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

Santa Clara Family Health Plan

Contract Number: 04-35398

Audit Period: April 1, 2016
Through
March 31, 2017

Report Issued: October 18, 2017

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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 (SCFHP) – to provide coverage to Medi-Cal Managed Care recipients.

SCFHP was licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act in 1996. SCFHP has been contracted by the State of California Department of Health Care Services (DHCS), formerly the Department of Health Services, since 1997 as the Local Initiative for Santa Clara County under the 2-Plan Model.

SCFHP (the Plan) contracts with six medical groups and two health plans to provide and arrange comprehensive health care services. The Plan delegates 67% of membership to the health plans.

As of March 16, 2017, SCFHP had 277,811 members of which 267,437 (96.27%) were Medi-Cal members. The Plan also covers 7,622 Cal Medi-Connect (2.74%), and 2,752 Healthy Kids (0.99%).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of April 1, 2016 through March 31, 2017. The onsite review was conducted from April 3, 2017 through April 14, 2017. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on September 7, 2017 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 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, Member Rights, Quality Management (QI), and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of April 1, 2015 through March 31, 2016 with onsite review conducted from April 18, 2016 through April 28, 2016 was issued August 29, 2016. The corrective action plan (CAP) closeout letter dated March 29, 2017 noted a number of previous findings as provisionally closed and requested this audit examine cited documentation for compliance and to determine to what extent the Plan has operationalized their CAP. Most of the CAP has been operationalized with the exception of repeat findings that are explained in the body of the report.

The summary of the findings by category follows:

Category 1 – Utilization Management (UM)

The audit revealed several deficiencies in the Plan's UM program. The Plan allowed a licensed vocational nurse (LVN) to make utilization management (UM) decisions and to work outside the scope of the LVN practice, which is in conflict with the contract's requirement for staffing the UM program with qualified individuals. The contract required the Plan to provide preventive services without prior authorization; the Plan required prior authorization (PA) for screening colonoscopies, a preventive procedure.

The Plan's notice of action (NOA) letters did not explain in clear and complete language the reasons for its denial decisions.

The Plan did not have a referral tracking system that tracked approved medical and behavioral health (mild to moderate) prior authorizations to completion on an ongoing basis. The Plan's method was limited to a review of approved prior authorizations from three months of the audit period. The contract requires referral tracking as a part of monitoring for under- and over-utilization.

A verification study revealed deficiencies in the appeal notification process. Letter rationales were unclear and inaccurate; the Plan did not consistently send acknowledgement and resolution letters to providers who appealed adverse UM decisions.

Category 2 – Case Management and Coordination of Care

Deficiencies in the area of case management and coordination of care included the following: the Plan did not have a system to ensure documentation of United States Preventive Services Task Force (USPSTF) recommended services in adult initial health assessments (IHA). The Plan did not have written procedures and did not provide training on a continuing basis regarding the providers' responsibility to include and document all components of IHA.

The contract requires that complex case management (CCM) services are provided by the Plan in collaboration with the primary care provider (PCP). The Plan did not provide evidence that it implemented its policy regarding PCP participation in the provision of CCM to each eligible member.

Category 3 – Access and Availability of Care

Category 3 covers the adjudication of claims for emergency services (ER) and family planning (FP) services. The Plan's claims processing system included edits that led to improper denials of ER and FP services. The Plan denied emergency services and family planning claims for potential California Children's Services (CCS) members. The Plan denied all ER claims for non-contracted providers. The Plan also denied ER claims for not having a prior authorization, even though the contract stated that prior authorizations shall not be applied to ER services.

The Plan must ensure provision of sufficient quantities of prescribed drugs in emergency situations. The Plan did not investigate and take corrective actions when it identified deficiencies upon monitoring members' access to pharmaceuticals in emergencies.

Category 4 – Member Rights

The contract requires referral of standard and clinical grievances to appropriate decision makers. The Plan did not consistently refer grievances involving clinical issues to a health care professional with clinical expertise in treating the member's condition.

The Plan did not consistently implement its procedure regarding exempt grievance classification and processing. Exempt grievances are qualified complaints that are resolved within 24 hours. Sample grievances reviewed were classified as exempt even though they were not resolved within 24 hours.

Category 4 includes requirements for appropriate handling of protected health information. The Plan did not consistently notify DHCS of suspected security incidents or unauthorized disclosures of protected health information (PHI) within 24 hours. The Plan also did not consistently submit investigation reports for suspected security incidents within 72 hours.

Category 6 – Administrative and Organizational Capacity

The contract requires administrative arrangements and procedures designed to guard against fraud and abuse to protect the integrity of the Plan and the Medi-Cal program. The Plan has not implemented procedures specified in its anti-fraud and abuse plan.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The on-site review was conducted from April 3, 2017 through April 14, 2017. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 29 medical and 29 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 25 medical and pharmacy prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial health assessment (IHA): 15 medical records were reviewed for timely completion and fulfillment of IHA requirements.

Complex case management (CCM): Five case files were reviewed for evidence of care.

Category 3 – Access and Availability of Care

Appointment availability verification study: 16 providers from the Plan's network of routine, urgent, specialty, and prenatal care providers were reviewed for adequate and timely access to care.

Claims: 20 emergency services and 20 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member Rights

Grievance procedures: 68 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level of review.

Confidentiality Rights: 15 Health Insurance Portability and Accountability Act (HIPAA)/protected health information (PHI) breach and security incidents were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

New provider training: 24 new provider training records were reviewed for timely Medi-Cal managed care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and abuse: Six fraud and abuse cases during the audit period were reviewed for appropriate reporting and processing.

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, 2016 through March 31, 2017	DATE OF AUDIT: April 3, 2017 through April 14, 2017

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM

Utilization Management (UM) Program Requirements:
Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. …(as required by Contract)
2-Plan Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
2-Plan Contract A.5.2.C

Review of Utilization Data:
Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.
2-Plan Contract A.5.4

SUMMARY OF FINDINGS:

1.1.1 Utilization management program staff

The Plan shall ensure that the utilization management (UM) program includes qualified staff responsible for the UM program. *(Contract A11, Exhibit A, Attachment 5(1)(A))*

The California Business and Professions Code describes the practice of vocational nursing as "the performance of services requiring those technical, manual skills acquired by means of a course in an approved school of vocational nursing, or its equivalent, practiced under the direction of a licensed physician, or registered professional nurse." *(CA BPC Section 2859)*

The Managed Care Quality Monitoring Division of the Department of Health Care Services (DHCS) describes licensed vocational nurses (LVNs) as "dependent practitioners who must be directed by a physician or a registered nurse (RN), and who can only collect explicitly defined basic data, but not analyze, interpret, synthesize or evaluate it." *(MMCD Policy Letter (PL) 14-004, Subject: Facility Site Review and Medical Record Review; Discussion; Level of Reviewer)*

The Plan did not ensure that staff responsible for implementing the UM program are qualified. The Plan allowed an LVN to make UM decisions and to work outside the scope of LVN practice.

