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DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

Elizabeth Darrow, CEO  
Santa Clara Family Health Plan  
210 E. Hacienda Ave.  
Campbell, CA 95008

RE: Department of Health Care Services Medical Audit

Dear Ms. Darrow:

The Department of Health Care Services (DHCS) Audits and Investigations Division conducted an on-site medical audit of Santa Clara Family Health Plan, a Managed Care Plan (MCP), from March 3, 2014 through March 14, 2014. The audit covered the review period of January 1, 2013 through December 31, 2013.

On October 24, 2014, the MCP provided DHCS with a response to its Corrective Action Plan (CAP) originally issued on September 23, 2014. On January 26, the MCP provided a response to an email from DHCS regarding provisionally closed deficiencies. We appreciate you sending us additional information on the provisionally closed items. We also appreciate SCFHP implementing policies that are consistent with closing deficiencies that we have open. To close the provisionally closed items, we will need evidence of the implementation of the policies or we can leave the item provisionally closed until the upcoming yearly audit. It is our understanding that the next audit for SCFHP is tentatively scheduled for the first quarter of 2016. The enclosed report will serve as DHCS's final response to the MCP's CAP.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

If you have any questions, contact Ms. Dana Durham, Chief, Contract Compliance Section, at (916) 449-5043 or [CAPMonitoring@dhcs.ca.gov](mailto:CAPMonitoring@dhcs.ca.gov).

Sincerely,

*Original Signed by Dana Durham*

Dana Durham, Chief  
Contract Compliance Section  
Managed Care Quality and Monitoring Division

Encl.

cc: Jonathan Prince, Contract Manager  
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MEDICAL REVIEW –ONTARIO SECTION  
AUDITS AND INVESTIGATIONS  
DEPARTMENT OF HEALTH CARE SERVICES

**SANTA CLARA FAMILY  
HEALTH PLAN**

Contract Number: 04-35398

Audit Period: January 1, 2013  
Through  
December 31, 2013

Report Issued: September 11, 2014

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## I. INTRODUCTION

Santa Clara Family Health Plan (SCFHP or the Plan) is a local, public, not-for-profit health plan dedicated to improving the health and well-being of the residents of Santa Clara County. SCFHP has been contracted by the State of California Department of Health Care Services (DHCS) since 1997 under the provisions of Welfare and Institutions (W&I) Code, Section 14087.3. SCFHP is a 2-Plan Model which received approval from the State to begin operations, and enrollment commenced as the Local Initiative for Santa Clara County on February 1, 1997.

SCFHP, based in Campbell, is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since 1996. SCFHP is not a National Committee on Quality Assurance (NCQA) accredited health plan.

SCFHP encompasses six separate networks: Kaiser, Palo Alto Medical Foundation, Physicians Medical Group of San Jose / Excel MSO, Premier Care of Northern California / Conifer Health, Valley Health Plan, and Direct Network / Independent Physicians directly contracted.

The stated mission of SCFHP is to provide high quality, comprehensive health care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price. This is accomplished by working in partnership with select providers, acting as a bridge between the health care system and those who need coverage.

As of December 31, 2013, SCFHP's enrollment for Healthy Families, Medi-Cal, Healthy Kids, and Healthy Workers was approximately 153,190. Enrollment by lines of business was as follows:

- Healthy Families: 1
- Medi-Cal: 147,232
- Healthy Kids: 5,440
- Healthy Workers: 517 (program ended 12/31/2013)

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of January 1, 2013 through December 31, 2013. The on-site review was conducted from March 3, 2014 through March 14, 2014. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

An exit conference was held with the Plan on August 12, 2014. The Plan was allowed fifteen calendar days from the date of the exit conference to provide supplemental information addressing the preliminary audit report findings. The due date to submit post exit documents was August 27, 2014. The reviewers evaluated Plan's additional information and the results are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability to Care, Member's Rights, Quality Management (QI), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

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

The Plan's UM Program process for the detection of under-utilization did not meet the contract requirements. The review of the UM committee's meeting minutes determined that there was no process in place for tracking and monitoring under-utilization of services.

The Plan did not meet the required time frames for processing requests for both medical and pharmacy Prior Authorizations (PA). Additionally, verification study showed PAs have insufficient documentation and follow-up by the Plan to ensure proper decision for denials.

SCFHP's tracking system for decisions on PA denials and subsequent overturn of denials, were inaccurate. These overturned denials were not recorded on the PA tracking sheet. The denials were kept in another file by the medical consultant and were made available only when requested during the review.

For the delegation of UM, please refer to Department of Managed Health Care's (DMHC) Seniors and Persons with Disability (SPD) report.

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

The Plan was not able to track all its new Members and was not able to monitor all the services delivered within the Plan's network. The records reviewed for complex case management did not have documented care plans.

