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

Santa Clara Family Health Plan

Contract Number: 04-35398

Audit Period: April 1, 2017
Through
March 31, 2018

Report Issued: September 11, 2018

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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.

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

The SCFHP (Plan) contracts with six medical groups and two health plans to provide and arrange comprehensive health care services. The Plan delegates 63% of membership to the two health plans.

As of January 1, 2018, SCFHP had 267,942 members of which 258,106 (96.33%) were Medi-Cal members. The Plan also covers 7,389 Cal Medi-Connect members (2.76%), and 2,447 Healthy Kids (0.91%).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit, for the period of April 1, 2017 through March 31, 2018. The onsite review conducted from April 9, 2018 through April 20, 2018. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on August 6, 2018 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings.

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

The prior DHCS medical audit for the period of April 1, 2016 through March 31, 2017 with the onsite review conducted from April 3, 2017 through April 14, 2017 issued October 18, 2017. The corrective action plan (CAP) closeout letter dated February 6, 2018, stated that CAPs closed due to all items reviewed found to be in compliance.

The summary of the findings by category follows:

Category 1 – Utilization Management

The language used by the Plan in the Notice of Action (NOA) letters sent to members were not clear, concise, at sixth grade reading level, and accurate. Instead, the NOA letters contained medical and technical language that was difficult to understand and inaccurate.

The Plan has implemented some corrective action plan (CAP) changes. However, the Plan acknowledged that further steps would be taken to ensure that denial letters were correct before being sent to members.

The Notice of Appeal Resolution (NAR) letters that were sent to members to inform them of appeal decisions did not contain clear, concise, and easy to understand language. NAR letters contained medical and technical language that was difficult for a layperson to understand. Resolution letters did not address all items mentioned in the initial acknowledgement letters.

The Plan had a similar finding in the prior year where the rationale in the appeal resolution letters were not consistently clear. In response to the CAP, the Plan submitted "Grievance & Appeals Resolution Letter Review," followed by updated policy and procedures, in which the licensed Plan Medical Director would review 30 appeal notices on a quarterly basis.

Category 2 – Case Management and Coordination of Care

The Plan did not provide the staff with the required training on evidence-based practice guidelines.

The Plan does not have an effective process to monitor and document the completion of a comprehensive initial health assessment (IHA) within the required timeframe. Medical records showed that the Plan did not document attempts to contact the members to schedule an IHA.

Category 3 – Access and Availability of Care

The Plan denied emergency room (ER) and family planning (FP) claims due to prior authorization and non-contracting providers. The Plan performed post payment monthly audits of the denied claims; however, the ER and FP claims were not paid.

Category 4 – Member's Rights

As part of the Grievance and Appeal requirements, the Plan must provide members with information regarding their right to a State hearing. The "Your Rights" attachment to the letters explains this right. The Plan did not update the timeframe to 120 calendar days from the date of the Plan's resolution letter to request a State Hearing in the "Your Rights" attachment. The resolution letters mailed to members had the wrong timeframe of 90 calendar days.

The Plan did not identify the correct discovery date when a breach or suspected security incident was known. This resulted in the Plan's failure to comply with contractual timeframe requirements for reporting, investigating, and completing reports.

Category 6 – Administrative and Organizational Capacity

The Plan does not have a process in place to identify all suspected cases of fraud and abuse, and they had no tracking log of cases referred to the Special Investigation Unit (SIU).

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity. In addition, the Plan's Senior, Persons with Disabilities (SPD) population was included in this review period.

PROCEDURE

DHCS conducted an on-site audit of Santa Clara Family Health Plan from April 9, 2018 through April 20, 2018. The audit included a review of the Plan's contract with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents reviewed and interviews conducted with Plan administrators and staff.

The following verification studies conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 15 routine medical (including three SPD) and 15 pharmacy (including three SPD) prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Prior Authorization Appeal Procedures: 15 appeals medical and pharmacy (including three SPD) were reviewed for appropriateness and timeliness of decision making.

