was no Medical Director documentation and involvement in the review of files. During the interview the Plan stated that their registered nurses reviewed and made decisions for QOC and expedited grievances. The Plan's process did not include Medical Director involvement in review of QOC and expedited grievances.

In addition, it was noted that in the majority of QOC files no medical records were requested from the provider in making the determination. The Medical Directors stated they get involved when the grievance case is referred out to the Quality Improvement Department as a Potential Quality Issue (PQI).

When the Medical Director is not involved in QOC and expedited grievances, unrecognized clinical and potential emergency situations may lead to delays in members receiving timely care.

**Recommendation:** Develop and implement procedure to ensure the participation of a Medical Director in the QOC and expedited grievances.

### 4.1.4 Grievance Records Oversight

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. (*Contract Exhibit E, Attachment 2*)

The written record of grievances shall be reviewed periodically by the governing body of the Plan, the public policy body created pursuant to section 1300.69, and by an officer of the Plan or his designee. This review shall be thoroughly documented. (*CCR, Title 28, section 1300.68 (b)(5)*)

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The Grievance and Appeal System is required to operate in accordance with all applicable federal regulations, state laws, and state regulations. The written record of grievances and appeals is required to be reviewed periodically by the governing body of the Plan, the public policy body, and by an officer of the Plan or designee. The review is required to be thoroughly documented. (*APLs 17-006 and 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

**Finding:** The Plan's governing body, public policy body, and an officer did not review the written record of grievances on a periodic basis.

The Plan's undated Procedure, *GA.11.01 v2: Grievance and Appeal Resolution Monitoring*, did not include APL requirements for the review of written record of grievances.

The Plan did not provide documentation to support the review of written record of grievances. The Plan was unaware of the APLs 17-006 and 21-011 requirements. The Plan did not ensure that the APLs requirements were incorporated into the most updated policy and procedure.

When the written record of grievances are not reviewed by the governing body, public policy body, and by an officer of the Plan or designee, this may result in missed opportunities to improve quality of the grievance process.

**Recommendation:** Develop and implement policy and procedure to ensure periodic review of written records of grievances is conducted by the governing body, public policy body, and a designated officer.

### 4.1.5 Billing Medi-Cal Members

The Plan and subcontractors are not required to submit a claim or demand, or otherwise collect reimbursement for any services provided under the Contract to a Medi-Cal member. (*Contract Exhibit A, Attachment 8*)

A provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter is required not to seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or a person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services. (*W & I Code section 14019.4(a)*)

A provider of service under the Medi-Cal program is required not to submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other

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persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service. (CCR, Title 22, section 51002(a))

**Finding:** The Plan providers billed fully Medi-Cal eligible members for services which were covered under the Contract.

A review of verification files revealed seven complaints were filed by members related to the Plan providers for billing fully Medi-Cal eligible beneficiaries for services which were covered under the Contract. Grievance Department did not address the following issues:

- Balance billing issue related to Medi-Cal line of business;
- The root causes of the balance billing;
- Did not address the Contract requirements to its providers that providers were prohibited from billing fully Medi-Cal eligible members for covered services.

During the interview, the Plan acknowledged the problem and stated that the Plan's resolution process is to reimburse members that complain.

The Plan did not educate its providers regarding prohibition of billing Medi-Cal members for covered services and possible disenrollment from the Medi-Cal program.

When the Plan does not protect its members from the financial liability by not addressing balance billing issues with its providers, this may discourage members from seeking medically necessary care.

**Recommendation:** Develop and implement policy and procedure to ensure that the Plan providers are prohibited from billing fully eligible Medi-Cal members for covered services.

### 4.1.6 Processing Billing Grievances

The Plan is required to develop, implement, and maintain a Member Grievance System in accordance with CCR, Title 28, sections 1300.68, and 1300.68.01, and CCR, Title 22, section 53858. (Contract Exhibit A, Attachment 14 (1)).

The grievance system shall be established in writing and provide for procedures that will receive, review, and resolve grievances within 30 calendar days of receipt by the Plan. (CCR, Title 28, section 1300.68 (a))

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The Plan is required to establish, implement, and maintain a grievance and appeal system to ensure the receipt, review, and resolution of grievances and appeals. A complaint is the same as a grievance. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance; an inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to questions pertaining to eligibility, benefits, or other Plan processes. (*APLs 17-006 and 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

**Finding:** The Plan did not capture, process, and resolve all billing complaints as grievances.

A review of four of seven billing grievances filed by the members indicated that the representative instructed the member to send the bill to the Claim Department or "not to worry about the bill". In addition, the Plan did not send acknowledgement or resolution letters to notify the member of the status of the grievance.