The Plan's skilled nursing facility (SNF)/long-term care (LTC) nurse approved continued stays for Plan members residing in care facilities. The California-licensed LVN in this position reviewed members' medical records; if cases met pre-set guidelines, the LVN approved a continued stay. If a case did not meet the criteria, the LVN deferred the decision to the medical director.

California law limits the scope of LVNs working in positions requiring their skills to the performance of functions named in law and ordered by a supervising nurse or physician. According to the Board of LVN, orders must be patient specific and issued before treatment.

The Plan's *2017 UM Program Description* stated that UM nurses make medical necessity determinations using multiple sources of information and "good nursing judgement." Plan *Policy # HS.03: Appropriate Professionals* stated, "only qualified licensed healthcare professionals assess clinical information used to support UM decisions." LVNs are healthcare personnel whose scope of practice specifically excludes independently assessing clinical information and making UM decisions.

A job description for a LTC Utilization Review Nurse for the Plan included LVNs as appropriate candidates for the position. A Plan organizational chart listed the position as SNF/LTC Review Nurse. Another organizational chart listed the individual serving as SNF/LTC Review Nurse as a nurse case manager; the contract, however, defines nurses as, at a minimum, California licensed RNs.

Requiring health plan staff to work inside their scope of practice as defined by state law ensures that a Plan adheres to a standard of quality established by the state. Allowing LVNs to work outside of these guidelines may unintentionally result in substandard health outcomes for plan members.

1.1.2 Consistency of UM criteria application

The Plan shall have written criteria or guidelines for utilization review that is based on sound medical evidence that is consistently applied, regularly reviewed, and updated. *(Contract A11, Exhibit A, Attachment 5(2)(C))*

The Plan did not employ its process for ensuring consistency for behavioral health (BH) requests UM decision-making. The Plan did not conduct inter rater reliability (IRR) testing

or any other method to regularly evaluate BH medical necessity decision-making.

The Plan described the integration of BH activities in the UM program in its *2017 UM Program Description*. UM and QI Committee meeting minutes demonstrated discussion of BH UM data, trends and programs, and the inclusion of a psychiatrist among the committees' voting members. The Plan's *Policy # HS.09.01: Inter Rater Reliability* stated that IRR testing would demonstrate accurate and consistent application of medical necessity criteria and would include "Medical/Behavioral Health/Pharmaceutical" staff.

The Plan did not include BH decision-makers in this year's IRR testing. The Plan required prior authorization (PA) for out-of-network mild to moderate mental health visits for psychotherapy, psychological testing, monitoring drug therapy and psychiatric consultation; there were no denials of requests for out of network mental health services in the audit period. The Plan also reported that there were few denials for behavioral health therapy (BHT) for autistic members in the audit period. Multiple clinicians, including the BH director, the chief medical officer (CMO) and consulting psychologist and psychiatrist often reviewed BH requests for services; this served as a type of cross checking of decision-making.

Although the Plan's policy included IRR testing of BH decision-making, it did not accomplish this goal in the audit period. This regular or formal type of review documents decision-makers' accuracy and consistency in UM decision-making, and provides a mechanism for imposing corrective measures should the process reveal deficiencies.

RECOMMENDATIONS:

1.1.1 Develop and implement policies and processes for LVNs performing UM work that comply with the contract and with Business and Professions Code and Board of Licensed Vocational Nursing and Psychiatric Technician's standards.

1.1.2 Implement policies and procedures to ensure the consistency of behavioral health UM decision-making. Include behavioral health in the Plan's inter rater reliability testing.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Santa Clara Family Health Plan	
AUDIT PERIOD: April 1, 2016 through March 31, 2017	DATE OF AUDIT: April 3, 2017 through April 14, 2017

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 (STD), 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

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 Prior authorization exclusions

The Plan shall provide emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing without prior authorization. (*Contract A11, Exhibit A, Attachment 5(2)(G))*

The Plan required prior authorization (PA) for screening colonoscopies, a preventative procedure.

The Plan stated that its list for services requiring PA included colonoscopies because not all colonoscopies are preventive procedures. The Plan further stated that it approved all screening colonoscopies. A review of the Plan's prior authorization log for the audit period confirmed this.

The Plan's provider manual and evidence of coverage (EOC) list preventive tests as those that do not need PA, though they do not mention colonoscopy. The provider manual stated that the Plan uses the United States Preventive Services Task Force (USPSTF) as a guideline; the EOC stated that the Plan uses cancer-screening guidelines established by the USPSTF. The Plan's website directs providers to the USPSTF website for preventive services guidelines. The USPSTF has approved colonoscopy as a standard colon cancer-screening test.

In requiring PA for colonoscopies ordered for colon cancer screening, the Plan subjects the test to possible denial, and eligible enrollees to delayed access to an important cancer-screening tool.

1.2.2 Notice of action (NOA) letters

The Plan shall notify members of a decision to deny, defer, or modify requests for prior authorization, in accordance with *CCR, Title 22, Sections 51014.1 and 53894* by providing written notification to members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. *(Contract A11, Exhibit A, Attachment 13(8)(A))* 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. *(HSC 1367.01(h)(4))*

The Plan's NOA letters did not include clear and concise explanations of the reasons for the Plan's decisions.

Plan *Policy # HS.04: Denial of Services Notification* and *Procedure # HS.04.01: Denial Notification* assure that each NOA letter provides a clear and concise explanation of the reason(s) for the Plan's decision and that that the Plan writes each letter in language easily understood by a layperson.

The Plan conducted a 4th quarter quality review of UM denials for 2016 in accordance with *Procedure # HS.04.01: Denial Notification.* The quarterly study revealed errors including criteria not clearly identified, and language that was not member-friendly. In an interview, the Plan reported that the available software for processing PAs and NOA letter did not provide a template that allowed writing complete but understandable reasons for the denials, and stated that it would soon have a system with more expansive letter-writing capacity.

A verification study consisting of 29 medical and 29 pharmacy denials revealed that NOA letters contained specialized or non-specific language and inaccurate rationales.

- Terms such as "comorbidity", "low risk factors", "electro diagnostic testing", "neuromuscular disorders", and "standard of care" are standard jargon for medical personnel.
- Terms employed in pharmacy NOA letters including "formulary alternative", "serum indicators", "liver fibrosis stage 2", and "equipotent" are technical in nature.
- The Plan could translate an explanation such as "Our records show that the member has primary coverage through California Children's Services (CCS). This request should be submitted to CCS using SAR # _____ and expiration date _____" into clearer language for the member.