Category 2 – Case Management and Coordination of Care

Behavioral Health Treatment (BHT): Ten behavioral health charts were reviewed for completeness, and compliance with BHT provision requirements.

Initial Health Assessment (IHA): 25 medical records (including seven SPD) were reviewed for timely completion and fulfillment of IHA requirements.

Complex Case Management: Nine medical records (including four SPD) were reviewed for evidence of care.

Category 3 – Access and Availability of Care

Emergency Services and Family Planning Claims: 24 emergency service claims (including nine SPD), and 24 family planning claims (including nine SPD) were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 15 quality of care grievances (including three SPD) and 13 quality of service grievances (including three SPD) were reviewed for timely resolution, response to complainant, and appropriate medical decision-making.

Confidentiality Rights: 11 Health Insurance Portability and Accountability Act (HIPAA) cases were reviewed for proper reporting of all suspected and actual breaches to the appropriate entities within the required timeframe.

Category 5 – Quality Management

Provider Training: Two new contracted providers were reviewed to determine if they received Medi-Cal Managed Care program training in a timely manner.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: One case was reviewed for proper reporting of all suspected fraud and/or abuse to the appropriate entities within the required timeframes.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: April 1, 2017 through March 31, 2018
DATE OF AUDIT: April 9, 2018 through April 20, 2018

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:
Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements…(as required by Contract)
2-Plan Contract A.5.2.A, B, D, F, H, and I.

Exceptions to Prior Authorization:
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.
2-Plan Contract A.5.2.G

Timeframes for Medical Authorization
Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto.
2-Plan Contract A.5.3.F

Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
2-Plan Contract A.5.2.H

Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.
2-Plan Contract A.13.4.C

Denial, Deferral, or Modification of Prior Authorization Requests:
Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.
2-Plan Contract A.13.8.A

SUMMARY OF FINDINGS:

1.2.1 Medical Prior Authorization Notice of Action (NOA) Letters

A written notification shall be provided to members of a decision to deny, defer, or modify requests for prior authorization. The Plan's response to the member shall be in writing and shall include a clear and concise explanation of the reasons for the Plan's decision.
2-Plan Contract A.13.8.A, Health and Safety Code Section 1367.01(h)(4)

The Plan shall ensure that all written member information is provided to members at a sixth grade reading level. The written member information shall ensure members' understanding of the health plan processes and ensure the member's ability to make informed health decisions.
2-Plan Contract A.13.4.C

Policy HS.04, Denial of Services Notification dated January 17, 2018, stated "Letters to members for denial, delay, or modification of all or part of the requested service include the following: 1. Provide a clear and concise explanation of the reason(s) for the Plan's decision. 2. Specifies the criteria or guidelines used for the Plan's decision. 3. Specifies the clinical reason(s) or rationale for the Plan's decision without medical jargon and technical language."

The Plan did not send Notice of Action (NOA) letters that were clear, concise, at a sixth grade reading level, and accurate.

A verification study revealed that NOA letters included medical and technical language not easily understood by a layperson. Examples of language included in the NOA letters were:

- 64650 chemodenervation eccrine glands both axillae"
- "J0585 Injection, onabotulinumtoxin A, per unit"

- "the plan uses pre-approved guidelines (Milliman Care Guideline Onabotulinumtoxin A (A-0296))"
- "asked to approve MRI-thoracic spine"
- "MRI is indicated for pain or nerve compression testing if there are abnormal neurologic exam findings"
- "in accordance with MCG criteria your needs of complex nursing management are completed"
- "asked to approve 95816 electroencephalogram w/rec awake & drowsy; 93886 transcranial Doppler stdy intracranial art compl; 93880 duplex scan extracranial art compl bi study"

In addition, the verification study showed two cases that included NOA letters with inaccurate information. In one case, the Plan's interpretation of the physician's review and recommendation was incorrect. Both the member and provider received letters that were not accurate. In the second case, the criteria included in the NOA letter was not accurate.

