MEDICAL REVIEW – SOUTH SECTION V
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Santa Clara Family Health Plan

Contract Number: 04-35398

Audit Period: March 1, 2019
Through
February 29, 2020

Report Issued: August 18, 2020

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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 has a network of 29 delegated groups and several vendors.

As of March 1, 2020, the Plan had 241,830 members of which 233,229 (96.4 percent) were Medi-Cal members and 8,601 (3.6 percent) Cal Medi-Connect members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of March 1, 2019 through February 29, 2020. The onsite review was conducted from March 9, 2020 through March 20, 2020. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on July 21, 2020. 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 July 5, 2020 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 audits evaluated five performance categories: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights and Quality Improvement (QI)/Quality Management.

The prior DHCS medical audit for the period of April 1, 2018 through February 28, 2019 was issued on July 11, 2019. This audit examined the Plan's compliance with its DHCS contract. Documents submitted to DHCS in response to the prior year audit's Corrective Action Plan (CAP) were reviewed.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 includes procedures and requirements for the delegation of UM, and mental health and substance abuse.

The Plan is responsible for the quality of all covered services regardless of the number of delegates and sub-delegates between the Plan and the provider. This includes the continuous monitoring and evaluation of the delegated functions. The Plan did not monitor its delegates and sub-delegated entities' UM activities.

The Plan is required to use a Medi-Cal-approved clinical screening and assessment tool, which is mutually agreed upon with the county Mental Health Plan (MHP). The Plan did not develop or implement policies and procedures that include the All Plan Letter (APL) 17-018 requirements to use a Medi-Cal approved clinical assessment tool to screen for mental health services either by the Plan or MHP. In addition, a mutually agreed upon clinical assessment tool was not identified in the Memorandum of Understanding (MOU) between the Plan and MHP.

Category 2 – Case Management and Coordination of Care

Category 2 includes procedures and requirements for Initial Health Assessment (IHA), Behavioral Health Treatment (BHT), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).

The Plan is required to cover and ensure the provision of a comprehensive IHA to each new member within 120 days of enrollment. In addition, the Plan is required to make reasonable attempts to contact a member to schedule an IHA. Documented attempts that demonstrate the Plan's unsuccessful efforts to contact a member and schedule an IHA is required to be considered evidence in meeting the IHA requirement. The Plan's medical records and documentation did not meet the contractual requirements for completion of a comprehensive IHA within the required timeframe.

The Plan is required to provide medically necessary BHT services for members under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits. The member's approved behavioral treatment plan must meet the 11 criteria outlined in APL 19-014. The Plan did not update its BHT program policy to include the 11 behavioral treatment plan criteria and did not have desktop procedures for providers.

The Plan is required to cover and pay for all medically necessary NEMT and NMT covered services for members. The Plan did not ensure that members received transportation services in a timely manner.

The Plan is required to ensure its NEMT providers are enrolled in the Medi-Cal Program. The Plan did not ensure that three NEMT providers in its network were enrolled in the Medi-Cal Program.

Category 3 – Access and Availability of Care

No findings were noted for the audit period.

Category 4 – Member's Rights

No findings were noted for the audit period.

Category 5 – Quality Management

No findings were noted for the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Medical Review Branch 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 on-site audit of the Plan from March 9, 2020 through March 20, 2020. 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. DHCS reviewed the Plan's documents and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 56 prior authorization (47 routine medical and nine pharmacy prior authorizations) requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to providers and members.

Prior authorization appeal procedures: 44 appeals relating to both medical and pharmacy services were reviewed for appropriateness and timeliness of decision making.

Category 2 – Case Management and Coordination of Care

Coordination of care and IHA requirements: 23 medical records were reviewed to confirm coordination of care and fulfillment of IHA/Individual Health Education Behavior Assessment (IHEBA) requirements.

Complex case management: Five medical records were reviewed to evaluate the performance of services.

BHT: Ten medical records were reviewed for coordination, completeness, and compliance with BHT provision requirements.

NEMT: 24 records were reviewed to confirm compliance with NEMT requirements.

NMT: 12 records were reviewed to confirm compliance with NMT requirements.

NEMT and NMT grievance: 15 records were reviewed for response to complainant and submission to the appropriate level of review.

Continuity of care: Ten medical records were reviewed to evaluate the performance of services.

