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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

December 12, 2018

Christine Tomcala, CEO
Santa Clara Family Health Plan
210 E. Hacienda Avenue
Campbell, CA 95008

RE: Department of Health Care Services Medical Audit

Dear Ms. Tomcala:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Santa Clara Family Health Plan, a Managed Care Plan (MCP), from April 9, 2018 through April 20, 2018. The survey covered the period of April 1, 2017 through March 31, 2018.

On November 27, 2018, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on September 11, 2018.

All items have been reviewed and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Full implementation of the CAP will be monitored 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) 345-7831 or Anthony Martinez at (916) 345-7828.

Sincerely,

Hannah Robins, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Jeff Kilty, 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

Audit Type: Medical Audit and State Supported Services **Review Period: April 1, 2017 – March 31, 2018**

MCPs 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. MCPs are required to submit the CAP via email in word format which 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 long term corrective action or a period of time longer than 30 days to remedy or operationalize, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved.

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

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1. Utilization Management				
1.2.1 Medical Prior Authorization Notice of Action (NOA Letters) The Plan did not send Notice of Action (NOA) letters that	SCFHP has conducted the following actions based on the DHCS finding of NOA letters: 1. The Plan completed staff training on 8/29/2017 and 8/31/2018. 2. The Plan will fully	• UM training materials • Training sign in sheets for dates 8/29/2017 and 8/31/2018.	9/30/2018 and Ongoing	**10/15/18** - The following documentation supports the MCP's efforts to correct this finding: - Policy HS01.01 Prior-authorization and Organization Decisions which includes the

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were clear, concise, at a sixth grade reading level, and accurate. The verification study revealed NOA letters included medical and technical language not easily understood. Two cases that included NOA letters had inaccurate information. In one case, the Plan's interpretation of the physician's review and recommendation was incorrect and both the member and provider received the incorrect letters. In the second case, the criteria in the NOA letter were inaccurate.	implement UM management review of all denial notices. The nursing staff will assign the proposed denial verbiage for each authorization to the manager/director for a second review. The UM manager / or Director will document his/her review and modification of the denial language within QNXT (the UM system) so that the process can be audited regularly. 3. The UM department updated the UM procedure to monitor all aspects of UM reviews including denial letter content on a weekly basis. 4. The Plan has also implemented a "Monitoring System" of the denial letters which includes review of each denial letter as stated above, and daily, monthly – until 3 months with no deficiencies. Then the audit will be conducted quarterly.	• UM procedure: HS.01.01 Prior Authorization Process		MCP's monitoring and reporting procedures. The MCP monitors the timeliness and the quality of the authorizations and clinical decision making. The MCP also monitors notifications for readability level and the accuracy of the reason for the denial is specific to the request and the member's condition. The policy states that all authorizations will be reviewed on a weekly basis. - Training materials and sign-in sheets from UM meetings held on 8/29/18 and 8/31/18 serve as evidence that UM staff was trained on acceptable and appropriate language to use for denials. The training also focused on using precise and accurate information in clinical documentation. **10/25/18** - The following additional documentation supports the MCP's efforts to correct this finding:

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	5. Results of monitoring will be presented as follow up items to the Utilization Management Committee.			- The MCP submitted fifteen samples of the review of denial language for appropriate verbiage for Member NOAs. **This finding is closed.**
1.4.1 Notice of Appeal Resolution (NAR) Letters The plan did not send NAR letters that were clear, concise, and at a sixth grade reading level. The verification study revealed the NAR letters included medical and technical language not easily understood. Two acknowledgement letters contradicted the resolution letters and the acknowledgement letters were not mentioned in the NAR letters.	A process was developed to allow for the SCFHP Medical Director(s) to review the appeal notices on a quarterly basis. The review will be conducted to ensure readability of the appeal resolution.	• GA.11 Member Grievance and Appeals Reporting and Monitoring (1) • GA.11.01 Grievance and Appeal Resolution Letter Monitoring (4)	11/5/2018	**10/31/18** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "G.A. 11.01, Grievance and Appeal Resolution Letter Monitoring" (05/11/18) which has been amended to include a section on reviewing appeal notices by the G&A Operations Manager and Medical Director. This is a random selection and review of appeal notices to ensure the readability and clarity of the appeal resolution. At least 30 appeal notices will be reviewed per quarter, which consists of 15 denial notices and 15 approval notices to be reviewed by a licensed SCFHP Medical Director. This is also overseen

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				by the Grievance and Appeals Review Committee on a quarterly basis. Sample log, “Q1 Appeals Review” (10/31/18) as evidence that the MCP is monitoring the Notice of Appeal Resolution letters to ensure that it is clear and concise. The Medical Director meets with the Grievance & Appeals Operations Manager to discuss each case and identify what should be simplified to ensure the NAR is readable. The Medical Director’s findings are documented in the log with details on how the language could have been adjusted. Once the review is completed by the Medical Director, the feedback is sent to the G&A Operations Manager for review. The G&A Manager discusses the overall feedback with the G&A staff as an opportunity for improvement during the daily and weekly meetings.