The Plan did not meet the required quarterly meetings with California Children Services (CCS). According to the CCS MOU meeting minutes received from the Plan, there were only two meetings that took place for the year 2013.

The Plan was not fully involved in the coordination of care between the PCPs and the regional center / Early Start Program and did not consistently have referrals. The Plan was also unable to identify all children with developmental disabilities in need of services from the regional center.

SCFHP did not ensure the provision of an Initial Health Assessment (IHA) for its new Members within the sixty and one hundred twenty calendar days following the date of enrollment with the health plan. Review of medical records showed immunizations were either missing or incomplete on some records. Dental screening was also not consistently included in the IHA.

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

The Plan did not monitor waiting times in the providers' offices. SCFHP did not monitor their delegated network health plan in providing timely medical appointments.

The Plan was not in compliance with the after-hours access standards for a licensed medical professional to return a Member's telephone call within thirty minutes.

The Plan did not monitor their delegated network health plan in providing medically necessary specialists' services within their network to accommodate the need for specialty care.

SCFHP did not forward misdirected claims to the appropriate capitated provider within ten working days of receipt of the claim. The Plan did not pay claims received later than six months following the date of service for either contract or non-contract providers during the audit year **(this is a repeat finding from the 2007 DHCS audit)**.

### **Category 4 – Member's Rights**

Identified grievances are classified as clinical or administrative by non-clinical staff. There was insufficient oversight by clinical personnel to ensure proper stratification of all incoming inquiries and grievances.

The Plan did not ensure that Members receive translated written materials in their identified threshold language as required by the Contract.

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

The Plan did not meet the quorum requirement and the representation of key members of the Quality Improvement Committee (QIC).

The Plan and its delegated entities did not have updated knowledge of the current Medical S&I list for suspended or ineligible providers.

The Plan did not ensure that a complete medical record is maintained for each Member. Record information that were missing included member identification on every page, individual personal biographical information, emergency contact, assigned PCP, allergies, problem and medication lists.

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

The Plan did not meet the requirement for a full time medical director position pursuant to Title 22, CCR, section 53857.

SCFHP did not ensure that all new providers receive training within ten working days after the Plan had placed a newly contracted provider on active status. The Plan was unable to provide any documentation that the training was performed by their delegated entities or that the required attendees were present.

### **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 March 3, 2014 through March 14, 2014. 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: 40 medical and 23 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Notification of Prior Authorization Denial, Deferral, or Modification: 63 denial and modification letters were reviewed for written notification requirements.

Appeal Procedures: 24 prior authorization appeals were reviewed for appropriate and timely adjudication.

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

CCS: 28 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Early Intervention Services and Developmental Disabilities (EI/DD) including pediatric files: 31 medical records were reviewed for evidence of coordination of care among the Plan, Early Start Program and regional centers.

IHA: 91 medical records were reviewed for completeness and timely completion.

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

Emergency Service Claims: 35 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 35 family planning claims were reviewed for appropriate and timely adjudication.

#### **Category 4 – Member’s Rights**

Grievance Procedures: 57 inquiries and 20 non-medical grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

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

Medical Records:

91 medical records were comprehensively reviewed for compliance with requirements. 35 medical records were reviewed for compliance with informed consent requirements.

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

New Provider Training: 30 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

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

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: January 1, 2013 – December 31, 2013

DATE OF AUDIT: March 3 – 14, 2014

### 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

**Under- and Over-Utilization:**

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:**

The Plan is required to include mechanisms within the UM program to detect under- and over-utilization of services. SCFHP's UM activities are developed, implemented and conducted by the UM Department under the direction of the director of Quality Management (QM) and the Chief Medical Officer (CMO) with the daily functions overseen by the UM Registered Nurse (RN) manager.

During the review of SCFHP's UM program it was verified that there are established criteria for approving, modifying, deferring, or denying requested services. Over-utilization of services was monitored by tracking bed days and re-admissions. However, a review of the Plan's UM program and the meeting minutes determined there was no process in place for tracking and monitoring under-utilization of services.

#### **RECOMMENDATIONS:**

- Develop and implement mechanisms to systematically detect under-utilization.
- Take action on the results of tracking and monitoring done and ensure it is documented.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: January 1, 2013 – December 31, 2013

DATE OF AUDIT: March 3 – 14, 2014

1.2

### PRIOR AUTHORIZATION REVIEW REQUIREMENTS

#### **Prior Authorization and Review Procedures:**

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements...(as required by Contract)

2-Plan Contract A.5.2.A, B, D, F, H, and I.