Category 3 – Access and Availability of Care

Emergency services and family planning claims: 15 emergency service claims and ten family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance procedures: 74 grievances (50 quality of care, 12 quality of service, seven exempt and five expedited) were reviewed for timely resolutions, response to complainants, appropriate level of review and medical decision-making.

Confidentiality rights: 18 Health Insurance Portability and Accountability Act cases were reviewed for proper reporting of all suspected and actual breaches to the appropriate DHCS individuals within the required timeframe for processing.

Category 5 – Quality Management

New provider training: Six newly contracted providers were reviewed for timely Medi-Cal Managed Care Program training.

Potential quality of care issues: 16 cases were reviewed for reporting, investigation, 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 (SCFHP)
AUDIT PERIOD: March 1, 2019 through February 29, 2020 **DATE OF AUDIT:** March 9, 2020 through March 20, 2020

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM REFERRAL TRACKING SYSTEM / DELEGATION OF UM MEDICAL DIRECTOR AND MEDICAL DECISIONS

1.1.1 Oversight of Delegated and Sub-Delegated Entities

The Plan may delegate UM activities. If the Plan delegates these activities, the Plan shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of QI Activities. *(Contract, Exhibit A, Attachment 5)*

The Plan is required to be accountable for the quality of all covered services regardless of the number of layers between the Plan and the provider. This includes the continuous monitoring and evaluation of the delegated functions. The Plan is accountable for all QI functions and responsibilities (e.g. UM) that are delegated to subcontractors. If the Plan delegates QI functions, the Plan and delegated entity (subcontractor) shall, at a minimum, include in their subcontract the Plan's oversight, monitoring, evaluation processes, and subcontractor's agreement to such processes. Additionally, the Plan shall maintain a system to ensure accountability for delegated QI activities that, at a minimum:

- Ensures subcontractor meets standards set forth by the Plan and DHCS.
- Includes the continuous monitoring, evaluation, and approval of the delegated functions**.** *(Contract, Exhibit A, Attachment 4)*

The Plan shall comply with Code of Federal Regulations (CFR), Title 42, section 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control). *(Contract, Exhibit A, Attachment 1)*

Disclosure from any provider or disclosing entity is due within 35 days after any change in ownership of the disclosing entity. *(CFR, Title 42, section 455.104)*

Finding: The Plan did not conduct delegation oversight that includes continuous monitoring and evaluation. The Plan did not conduct annual audits of its delegates and oversight of the delegates subcontracts with sub-delegates to ensure that sub-delegates met Contract requirements for ownership disclosure.

Plan policies and procedures describe processes for oversight, continuous monitoring, and evaluation of delegates.

- Plan Policy *DE.01 Delegation Oversight* (April 28, 2016) establishes that the Delegation Oversight Department is responsible for initiating, monitoring,

reporting, auditing, and documenting processes related to internal and external delegation oversight. The Plan's Compliance Committee oversees the Delegation Oversight process and the Delegation Oversight Committee. The QI Committee oversees the performance of delegated functions and contracted provider and practitioner partners. The portion of Delegation Oversight specific to the QI program are the reporting submitted by the delegated entities and the functional operational area overseeing CAPs.

- Plan Policy *DE.06 Delegation Audit* (April 28, 2016) required the Plan to conduct an audit at least annually, and more frequently for substandard findings, or if performance indicates concerns. The annual audit is based on established criteria to review and score policies and procedures, file reviews, and administrative capacities.

The Delegation Agreements between the Plan and its delegates stated that the Plan will conduct annual audits to evaluate performance of delegated functions.

The Plan did not adhere to its policies and Delegation Agreements that require an annual audit of its delegates. Review of documents submitted revealed that the Plan did not conduct an annual audit of its delegates. In addition, there were no procedures to conduct oversight of the delegate's Delegation Agreement with sub-delegates. As a result, the Plan was unable to provide supporting documents related to changes in ownership and management of the sub-delegate of its delegated entity during the audit period.

In an interview, the Plan stated that it did not conduct annual audits of entities delegated to perform UM activities. The Plan explained that it experienced changes in key departments responsible for delegation oversight:

- The Plan's Chief Compliance and Regulatory Affairs Officer, in charge of the Compliance Department, resigned and the Plan did not hire staff to fill this vacant position.
- The Delegation Oversight Department Manager resigned.
- The Plan stated that the Delegation Oversight Committee disbanded temporarily and reconvened on April 2019.