This was a finding last year. The Plan submitted documentation to the Managed Care Quality Monitoring Division (MCQMD) showing that they had made changes to improve their letters. The Plan updated the language matrix, for denial NOA letters, which they used as a template for writing complete and understandable reasons for the denial. The Plan updated their policies and procedures, and quarterly monitoring template to ensure that the NOA letters would be clear and concise and the rationale accurate and member specific.

The corrective action plan (CAP) closed on November 15, 2017. The Plan was in the early stages of the implementation process. The NOA letters with the language mentioned above were files dated after the CAP implementation date.

During the interviews, the Plan confirmed that staff trainings in regards to denial letters and language did take place, and despite new policy, procedures, and trainings these policies and procedures were not being followed. Therefore, the Plan stated that starting in April 2018 the Manager would review the denial letters to ensure that all elements were correct before sending to the member.

When the NOA letter includes language that is difficult to understand, interpret, and contains inaccurate information, this can affect the member's ability to make informed health decisions.

This is a repeat finding.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Santa Clara Family Health Plan
AUDIT PERIOD: April 1, 2017 through March 31, 2018 DATE OF AUDIT: April 9, 2018 through April 20, 2018

RECOMMENDATIONS:

1.2.1 Develop and implement a process to ensure policy and procedures support compliance with the requirement that written information should be clear, concise, at a sixth grade reading level and contains accurate information.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Santa Clara Family Health Plan
AUDIT PERIOD: April 1, 2017 through March 31, 2018 DATE OF AUDIT: April 9, 2018 through April 20, 2018

1.4	PRIOR AUTHORIZATION APPEAL PROCESS

Appeal Procedures:
There shall be a well-publicized appeals procedure for both providers and patients.
2-Plan Contract A.5.2.E

Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.
2-Plan Contract A.13.4.C

SUMMARY OF FINDINGS:

1.4.1 Notice of Appeal Resolution (NAR) Letters

The Plan's response to the member shall be in writing and shall include a clear and concise explanation of the reasons for the Plan's decision.
Health and Safety Code Section 1367.01(h)(4)

The Plan shall ensure that all written member information is provided to members at a sixth grade reading level. The written member information shall ensure members' understanding of the health plan processes and ensure the member's ability to make informed health decisions.
2-Plan Contract A.13.4.C

Policy GA.08.01, Member Grievance & Appeals Process dated 7/3/17 stated that their appeal notifications shall include: "1. Specific reasons for the appeal decision, in easy-to-understand language; 2. Does not include abbreviations or acronyms that are not defined; or health care procedure codes that are not explained."

The Plan did not send NAR letters that were clear, concise, and at a sixth grade reading level.

A verification study revealed that NAR letters included medical and technical language not easily understood by a layperson. Examples of language included in the NAR letters were:

- "the medical documentation indicates that this was a follow up exam EKG and Echo for Ventricular Septal defect (VSD)"
- "analgesics or non-steroidal anti-inflammatory drugs (NSAIDS)"
- "29823 arthroscopy shoulder surgery, 29828 biceps tenodesis, 29826 w/coracoacrm ligmnt releases, and 29824 distal claviculectomy"
- "MCG A0136 specifically states that an EEG is indicated in work up of syncope…tonic clonic movements"
- "MCG A0136 states that EEG is not indicated for headaches
- "your appeal for SPECT (78452), Cardiovascular Stress Test (93015), TC-99M Tetrofosmin Diagnostic Study (A9502), Injection of Adenosine 1 mg (J0153)
- "last stage in breast reconstruction following mastectomy"

The verification study disclosed that two acknowledgement letters contradicted the resolution letters. In both cases, the studies included in the acknowledgement letters were not mentioned in the NAR letters.