Letters stated that cases did not meet criteria without specifying criteria and included inaccurate information (e.g., claiming that the member had no comorbidities, that rosacea is a cosmetic problem whose treatment is not covered, that a bowel preparation was a formulary alternative to bowel contrast material, and claiming that a standard treadmill test was the community standard).

Pharmacy *Policy # PH03: Prior Authorization* noted, "the Plan provided clear and concise requirements of prior authorization denial notifications to members and requesting providers and practitioners."

Verification study files showed that the pharmacist provided the reasons for PA decisions used in pharmacy NOA letters. The pharmacy included standardized language in its denial NOA letters. Pharmacy leaders indicated that a NOA letter improvement campaign was underway.

Unclear NOA letters with technical language or non-specific and inaccurate information make informed health care decisions more difficult to accomplish.

1.2.3 Prior authorization timeframes for behavioral health treatment

For members under 21 years of age diagnosed with Autism Spectrum Disorder (ASD), or for members under 3 years of age with a rule out or provisional diagnosis, the Plan shall cover medically necessary behavioral health treatment (BHT) services. *(Contract A22, Exhibit A, Attachment 10(5(G))*

The Plan has up to 14 calendar days from the date of receipt of a request for services to make a prior authorization decision. The Plan may take 14 additional calendar days should they be necessary. In all, the Plan has a total of 28 days from the date of receipt by the Plan for a decision. *(Contract A11, Exhibit A, Attachment 5(3)(G))*

The Plan authorized BHT services more than 28 days after receipt of the request for services.

Plan *Policy # HS.01: Prior Authorization*, stated that the Plan makes UM medical necessity decisions timely and without undue delay. Plan memos to providers available on its website described the authorization timeframe for routine requests as 5 working days; the provider manual stated that the Plan has 14 days but may extend PA decision-making to 28 calendar days.

Plan document *Prior Authorization Guidelines* for *BHT coverage for Children Diagnosed with ASD* described the process for submitting authorization requests for both an initial assessment/evaluation and for ABA/BHT services. The Plan instructed the provider to stipulate desired start and end dates for all services in their authorization request.

Review of a log documenting the Plan's requests for BHT services during the audit period showed:

- Of 109 cases approved during the audit period, 30 cases required more than 28 days to approve ABA services.
- Three of the 30 showed an approval date at least one year after the date of submission.

Plan compliance committee meeting minutes from May 25, 2016 included a discussion of the DHCS' concern over the number of Plan members on a waitlist for BHT services. DHCS subsequently asked that the Plan expand its network to include out of Plan BHT providers in surrounding counties.

Postponing authorization of BHT services may result in missed opportunities for approval of services and referral to out of network providers who can evaluate and treat the member at that moment in time. At a later date, the member's health status and eligibility may change to the member's disadvantage and lead to poor behavioral health outcomes.

1.2.4 Sexually transmitted disease (STD) treatment

The Plan shall provide access to STD services without prior authorization to all Members both within and outside its provider network. Members may access out-of-plan STD services through local health department (LHD) clinics, family planning clinics, or through other community STD service providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode. For community providers other than LHD and family planning providers, out-of-plan services are limited to one office visit per disease episode…" (*Contract A11, Exhibit A, Attachment 9(9)(B))*

The Plan informed members that they must always visit their primary care physician (PCP) for follow up STD treatment, which is in conflict with the contract's guidance regarding this service.

Though Plan *Policy # HS.01 Prior Authorization* and the member evidence of coverage (EOC) inform members that STD treatment did not require PA, and that they may obtain initial care outside of network, the EOC stated, "After the first treatment of an STD, you have to go to your PCP for continued treatment." The contract, however, allows members to continue their treatment of these problems with out of Plan LHD and family planning clinics without PA.

Requiring members to obtain follow up STD care with their PCP in all cases conflicts with the contract and inappropriately subjects members to sensitive situations; this may cause avoidance of follow up visits, incomplete care, and impaired health outcomes for enrollees and their communities.

RECOMMENDATIONS:

1.2.1 Revise and implement policy and procedures to ensure preventive services such as screening colonoscopies are not subject to prior authorization.

1.2.2 Implement policy and procedures to ensure clear and concise notice of action letters that contain specific and accurate denial information.

1.2.3 Revise and implement policy and procedures that require contractually compliant timeframes for processing BHT prior authorizations.

1.2.4 Revise the member EOC to indicate that enrollees may obtain follow-up STD care in out-of-network local health departments and family planning clinics.

1.3	REFERRAL TRACKING SYSTEM

Referral Tracking System:
Contractor is responsible to ensure that the UM program includes: … An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.
2-Plan Contract A.5.1.F

SUMMARY OF FINDINGS:

1.3.1 Referral tracking

The Plan shall 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 timeliness of the referrals. This specialty referral system should include non-contracting providers." *(Contract A11, Exhibit A, Attachment 5 (1)(F))*

The Plan did not have a referral tracking system which tracks approved prior authorizations to completion on an ongoing basis. The Plan's method was limited to a review of approved prior authorizations from three months of the audit period to completion. In addition, the Plan did not track approved PAs for treatment of mild to moderate behavioral health issues to their completion.

The Plan presented a new *Policy # HS.01.0: Specialty Referral Tracking System* to correct a deficiency noted during the Department's audit last year. During the audit period, the Plan developed and implemented the following process:

- The Plan tracked a sample of 62 PAs from three months of the audit period to their completion. Tracking an approved PA to its completion means matching an approved service to a paid claim, thus confirming delivery of the service.
- The Plan investigated the reasons for the apparent non-delivery (i.e., no matching paid claim) of a small number of approved services.
- The Plan did not include behavioral health prior authorizations in the prior study.

The Plan presented its findings and suggestions upon completion of the study to the Utilization Management Committee (UMC) in January 2017. The UMC recommended

yearly completion of this limited study, though not ongoing tracking of all PAs to their completion.

In an interview, the Plan reported that it denied no PA requests for out-of-network mild to moderate behavioral health services during the audit period, and that it did not track service requests once authorized.

A log of out-of-network approved PAs for treatment of mild to moderate mental health (MH) issues from the audit period showed eight requests for services, all approved timely. The document captured the date of referral, the approval date, provider to deliver the service, and notes regarding the case. The log did not indicate whether the visit(s) occurred or when.

Tracking unused authorizations for special services provides important utilization information for the health plan, and supplies it an additional method of investigating the matter of unused benefits and service requirements.

This is an ongoing finding.

1.3.2 Referral tracking and providers

The Plan shall 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 did not notify contracted providers of the prior authorization tracking process.

In a written communication, the Plan revealed that it has not notified providers of referral tracking or of the results of the tracking study presented to the UMC in 1/2017, but that it will consider this action in the future. Plan documentation including the provider manual, the Plan website, and provider memos did not contain referral tracking information.