Lack of appropriate oversight and monitoring of delegates could have adverse effects on the delivery of appropriate medical services to members.

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Recommendation: Implement policies and procedures to ensure that delegation oversight includes continuous monitoring and evaluation. Develop and implement procedures to conduct oversight of the delegate's Delegation Agreements with sub-delegates to ensure ownership disclosure requirements are met.

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1.4	MENTAL HEALTH AND SUBSTANCE ABUSE

1.4.1 Mental Health Screening and Assessment Tool

The Plan is required to cover outpatient mental health services that are within the scope of practice of primary care physicians. The Plan shall establish and maintain mechanisms to identify members who require non-covered psychiatric services and ensure appropriate referrals are made. (*Contract, Exhibit A, Attachment 10)*

APL 13-018 Memorandum of Understanding (MOU) Requirements for Medi-Cal Managed Care Plans states that the Plan and MHP must execute an MOU that shall address policies and procedures for management of the beneficiary's care, including, but not limited to, the following: screening assessment and referrals, medical necessity determination, care coordination, and exchange of medical information. The Plan and MHP shall develop and agree to written policies and procedures that include screening and assessment tools for use in determining if the Plan or MHP will provide mental health services.

APL 17-018 Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services states that each Plan is obligated to ensure that network Primary Care Providers (PCPs) conduct a mental health screening of beneficiaries. PCPs must use a Medi-Cal approved clinical assessment tool or set of tools mutually agreed upon and identified in the MOU between the Plan and the MHP.

The Plan developed Plan *Policy QI.24, Outpatient Mental Health Services: Mental Health Parity* (June 3, 2019) to address APL 17-018 requirements. However, this policy does not include the requirements for the Plan to use a Medi-Cal approved clinical assessment tool or set of tools to screen and determine whether mental health services should be provided by the Plan or MHP.

Finding: The Plan did not develop or implement policies and procedures that include the APL 17-018 requirements to use a Medi-Cal approved clinical assessment tool to screen if mental health services should be provided by the Plan or MHP. A mutually agreed upon clinical assessment tool was not identified in the MOU between the Plan and county MHP.

The Plan and the county MHP executed a *Master Service Agreement* (MSA), (January 1, 2014) requiring the development of written policies and procedures that include screening and assessment tools for use in determining mental health services. The MSA did not identify a Medi-Cal approved clinical assessment tool or set of tools in accordance with MOU requirements delineated in APL 17-018.

In an interview, the Plan stated that its in-network PCPs and mental health providers referred members to and relied on the MHP to conduct screenings for mental health services. The Plan also stated that the MHP is responsible for mental health services; therefore, the Plan did not see the need to include the requirement of a screening tool in their policies and procedures. On the other hand, APL 17-018 requires that the Plan's network PCPs must conduct mental health screening of beneficiaries using a Medi-Cal approved clinical assessment tool or sets of tools (mutually agreed upon by the Plan and MHP) to be included in policies and procedures as well as identified in the MOU between the Plan and the county MHP.

The use of clinical tools to assess the beneficiary's mental health disorder or level of impairment is integral to making appropriate referrals. Inadequate screening can lead to a delay or inadequate mental health treatment and services.

Recommendation: Develop and implement policies and procedures that ensure PCPs use a Medi-Cal approved clinical assessment tool in determining mental health services. Include and identify this screening tool in the MOU between the Plan and MHP.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	BASIC CASE MANAGEMENT CALIFORNIA CHILDREN'S SERVICES (CCS) EARLY INTERVENTION / DEVELOPMENTAL DISABILITIES INITIAL HEALTH ASSESSMENT

2.1.1 Completion of Initial Health Assessment

The Plan is required to cover and ensure the provision of an IHA to each new member within 120 days of enrollment. An IHA consists of a history and physical examination and an Individual Health Education Behavior Assessment (IHEBA), also called Staying Healthy Assessment (SHA), using an age appropriate DHCS approved assessment tool. *(Contract, Exhibit A, Attachment 10)*

The Plan is required to ensure that a member's completed IHA and IHEBA tools are contained in the member's medical record. *(Contract, Exhibit A, Attachment 10)*

The Plan is required to make reasonable attempts to contact a member to schedule an IHA. The Plan's unsuccessful attempts to contact a member to schedule an IHA will be considered evidence in meeting the IHA requirement.
(Contract, Exhibit A, Attachment 10)

Finding: The Plan did not meet contractual requirements to complete a comprehensive IHA within the required timeframe.