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				This finding is closed.
2. Case Management and Coordination of Care				
2.4.1 Preventive Services for Adult Members The plan must have written procedures and must provide training requiring providers to include and document all components of the IHA. The plan has not started training the staff on evidence base practice guidelines for IHA. Annual attestations of the PCPs who received training through the provider portal have not been implemented. Medical records showed the	SCFHP is developing a training for all staff on evidence based practice guidelines for IHA. Staff will be trained on IHA requirements during Q4 2018. The plan has previously indicated it will implement annual attestations for PCPs who receive training through the provider portal. Due to system limitations in the portal the plan is unable to implement this process there. To ensure that SCFHP PCPs are receiving IHA training, plan Provider Network Management team will be conducting training to its contracted PCPs beginning in Q1 2019 for a comprehensive training on overall plan		Anticipated 10/15/18 Anticipated 3/31/19	**11/08/18** – The following documentation supports the MCP's efforts to correct this finding: - PowerPoint training, "Quality Improvement" (11/08/18) as evidence that the MCP is providing training. The training materials address the IHA requirements and timeframe. - Training document, "Role of PCP-IHA" (11/08/18) as evidence that the MCP is providing training to providers regarding the IHA. This document explains the IHA requirements and timeframe. It also reminds the provider to access the SCFHP portal for their list of new members to schedule an IHA. The MCP's

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documentation did not have the age and gender specific recommendations and were not addressed by the provider.	requirements, including IHA. SCFHP will provide a sign in sheet for providers to indicate they have received the training at least annually.			Provider Network Management team will conduct a comprehensive training on overall plan requirements in the first quarter of 2019. - Updated Policy, "PS019_03: Educating PCPs About Member Initial Health Assessment and the Initial Health Education Behavioral Assessment" (11/08/18) as evidence that the MCP is conducting a comprehensive training on overall plan requirements regarding the IHA. The Provider Services Department educates new PCPs about the IHA and IHEBA within the first 10 days of their effective date, during the new provider orientation and annually thereafter. This training will begin in the first quarter of 2019. The QI department monitors PCP's IHA and IHEBA process during periodic site reviews. **This finding is closed.**

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2.4.2 Monitoring of Comprehensive Initial Health Assessment (IHA) Compliance The plan did not have documentation that the comprehensive IHAs were completed within the timeframe. 20 medical records did not have complete comprehensive IHAs. 9 of those medical records had no documentation and there was no documentation that attempts were made to contact the new member to schedule IHAs.	SCFHP monitors IHAs through a quarterly audit of medical records. At the end of each quarter, the plan randomly selects 10 providers and a random 5 medical records from each of the selected provider for IHA medical record review. Medical records are scored to ensure a comprehensive IHA was completed for each member. If any noncompliant charts are identified, the plan will educate the provider about the importance of completing an IHA and documenting attempts to new members. Starting with Q1 2019, the plan will re-audit any providers whose medical record charts scored 80% or less during IHA audit in a previous quarter. If the provider should fail during the re-audit process, SCFHP will request a corrective action plan from the provider for IHA.		Q1 2019	**11/14/18** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "QI.10.02: Initial Health Assessments (IHA) and Staying Healthy Assessment (SHA)" (11/14/18) which has been amended to include a section on IHA Provider Training and IHA Oversight and Monitoring (page 8). The IHA Provider Training section includes IHA contract requirements and timelines. The IHA Oversight and Monitoring section includes quarterly medical record audits for each of the required elements of an IHA: a. Ten randomly selected providers are chosen in each quarter and requested to submit 5 records of members who received an IHA during that quarter. Only

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	The plan also monitors IHA completion during facility site reviews (FSR) as part of the medical record review process. For any non-compliance found during FSR, the QI nurse will educate the provider onsite and schedule training visits for the provider and/or their clinic.			providers with 10 or more IHAs in the quarter are reviewed to provide an adequate pool of members for review. b. Three (3) attempts are made to retrieve charts. Providers who do not return charts after three attempts are scored as a fail. c. Charts are scored for presence or absence of the elements of the IHA, including the SHA. d. A provider who scores 80% or less on the individual chart score or the overall score, will be considered a fail. e. For providers who score 80% or less, the QI Department coordinates with the Provider Network Department to educate