#### **Exceptions to Prior Authorization:**

Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

2-Plan Contract A.5.2.G

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:**

SCFHP has a policy for the Prior Authorization (PA) of procedures and pharmacy services as explained in the Plan's policy UM039\_02 Review Standards, Criteria and Guidelines, UM001\_06 Member Notification Regarding Medical Service Determination, UM001\_06 Member Notification Regarding Medical Services Determination and finally policy UM002\_08 Prior Authorization for Non-delegated SCFHP Members Specialty Program. The Plan used Medi-Cal Provider Manual guidelines, Milliman Care Guidelines, National Specialty board guidelines and consultants and Pharmacy Formulary guidelines to determine and process PAs. Pharmacy Department personnel under the direct supervision of the Pharmacy Director authorized, modified or denied pharmacy PAs with the guidance, if necessary of the CMO. Medical PAs that required medical necessity determination were reviewed by the appropriate medical personnel.

The Contract requires (2-Plan Contract A.5.3 F and G) 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 PA) 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. Pharmaceuticals: 24 hours on all drugs that require prior authorization in accordance with W&I Code section 14185 or any future amendments thereto. However, decisions for routine PAs (medical and pharmacy) were not made within the required contract timeframes. A verification study on deferred PAs were out of compliance with the contract delineated timeframes for decision making of twenty-eight days. Pharmacy PAs were not in compliance with the contract 24-hour decision timeframe requirements on four of twenty-three PAs reviewed.

The Contract requires (2-Plan Contract A.5.2.C and D) a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, updated, and reasons for decisions are clearly documented. However, eleven of thirty-five PAs showed insufficient documentation to support the medical necessity and insufficient follow-up by the Plan to ensure proper decision for denial.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: January 1, 2013 – December 31, 2013

DATE OF AUDIT: March 3 – 14, 2014

### **RECOMMENDATIONS:**

- Ensure that reasons for medical decisions are clearly documented and written criteria/guidelines for utilization review are consistently applied.
- Process medical and pharmacy PAs according to the time frames in the contract.

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

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: January 1, 2013 – December 31, 2013

DATE OF AUDIT: March 3 – 14, 2014

**1.3**

**REFERRAL TRACKING SYSTEM**

**Referral Tracking System:**

Contractor is responsible to ensure that the UM program includes: ... An established specialty referral system to

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**SUMMARY OF FINDINGS:**

The Contract requires (2-Plan Contract A.5.1.G) integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. The contract also requires (2-Plan Contract A.5.2.D) reasons for decisions are clearly documented.

SCFHP has a tracking system for PAs however; the system is inaccurate for denied decisions. The Plan has a file for all PA documents. During the review of denials, inconsistencies were found regarding denial decisions and subsequent overturn of denials. These overturned denials were in another file kept by the medical consultant, which were made available only when requested during the review and not recorded on the PA tracking sheet.

**RECOMMENDATION:**

Ensure integration of all documented reports relating to overturned denied PA decisions.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: January 1, 2013 – December 31, 2013

DATE OF AUDIT: March 3 – 14, 2014

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

2.1

#### CASE MANAGEMENT AND COORDINATION OF CARE: WITHIN AND OUT-OF-PLAN

##### **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.

2-Plan Contract A.11.1

##### **Out-of-Plan Case Management and Coordination of Services:**

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out of plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services...

2-Plan Contract A.11.5

#### **SUMMARY OF FINDINGS:**

The Plan is required to 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. However, review of medical records verified the Plan was not able to track all its new Members and was not able to monitor all the services delivered within the Plan's network.

Complex Case Management Services are provided by the PCP, in collaboration with the Contractor, and shall include, at a minimum: Basic Case Management Services, Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team, Intense coordination of resources to ensure member regains optimal health or improved functionality, With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually. However, the records reviewed for complex case management did not have documented care plans.

#### **RECOMMENDATIONS:**

- Ensure that the Plan is able to track and monitor all its new Members and all services delivered within the Plan's network.
- Take action on the results of tracking and monitoring done and ensure it is documented.
- Ensure coordination of care and care plans are documented.

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

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: January 1, 2013 – December 31, 2013

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**2.2**

**CALIFORNIA CHILDREN'S SERVICES (CCS)**

**California Children's Services (CCS):**

Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program....(as required by Contract)

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program...for the coordination of CCS services to Members.

2-Plan Contract A.11.9.A, B

**SUMMARY OF FINDINGS:**

The Plan and CCS have a Memorandum of Understanding (MOU) in place as is required in the Plan's contract. Attachment A, Exhibit 1 to Master Agreement, MOU, on page 2, item number 5, under column heading, "SCFHP will meet with CCS Director and liaison on a quarterly basis (or more frequently) to review case(s) for status and transition needs to mainstream managed care." However, according to the CCS MOU meeting minutes received from the Plan, there were only two meetings that took place for the year 2013, dated September 9, 2013 and November 4, 2013.