During the interview, the Plan acknowledged that their resolution process for billing issues was for members to send the bill to the Claims Department. However, there were two cases where the members' issues were not resolved since the billing provider continued to send billing statements a month later. These examples demonstrate the outcome of inadequate processing of grievances.

When the Plan does not process billing grievances correctly, this may adversely impact members financially and may potentially delay in receiving future medically necessary services.

**Recommendation:** Develop and implement policy and procedure to ensure that all member complaints are captured and processed correctly through the grievance system.

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**CATEGORY 5 – QUALITY MANAGEMENT**

<b>5.1</b>	<b>QUALITY IMPROVEMENT SYSTEM</b>
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**5.1.1 Quality Improvement Opportunities**

The Plan is required to implement an effective QIS in accordance with the standards set forth in CCR, Title 28, section 1300.70 and 42 CFR 438.330. The Plan is required to monitor, evaluate, and take effective action to address any needed improvements in the QOC delivered by all providers rendering services on its behalf, in any setting. *(Contract Exhibit A, Attachment 4)*

The Quality Assurance (QA) program must be directed by providers and must document that the QOC provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated. *(CCR, Title 28, section 1300.70)*

The Plan's governing body, its QA Committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. In addition, the reports to the Plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal components which the QA program has identified as presenting significant or chronic QOC issues. *(CCR, Title 28, section 1300.70 2(c))*

The written record of grievances and appeals must be submitted at least quarterly to the Plan's Quality Assurance Committee for systematic aggregation and analysis for quality improvement. Grievances and appeals reviewed must include, but not be limited to, those related to access to care, QOC, and denial of services. Plans must take appropriate action to remedy any problems identified. *(APLs 17-006 and 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

**Finding:** The Plan did not take effective action to address any needed improvements in the QOC based on its identified issues related to medical services, access to appointments, and timeliness of referrals.

The Quality Improvement Program Description stated that the Grievance and Appeals Committee conducts an analysis of the Plan's grievance and appeal cases and reports the results to the Quality Improvement Committee and Board of Director, including any



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intervention projects to improve services for the Plan members. Issues related to medical services, access to appointments, and timeliness of referrals were identified and presented at both meetings. These identified issues had no documentation for interventions and no reports were presented to measure or reassess the effectiveness.

During the interview the Plan stated that it monitored access and timeliness of services through claims and access survey reports. However, the Plan did not document any effective action to improve QOC where deficiencies were identified, and that follow-up was planned.

When the Plan does not perform quality improvement interventions, it may lead to members not receiving timely medically necessary services.

**Recommendation:** Develop and implement policy and process to ensure effective action is taken to address needed improvement interventions related to medical services, access to appointments, and timeliness of referrals.

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**CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY**

<b>6.2</b>	<b>FRAUD AND ABUSE</b>
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**6.2.1 Verification of Services Rendered**

The Plan is required to have provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members, and the application of this verification process on a regular basis. *(Contract Exhibit E, Attachment 2,(26),(B),(5))*

The Plan is required to implement and maintain arrangements or procedures that are designed to detect and prevent FWA. The procedures must include the following: Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members, and the application of this verification process on a regular basis. *(CFR, Title 42, section 438.608)*

**Finding:** The Plan did not have a process to verify that services that have been represented have been delivered and the application of the verification process on a regular basis.

The Plan stated that the Compliance’s Special Investigation Unit (SIU) conducts service verification during preliminary investigation of suspected FWA activities. SIU tracks and reports FWA activities quarterly to the Compliance Committee and the FWA Work Group.

The Plan’s existing process did not verify that services represented to have been delivered by network providers were received by members. The verification of services done by the SIU unit is for the reported credible allegation cases and did conduct sampling or other methods to verify services provided.

Without a process to verify that rendered services have been delivered to members the Plan may not be able to identify service delivery problems.

