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

REPORT ON THE MEDICAL AUDIT OF

SANTA CLARA COUNTY HEALTH AUTHORITY
dba SANTA CLARA FAMILY HEALTH PLAN

2023

Contract Number:	04-35398
Audit Period:	March 1, 2022 Through February 28, 2023
Dates of Audit:	March 27, 2023 Through April 6, 2023
Report Issued:	September 6, 2023

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I. INTRODUCTION

In 1995, the Santa Clara County Board of Supervisors established the Santa Clara County Health Authority (SCCHA) under the authority granted by Welfare and Institutions Code section 14087.36. The SCCHA distinct from the County was given the mission to develop a community-based health plan, Santa Clara Family Health Plan (Plan), to provide coverage to Medi-Cal Managed Care recipients.

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

The Plan delivers services to members through delegated groups and vendors. The Plan partners with over 4,400 providers which include primary care providers (seven delegate groups), specialists, hospitals (including all hospitals in Santa Clara County), pharmacies, long term service supports and allied providers.

As of February 2023, the Plan had 329,602 members of which 318,944 were Medi-Cal members and 10,658 were Cal Medi-Connect members.

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

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of March 1, 2022 through February 28, 2023. The audit was conducted from March 27, 2023 through April 6, 2023. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on August 8, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On August 23, 2023, 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 three categories of performance: Utilization Management, Access and Availability of Care, and Quality Management.

The prior DHCS medical audit for the period of March 1, 2021 through February 28, 2022 was issued on January 18, 2023. This audit examined the Plan's compliance with its DHCS Contract and assessed implementation of prior year's Corrective Action Plan (CAP).

The summary of the findings by category follows:

Category 1 – Utilization Management

No findings were noted during the audit period.

Category 3 – Access and Availability of Care

No findings were noted during the audit period.

Category 5 – Quality Management

The Plan is required to monitor, evaluate, and take effective action to address any needed improvements in the Quality of Care (QOC) delivered by its providers. The Plan did not evaluate Potential Quality Issues (PQIs) and did not take effective action to address needed improvements for PQIs.

The Plan is required to implement and maintain policies that specify the responsibilities of the governing body, including routinely written progress reports from the Quality Improvement Committee (QIC) describing actions taken, progress in meeting Quality Improvement System (QIS) objectives, and improvements made, on a scheduled basis. The Plan's QIC did not report findings of PQI processing issues to the governing board for further actions and improvements.

The Plan is required to implement and maintain a system for provider review of QIS findings that demonstrates physician and professional involvement. The Plan did not demonstrate provider involvement in the review of PQI cases.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from March 27, 2023 through April 6, 2023. The audit included a review of the Plan's Contract with DHCS, its policies and procedures for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Service Requests: A total of 50 medical services requests were reviewed for timeliness, consistent application of criteria, and appropriate review. Of the 50 cases, 20 were retrospective requests, 26 were prior authorization requests, and four were concurrent review requests.

Category 3 – Access and Availability of Care

Claims: 17 emergency services and 17 family planning claims were reviewed for appropriate and timely adjudication.

Category 5 – Quality Management

PQI: Eight PQI cases were reviewed for appropriate evaluation, investigation, and effective action taken to address improvements and remediation.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Santa Clara Family Health Plan
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CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM

5.1.1 Evaluation of PQI

The Plan is required to implement an effective QIS in accordance with the standards set forth in California Code of Regulations (CCR), Title 28, section 1300.70 and Code of Federal Regulations (CFR), Title 42, section 438.330. The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the QOC delivered by all providers rendering services on its behalf, in any setting. *(Contract, Exhibit A, Attachment 4(1))*

The Plan is required to establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees that must include at least the following basic elements: performance improvement projects, collection and submission of performance measurement data, mechanisms to detect both under and over utilization of services, and mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. *(CFR, Title 42, section 438.330)*

The Plan's policy, *QI.05, Potential Quality of Care Issues, v1* (approved 06/06/2018), and standard operating procedure, *QI.05.01, Potential Quality of Care Issues*, outlined the Plan's steps in processing PQI cases. It stated that the Plan must maintain a systematic process for identifying, reporting, investigating, resolving, and trending PQI to ensure that services provided to members meet established professional QOC standards and that opportunities to improve QOC are identified and actively pursued. The Plan established the timeframe of 90 calendar days unless a CAP is still in effect. The final determination of the severity level is assigned by the Chief Medical Officer or Medical Director based upon the case review as follows:

- Level 0 – Not our member, or not our provider, or not a covered benefit. No further investigation.
- Level 1 – No QOC issue identified. Investigation complete.
- Level 1A – No QOC issue identified. E.g., Service issue.
- Level 2 – Minor opportunity for improvement in care, or system identified – no adverse outcome.