**RECOMMENDATION:**

Ensure meetings with the Plan and CCS are held at least quarterly as required by the contract.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

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2.3

### EARLY INTERVENTION SERVICES/DEVELOPMENTAL DISABILITIES

#### **Services for Persons with Developmental Disabilities:**

Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers...for the coordination of services for Members with developmental disabilities.

2-Plan Contract A.11.10.A, C, E

#### **Early Intervention Services:**

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program....Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

2-Plan Contract A.11.11

### **SUMMARY OF FINDINGS:**

SCFHP had policies and procedures for identification, assessment, case management and coordination of care for Members with special health care needs and persons with Developmental Disabilities (DD).

The review of medical records indicated that some had no documentation of either a referral or coordination of care and services between the Plan, the PCPs, and the Early Start Program. There was a medical record, not part of the SCFHP EI/DD Member List but included in the SCFHP CCS Tracking List, that showed that the member has diagnoses of "Attention Deficit Disorder with Hyperactivity (314.01)", "Hyperkinesia with Developmental Delay (314.1)", and "Unspecified Delay in Development (315.9)". However, there was nothing in the medical record to show that the member has been referred by the PCP to or been seen by the Early Start Program during the audit period.

### **RECOMMENDATIONS:**

- Ensure documentation of identification, case management and coordination of care for all Members with special health care needs and persons with DD among the Plan, PCP and the regional center.
- Ensure the Plan follows their established policies and procedures.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

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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 60 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

### **SUMMARY OF FINDINGS:**

SCFHP has a policy QM006 that clarifies the contractual requirement for provision of the IHA services. Basic case management services are provided by the PCP in collaboration with the Plan and shall include IHA.

Medical record review established that the Plan did not ensure the provision of an IHA (comprehensive history and physical examination) for its new Members were completed within the sixty and one hundred twenty calendar days following the date of enrollment with the health plan.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

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The Contract requires (2-Plan Contract A.10.5.C and 6.C) timely provision of vaccines in accordance with the most current California immunization recommendations. Immunization must be provided according to the current schedule of the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Family Physicians (AAFP), as provided in "Recommended Childhood and Adults Immunization Schedule." However, review of medical records showed immunizations were either missing or incomplete on seventy six of ninety one records.

Dental services are not covered under this Contract (2-Plan Contract A.11.15). However, contractor shall cover and ensure that dental screenings for all Members are included as a part of the initial health assessment. The review of medical records also revealed that dental screening was not consistently included in the IHA by the Plan.

### **RECOMMENDATIONS:**

- Ensure all IHAs are completed within the required time frames pursuant to regulatory and contractual requirements.
- Ensure timely provisions of adult and pediatric vaccinations based on current CA immunization recommendations.
- Ensure coverage of dental screenings for all Members as part of IHA.
- Ensure the Plan follows their established policies and procedures.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: January 1, 2013 – December 31, 2013

DATE OF AUDIT: March 3 – 14, 2014

### CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

#### APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

**Appointment Procedures:**

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

2-PlanContract A.9.3.A

**Prenatal Care:**

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

2-Plan Contract A.9.3.B

**Monitoring of Waiting Times:**

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments...

2-Plan Contract A.9.3.C

#### **SUMMARY OF FINDINGS:**

The Plan's policies (QM001\_05, Policy PS001-09, Policy PS005\_04) describe the accessibility standards for routine, urgent care, specialty and emergency care appointments and services. These standards are communicated to the providers during the new provider orientation, during quarterly meetings with the providers and via the Physician and Medical Services Operating Manual. In addition, the Member Evidence of Coverage (EOC) guide reiterates these standards to inform Members about such services and appointments.

The Plan's policies state that accessibility standards are monitored through the Plan's Provider Services Department (PSD). PSD reviews and assesses the results of the plan's monitoring and performance reporting activities to determine compliance with the plan's standards in accordance with contractual, regulatory and accrediting agencies' requirements and reports the findings to the QIC.

The Plan did not monitor waiting times in the providers' offices to ensure that providers are meeting the Plan's access standards. SCFHP staff stated that the Plan did not monitor waiting times in the providers' offices in 2013.

From interviews with providers in category 2.1 (Coordination of Care-Within and out of Network), the Plan did not monitor their delegated network health plan in providing timely medical appointments.