Informing providers of the tracking process involves them in the process of answering important questions about service delivery and the health care needs of their patients. Providers can learn that the plan prioritizes timely processing of requested tests and procedures. In addition, providers learn that information about their patient's utilization patterns exists which can help them in their own practice planning.

RECOMMENDATIONS:

1.3.1 Develop and implement a system to track all approved PAs to completion in an ongoing and year round process; include behavioral health PAs and those for contracted and non-contracted providers.

1.3.2 Revise Plan informing materials for providers to ensure providers are aware of the prior authorization tracking process.

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

SUMMARY OF FINDINGS:

1.4.1 Provider appeal letters

The Plan shall implement and maintain a member grievance system in accordance with *Title 28, CCR, Section 1300.68…" (Contract, Exhibit A, Attachment 13(1))* "The plan shall respond to grievances as follows: (1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received… (3) The Plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt…" *(Title 28 CCR 1300.68(d)(1)* and (3)) "(3) 'Complainant' is the same as 'grievant,' and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee." *(CCR, Title 28, section 1300.68(a)(2))*

The Plan did not consistently send providers acknowledgement or resolution letters when they appealed adverse UM decisions on members' behalf.

Plan *Policy # GA001_011: Member Grievance and Appeal Process* stated that in the case of a medical- related grievance or appeal, the Plan compliance officer or grievance and appeals coordinator will send the complainant the response (resolution) letter. The Plan is reportedly revising the policy, which was last updated September 21, 2015. A review of grievance and appeals committee meeting minutes for June 2016 indicated that the Plan lost two grievance coordinators by that date; the departure of the Plan's then- grievance and appeals manager occurred before the subsequent committee meeting of September 2016. The Plan reported in interviews that it sent provider letters inconsistently in the past. The Plan instituted a new process for reviewing grievance and appeal resolution letters in 2/2017, and processed the deficient cases noted above before that date.

In a verification study consisting of a sample of 25 UM appeals, providers submitted 13 of

the appeals. The Plan did not send either an acknowledgement or a resolution letter in 10 cases of the 13. In three cases, the Plan sent neither an acknowledgement nor a resolution letter to the appealing provider.

Acknowledgement and resolution letters provide written and verifiable documentation of timely appeal receipt and resolution for providers advocating for patients. Informing the clinician advocate via a consistent process with reproducible documentation keeps them involved in the process of determining medical necessity and appeal resolution. This is especially important for a member without other assistance in the matter.

1.4.2 Appeal letter rationale

The Plan shall implement and maintain a member grievance system in accordance with *CCR, Title 28, Section 1300.68…" (Contract, Exhibit A, Attachment 13(1))* "The plan shall respond to grievances as follows: (3) The plan's resolution… shall contain a clear and concise explanation of the plan's decision." (*CCR, Title 28, Section 1300.68(d)(3)*

The rationale in the Plan's appeal resolution letters was not consistently clear.

A verification study consisted of 25 UM appeals, of which 12 were appeals for denied medications. In three cases, the medical record findings conflicted with the written denial rationale. The reason for the denial was not clear.

- In an upheld EEG denial, the medical record indicated a diagnosis of seizures and an EEG read as "Sharp waves during hyperventilation. Otherwise, this is a normal awake and a drowsy EEG." The decision maker's denial rationale included "the recent ambulatory EEG showed a clinical impression of 'sharp waves.' However, the EEG is noted as normal…" The letter stated, "The EEG recently performed is noted as normal." This is an inaccurate representation of the decision-maker's rationale.

- The Plan upheld a denial for "comprehensive epilepsy panel" with the decision-maker indicating, "There is no documentation of any genetic syndrome or abnormality. Epilepsy is not a genetic disorder and is not an indication for genetic testing." The letter stated, "The documentation submitted with your appeal shows epilepsy which is not a genetic disorder, therefore there is no indication for genetic testing based on Medi-Cal criteria." This does not accurately reflect the decision-maker's rationale.

- In the case of an upheld denial for a brand drug, the decision-maker noted that the Plan had a generic equivalent that is the same ingredient as the brand drug requested. The letter stated the above and that doctor notes did not indicate the member had tried

a formulary alternative. The latter is incorrect, as the physician's prescription indicated trial and failure of the generic due to anxiety and pharmacy record review showed that the member had tried the generic medication multiple times.

In two cases, the Plan rationale stated that additional information made the overturn possible, but did not elaborate.

Plan *Policy # GA001_11: Member Grievances and Appeals Process* stated that the grievances and appeals coordinator or the compliance officer prepares the written resolutions to members' appeals. At the time of the audit, Plan grievance and appeal coordinators completed this task after the medical director or chief medical officer (CMO) provided the decision to uphold or overturn the denial and the reasons for the determination. The Plan reported that is engaged in an effort to ensure appeal letters meet contractual standards.

Without a clear and accurate statement of the reason for the Plan's decisions in appeals, members and providers do not receive true and complete information about decisions about their health care. In the case of upheld denials, this is problematic when members and providers must decide next steps in the management of a health problem. In the case of an overturned denial, no clear reason for the overturn makes the action and the original denial seem arbitrary and not evidence–based as the contract requires.

RECOMMENDATIONS:

1.4.1 Revise policy and establish procedures for sending providers acknowledgement and resolution letters when they appeal adverse UM decisions.

1.4.2 Develop and implement procedures to ensure appeal resolution letters include a clear and accurate rationale for the Plan's decisions.

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, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.
2-Plan Contract A.10.3.A

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

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Santa Clara Family Health Plan	
AUDIT PERIOD: April 1, 2016 through March 31, 2017	DATE OF AUDIT: April 3, 2017 through April 14, 2017

SUMMARY OF FINDING:

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. The Plan shall ensure that the latest edition of the *Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force* (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult members, age 21 or older. All preventive services identified as USPSTF "A" and "B" recommendations must be provided. *(Contract A17, Exhibit A, Attachment 10(6)(B)(1))*

The Plan must adhere to the current edition of the *Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force* (USPSTF), specifically USPSTF "A" and "B" recommendations for providing preventive screening, testing and counseling services. Status of current recommended services must be documented. *(MMCD PL 08-003, Initial Comprehensive Health Assessment)*

The Contract requires the Plan to ensure all appropriate staff receive training on a continuing basis regarding evidence-based practice guidelines. *(Contract A11, Exhibit A, Attachment 7 (5) (B))* The Plan must have written procedures and must provide training requiring providers to include and document all components of the IHA. *(MMCD PL 08-003)*

The Plan did not have a policy or written procedures requiring providers to include and document the status of USPSTF "A" and "B" recommended services. The Plan's provider manual did not inform providers about the contract requirements regarding these recommendations and the Plan's leadership staff could not verify that providers were trained or informed of this requirement. During interviews, a sample of providers could not confirm that they were informed by the Plan of the requirement to provide "A" and "B" recommended services. A sample of medical records did not contain documentation confirming that members received "A" and "B" recommended services from the current edition of the USPSTF guide to clinical preventive services.