The Plan had a similar finding in the prior year where the rationale in the Plan's appeal resolution letters were not consistently clear. In response to the corrective action plan (CAP), the Plan submitted "Grievance & Appeals Resolution Letter Review," followed by an updated policy stating that all notices would include language that is easily understood by a layperson.

During the interviews, the Plan confirmed that staff trainings in regards to grievance and appeals resolution letter review and language did take place. Despite new policy, procedures, and trainings these policy and procedures were not being followed. They stated that trainings are ongoing, and staff would continue to work towards ensuring that all letters meet the contractual requirements. The Plan's newest policy states that as a quality measure they would review a random sample of appeal notices to ensure that requirements are satisfied. This would include 30 appeal notices per quarter and a licensed Plan Medical Director would do a review of said notices.

If NAR letters include language that is difficult for a layperson to interpret and inaccurate, this could affect the members' ability to make informed health decisions.

This is a repeat finding.

RECOMMENDATIONS:

1.4.1 Develop and implement a process to ensure policy and procedures support compliance with the requirement that written information should be clear, concise and at a sixth grade reading level, and all issues addressed in the acknowledgement letter.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4	INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:
Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Section 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.
2-Plan Contract A.10.3.A

Contractor shall develop and implement a process to provide information to providers and to train providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines…
2-Plan Contract A.7.5

Provision of IHA for Members under Age 21
For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.
2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
   a) blood pressure,
   b) height and weight,
   c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
   d) clinical breast examination for women over 40,
   e) mammogram for women age 50 and over,
   f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,

g) Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
i) health education behavioral risk assessment.
2-Plan Contract A.10.6.A

Contractor shall cover and ensure the delivery of all preventive services and Medically Necessary diagnostic and treatment services for adult Members.
2-Plan Contract A.10.6.B

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.
2-Plan Contract A.10.3.D

SUMMARY OF FINDINGS:

2.4.1 Preventive Services for Adult Members

The Plan shall cover and ensure the delivery of all preventive services and medically necessary diagnostic and treatment services for adult members.
2-Plan Contract A.7.5.B

The Plan shall ensure all appropriate staff receive training on a continuing basis regarding evidence-based practice guidelines.
2-Plan Contract A.10.6.B

The Plan must have written procedures and must provide training requiring providers to include and document all components of the initial health assessment (IHA).
MMCD Policy Letter 08-003

The Plan addressed the finding in the prior year by initiating Procedure No. QI.10.04: Clinical Practice Guideline Use for IHA. This procedure directs all Plan staff and primary care physicians (PCPs) to receive training on a continuing basis about evidence based practice guidelines. The Plan initiated changes by posting U.S. Preventive Services Task Force (USPSTF) A and B recommendations on the Plan's website and sending provider's newsletters and fax blasts.

The Plan has not started training the staff on evidence based practice guidelines for IHA. Annual attestations of primary care physicians (PCPs) who received training through the provider portal have not been implemented. Review of medical records showed that the documentation did not have the age and gender specific recommendations, and were not addressed by the provider. During the interview, the Plan acknowledged that the new procedure had not been fully implemented. The Plan is in the early stages of implementation, but trainings should be completed in December 2018.

When USPSTF A and B recommendations are not performed, early diagnosis of a member's health condition may be missed and consequently, a delay in treatment may occur, increasing the potential for member harm.

This is a repeat finding.

2.4.2 Monitoring of Comprehensive Initial Health Assessment (IHA) Compliance

The Plan shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with Title 22, CCR, section 53851 (b)(1) to each new member within 120 calendar days of enrollment. The Plan shall make reasonable attempts to contact a member and schedule an IHA. All documented attempts that demonstrate the Plan's unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement.
2-Plan Contract A.10.3.A, 2-Plan Contract A.10.6, 2-Plan Contract A.10.3.D

Policy QI.10, Initial Health Assessments (IHA's) and Individual Health Education Behavior Assessment (IHEBA) states that the Plan's policy is to meet the contractual requirements for IHA and an IHEBA is to be performed within 120 days of a member's enrollment in Santa Clara Family Health Plan (SCFHP). A subsequent IHEBA is re-administered at appropriate age intervals.