#### **RECOMMENDATIONS:**

- Ensure monitoring of waiting times in the providers' offices.
- Continue monitoring procedures to ensure that their delegated network health plan is providing timely medical appointments.
- Ensure the Plan follows their established policies and procedures.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: January 1, 2013 – December 31, 2013

DATE OF AUDIT: March 3 – 14, 2014

3.3

### TELEPHONE PROCEDURES / AFTER HOURS CALLS

#### Telephone Procedures:

Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

2-PlanContract A.9.3.D

Contractor shall maintain the capability to provide Member services to Medi-Cal Members or potential members through sufficient assigned and knowledgeable staff

2-Plan A.13.2.A

#### After Hours Calls:

At a minimum, Contractor shall ensure that a physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls.

2-PlanContract A.9.3.E

### **SUMMARY OF FINDINGS:**

The Plan has policies and procedures (QM001\_05, PS027, MS-11-01, MS-12-02) that describe accessibility standards for telephone and after-hours calls. These standards are communicated to the providers during the new provider orientation, during quarterly meetings with the providers and via the Physician and Medical Services Operating Manual. In addition, the Member EOC guide reiterates these standards to inform Members about such services. The Plan also provides access to twenty-four hour telephone interpreter services and sign language to assist members for medical/triage telephone calls.

The Plan has a contract with an outside vendor (CareNet) to provide timely and appropriate twenty-four hour nurse advice coverage for SCFHP Members. The Plan conducted a survey of PCP and specialty providers in October 2013 to evaluate after-hours access to services by a licensed medical professional and the ability to return a Member's telephone call within thirty minutes of the request for access. The survey results showed that the Plan was not in compliance with the after-hours access standards.

### **RECOMMENDATION:**

Ensure compliance with the after hours access standard to return a Member's telephone call within thirty minutes.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: January 1, 2013 – December 31, 2013

DATE OF AUDIT: March 3 – 14, 2014

3.4

### SPECIALISTS AND SPECIALTY SERVICES

#### **Specialists and Specialty Services:**

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with Title 22 CCR Section 53853(a) and W & I Code Section 14182(c)(2) 2-Plan Contract A.6.6

Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined Medically Necessary. 2-Plan Contract A.9.3.F

#### **SUMMARY OF FINDINGS:**

The Plan has policies and procedures (QM001\_05, PS001-09, MS-11-01, PS016\_02, UM006\_01) that describe accessibility standards for specialists and specialty services appointments. These standards are communicated to the providers during the new provider orientation, during quarterly meetings with the providers and via the Physician and Medical Services Operating Manual. In addition, the Member EOC guide reiterates these standards to inform Members about such services and appointments.

The Plan shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition. In addition, the Plan shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care. However, from interviews with providers in section 2.1 (Coordination of Care-Within and out of Network), the Plan did not monitor their delegated network health plan in providing the timely medical appointments and medically necessary specialists' services within their network to accommodate the need for specialty care. Provider representatives interviewed stated that their Members have to wait from four-six months or more for specialty appointments and specialty services.

#### **RECOMMENDATION:**

Ensure Members receive timely access to specialists and specialty services within and/or outside the network.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: January 1, 2013 – December 31, 2013

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3.5

### EMERGENCY SERVICE PROVIDERS (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

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

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

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:**

SCFHP policy (CL001\_04) states that it will send misdirected claims to the capitated entities within ten working days of receipt by SCFHP. Based on verification study, claims were not forwarded within ten working days. It was also verified through interview that SCFHP did not forward misdirected claims to the appropriate capitated provider within ten working days of receipt of the claim. Pursuant to CCR, Title 28, section 1300.71 (b) (2) (A) states, "For a provider claim involving emergency service and care, the plan shall forward the claim to the appropriate capitated provider within ten (10) working days of receipt of the claim that was incorrectly sent to the plan".

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

AUDIT PERIOD: January 1, 2013 – December 31, 2013

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SCFHP policy (CL029) states that there is a ninety days billing time limit for contracted providers and one hundred eighty days billing time limit for non-contracted providers. Based on verification study, five claim lines were denied due to claims submitted beyond the billing time limit. It was also verified through interview that SCFHP did not pay claims received later than six months following the date of service for either contract or non-contract providers during the audit year. Pursuant to W&I Code, section 14115, it allows a pro rata payment after six months to one year. **This is a repeat finding from the 2007 DHCS audit.**

### **RECOMMENDATIONS:**

- Ensure misdirected emergency service claims and written notices are sent to subcontractors within ten working days.
- Ensure emergency service claims received later than 6 months following the date of service are paid in accordance with W&I Code, section 14115 which allows a pro rata payment after six months to one year.
- Revise policy CL029 to comply with W&I Code, section 14115 on pro rata payment after six months to one year.
- Ensure the Plan follows their established policies and procedures.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

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DATE OF AUDIT: March 3 – 14, 2014

3.6

### FAMILY PLANNING (PAYMENTS)

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:**

SCFHP policy (CL001\_04) states that it will send misdirected claims to the capitated entities within ten working days of receipt by SCFHP. Based on verification study, five claims were not forwarded within ten working days. It was also verified through interview that SCFHP did not forward misdirected claims to the appropriate capitated provider within ten working days of receipt of the claim. Pursuant to CCR, Title 28, section 1300.71 (b) (2) (B) (2) states, "A plan is required to forward claims to the appropriate capitated provider within ten working days of receipt of the claim that was incorrectly sent to the plan".