USPSTF "A" and "B" recommended services must be provided by primary care providers to promote preventive health practices to improve the member's health and reduce the need for medical treatment.

RECOMMENDATION:

2.4.1 Develop and implement policies and procedures that support compliance with the requirement to provide preventive health services including USPSTF "A" and "B" recommended services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Santa Clara Family Health Plan	
AUDIT PERIOD: April 1, 2016 through March 31, 2017	DATE OF AUDIT: April 3, 2017 through April 14, 2017

2.5	COMPLEX CASE MANAGEMENT

Case Management and Coordination of Services:
Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.

Complex Case Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include, at a minimum:

1) Basic Case Management Services
2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3) Intense coordination of resources to ensure member regains optimal health or improved functionality
4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually

Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical data, and any other available data, as well as self and physician referrals.
2-Plan Contract A.11.1

SUMMARY OF FINDING:

2.5.1 Provision of complex case management to eligible members

The Plan shall ensure the provision of comprehensive medical case management to each member either through basic or complex case management (CCM) activities based on the medical needs of the member. CCM services are to be provided by the Plan, in collaboration with the primary care provider (PCP), and include the development of care plans specific to individual needs with member and PCP input. *(Contract A14, Exhibit A, Attachment 11 (B)(4*)

The Plan did not ensure PCP participation in the provision of CCM to each eligible member.

Plan *Policy # CM030_05: Case Management* stated a clinical case manager was responsible to communicate with the primary care or treating physician about plans for and coordination of the member's care. The provider manual indicated that Plan's case management depended on close communication between the Plan's case managers and PCPs to ensure member's care plan was coordinated. Neither the Plan's policy nor its provider manual defined the role of the PCP in the provision of CCM services.

According to the Plan's staff, care plans were initiated and developed by case managers based on the member's assessment. The Plan did not provide evidence that PCPs participated in the development of the member's care plan. Plan staff reported that completed care plans were sent to PCPs upon member's request.

During onsite clinic visits, multiple Plan providers were interviewed and most were familiar with the Plan's CCM program. Although they had members receiving CCM services, the PCPs could not recall having been contacted by the Plan's case management staff regarding a care plan.

A care plan tailored to the member's needs and based on the comprehensive assessment forms the foundation for care coordination. As a member of the multidisciplinary case management team, the PCP's participation is an important element in the care of members with complex needs, including in the care planning process.

RECOMMENDATION:

2.5.1 Implement procedures to ensure participation of PCPs in the provision of CCM services to eligible members.

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

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

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 Emergency room service and family planning claims for possible CCS members

The Plan is required to reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 45 working days after the date of receipt of the complete claim. *(CCR, Title 28, Section 1300.71(g))* The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim. *(H&S Code Section 1371)* The Plan may not arbitrarily deny or reduce the amount, duration, scope of a required service solely because of the diagnosis, type of illness, or condition*. (Contract A11, Exhibit A, Attachment 10(1)(B))*

The Plan inappropriately denied emergency room service (ER) and family planning (FP) claims for potential California Children's Services (CCS) members.

The Plan automatically denied claims when a potential CCS diagnosis was indicated on the claim. The Plan denied claims based solely on a list of CCS covered diagnoses without verifying the member's CCS eligibility status. The Plan's claim system had edits that automatically denied these claims without a secondary review to confirm whether ER/FP claims were related to the member's CCS condition. DHCS' verification study showed that 5 out of 9 ER claims and 2 out of 2 FP claims were improperly denied as potential CCS claims.

The Plan did not have policies and procedures in place during the audit period to address claims processing for potential CCS members. During the prior year audit, the Plan denied claims based solely on a list of CCS covered diagnoses without verifying the member's CCS eligibility status. The Plan's corrective action process for this finding was not implemented until after the audit period. The new process included performing a manual pre-check review of any claims denied for CCS eligibility. This process includes a manual review by claim staff, potential CCS eligibility confirmation by a nurse, and a final determination for claims payment.

Inappropriate denials of emergency service and family planning claims may cause undue harm to a provider's practice and members' care. Provider's ability to continue as a going concern may be affected by lack of payment for resources used and services provided.

This is a repeat finding.

3.5.2 Prior authorizations for emergency room service claims

Emergency services shall not be subject to prior authorization by the Plan. (*Contract, Exhibit A, Attachment 8(13)(A))* 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(2)(F))*

Plan *Policy # CL026: Reimbursement to Emergency Room Physicians*, stated in part that the Plan will reimburse claims without regard to the provider's contract status and without prior authorization.

The Plan automatically denied emergency services claims containing service billing codes that require prior authorization. The Plan's claims system had edits that automatically denied these claims without a secondary review. A review of 20 emergency service claims found two ER claims for services that normally require a prior authorization. Two claims were improperly denied for not having a prior authorization. The Plan's policies and procedures did not address the process of not requiring prior authorization for the reimbursement of ER claims.

During the prior year audit, the Plan was found inappropriately denying claims for services that require prior authorization. The Plan's corrective action plan for this finding was to establish an oversight process where all denied claims go through a pre-check run. This process was not implemented during the audit period.

Inappropriate denials of emergency service claims may cause undue harm to a provider's practice and limit members' access to care. Provider's ability to continue as a going concern may be affected by lack of payment for resources used and services provided.

This is a repeat finding.

3.5.3 Emergency room service claims for non-contracted providers

The Plan 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 services rendered to a member until the member's condition has stabilized sufficiently to permit discharge. *(Contract A11, Exhibit A, Attachment 8(13)(A))* The Plan shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal fee for service rate. *(Contract A11 Exhibit A, Attachment 8(9))*

Plan *Policy # CL026: Reimbursement to Emergency Room Physicians* stated in part that the Plan will reimburse claims without regard to the provider's contract status and without prior authorization.

The Plan automatically denied all ER claims submitted by non-contracted providers. The Plan's claims system had edits that automatically denied these claims without a secondary review. A review of 20 emergency service claims found one ER claim submitted by a non-contracted provider that was improperly denied for being submitted by an out-of-network provider. The Plan's policies and procedures did not address the process of reimbursing ER claims for non-compliant providers.

Inappropriate denials of ER claims submitted by non-contracted providers may cause these providers to be reluctant to treat Plan members in the future.