Procedure Q1.10.02, Initial Health Assessments (IHA's) and Individual Health Education Behavior Assessment (IHEBA) states that the Plan's procedure is to document and clarify the use of the Staying Health Assessment (SHA)/IHEBA tools and providers are trained on all relevant requirements.

The Plan did not have documentation to support that comprehensive IHAs were completed within the timeframe. The verification study showed that 20 medical records did not have complete comprehensive IHAs. Nine of those medical records had no documentation, and there was no documentation that attempts were made to contact the new member to schedule IHAs. The Plan explained that the member may have changed primary care physician anytime within 120 days of enrollment. The Plan was unable to substantiate that the nine new members received IHA under different primary care

physicians (PCPs).

The Plan stated that the PCPs were not using the SHA/IHEBA questionnaire, not documenting attempts to contact new members to schedule IHAs, not checking the provider portal regularly for new member list, and they lack training regarding IHA requirements. The Plan has the policies and procedures to document and clarify the requirements regarding IHA; however, they are not being followed.

When the Plan does not ensure timely completion of comprehensive IHA, there may be a delay in the management of acute and chronic condition. Therefore, this may lead to poor health outcomes.

RECOMMENDATIONS:

2.4.1 Implement and monitor staff training and annual attestations that support compliance with the requirement to provide preventive health services including USPSTF A and B recommended services.

2.4.2 Develop a method to monitor and document the completion of comprehensive IHA within the required timeframe.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Santa Clara Family Health Plan
AUDIT PERIOD: April 1, 2017 through March 31, 2018 DATE OF AUDIT: April 9, 2018 through April 20, 2018

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.5	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims):
Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the plan.
2-Plan Contract A.8.13.A

Contractor shall pay for emergency services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically
Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge….
2-Plan Contract A.8.13.C

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
2-Plan Contract A.8.13.D

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D). 3
2-Plan Contract A.8.13.E

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.
2-Plan Contract A.9.7.A

Family Planning (Claims):
Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate….(as required by Contract)
2-Plan Contract A.8.9

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Santa Clara Family Health Plan
AUDIT PERIOD: April 1, 2017 through March 31, 2018 DATE OF AUDIT: April 9, 2018 through April 20, 2018

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section…Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.
2-Plan Contract A.8.5

Members have the right to access family planning services through any family planning provider without prior authorization.
2-Plan Contract A.9.9.A

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).
CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

3.5.1 Denials of Emergency Room (ER) and Family Planning (FP) Claims

The Plan is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the plan.
2-Plan Contract A.8.13.A

The Plan shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.
2-Plan Contract A.9.7.A

The Plan shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal fee for service (FFS) rate.
2-Plan Contract A.8.9

Members have the right to access family planning services through any family planning provider without prior authorization.
2-Plan Contract A.9.9.A

The Plan's policy CL.07, Emergency Room Services states non-contract providers will be reimbursed at the rates in accordance with the applicable Medi-Cal fee schedule. The Plan's procedure CL.07.01, Emergency Room Services Procedure states that emergency services do not require prior authorization.

The Plan's procedure CL.13.01, Processing of Family Planning Claims Procedures states that Medi-Cal members may self-refer to any qualified family planning provider regardless if the provider is in network or out of network. Family planning services do not require prior authorization.

The Plan denied ER and FP claims due to prior authorization and non-contracting providers. The Plan performed post payment monthly audits of the denied claims; however, the ER and FP claims were not paid.

In the prior year, the Plan had a similar finding; ER claims were being denied due to prior authorization and non-contracting providers. In response to the finding, the Plan implemented a new claims processing system, QNXT, in July 2017. Experienced staff was hired. Training is ongoing, and meetings are conducted regularly to discuss problems.