SCFHP policy (CL029) states that there is a ninety days billing time limit for contracted providers and one hundred-eighty days billing time limit for non-contracted providers. Based on verification study, four claim lines were denied due to claims submitted beyond the billing time limit. It was also verified through interview that SCFHP did not pay claims received later than six months following the date of service for either contract or non-contract providers during the audit year. In accordance with W&I Code, section 14115, it allows a pro rata payment after six months to one year. **This is a repeat finding from the 2007 DHCS audit.**

#### **RECOMMENDATIONS:**

- Ensure misdirected family planning claims and written notices are sent to subcontractors within ten working days.
- Ensure family planning claims received later than 6 months following the date of service are paid in accordance with W&I Code, section 14115 which allows a pro rata payment after six months to one year.
- Revise policy CL029 to ensure compliance with W&I Code, section 14115 on pro rata payment after six months to one year.
- Ensure the Plan follows their established policies and procedures.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

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### CATEGORY 4 – MEMBER’S RIGHTS

4.1

#### GRIEVANCE SYSTEM

##### **Member Grievance System and Oversight:**

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

2-Plan Contract A.14.1

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

2-Plan Contract A.14.2

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

2-Plan Contract A.14.3.A

#### **SUMMARY OF FINDINGS:**

The Plan receives inquiries/grievances from members who call the customer support center. Inquiries and grievances are forwarded to Member Service Representative (MSR), who documents information in the health plan’s system. MSR classifies the inquiry and grievance according to the type of issue (i.e. access, coverage, pharmacy, quality of care, etc). The initial intake process of inquiries/grievances did not include clinical staff review to ensure appropriate classification. Grievance identified as non-clinical was sent to the Compliance Officer (CO) for review. Grievance identified as clinical was also sent to the CO, and then to the CMO for a second review. During the interview with the Plan, it was confirmed that MSR employees have no clinical background.

The Plan under-reported grievances because inquiries/grievances that were resolved within twenty-four hours were categorized as exempt and were not tracked. There were no audits of inquiries conducted to detect if these were true inquiries or were grievances. Identified grievances are classified as clinical or administrative by non-clinical staff. There was insufficient oversight by clinical personnel to ensure proper stratification of all incoming inquiries and grievances.

#### **RECOMMENDATIONS:**

- Ensure inquiries/grievances are properly classified by clinical personnel so potential quality of care issues is not missed.
- Ensure all grievances are tracked.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

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4.2

### CULTURAL AND LINGUISTIC SERVICES

#### **Cultural and Linguistic Program:**

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the group needs assessment requirements...

2-Plan Contract A.9.13

Contractor will assess, identify and track the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical).

2-Plan Contract A.9.13.B

Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program.

2-Plan Contract A.9.13.F

#### **Linguistic Services:**

Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, 45 C.F.R. Part 80) that prohibits recipients of Federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

2-Plan Contract A.9.12

Contractor shall comply with Title 22 CCR Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact...either through interpreters, telephone language services, or any electronic options...

2-Plan Contract A.9.14.A

#### **Types of Linguistic Services:**

Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential Members:

- 1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those that speak the threshold or concentration standards languages.
- 2) Fully translated written informing materials...
- 3) Referrals to culturally and linguistically appropriate community service programs.
- 4) Telecommunications Device for the Deaf (TDD).

2-Plan Contract A.9.14.B

#### **Key Points of Contact Include:**

- 1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care providers including pharmacists.
- 2) Non-medical care setting: Member services, orientations, and appointment scheduling.

2-Plan Contract A.9.14.D

### **SUMMARY OF FINDINGS:**

The Contract requires (2-Plan Contract A.14.3.B.2) submission of quarterly grievance report for Medi-Cal Members. The following additional information should be included on each grievance: timeliness of responding to the Member, geographic region, ethnicity, gender, primary language of the Member, and final outcome of the grievance.

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

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The Plan translates the health education and member informing materials into 2 threshold languages: Spanish, and Vietnamese. The Contract requires that “Contractor shall ensure equal access to health care services for limited English proficient Medi-Cal Members or potential members through provision of high quality interpreter and linguistic services.”

For grievance cases reviewed related to interpreting services, the resolution letters written in English were sent the same day the grievances closed. However, the resolution letters written in Spanish were sent four months to one year after the grievances were closed.