In a verification study, 11 of 23 medical records lacked documentation of IHA completion within 120 days of enrollment with the Plan.

- Medical records did not contain IHA-required elements of a comprehensive history and physical examination that includes an IHEBA.

- Although the Plan's unsuccessful efforts to contact a member for IHA scheduling is considered evidence that meets the IHA requirement, medical records did not document outreach efforts by PCPs to schedule an IHA.

Plan Procedure *QI.10.01*, *Initial Health Assessment Validation* (March 9, 2017), describes the Plan's methodology to validate IHA completion. From the Plan's universe of completed IHAs, each quarter the Plan conducts a random selection of ten members from five providers to validate IHA completion. To ascertain that medical records reflect a timely and comprehensive IHA, the Plan reviews the members' medical records

associated with encounter dates of office visit codes recorded in the Plan's universe of completed IHAs. The Plan validates its IHA assessment methodology annually.

During the interview, the Plan stated that the methodology captured "false positives", which meant that the office visit codes used by providers did not necessarily reflect completion of IHA. The Plan acknowledged that the monitoring system for IHA completion was not accurate.

Plan Procedure *QI.10.02, Initial Health Assessment and Staying Healthy Assessment* (November 5, 2018) was updated as a response to the prior year audit. The Plan's procedure was amended to include a CAP for non-compliant providers, e.g., no documentation of unsuccessful outreach attempts to schedule an IHA, failure to provide medical records, substandard scoring on IHA and IHEBA/SHA audits for two consecutive quarters, and not completing the IHA within 120 days.

The Plan's dashboard demonstrated that in 2019 only 46.2 percent had IHAs completed within the required 120 days. Although quarterly IHA audits were conducted, the Plan denied that CAPs were issued to non-compliant providers. The Plan did not follow the updated procedure.

Members may experience missed or delayed diagnosis and treatment of health conditions due to non-timely and non-comprehensive IHAs.

This is a repeat finding from prior year's audit 2.1.1 Lack of Initial Health Assessment Completion by Primary Care Provider.

Recommendation: Implement procedures to ensure timely completion of a comprehensive IHA.

2.3	BEHAVIORAL HEALTH TREATMENT

2.3.1 Early and Periodic Screening, Diagnosis and Treatment Requirements for Behavioral Health Treatment Services

The Plan is required to cover and ensure that members under the age of 21 receive screening, preventive and medically necessary diagnostic and treatment services including EPSDT supplemental services. The Plan is required to ensure that these services are initiated as soon as possible. *(Contract, Exhibit A, Attachment 10)*

In addition, the Plan has agreed to any provisions of the Contract, which is in conflict with current or future applicable federal or state laws or regulations to be amended to conform to the provisions of those laws and regulations and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. *(Contract, Exhibit E, Attachment 2)*

APL 19-014, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 (November 12, 2019, Supersedes APL 18-006), provides guidance to Managed Care Plans about the provision of medically necessary BHT services for members under the EPSDT benefit. BHT services must be provided, observed, and directed under an approved behavioral treatment plan. The behavioral treatment plan must meet the following 11 criteria:

1. Description of patient information, reason for referral, brief background information, clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.

2. Delineate both the frequency of baseline behaviors and the treatment plan to address the behaviors.

3. Identify measurable long-, intermediate-, and short-term goals and objectives.

4. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.

5. Member’s current level of need including baseline behavior, introduction, and estimated date of mastery.

6. Utilize evidence-based BHT services tailored to the member.

7. Identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual provider who is responsible for delivering services.

8. Include care coordination that involves the parents or caregiver(s), school, state disability programs, and other programs and institutions, as applicable.

9. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.

10. Deliver BHT services in a home or community-based setting, including clinics.

11. Include an exit plan/criteria.

Finding: The Plan did not ensure that the approved behavioral treatment plan met the 11 criteria required in accordance with APL 19-014 or previous 18-006.