RECOMMENDATIONS:

3.5.1 Develop and implement a process to properly adjudicate ER and FP claims for potential CCS members.

3.5.2 Develop and implement a process to ensure ER claims are not subject to PA by the Plan.

3.5.3 Develop and implement a process to ensure ER claims submitted by non-contracting providers are appropriately adjudicated.

3.6	ACCESS TO PHARMACEUTICAL SERVICES

Pharmaceutical Services and Prescribed Drugs:
Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.
2-Plan Contract A.10.8.G.1

SUMMARY OF FINDING:

3.6.1 Monitoring the provision of drugs prescribed in emergency circumstances

The Plan is required to ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the member can reasonably be expected to have the prescription filled. *(Contract, Exhibit A, Attachment 10 (8)(G)(1))*

Plan *Policy # PH05: Continuity of Care for Pharmacy Services* stated that the Plan defines how an emergency 72-hour supply of medications are available on all drugs regardless of formulary status to support transition of care. Plan *Policy # PH.05.02: Emergency Supply Access Monitoring* stated that the pharmacy department will work with the finance department to create a quarterly report evaluating access to emergency supply medications post emergency room visit. The Plan's monitoring methodology includes: analysis of review of paid vs denied claims, associated prescription claims with ER visit diagnosis, and claims with 72-hour emergency prior authorization override.

The Plan did not ensure that drugs prescribed in emergency circumstances were dispensed in amounts sufficient to last until the member could reasonably be expected to have the prescription filled.

The Plan conducted quarterly monitoring for access to pharmaceuticals in emergency circumstances in the second and third quarter of 2016. According to the Q3 2016 Emergency Prescription Access Report, the Plan reviewed the number of ER visits with or without a prescription, top diagnoses for ER visits, quantity of visits for top service providers, highest frequency of prescription drugs dispensed, and in-network pharmacy activity. The Plan focused on ER visits for UTI because a UTI diagnosis should result in a prescription for an antibiotic. The Plan determined that 55% of all ER visits for a UTI had a corresponding prescription within 72 hours. However, the Plan did not examine the cause of 45% of UTI ER visits not having a corresponding prescription filled within 72 hours. The Plan also did not determine whether members were receiving sufficient amounts of pharmaceuticals in emergency circumstances when prescriptions were filled. The Plan had the raw data of quantity of pharmaceuticals dispensed but it was not analyzed in the quarterly report.

Although the Plan monitored access to pharmaceuticals in emergency circumstances, the Plan did not investigate and follow-up on the identified disparities monitoring access to pharmaceuticals.

Monitoring drugs prescribed in emergency circumstances are dispensed in sufficient amounts provides the Plan with information regarding possible barriers for members' access to pharmaceutical services. The Plan's lack of further investigation for identified discrepancies in their monitoring may lead to missed opportunities for improvement for members' access to pharmaceutical services.

RECOMMENDATION:

3.6.1 Revise and implement policies and procedures to take actions when deficiencies in the provision of drugs prescribed in emergency circumstances are identified.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Santa Clara Family Health Plan	
AUDIT PERIOD: April 1, 2016 through March 31, 2017	DATE OF AUDIT: April 3, 2017 through April 14, 2017

CATEGORY 4 – MEMBER 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

SUMMARY OF FINDINGS:

4.1.1 Quality of care (QOC) grievances

The Plan shall ensure that, "grievances related to medical quality of care (QOC) issues shall be referred to the Contractor's medical director." *(Contract A11, Exhibit A, Attachment 14(2)(E)*) In addition, the Contract requires that the Plan have a "procedure to ensure that the person making the final decision for the proposed resolution of a grievance…is a health care professional with clinical expertise in treating the member's condition or disease if any of the following apply…3) any grievance or appeal involving clinical issues." *(Contract A11, Exhibit A, Attachment 14(2)(G)(3))*

The Plan did not refer all grievances involving clinical issues to a health care professional with clinical expertise in treating the member's condition or disease.

Pertinent points about the Plan's process for adjudicating QOC grievances include:

- Quality improvement (QI) registered nurses (RNs) review all grievances and make the final determination as to whether the matter is one of QOC.

- The Plan reported that the QI RN may determine whether a case is QOC based on the initial report (i.e., complaint only, no medical records).
- Only these QOC grievances (otherwise known as PQIs) receive the CMO or medical director's review.

Plan policies describing the adjudication of grievances that may be of a medical nature include *QI05 Potential Quality of Care Issue* and *GA001-10 Member Grievance and Appeals Process.* Policies do not describe how the Plan monitors its QI RNs' ability to reliably distinguish quality of care from service grievances. The Plan did not describe such a process in interviews.

A verification study of 11 cases initially identified as QOC grievances revealed that QI RNs categorized four cases as not quality of care issues. The following complaints about clinical issues did not receive a physician's review:

- The doctor prescribed medications that caused gastrointestinal upset while I waited for a delayed diagnosis.
- The doctor only prescribed single vision lenses and would not re-examine me.
- The doctor provides unsatisfactory care by not reviewing my lab and x-ray studies.
- The durable medical equipment (DME) provider supplied an ill-fitting and uncomfortable wheelchair.

Grievances involving clinical matters that do not receive review from an appropriate health care professional may represent missed opportunities for spotting trends and problems eventually affecting member's health outcomes in adverse ways. Documentation is critical for ensuring appropriate case review and determination.

4.1.2 Exempt grievances

The Plan is required to 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. *(Contract A11, Exhibit A, Attachment 14(2))* Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. *(Title 28, CCR, Section 1300.68 (d)(8))*

Per *Procedure # CS.12.01: Customer Service Intake of Grievances & Appeals,* the customer service representative (CSR) will use a set of standards for categorizing and routing member grievances and appeals. If the member or member representative is not able to access health care service and CSR is able to resolve the issue the same day or by the close of the following calendar day, the grievance is recorded as an exempt

grievance. If the grievance is not resolved within the same day or by the close of the third calendar day, the case is then forwarded to the Grievance & Appeals department for a formal acknowledgement, further investigation and resolution.

The procedure then provides an example of a grievance where the member has unsuccessfully attempted to get an appointment or there is an unsatisfactory wait time to get an appointment. The resolution steps for this example include:

- Contact member with new appointment date.
- Document discussion notes in the system of record.
- If there are no pending issues with the grievance and it was resolved to the satisfaction of the member, the same or by the close of the following calendar day, document the resolution date for accurate reporting of exempt grievances.

The Plan did not consistently implement its procedure regarding exempt grievance classification and processing. The customer service department inconsistently classified and processed multiple grievances as exempt grievances instead of processing them as a standard grievance. These complaints and expressions of dissatisfaction were not properly classified, processed, and resolved.