**RECOMMENDATION:**

Ensure that Members receive fully translated written materials in their identified threshold language as required by the Contract.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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### CATEGORY 5 – QUALITY MANAGEMENT

5.1

#### QUALITY IMPROVEMENT SYSTEM

##### **General Requirements:**

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

2-Plan Contract A.4.1

#### **SUMMARY OF FINDINGS:**

The Contract requires (2-Plan Contract A.4.4.A) to maintain a QIC which shall be facilitated by the medical director or a physician designee. Contractor must ensure that subcontractors actively participate on the committee or medical sub-committee that reports to the QIC.

In accordance with the Quality Improvement Program (QIP) 2013 Policy, the QIC oversees the development, implementation and effectiveness of the QIP and is accountable to the Santa Clara County Health Authority. The QIC shall consist of at least 8 voting members to include the chairs of Credentialing, Pharmacy and Therapeutics (PT), UM and Provider Advisory Council (PAC), and a designated representative from a major subcontractor. Other members include PCPs and specialists. Quorum is defined as 50% plus 1 voting members. Meetings are held on a quarterly basis or more as required to conduct business.

The QIC composition and meeting minutes were reviewed. The composition as documented by the roster is incomplete. Missing representation from the UM department were verified by the absence of signatures on the attendance sign in sheet for the quarterly QIC meetings.

#### **RECOMMENDATIONS:**

- Ensure that the Plan meets the quorum requirement and the representation of key members of the QIC.
- Ensure the Plan follows their established policies and procedures.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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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

#### **Provider Participation:**

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

#### **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:**

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 FINDINGS:**

The Contract requires (2-Plan Contract E.2.26.B.5) the Plan to have knowledge of any providers on the Suspended and Ineligible (S&I) list. 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. A list of S&I providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (<http://www.medi-cal.ca.gov>) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (<http://oig.hhs.gov>).

During the interview it was revealed that the Plan and its delegated entities review the S&I provider list biannually or when a provider was up for re-credentialing.

### **RECOMMENDATION:**

Ensure that the Plan and its delegated entities have updated knowledge of the current Medi-Cal S&I list for suspended or ineligible providers.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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### 5.5

### MEDICAL RECORDS

#### Medical Records

##### A. General Requirement

Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR, section 53861 and MMCD Policy Letter 02-02.

##### B. Medical Records

Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:

- 1) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.
- 2) To ensure that medical records are protected and confidential in accordance with all Federal and State law.
- 3) For the release of information and obtaining consent for treatment.
- 4) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

##### C. On-Site Medical Records

Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

##### D. Member Medical Record

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes:

- 1) Member identification on each page; personal/biographical data in the record.
- 2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
- 3) All entries dated and author identified; for Member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
- 4) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.
- 5) Allergies and adverse reactions are prominently noted in the record.
- 6) All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.
- 7) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.
- 8) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
- 9) For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.
- 10) Health education behavioral assessment and referrals to health education services.

2-Plan Contract A.4.13.A, B, C, D

### **SUMMARY OF FINDINGS:**

The Plan is required to ensure that appropriate medical records for each Member are available at each encounter. SCFHP has guidelines/standards for patient medical records taken from their Physician and Medical Service Operating Manual, DHCS facility site review criteria, the National Committee for Quality Assurance and Adult and Pediatric Preventative Health Guidelines. The Plan is required to develop, implement and maintain written

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Santa Clara Family Health Plan

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procedures pertaining to any form of medical records and to ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care including ancillary services.

Verification studies on ninety-one medical records revealed that minimum requirements were not met in the medical record documentation. Record information that were missing included member identification on every page, individual personal biographical information, emergency contact, assigned PCP, allergies, problem and medication lists to name a few. In addition, entries were not consistently dated, legibly signed and author identified by title. Errors on paper medical records were not corrected according to legal medical documentation standards. Missed appointments were not followed up on a regular basis.

Records did not consistently show preventive health screenings. Adult and pediatric immunizations and procedures were missing. Age and gender appropriate health screenings such as cholesterol level, mammogram, pap smear, tuberculosis risk factors and chlamydia screening were not documented. Chronic and ongoing problems were not always addressed on subsequent visits by the PCP.

### **RECOMMENDATIONS:**

- Ensure that a complete medical record is maintained for each Member.
- Develop and implement a monitoring system to ensure that medical records are consistently completed and maintained.
- Take action on the results of tracking and monitoring done and ensure it is documented.
- Ensure the Plan follows their established policies and procedures.