Verification study showed that 23 ER claims and 12 FP claims were denied due to prior authorization and non-contracting providers. During the interviews, the Plan recognized that even experience staff were not processing the claims correctly and changes needed to be made. The Plan intends to conduct monthly prepayment audits starting in April 2018.

When prior authorization and non-contracting emergency room and family planning claims are denied, they may affect a member's access to care. In addition, denials may have an impact on a provider's willingness to provide services to Medi-Cal members.

This is a repeat finding.

RECOMMENDATIONS:

3.5.1 Update the claims processing system to ensure that Emergency Room and Family Planning Claims are paid.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: April 1, 2017 through March 31, 2018
DATE OF AUDIT: April 9, 2018 through April 20, 2018

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan Contract A.14.1

Contractor shall implement and maintain procedures…to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858….(as required by Contract)
2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
2-Plan Contract A.14.3.A

Information on State Fair Hearings shall also include information on the timelines which govern a Member's right to a State Fair Hearing, pursuant to Welfare and Institutions Code Section 10951.
2-Plan Contract A.13.4.D.16

ALL PLAN LETTER 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments:
Effective July 1, 2017, All Plan Letter (APL) 17-006 provides Medi-Cal managed care health plans (MCPs) with clarification and guidance regarding the application of new federal and existing state regulations for processing Grievances and Appeals.

Grievance Timeframes for Filing:
Timeframes for Filing Grievances are lineated in both federal and state regulations. While existing state regulations establish a timeframe of at least 180 calendar days from the date of the incident subject to the beneficiary's dissatisfaction, new federal regulations allow Grievances to be filed at any time. MCPs shall adopt the standard which is least restrictive to beneficiaries and allow Grievances to be filed at any time.

SUMMARY OF FINDINGS:

4.1.1 State Fair Hearing

Contract states that information on State Fair Hearings shall include information on the timelines, which govern a Member's right to a State Fair Hearing, Pursuant to Welfare and Institutions Code Section 10951.
2-Plan Contract A.13.4.D.16

All Plan Letter (APL) 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments effective July 1, 2017, clarifies and provides guidance regarding the application of new federal and existing state regulations for processing grievances and appeals. In "Your Rights" attachment, the beneficiary's right to request a State Hearing no later than 120 calendar days from the date of the Managed Care Plan's (MCPs) written Appeal resolution and instructions on how to request a State Hearing.

Policy GA.09, State Hearings states it is the policy of Santa Clara Family Health Plan (SCFHP) to provide each member with information regarding when and how to file State Hearing. SCFHP members have an opportunity to file a State Hearing on an appeal decision to deny coverage or reimbursement of a medical service or item or medication. A member or authorized representative has the right to request a State Hearing with DHCS, but must do so no later than 120 calendar days from the date on the Notice of Appeal Resolution (NAR).

Policy GA.03, Medi-Cal Grievances states that the Grievance and Appeals Operations Manager is responsible for overseeing the investigation and resolution process for all grievances.

The Plan did not update the timeframe of 120 calendar days from the date of the MCP's written appeal resolution to request a State Hearing in the "Your Rights" attachment.

Review of the grievance files showed that the "Your Rights" attachment has a timeframe of 90 days instead of 120 days to request a State Hearing. The Plan was unaware that the "Your Rights" attachment sent with the grievance letters to members had the wrong timeframe.

The Plan was aware of the requirements in APL 17-006, but not all updates had been made. The Plan's website was not updated, but when the Plan was made aware of this, it was corrected. The Plan had not fully implemented the requirements in APL 17-006.

If written member information is not updated with current information, such as with new timeframes on when to file a state hearing, members may be prevented from exercising their right to file a state hearing in a timely manner. The potential outcome is denial of services and delayed provision of health care.