- Level 3 – Opportunity for improvement in care, or system identified – adverse outcome.
- Level 4 – Unacceptable care – immediate jeopardy.

Finding: The Plan did not evaluate PQIs and did not take effective actions to address needed improvements.

In a verification study, documentation in three PQI cases revealed that the Plan did not conduct thorough investigations as part of its evaluation, nor did it perform effective follow up actions to address quality issues.

- In one case regarding a member's assertion of incorrect determination of qualification for hospice services, the Plan did not implement its policies for severity stratification by assigning a severity level of zero despite a history of non-reported falls. Records noted that the Plan was the secondary payer since the member had "other primary health insurance coverage". Although the Plan is responsible for ensuring QOC in the provision of covered Medi-Cal services, there is no documentation that the Plan conducted further investigation for this case.
- In a second case, the Plan appropriately assigned a severity level of three for a PQI involving a member with two fall incidents. The Plan reported the case to DHCS and requested for the Skilled Nursing Facility's (SNF) CAP to aid in its investigation of the case. However, documentation revealed that the Plan did not perform any tracking and monitoring of the PQI resolution process. Furthermore, it did not persist in repeated attempts to request for the SNF CAP, nor did it conduct further investigation of the case. Ultimately, there is no record of the Plan performing corrective actions to address the QOC issue identified.
- In a third case, the Plan appropriately assigned a severity level of three for a PQI involving a member who developed a catheter based urinary tract infection during a hospital stay. A delay of six months occurred prior to the Plan's review of this PQI case. Following the review, the Medical Director recommended the following: obtain policies and procedure, develop and send a CAP to the facility, and obtain proof of Provider Preventable Conditions (PPC) reporting to DHCS. Documentation revealed that the Plan did not perform any tracking and monitoring of the PQI resolution process. No CAP was issued to the facility and no further review and follow-up was conducted by the Plan to close the PQI case.

The Plan's standard operating procedure, *QI.05.05, Quality of Care Review Oversight*, (undated and unsigned), outlined the process for the Plan's management of grievances related to medical QOC issues. It stated that all QOC issues are investigated by the Grievance & Appeals Clinical Specialist(s) and all issues identified as a QOC issue are

investigated by the Quality Improvement (QI) nurse(s) and regularly presented to the Plan's Medical Director(s).

During the interview, the Plan confirmed the delay in processing PQI cases was due to a shortage in staffing. Furthermore, the Plan stated PPC's were reported to DHCS, but were not investigated. Reviews of the PQI samples illustrate that the Plan did not fully close its investigations relating to PQI cases.

When the Plan does not conduct investigations or track PQI resolutions, this can lead to inadequate evaluations and failure to perform effective corrective action may result in member harm.

Recommendation: Revise and implement policies and procedures to ensure the Plan investigates and evaluates all PQIs identified to determine if actions are needed to address QOC issues.

5.1.2 Reporting of PQI to Governing Board

The Plan is required to implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following: (A) Approves the overall QIS and the annual report of the QIS, (B) Appoints an accountable entity or entities within Plan's organization to provide oversight of the QIS, (C) Routinely receives written progress reports from the QIC describing actions taken, progress in meeting QIS objectives, and improvements made, (D) Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.
(Contract, Exhibit A, Attachment 4(3)(A-D)

The Plan is required to implement and maintain a QIC designated by, and accountable to the governing body. The activities, findings, recommendations, and actions of the committee is required to be reported to the governing body in writing on a scheduled basis.
(Contract, Exhibit A, Attachment 4(4))

Reports to the governing body shall be sufficiently detailed to include findings and actions taken as a result of the Quality Assurance (QA) program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic QOC issues.
(CCR, Title 28, section 1300.70(b)(2)(C))

The Plan's, *QI Program Description* and its *QI Charter,* stated the governing board must routinely receive reports from the QIC describing actions taken, progress in meeting

quality objectives and improvements made. The board then makes recommendations regarding additional interventions and actions to be taken when objectives are not met. The scope of the QI Program includes the monitoring, evaluation, and driving improvements for key areas, including but not limited to PQI.

Finding: The Plan's QIC did not report actions taken and improvements made for PQI processing issues to the governing board.

The verification study and QIC reports illustrated data that showed significantly high rates of delayed closure of PQI investigation cases. Review of the monthly QIC meeting minutes and quarterly Governing Board meeting minutes and packets, demonstrated that the Plan did not analyze the data and report the significant findings to the governing board for corrective actions. QIC minutes focused on the late closure rates of PQI's; however, the Plan did not document any interventions to improve the processing of PQI cases.

The Plan's policy, *QI.05.01, Potential Quality of Care Issues* (undated and unsigned), stated the QIC reviews reports of all PQI quarterly. The QI Department is responsible for any follow-ups and/or corrective actions recommended by QIC. PQI with level 2 and above are also reported to the appropriate network.