The Plan's policy did not include the criteria to ensure that providers met the requirements when developing behavioral treatment plans for members. The Plan did not have a desktop procedure listing the treatment plan criteria.

As a corrective action to the prior year's audit deficiency (2.3.1 Policy and Program Description did not reflect APLs 15-025 and 18-006 EPSDT Requirements), the Plan revised policy *Q1.17 Behavioral Health Care Coordination* (June 12, 2019) to reflect changes in APL 18-006 (supersedes APL 15-025). The revised policy did not include the 11 criteria needed for behavioral treatment plans in accordance with APL 19-014 (supersedes APL 18-006).

Meeting minutes of Applied Behavioral Analysis (ABA) workgroup, dated December 5, 2019 indicated that the providers were informed to use the criteria in the APL when submitting behavioral treatment plans to the Plan. Criteria #5, 7, 9 and 10 were addressed as common issues/concerns that were found in treatment plans that the Plan receives from ABA providers. The Plan found the treatment plans deficient in those areas when reviewed against the criteria specified in the APL.

Members may experience substandard behavioral health outcomes if Plan policies and procedures lack guidance in requiring a behavioral treatment plan that is person-centered and based on individualized, measurable goals and objectives over a specific timeline for the specific member being treated.

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Recommendation: Revise and implement policies and procedures to include behavioral treatment plan requirements and criteria changes listed in the most updated APL 19-014.

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2.4	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICALTRANSPORTATION

2.4.1 Timely Access to NEMT and NMT Services

The Plan is required to cover and pay for all medically necessary covered services for the member, including NEMT services, as provided for in CCR, Title 22, section 51323 (Medical Transportation Services), required by member to access Medi-Cal covered services. *(Contract, Exhibit A, Attachment 10)*

APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services, states that Medi-Cal Managed Care Plans (MCPs) are responsible for ensuring their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including APLs. In addition, Medi-Cal MCPs must timely communicate these requirements to all delegated entities and subcontractors in order to ensure compliance.

In addition, APL states that the Plans are contractually required to meet timely access standards. The Plans that have a Knox-Keene license are also required to meet the timely access standards contained in CCR, Title 28, section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the Plans from complying with their timely access standard obligations.

APL 17-004, Subcontractual Relationships and Delegation, states that Plans must have in place policies and procedures for imposing corrective action and financial sanctions on subcontractors upon discovery of non-compliance with the subcontract or other delegated entity.

Finding: The Plan did not ensure that members received transportation services in a timely manner.

Plan's procedure *CS.14.01, Non-Medical Transportation* (March 21, 2019), *Section on Reporting and Monitoring,* states that on a daily basis, the Plan's Transportation Specialists and Customer Service Supervisor monitor the requests and coordinate transportation to ensure timely access standard of transportation is met. In addition, the staff will track and report any trends to other operations teams, workgroups, committees, and regulators when needed.

In a verification study to determine the Plan's compliance with contractual and APL requirements for NEMT/NMT services, 33 of 51 files revealed that:

1. Fifteen members did not receive services on time due to delay in drop off/pick up by the drivers.
2. Fourteen members were not picked up at all by the drivers and had to reschedule medical appointments with providers.
3. Four members were stranded and had to arrange for the return trip.

During the audit, it was noted that the Plan's monitoring system was ineffective. Plan staff stated during the interview that they identify NEMT/NMT issues and trends through customer service calls, member grievances, fraud, waste, and abuse reports, and joint operations committee meeting. However, the NEMT/NMT transportation providers responded to some complaints and ignored some. The Plan did not pursue further to address the issues with NEMT/NMT providers. Therefore, the Plan did not have an effective system to resolve members' transportation issues in a timely manner.

When the Plan provides non-timely NEMT/NMT services it potentially leads to delay in members care and treatment.

Recommendation: Develop and implement procedures for the Plan to take effective follow-up action and address problems for the provision of timely transportation.