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				the provider about the requirements for completing an IHA and SHA. If the provider scores 80% or below on the IHA audit a second time in the next quarter, a Corrective Action Plan is given. The provider is reviewed again the following quarter. Providers who fail IHA and receive a CAP are also reported to the FSR Program for follow-up during the regularly scheduled site reviews. f. Aggregate results are shared with the Quality Improvement Committee (QIC) quarterly. **This finding is closed.**

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3. Access and Availability of Care				
3.5.1 Denials of Emergency Room (ER) and Family Planning (FP) Claims The plan denied 23 ER and 12 FP claims due to prior authorization and non-contracting providers. The plan performed post payment monthly audits of denied claims, but the ER and FP claims were not paid.	In April 2018, a manual process was established to review ER and FP denied claims **prior** to each weekly check run. The denied claim reports are reviewed by a Claims Manager or Lead to determine that no claims are denied for authorizations or for non-contracted providers. Any claims that were denied in error are corrected before the claim is finalized on the check run. These reports are saved in our Claims shared drive after being reviewed.	• Pre Check Run MC ER Denials 09.04.18.xlsx • Pre Check Run FP-SSS denials 09.04.18.xlsx	4/21/18	**11/06/18** – The following documentation supports the MCP's efforts to correct this finding: - Desktop procedure, "ER Pre-Check Run Report" (11/06/18) as evidence that the MCP is conducting weekly prepayment audits to ensure that any claims that were denied in error are corrected before the claim is finalized on the check run. The report will run weekly, and is reviewed and audited by either the Claims Manager or Claims Lead to determine that no claims are denied for no authorization. - Sample reports, "Pre Check Run MC ER Denials" and "Pre Check Run FP-SSS Denials" (09-04-18) as evidence that the MCP is conducting weekly prepayment audits.

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				- Written email response (11/06/18) which indicates that the MCP conducts a weekly prepayment audit. The Claims Manager and Claims Lead were both trained on the "ER Pre Check Run Desktop Procedure" document. **This finding is closed.**
4. Members' Rights				
4.1.1 State Fair Hearing The plan did not update the timeframe from 120 calendar days from the date of the MCP's written appeal resolution to request a State Hearing in the "Your Rights" attachment. The G&A files showed the "Your Rights" attachment	The notice was updated to accurately reflect that a member has the right to file a State Hearing within 120 days from the Notice of Appeal Resolution. Additionally, a letter repository was created to ensure the Grievance & Appeals Coordinators are using the most updated notice	• Appeal - NAR - Uphold - 50224E • Medi-Cal Grievance and Appeals Notices	10/1/2017	**10/15/18** – The following documentation supports the MCP's efforts to correct this finding: -An updated template for Notice of Appeal Resolution (NAR) letter with "Your Rights" attachment which shows the timeframe to request a State Fair Hearing is within 120 days from the date NAR is received. **10/26/18 –** The following additional documentation

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has a timeframe of 90 days instead of 120 days to request a State Hearing.				submitted supports the MCP's efforts to correct this finding: -Several samples of Notice of Appeal Resolution (NAR) letters sent to members recently (from May of 2018 through October of 2018) to validate the "Your Rights" attachment shows the correct time frame of 120 days for requesting State Fair Hearing. **This finding is closed.**
4.3.1 Breach incident Reporting for Required Time Frames The plan did not identify and use the correct breach dates and did not consistently notify DHCS of suspected security incidents within the required	The Compliance Department created a revised disclosure tracking log, which includes a new column to track the date and time the suspected incident occurred, in addition to the previous column recording the date reported to compliance. By the end of Q4 2018, the Compliance Department will be implementing the following:	• REVISED 2019 SCFHP Disclosure Tracking Log	Q4 2018	**10/31/18 -** The following documentation supports the MCP's efforts to correct this finding: -Revised disclosure tracking log "2018 SCFHP HIPAA Disclosure Log" which shows MCP has added a new column to track the date and time the suspected incident occurred.