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**CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY**

**6.1**

**MEDICAL DIRECTOR**

**Medical Director:**

Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:

- A. Ensuring that medical decisions are:
  - 1) Rendered by qualified medical personnel.
  - 2) Are not influenced by fiscal or administrative management considerations.
- B. Ensuring that the medical care provided meets the standards for acceptable medical care.
- C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
- D. Developing and implementing medical policy.
- E. Resolving grievances related to medical quality of care.
- F. Direct involvement in the implementation of Quality Improvement activities.
- G. Actively participating in the functioning of the plan grievance procedures.

2-Plan Contract A.1.6

**SUMMARY OF FINDINGS:**

The Contract requires (2-Plan Contract A.1.6) a full time California licensed physician as medical director. During the interview with the CMO, it was revealed that the medical director only served on a part-time basis. The Plan is not in compliance with the required full time medical director.

**RECOMMENDATION:**

Ensure that the Plan meets the requirement for a full time medical director position pursuant to Title 22, CCR, section 53857.

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

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**6.4**

**PROVIDER TRAINING**

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**SUMMARY OF FINDINGS:**

The Contract requires (2-Plan Contract A.7.5) training for all providers within ten working days after the Plan places a newly contracted provider on active status.

The Plan tracks New Provider Orientation (NPO) training using a new provider list. Verification study of newly contracted providers revealed that the Plan was not in compliance with the required new provider orientation within ten working days after being placed on active status. It was also noted that the Plan could not provide any documentation that the delegated entities performed the trainings within the required ten days.

**RECOMMENDATION:**

Ensure that all new providers receive training within ten working days after the Plan places a newly contracted provider on active status.

MEDICAL REVIEW - ONTARIO SECTION  
AUDITS AND INVESTIGATIONS  
DEPARTMENT OF HEALTH CARE SERVICES

**SANTA CLARA FAMILY  
HEALTH PLAN**

Contract Number: 03-75802  
State Supported Services

Audit Period: January 1, 2013  
Through  
December 31, 2013

Report Issued: September 11, 2014

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## INTRODUCTION

Santa Clara Family Health Plan (SCFHP or the Plan) has been contracted by the State of California Department of Health Care Services (DHCS) since 1997 under the provisions of Welfare and Institutions (W&I) Code, section 14087.3. SCFHP is a 2-Plan Model which received approval from the State to begin operations and enrollment commenced as the Local Initiative for Santa Clara County on February 1, 1997. DHCS entered into Contract 03-75802 with SCFHP for State Supported Services in addition to services in Contract 04-35398.

SCFHP, based in Campbell, is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since 1996. SCFHP is not a National Committee on Quality Assurance (NCQA) accredited health plan.

SCFHP encompasses six separate networks: Kaiser, Palo Alto Medical Foundation, Physicians Medical Group of San Jose / Excel MSO, Premier Care of Northern California / Conifer Health, Valley Health Plan, and Direct Network / Independent Physicians directly contracted.

The stated mission of SCFHP is to provide high quality, comprehensive health care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price. This is accomplished by working in partnership with select providers, acting as a bridge between the health care system and those who need coverage.

This audit report presents the findings of the contract compliance of SCFHP and its implementation of the State Supported Services contract with the State of California. The State Supported Services contract covers abortion services for SCFHP.

The onsite audit was conducted from March 3, 2014 through March 14, 2014. The audit period is from January 1, 2013 through December 31, 2013 and consisted of document review of materials supplied by the Plan and an interview conducted onsite.

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

PLAN: **Santa Clara Family Health Plan**

AUDIT PERIOD: January 1, 2013 – December 31, 2013

DATE OF AUDIT: March 3-14, 2014

**STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS**

**Abortion**

*Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:  
Current Procedural Coding System Codes\*: 59840 through 59857  
HCFA Common Procedure Coding System Codes\*: X1516, X1518, X7724, X7726, Z0336*

*\*These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.  
State Supported Services Contract Exhibit A.1*

**SUMMARY OF FINDINGS:**

Santa Clara Family Health Plan (SCFHP) policy CL025 covers abortion as a physician service regardless of the gestational age of the fetus. Medical justification and prior authorization for abortion is not required. If the Plan does not have contracted providers who perform abortions, the Plan will arrange and pay for abortions from a non-contracted provider. The Plan also holds its sub-contractors accountable for ensuring that Medi-Cal policy on abortion is honored.

SCFHP policy CM036\_04 Sensitive Services states, "While primary care physicians (PCPs) are encouraged to refer members to Family Health Plan providers for family planning services, a member is not required to obtain prior authorization from a PCP before seeking such services. Members may obtain family planning services from any qualified family planning provider inside or outside the SCFHP network, without obtaining prior authorization."

Based on the Evidence of Coverage (EOC) on the Plan's website, SCFHP covers abortions that do not require Inpatient Hospitalizations when receive from any qualified provider. The Provider Manual informs providers of these services.

**RECOMMENDATION:**

None