The verification study confirmed that in 4 of 10 exempt grievance files reviewed, grievances were classified as exempt grievances even though they were not fully resolved within 24 hours. These were complaints regarding eligibility and appointment access. For the appointment access grievances, the Plan was either not able to make an appointment or when they were able to, it was beyond the appointment availability standards. These complaints were not resolved to the satisfaction of the member by the close of the next business day.

By classifying standard grievances as exempt grievances, the Plan is not complying with regulatory requirements to ensure grievance acknowledgment letters are sent to complainants. In cases where grievances are resolved after 24 hours, complainants need to be informed whether the complaint was received and resolved by the Plan.

4.1.3 Grievances on behalf of a member

The Plan shall provide a written acknowledgement to the complainant within five calendar days of receipt. *(CCR, Title 28, Section 1300.68(d)(1))* The Plan's resolution, containing a written response to the grievance, shall be sent to the complainant within thirty calendar days of receipt. *(CCR, Title 28, 1300.68(d)(3))* Complainant means the person who filed the grievance including the member, a representative designated by the member, or another individual with authority to act on behalf of the member. *(CCR, Title 28, Section 1300.68(a)(3))* (*Contract A11, Exhibit A, Attachment 14 (1)(2A))*

Plan *Policy # GA001_11: Member Grievance and Appeals Process* stated, "All Plan correspondence sent to a Complainant who files a grievance shall follow current regulatory requirements…The Compliance Officer or Appeals and Grievance Coordinator will prepare a written response to the Complainant with a resolution to the grievance…" This policy defines a complainant or grievant as, "the person who filed the grievance including the member, a representative designated by the member, or other individual with authority to act on behalf of the member."

The Plan did not consistently send acknowledgement and resolution letters to complainants who filed grievances on members' behalf.

The DHCS' verification study confirmed that in 7 of 23 standard and expedited grievances submitted on behalf of a member, the required written acknowledgments and resolutions to the grievances were not sent to the complainants. The Plan did not consistently implement its policy regarding correspondence with complainants.

Not sending the grievance acknowledgment and resolution letters to all complainants leads to incomplete communication between the Plan and its members' representatives.

4.1.4 Grievance training material

Members have up to 180 days from the date of the incident or action that caused the member to be dissatisfied to file a grievance. *(Contract A11, Exhibit A, Attachment 14 (4)(E))*

The Plan provided incorrect information regarding time limitation for filing a grievance to its member-facing staff, which included Grievance and Appeals, Utilization Management, Customer Service, Eligibility, and Pharmacy departments. Per the *Medi-Cal Appeals and Grievances Annual Training* provided to the above departments in February 2017, "All appeals and grievances should be received within 90 calendar days of the incident. A&G can accept a request up to 180 calendar days if the member or provider gives a 'good cause' reason for not filing timely." The contract allows members to file a grievance within 180 days of the incident without any other requirements or restrictions.

Plan *Policy # GA001_11: Member Grievance and Appeals Process*, correctly stated the members have 180 days to file a grievance. The Plan's evidence of coverage, provider manual, and the website identified the correct timeframe of 180 days for filing a grievance.

Provision of inconsistent information to Plan staff for grievance processing requirements may cause a member to miss an opportunity to file a complaint due to shorter time constraints.

RECOMMENDATIONS:

4.1.1 Ensure that a health care professional with clinical expertise in treating a member's condition or disease resolves grievances that involve clinical issues.

4.1.2 Consistently implement the procedure to ensure exempt grievances are fully resolved prior to closing a case within 24 hours. Implement a process to monitor the classification of standard and exempt grievances.

4.1.3 Implement the policy to send all complainants the required written acknowledgment and responses to the grievances.

4.1.4 Revise training materials provided to staff to be consistent with contractual requirements.

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 Notification of unauthorized disclosure of protected health information

The Plan shall notify DHCS immediately, or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of protected health information (PHI). *(Contract A11, Exhibit G (H)(1))*

The Plan *Procedure # CP20.01: Health Information Privacy Policies and Procedures* required the Plan to notify any required reports of unauthorized disclosure or notices of privacy data or intrusion breaches affecting Medi-Cal members simultaneously with the DHCS Contract Manager, DHCS Privacy Officer and DHCS Information Security Officer within twenty-four (24) hours of discovery during a work week.

The Plan did not consistently notify DHCS of suspected security incident or unauthorized disclosure of PHI within the required timeframes.

The verification study confirmed that in 7 of 12 incidents reviewed, DHCS was not notified within 24 hours by e-mail or fax. Six of these seven incidents occurred between early November to mid-December when two key compliance staff were on leave. Although temporary staff were hired for this time, the Plan had not notified DHCS of these incidents by the time of the onsite. The seventh incident was from a delegate where the delegate reported the incident to DHCS 18 days after the discovery.

In the prior year audit finding, the Plan did not notify DHCS within 24 hours of discovery of unauthorized disclosure of PHI incidents. As a corrective action, the Plan revised its health information privacy policies and procedures to be in compliance with the required timeframes. To meet the timeframe requirements, the Plan also began implementing a disclosure tracking log to capture the date reported to DHCS. However, this disclosure tracking log was not implemented until the end of the audit period. The Plan staff stated the log has one case as of April 2017.

By ensuring that Plan consistently reports all privacy breaches and security incidents to the DHCS Privacy Officer and Information Security Officer, the Plan will meet both its contractual and regulatory requirements in safeguarding the privacy of members' protected health information.

This is a repeat finding.

4.3.2 Submission of suspected protected health information breach investigations

The Plan shall immediately investigate security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Plan shall notify the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer of:

a) What data elements were involved and the extent of the data involved in the breach,
b) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data,

c) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized,
d) A description of the probable causes of the improper use or disclosure; and
e) Whether Civil Code sections 1798.29 or 1798.82 or any other Federal or state laws requiring individual notifications of breaches are triggered. *(Contract A11, Exhibit G (H)(2))*

The Plan *Procedure # CP20.01: Health Information Privacy Policies and Procedures* stated, "In addition, the Plan is required 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 Officer within seventy-two (72) hours of the discovery."

The Plan did not consistently submit the suspected security incident investigations within the required timeframes.

The verification study confirmed that in 6 of 12 incidents reviewed, the Plan did not submit the suspected security incident investigations nor notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer within 72 hours of discovery of a breach. These incidents occurred when two key compliance staff were on leave around November to December 2016

In the prior year audit finding, the Plan did not submit the suspected PHI breach investigation reports to DHCS within 72 hours of discovery. As a corrective action, the Plan revised its health information privacy policies and procedures to be in compliance with the required timeframes. To meet the timeframe requirements, the Plan also began implementing a disclosure tracking log to capture the date reported to DHCS. However, this disclosure tracking log was not implemented until the end of the audit period. The Plan staff stated the log has one case as of April 2017.

Submission of investigation report to DHCS timely allows the Department to take appropriate actions in response to the incident that occurred based on the information gathered during the investigation.