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contractual timeframes. Case file review showed some dates of discovery reported in the Privacy Incident Reports did not reflect the first day on which the breach was known by employees, officers, or other agents, which resulted in delay in the contractual timeframe requirements.	• Email to all internal staff reminding them of the need to report any suspected incidents immediately to the Compliance Department, so that the DHCS can be notified within the 24 hour contractual timeframe. • Brief presentation at the November 15, 2018, "All Staff" meeting again reminding staff of the need to report any suspected incidents immediately to the Compliance Department, so that the DHCS can be notified within the 24 hour contractual timeframe. • A memo will be distributed to all delegates reminding them of the contractual requirement to immediately report any			**11/21/18 –** The following additional documentation submitted supports the MCP's efforts to correct this finding: -Copy of an email sent to the internal staff (09/14/18) informing them of an online Annual Compliance Trainings. -Copy of a memo sent to providers and the delegates (11/16/18) reminding them to report any suspected incidents immediately. -"2018 HIPAA Training tracking log" as evidence that shows MCP has provided these trainings for the staff between September of 2018 through November of 2018. **This finding is closed.**

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	suspected incidents so that the Plan can notify DHCS within the 24 hour contractual timeframe. Additionally, during Q1 2019, the Oversight team will add an agenda item to Joint Operations Committee meetings with our delegates to re-emphasize that all suspected incidents must be reported to the Plan immediately to ensure that the Plan can comply with the 24-hour DHCS contractual reporting timeframe.		Q1 2019	
6. Administrative and Organizational Capacity				
6.3.1 Identifying Fraud and Abuse Cases The plan did not identify potential and/or suspected fraud and abuse cases and did not	By the end of Q4 2018, the Compliance Department will revise its FWA procedure to reflect the process for tracking all potential and/or suspected FWA case. The Compliance Department is in the process of developing		End of Q4 2018 10/26/18	**10/25/18** – The following documentation supports the MCP's efforts to correct this deficiency: -Special Investigations Unit Services Agreement between the MCP and T&M Protection Resources, LLC which will be

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have tracking or referral logs of suspected cases referred to the SIU.	a new tracking tool that will be utilized to track all potential and/or suspected FWA cases, including hotline calls, internal referrals, and issues identified by Plan delegates. The log will include a status on each case, including: • cases referred to the Plan's SIU for continued investigation • cases reported to DHCS based on the Plan's reason to believe that an incident of fraud and/or abuse has occurred, including referral date.			responsible for the design and implementation of the MCP's fraud, waste and abuse plan. Agreement covers delegate's responsibilities and functions, including reporting requirements. The MCP shall maintain oversight and have ongoing responsibility for statutory and regulatory compliance. MCP maintains the right to conduct on-site reviews of delegate's practices, protocols, and procedures. MCP's Compliance Unit will conduct ongoing monitoring and require remediation and/or corrective action within a set time frame. Failure to comply could result in termination of agreement. -PowerPoint training, "Healthcare, Fraud, Waste and Abuse." Training materials address examples of FWA, health care FWA laws and regulations and the role of healthcare entities, employees

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				and contractors in FWA prevention, detection and reporting. -An email (09/14/18) which informed staff of online FWA mandatory training requirements to be completed by 11/1/18. **11/09/18** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Updated P&P, Policy Number: CP02.01 Fraud, Waste & Abuse (11/15/18) which has been amended to monitor FWA, comply with any monitoring and auditing requests from MCP, develop, implement and monitor reporting mechanisms and provide ongoing training. Additionally, comply with DHCS reporting requirements, document and track potential FWA (referral log) and formal reporting requirements.

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				-Sample case referral and disposition status (tracking) log as evidence that MCP is monitoring status and disposition of FWA cases. **11/27/18** – The following additional documentation supports the MCP's efforts to correct this deficiency: -PowerPoint training slides and review questions, samples of certificates of compliance, and FWA training tracking log as evidence training was completed **This finding is closed.**
7. State Supported Services				
Two State Supported Services claims were denied. The first claim required additional documentation and the section was a misdirected claim.	The two claims referenced were correctly adjudicated and do not appear to be deficiencies. We have, however, updated our processes to be sure claims are not denied inappropriately. In April 2018, a manual	• Pre Check Run FP-SSS denials 09.04.18.xlsx	4/21/18	

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	process was established to review SSS denied claims **prior** to each weekly check run. The denied claim reports are reviewed by a Claims Manager or Lead to determine that no claims are denied for authorizations or for non-contracted providers. Any claims that were denied in error are corrected before the claim is finalized on the check run. These reports are saved in our Claims shared drive after being reviewed.			

Submitted by: Jordan Yamashita **Date: October 12, 2018**
Title: Compliance Manager