**Recommendation:** Develop and implement policy and procedure to ensure verification of delivered services.

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### 6.2.2 Reporting of Recovery of Overpayments

The Plan is required to have a mechanism for a network provider to report to the Plan when it has received an overpayment, to return the overpayment to the Plan within 60 calendar days after the date on which the overpayment was identified, and to notify the Plan in writing of the reason for the overpayment. In addition, the Plan must report annually to the State on their recoveries of overpayments in accordance with CFR, Title 42, section 438.608(d)(3). (*Contract Exhibit E, Attachment 2, 34B and C*)

The Plan is required to create an internal retention and documentation process for recovery of all overpayments and review quarterly for accuracy. The Plan is required to report annually to DHCS of their recoveries of overpayments, including those made to a network provider that was otherwise excluded from participation in the Medicaid program and those made to a network provider due to FWA. (*APL 17-003: Treatment of Recoveries made by the Managed Care Health Plan of Overpayments to Providers*)

The Plan's Policy, CL.23 v2: *Overpayment Recovery* (Recommended: 05/27/2021), establishes the policy requesting providers refunds and receiving voluntary refunds from a provider related to overpayment of claims and to outline the Plan's recovery process of overpaid claims through the refund request letter from contracted and non-contracted providers it adheres to requirements specified in sections 1300.71 and 1300.71.38 and CCR, Title 28, claims settlement practices and dispute resolution mechanism. Claims and Finance Management annually reports to DHCS its recoveries of overpayments.

**Finding:** The Plan did not account and report all overpayments identified during the audit period to DHCS.

The Plan's undated and unsigned Procedure, CL.23.01 v1: *Overpayment Recovery*, stated that the procedure to request and receive refund related to provider overpayments is that the provider is given 30 days to refund monies or to dispute the request. However, it did not contain the Contract requirement that the Plan must report annually to the State on their recoveries of overpayments as required.

The Plan reported zero dollar overpayment amounts for its providers to the DHCS. In a written statement, the Plan stated that it submitted an annual overpayment report to DHCS for zero amount since the overpayments were zeroed out against the future claims. The Plan's response provided had insufficient information to support all overpayments reported for its providers to DHCS.

The Plan's failure to report all overpayments to DHCS, may result in DHCS being unable to determine FWA in overpayment.

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**Recommendation:** Develop and implement a process to ensure the Plan identifies and reports all overpayment recoveries to DHCS.

CONTRACT AND ENROLLMENT REVIEW  
DIVISION – SOUTH LOS ANGELES  
AUDITS AND INVESTIGATIONS  
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON STATE SUPPORTED SERVICES

**SANTA CLARA COUNTY HEALTH AUTHORITY  
dba SANTA CLARA FAMILY HEALTH PLAN**

**2022**

Contract Number: 03-75802  
State Supported Services

Audit Period: March 1, 2021  
Through  
February 28, 2022

Dates of Audit: March 7, 2022  
Through  
March 18, 2022

Report Issued: January 18, 2023

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## **INTRODUCTION**

This report presents the audit of Santa Clara County Health Authority dba Santa Clara Family Health Plan (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 audit was conducted from March 7, 2022 through March 18, 2022. The audit covered the audit period from March 1, 2021 through February 28, 2022. It consisted of document reviews and interviews with the Plan's staff.

An Exit Conference with the Plan was held on November 29, 2022. There were no deficiencies found for the review period on the Plan's State Supported Services.

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**PLAN:** Santa Clara County Health Authority dba Santa Clara Family Health Plan

**AUDIT PERIOD:** March 1, 2021 through February 28, 2022

**DATES OF AUDIT:** March 7, 2022 through March 18, 2022

**STATE SUPPORTED SERVICES**

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

The Plan is required to maintain procedures to ensure confidentiality and access to sensitive services, such as abortion services. Plans that provide physician services must not require medical justification and/or prior authorization. Members may access services through any provider of their choice regardless of the provider's network affiliation. (*All Plan Letter 15-020, Abortion Services*)

The Plan's Policy, *CL.22 v4: Processing of Abortion Claims* (Approved: 01/28/2021), and Procedure, *CL.22.01 v4: Processing of Abortion Claims Procedure* (Approved: 01/22/2021), described the process of members timely access to abortion services, from any qualified contracted and non-contracted providers honoring such service without prior authorization. The Plan arranges and pays for the termination of pregnancy as a physician service regardless of the gestational age of the fetus, including the process related services and supplies.

The Plan maintained a list of CPT Codes for procedures and related services which are exempt from prior authorization that the Plan's Claims Department used in auto payment of claims processing. The Plan's claims system configuration ensured no prior authorization was needed. The billing codes for sensitive services which are exempt from prior authorization included the CPT Codes 59840 through 59857.

Based on the review, no deficiencies were noted for the audit period.

**Recommendation:** None.