RECOMMENDATIONS:

4.1.1 Develop and implement a process to ensure that All Plan Letter 17-006 and contractual requirements are met, and that written information is accurate.

4.3	CONFIDENTIALITY RIGHTS

Members' Right to Confidentiality
Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

2-Plan Contract A.13.1.B

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:
Business Associate agrees:

Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

2-Plan Contract G.III.C.2.

Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1**. Notice to DHCS**. (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.
2. **Investigation and Investigation Report***.* To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
3. **Complete Report**. To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.
2-Plan Contract G.III.J

SUMMARY OF FINDINGS:

4.3.1 Breach Incident Reporting for Required Time Frames

The Plan shall notify Department of Health Care Services (DHCS) within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract, or potential loss of confidential data affecting this Contract. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate. The Plan immediately investigates such security incident, breach, or unauthorized use of disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer of the outcome of the investigation.
2-Plan Contract G.III.J

The Plan's procedure CP20.01, Health Information Privacy Policies and Procedures requires the Plan to notify any required reports of unauthorized disclosures or notices of privacy data or intrusion breaches affecting Medi-Cal members simultaneously with the DHCS Contract Manager, DHCS Privacy Office and DHCS Information Security Office within twenty four (24) hours of discovery during a work week. In addition, it requires the Plan to investigate such breach, or unauthorized use of disclosure of PHI, and provide an updated "Privacy Incident Report" of the investigation to the DHCS Privacy Office within seventy-two (72) hours of discovery. A complete report of the investigation will be sent to DHCS Contract manager, DHCS Privacy Office, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use of disclosure.

The Plan did not identify and use the correct breach dates, and did not consistently notify DHCS of suspected security incidents, within the required contractual timeframes.

Desktop procedure, HIPAA Incident Desk Reference provided the Plan with guidance on how to report security breach incidents to DHCS timely at all three reporting timeframes and to each of the three required DHCS contacts. The Plan cross trained several individuals to ensure that adequate staffing would be available to complete the reporting within the contractual timeframes.

Case file review showed that 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. During the interview, the Plan acknowledged that they understood which date was the date of discovery, but instead they used the date the Compliance Department was informed.

When the Plan consistently identifies the correct discovery dates and reports breaches timely, it helps safeguard the member's protected health information. In addition, it allows DHCS to take appropriate action.

RECOMMENDATIONS:

4.3.1 Develop and implement a process to document accurate dates for suspected breaches, and meet all reporting contractual requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Santa Clara Family Health Plan
AUDIT PERIOD: April 1, 2017 through March 31, 2018 DATE OF AUDIT: April 9, 2018 through April 20, 2018

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3	FRAUD AND ABUSE

Fraud and Abuse Reporting
Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse….

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.

2) Contractor shall provide effective training and education for the compliance officer and all employees.

3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.

4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity….

5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs….

2-Plan Contract E.2.26.B

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Santa Clara Family Health Plan
AUDIT PERIOD: April 1, 2017 through March 31, 2018 DATE OF AUDIT: April 9, 2018 through April 20, 2018

SUMMARY OF FINDINGS:

6.3.1 Identifying Fraud and Abuse Cases

Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program. Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees.
2-Plan Contract E.2.26.B

Procedure CP02.01, Fraud, Waste and Abuse (FWA) states a reasonable inquiry includes a preliminary investigation by the appropriate Compliance staff. The Plan is required to report suspected fraud cases directly to the Department of Health Care Services (DHCS) within ten (10) working days of when the Plan becomes aware of, or is on notice of, the suspected fraud. The Plan's Compliance Officer has the primary responsibility for documenting and tracking suspected fraud cases in the current referral log.

The Plan did not identify potential and/or suspected fraud and abuse cases and was unable to provide a tracking log of cases referred to the Special Investigation Unit (SIU).