2.4.2 Medi-Cal Enrollment of NEMT/NMT Providers

The Plan has agreed to "Any provisions of the Contract, which is in conflict with current or future applicable federal or state laws or regulations to be amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statues or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties."
(*Contract, Exhibit E, Attachment 2)*

APL 19-004, *Provider Credentialing/Re-credentialing and Screening/Enrollment*, (supersedes *APL 17-019),* states that the Final Rule extended the provider screening and enrollment requirements for all network providers. Part One of the APL related to the screening and enrollment requirements, states that MCP network providers that have a state-level enrollment pathway must enroll in the Medi-Cal Program. State-level enrollment pathways are available through either DHCS Provider Enrollment Division or another State Department with a recognized pathway. MCPs have the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirement of the APL. In addition, the Plan may screen and enroll network

providers in a manner that is substantively equivalent to DHCS' provider enrollment process.

Furthermore, the Medi-Cal Managed Care program and MCPs must comply with statewide Medi-Cal Fee-For-Service enrollment standards and federal enrollment standards when verifying enrollment of providers through a state-level enrollment pathway or developing a provider enrollment pathway.

APL 17-004, Subcontractual Relationships and Delegation, states that the Plans are responsible for ensuring that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; Contract requirements; reporting requirements; and other DHCS guidance including, but not limited to APLs. The Plan must have in place policies and procedures to communicate these requirements to all subcontractor and delegated entities.

Finding: The Plan did not ensure that three NEMT providers in its network were screened and enrolled in the Medi-Cal Program in accordance with APL 19-004 requirements.

The Plan does not have policies and procedures requiring NEMT network providers to be screened for Medi-Cal enrollment in accordance with APL requirements.

During the interview with the Plan, the staff stated that all network providers were enrolled in the Medi-Cal Program. However, review of 39 NEMT/NMT files determined that three of the providers who provided NEMT transportation services to members were not enrolled in the Medi-Cal Program during the audit period.

Medi-Cal members may be subjected to substandard transportation services if an NEMT provider does not undergo the screening process to qualify as a Medi-Cal provider.

Recommendation: Develop and implement policies and procedures to ensure that NEMT providers in the Plan's network are screened and enrolled in the Medi-Cal Program.

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

REPORT ON THE MEDICAL AUDIT OF

SANTA CLARA FAMILY HEALTH PLAN

Contract Number:	03-75802 State Supported Services
Audit Period:	March 1, 2019 Through February 29, 2020
Report Issued:	August 18, 2020

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I. INTRODUCTION

This report presents findings 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 contracted with the Plan.

The onsite audit was conducted from March 9, 2020 through March 20, 2020. The audit covered the review period from March 1, 2019 through February 29, 2020. It consisted of document reviews and interviews with Plan staff.

An Exit Conference with the Plan was held on July 21, 2020. There were no deficiencies found for the review period on the Plan's State Supported Services.

✖ COMPLIANCE AUDIT FINDINGS (CAF) ✖

PLAN: Santa Clara Family Health Plan

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STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

The Plan agrees to provide, or arrange to provide, to eligible members the following State Supported Services based on the following codes:

- ð Current Procedural Terminology Coding System: 59840 through 59857
- ð Health Care Finance Administration Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336

(State Supported Service Contract, Exhibit A.1)

Outpatient abortion is a sensitive service covered by the Medi-Cal program without prior authorization. The Plan is required to ensure that members can access these services from in- or out-of-network providers. The Plan provides pregnancy termination procedures through any qualified provider without prior authorization, except for inpatient abortions.
(State Supported Service Contract, Exhibit A.1)

The Plan is responsible to provide members timely access to abortion services. Plans that provide physician services must not require medical justification and/or prior authorization for outpatient abortion services.
(All Plan Letter (APL) 15-020)

The Member Handbook/Evidence of Coverage listed the following family planning services offered to members: pregnancy testing, family planning visits, all Food and Drug Administration approved contraceptive birth control drugs, surgical birth control, outpatient abortion including minors' right to pregnancy termination services and to receive services outside of the health plan's network without referral.

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

The Plan's policy *CL.22.01, Processing of Abortion Claims Procedure* (January 1, 2020) ensures that neither medical justification nor prior authorization for outpatient abortion services is required. Requests for inpatient abortion require prior authorization.

The Plan's claims system maintains a list of procedure and service codes that are automatically exempt from prior authorization.

Review of six claims revealed that the Plan provided the services and processed the claims properly per Contract requirements.

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Based on review of the Plan's policies, member and provider information materials, and staff interviews, no deficiencies were noted for the current audit period. The Plan provided eligible members with the required State Supported Services based on the Contract and APL 15-020 requirements.

Recommendation: None