This is a repeat finding.

RECOMMENDATIONS:

4.3.1 Implement the policies and procedures to ensure privacy breaches and security incidents are reported to DHCS within 24 hours.

4.3.2 Implement the policies and procedures to ensure reports of suspected security incidents investigations are submitted to DHCS within 72 hours.

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CATEGORY 5 – QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:
Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.
Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
2-Plan Contract A.4.12

Standards:
All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered….Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
2-Plan Contract A.4.12.A

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status….
2-Plan Contract A.7.*5*

Delegated Credentialing:
Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities…
2-Plan Contract A.4.12.B

Disciplinary Actions:

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Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.
2-Plan Contract A.4.12.D

SUMMARY OF FINDING:

5.2.1 Provider training on recommended preventive services for adults

The plan shall ensure that all providers including new providers on active status receive training regarding the Medi-Cal Managed Care program that include initial health assessments (IHA). The Contract requires the Plan to ensure all appropriate staff receive training on a continuing basis regarding evidence-based practice guidelines. *(Contract A11,Exhibit A, Attached 7, 5(A) and (B))* The Plan must have written procedures and must provide training requiring providers to include and document all components of the IHA. *(MMCD PL 08-003)*

The Plan must adhere to the current edition of the *Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force* (USPSTF), specifically USPSTF "A" and "B" recommendations for providing preventive screening, testing, and counseling services. Status of current recommended services must be documented. *(MMCD PL 08-003, Initial Comprehensive Health Assessment)*

Plan procedure *PN04.01 New Provider Orientation Process* stated new provider orientation may be conducted in person, over the phone, or online. According to this procedure, the Plan's orientation process provides the tools and resources to ensure compliance with the Plan's contract with the providers and applicable federal and state statutes.

The Plan did not provide evidence that providers received training regarding recommended preventive services for adults. The Plan's new provider orientation 2017 presentation included the contract requirement for providers to complete IHA within 120 days, however it did not include USPSTF "A" and "B" recommended services. During the audit period, the Plan's provider manual and website did not inform providers about the contract requirements regarding these recommendations.

Training providers regarding all contract requirements such as USPSTF "A" and "B" recommended services ensures members receive these key preventive services and maintain optimal health.

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RECOMMENDATION:

5.2.1 Revise provider orientation materials to include training on Medi-Cal Managed Care program including requirements to provide and document the current edition of USPSTF "A" and "B" recommended services.

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

SUMMARY OF FINDING:

6.3.1 Anti-fraud and abuse program implementation

The Plan 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. The Plan 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. *(Contract A11, Exhibit E, Attachment 2 (26)(B)(1))*

Plan *Procedure # CP02.01: Fraud, Waste, and Abuse*, stated the Plan's compliance department is to perform data analysis in order to monitor, detect, and prevent potential fraud, waste and abuse (FWA) cases. The compliance department is also to perform a detailed investigation of potential cases received from various internal and external sources. Employees who have concerns or suspect fraud should report the situation promptly, with supporting documentation, to his or her department supervisor.

The department supervisor who is informed by an employee of a potential FWA case must forward the case promptly to the appropriate compliance staff. The compliance officer has the primary responsibility to document and track suspected fraud cases in the current referral log as well as forward documentation of credible allegation of fraud to the compliance committee.

The Plan did not implement all of the steps in its fraud and abuse procedure. Plan staff confirmed that they have not begun performing data analysis, tracking suspected fraud cases in the current referral log, and forwarding documentation of credible allegation of fraud to the compliance committee.

In addition, potential fraud cases identified or received outside of the compliance department were not investigated and reported to DHCS. For example, there is a case on the member services call inquiry log involving possible stolen identity, where the member services staff commented, "This is fraud." This case was not forwarded to compliance department to be investigated. Thus, it was not identified in the Plan's *Fraud, Waste, and Abuse Log*. Although the Plan had procedures to report to the compliance department when employees suspect fraud, the above instance indicates the procedures were not implemented.

The prior year audit found that the Plan did not have an anti-fraud and abuse plan. As part of the corrective action, the compliance department has been restructured and a work plan is in process to engage a fraud, waste, and abuse vendor for data mining, analysis, and benchmarking with other Plans' data. The Plan did not fully implement its anti-fraud and abuse procedures due to staff turnover during the audit period and the lack of oversight for policy implementation over the temporary staff.

When significant procedures that are part of the Plan's anti-fraud and abuse program are not implemented, the Plan increases its exposure to fraud and abuse that could have been detected, investigated, and prevented.

This is an ongoing finding.

RECOMMENDATION:

6.3.1 Fully implement all policies and procedures to guard against fraud and abuse.

MEDICAL REVIEW - NORTHERN 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, 2016 Through March 31, 2017
Report Issued:	October 18, 2017

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INTRODUCTION

This report presents the audit findings of Santa Clara Family Health Plan (the Plan) State Supported Services contract No. 03-75802. The State Supported Services contract covers contracted abortion services with the Plan.

The onsite audit was conducted from April 3, 2017 through April 14, 2017. The audit period was April 1, 2016 through March 31, 2017 and consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on September 7, 2017 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. No additional information was submitted following the Exit Conference.

Twenty state supported services claims were reviewed for appropriate and timely adjudication.

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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 FINDING:

SSS.1 Out of network providers

The Plan shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal rate. *(Contract, Exhibit A, Attachment 8(9)*) The Plan is bound by all applicable terms and conditions of the Primary Contract as of the effective date of this Hyde Contract. *(Hyde Contract, Exhibit E(1)*)

The Plan did not pay non-contracting providers for state supported services claims.

Plan *Policy # CL025: Processing of Abortion Claims* states that the Plan, for any reason, arranges and pays for abortion services and supplies listed above to a non-contracted provider, the Plan reimburses the rate negotiated by the Plan and the non-contracted provider. The Plan's policies and procedures did not address how the Plan will reimburse all complete claims from non-contracting providers for state supported services at the appropriate Medi-Cal rate.

The Plan automatically denied state supported services claims submitted by out-of-network, non-contracted providers. The Plan's claims system includes edits that automatically denied these claims without a second review. Verification study showed that 2 out of 2 state supported services claims were automatically denied for being a non-contracted provider.

The Plan became aware of this issue during its preparation for this audit. In response, the Plan began manually reviewing all state supported services claims submitted by non-contracted providers. The Plan began re-adjudicating prior improperly denied claims. This process was not formalized in a policy and procedure at the time of onsite.

Inappropriate denials of state supported services claims submitted by non-contracted providers may cause these providers to be reluctant to treat Plan members in the future.

RECOMMENDATION:

SSS.1 Develop and implement a process to ensure claims submitted by non-contracting providers are appropriately adjudicated.