In June 2017, the Plan made an agreement to delegate Fraud and Abuse responsibilities, such as SIU functions to another entity. Some of the responsibilities of the SIU are datamining and investigations of providers. According to the service agreement, the Plan retained responsibility for the establishment and oversight of the Plan's policies, management and overall operation, regardless of the existence of any management agreement. The Plan had no tracking or referral logs of the suspected cases referred to SIU.

In the Fraud and Abuse Program Questionnaire, the Plan stated that DHCS is notified of a suspected case of fraud or abuse once it is a credible case. During the interview, the Plan confirmed that they only report credible allegation of fraud cases to DHCS and not all suspected cases as is required by the contract.

Although the Plan has a policy and procedure to identify, investigate, report to DHCS all suspected fraud and abuse cases, and track and log these cases, the Plan is not fully implementing this policy and procedure.

Opportunity to prevent, detect and investigate fraud and abuse is lost when the Plan does not fully implement policy and procedure to identify and report all potential or suspected cases of fraud and abuse. In addition, fraud and abuse affects the overall cost of health care on members.

RECOMMENDATIONS:

6.3.1 Develop and implement a process to ensure that policies and procedures identify and report potential and suspected fraud and abuse cases.

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

Santa Clara Family Health Plan

Contract Number: 03-75802
State Supported Services

Audit Period: April 1, 2017
Through
March 31, 2018

Report Issued: September 11, 2018

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INTRODUCTION

The audit report presents findings of the Santa Clara Family Health Plan (Plan) compliance and its implementation of the State Supported Services contract with the State of California. The State Supported Services contract covers contracted abortion services with the Plan.

The onsite audit was conducted from April 9, 2018 through April 20, 2018. The audit covered the review period from April 1, 2017 through March 31, 2018 and consisted of the review of documents supplied by the Plan and interviews conducted onsite.

An Exit Conference was held on August 6, 2018 with the Plan. There were no deficiencies found for the review period of the Plan's State Supported Services.

Four state supported services claims were reviewed for proper adjudication and timely payment.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Santa Clara Family Health Plan
AUDIT PERIOD: April 1, 2017 through March 31, 2018 DATE OF AUDIT: April 9, 2018 through April 20, 2018

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services: Current Procedural Coding System Codes*: 59840 through 59857 HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336 *These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract. State Supported Services Contract Exhibit A.1

SUMMARY OF FINDINGS:

Abortion is a sensitive service that is covered by the Medi-Cal program. The Santa Clara Family Health Plan (SCFHP) is required to ensure members can access these services from in- and – out-of-network providers. The Plan provides pregnancy termination procedures through any qualified provider without requiring prior authorization, except for inpatient abortions.

The Medi-Cal Member Evidence of Coverage listed the family planning services offered to Medi-Cal member which includes pregnancy testing, family planning visits, all FDA approved contraceptive birth control drugs, surgical birth control, outpatient abortion, including minors, of their rights to pregnancy termination services and to receive services outside of their health plan's network without a referral.

The Plan's provider manual informs providers that members have the right to receive family planning services, including outpatient abortions, outside of their health plan's network and through any family planning provider without a prior authorization

The Plan maintains a list of CPT codes for procedures and services which are exempt from prior authorization for the Plan's Claims department to use in auto payment of claims submitted. The Plan's claims system configuration ensures no prior authorization is needed. The billing codes for sensitive services which are exempt from prior authorization include the Current Procedural Terminology (CPT) Codes 59840 through 59857, and Healthcare Common Procedure Coding

System (HCPCS) Codes S0199 (Medical Abortion), S0190 (Mifepristone 200 mg), and S0191 (Misoprostol 200 mcg).

The Plan provides or arranges to provide eligible members with the required State Supported Services and complies with contract requirements.

The verification study showed that two State Supported Services claims were denied, however, the first claim required additional documentation and the second was a misdirected claim. In the prior year audit, SSS claims were denied because the providers were out of network. This was not the case in the current year.

RECOMMENDATION:

None