During the interview, the Plan acknowledged that it identified a problem with the PQI system where PQI investigations were significantly delayed, leading to prolonged processing times and closure of cases, beyond the targeted timeframes. However, the Plan stated that it did not perform an analysis of the PQI data any further than compiling it but did have discussions in their weekly team meetings. However, further discussions were not documented in any of the QIC meetings or reports.

The Plan acknowledged that PQI issues were not presented to the governing board and stated it could improve upon its process by performing a more thorough analysis to "close the loop" on significant issues for QI, as well as make its governing board aware of significant areas of concern that may require corrective action or improvement.

When the Plan does not analyze and report significant QI system issues to the governing board this may cause PQI to go unresolved, leading to poor patient care and harm.

Recommendation: Develop and implement policies and procedures to identify, report, correct, and improve QIS issues.

5.1.3 Provider Involvement of PQI cases

The Plan is required to implement and maintain a description of the system for provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.
(Contract Exhibit A, Attachment 4 (7)(D))

Finding: The Plan did not demonstrate provider involvement in the review of PQI cases.

The verification study revealed that in two PQI cases, the Plan's contracted providers, including hospitals and facilities did not respond to requests for records. Furthermore, the providers did not respond to Plan's CAP when PQI were identified.

The Plan's standard operating procedure, *QI.05.01, Potential Quality of Care Issues*, (unsigned and undated), delineated the Plan's clinical review process when QI Coordinator makes outreach for medical records. If the deadline for medical records or supporting documentation is missed, the QI Department and CMO/Medical Director have the right to resolve the case without the benefit of medical records or provider recommendation. This includes closing the case at a Level II; opportunity for improvement. Additionally, tracking and trending of these cases will be performed every six months. If a provider is found not sending medical records for three or more cases in a 6-month period, then a CAP will be sent. If no response is received within 30 days of the initial CAP date, QI nurse conducts two follow-up telephone call with provider.

Further, if no response is received within 45 days, then the CMO/Medical Director and designee reviews the case, the provider's response or lack of response and determines any further action to be taken. Actions include but are not limited to the following:
(a) Accept the CAP, (b) Call the provider to discuss the CAP, (c) Forward the case to the QIC for review and any further recommendation(s), (d) Dismissal from the network.

Further review of the Plan's PQI tracking and trending log identified cases where the Plan and contracted providers were non-compliant with requests for documentation and did not provide CAP responses so that PQI cases could be completed.

During interviews, the Plan acknowledged that they had significant difficulty obtaining documentation, records, and CAP responses from its providers, particularly, its hospitals and facilities, in efforts to complete PQI Investigations. The PQI cases were closed despite the lack of response from the contracted providers without the necessary additional information.

When the Plan does not perform effective oversight of its contracted provider involvement in PQI investigations, it may lead to potential unresolved issues and adversely affect patient care.

Recommendation: Develop and implement policies and procedures to ensure Plan's involvement and oversight in the contracted providers' review of PQI processes.

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2023

Contract Number:	03-75802 State Supported Services
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I. INTRODUCTION

This report presents the results of the audit of Santa Clara Family Health Plan's (Plan) compliance and implementation of the State Supported Services contract with the State of California. The Contract covers abortion services provided by the Plan.

The audit was conducted from March 27, 2023 through April 6, 2023. The audit covered the audit period from March 1, 2022 through February 28, 2023. It consisted of document reviews and interviews with the Plan's staff.

An Exit Conference with the Plan was held on August 8, 2023. There were no deficiencies found for the audit period of the Plan's State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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STATE SUPPORTED SERVICES

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology Codes 59840 through 59857 and Health Care Financing Administration Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. *(State Supported Services Contract, Exhibit A, (1))*

Plan Policy, *CL.22 v5, Processing of Abortion Claims* (Approved 07/28/22), stated that members may go to any provider of their choice for abortion services, at any time for any reason, regardless of network affiliation. Contracted provider shall be paid in accordance with their applicable contract while non-contract providers are paid for covered services at not less than 100 percent of the Medi-Cal Fee For Service rates.

Plan's procedure, *CL.22.01 v4*, *Processing of Abortion Claims Procedure* (Revised 1/22/21), further stated that medical justification and prior authorization for abortion is not required.

The Plan's Medi-Cal Member Handbook (Evidence of Coverage) informed members they may choose any doctor or clinic for outpatient abortion services and do not require prior authorization. The doctor or clinic does not have to be a part of the Plan's network. Members can go to any provider without a referral or prior authorization for services.

The verification study revealed the Plan appropriately processed abortion claims for payment and did not demonstrate any deficiencies related to State Supported Services.

Based on the review of the Plan's documents, there were no deficiencies noted for the audit period.

Recommendation: None.