

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: April 1, 2018  
Through  
February 28, 2019

Report Issued: July 11, 2019

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## I. INTRODUCTION

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

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

The Plan delivers services to members through delegated groups and vendors. The Plan has twenty-eight delegate groups and vendors.

As of March 1, 2019, the Plan had 251,068 members of which 239,836 (95.53%) were Medi-Cal members, 7,884 (3.14%) Cal Medi-Connect members and 3,348 Healthy Kids (1.33%).

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit, for the period of April 1, 2018 through February 28, 2019. The onsite review was conducted from March 18, 2019 through March 29, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on June 13, 2019 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On June 27, 2019 the Plan submitted a response after the exit conference. The results of our evaluation of the Plan's response are reflected in this report.

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

The prior DHCS medical audit for the period of April 1, 2017 through March 31, 2018 was issued on September 11, 2018. The corrective action plan (CAP) closeout letter, was dated December 12, 2018. This audit examined the Plan's compliance with its DHCS contract and assessed implementation of the prior year's CAP.

The summary of the findings by category follows:

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

Category 1 covers procedures and requirements for the Plan's delegation oversight and Utilization Management (UM) prior authorizations review.

The Contract requires the contractor to determine and to monitor a prospective delegate's ability to perform subcontracted services. The Plan must oversee and remain accountable for any delegated functions and responsibilities. However, neither the Plan nor its delegated entity disclosed the latter's subcontracting with a separate entity for claims processing. In addition, the delegated entity failed to disclose an additional three subdelegated entities to the Plan. As such, the Plan did not meet its contractual obligations to Department of Health Care Services (DHCS).

The Plan is required to communicate to the provider by telephone or fax of an adverse benefit determination for a medical service requested on behalf of a covered beneficiary. The Plan failed to notify prescribing physicians of prior authorization decisions due to facsimile failure. The Plan did not have a written procedure or monitoring mechanism in place to ensure timely notifications regarding prior authorization.

The Contract requires the Plan to have “a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.” The Plan did not consistently apply medical necessity criteria for pharmacy prior authorization decisions based on its criteria or guidelines that are supported by clinical principles and processes.

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

Category 2 covers requirements to provide Initial Health Assessment (IHA), complex case management, behavioral health treatment, non-emergency medical transportation and non-medical transportation, and continuity of care.

The Plan is required to maintain procedures for monitoring coordination of members' care, including completion of an initial health assessment (IHA) for each new member within 120 calendar days of enrollment. The Plan shall make reasonable attempts to contact the member and schedule an IHA and all attempts shall be documented. The Plan did not meet the Contract requirements for completion of an IHA for members within 120 calendar days of enrollment due to primary care physicians (PCPs) not documenting their attempts to contact members to schedule an IHA.

According to the Department of Health Care Services (DHCS) Contract, complex case management (CCM) services are provided by the primary care provider, in collaboration with the Plan, and shall include the development of care plans specific to individual needs, with member and PCP input. However, the Plan's PCPs did not participate and did not provide input in the development of member care plans.

The Contract requires the Plan to cover and ensure the provision of screening, preventive and medically necessary diagnostic and treatment services for members under 21 years of age including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services. In addition, the Plan is responsible for the provision of EPSDT services for members under 21 years of age. The Plan did not update its policy and BHT program description to reflect the APL requirements.

According to the Contract, the Plan is required to cover and pay for all medically necessary services for the members, including all non-emergency medical transportation services pursuant to CCR, Title 22, Section 51323. The Plan did not consistently provide members with transportation services in a timely manner or monitor their NEMT and NMT delegates.

The Contract requires the Plan to provide covered services for members with an acute condition, serious chronic condition, pregnancy, terminal illness and care of a newborn child between birth and age 36 months and surgery or other authorized procedures. The Plan's Procedure HS.01.05 Out of Area/Continuity of Care and the provider manual did not reflect the requirement that covered services be provided for the duration of three trimesters in cases of pregnancy.

The Plan is required to provide members with pre-existing provider relationships who make a continuity of care request the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. However, the Plan's desktop resource did not

indicate that members with pre-existing provider relationships could continue to see their current provider. In addition, the plan did not provide any documentation related to continuity of care requests by members with pre-existing provider relationships.

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

No findings were noted for the review period.

### **Category 4 – Member’s Rights**

Category 4 covers grievance system and confidentiality rights.

Federal regulations require that members exhaust the Plan’s appeal process and are issued a Notice of Appeal Resolution (NAR) before they can request a State Fair Hearing.

The Plan incorrectly provided the option of a State Fair Hearing in grievance resolution letters to Medi-Cal members.

The Plan is required to notify DHCS within 72 hours of the discovery of a suspected breach; however, the Plan did not notify DHCS within the required timeframe during the audit period.

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

Category 5 covers new provider training.

The Contract requires the Plan to conduct training for all new providers within 10 working days after the contractor places a newly contracted provider on active status. The Plan’s policies related to New Provider Orientation and Provider Training and Communications did not correctly reflect the 10-working-days contract requirement. In addition, the Plan did not keep records demonstrating that their new providers completed the training.

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

No findings were noted for the review period.

### **III. SCOPE/AUDIT PROCEDURES**

#### **SCOPE**

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

#### **PROCEDURE**

An onsite review was conducted from March 18, 2019 through March 29, 2019. The audit included a review of the Plan's policies and procedures for providing services, as well as 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: 76 routine medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Prior Authorization Appeal Procedures: 47 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 Initial Health Assessment (IHA) requirements: 20 medical records were reviewed to confirm coordination of care and fulfillment of IHA requirements.

California Children's Services (CCS) requirements: Five medical records were reviewed to evaluate coordination of services.

Complex Case Management: Five medical records were reviewed to evaluate the performance of services.

Behavioral Health Treatment (BHT): 10 medical records for behavioral health were reviewed for coordination, completeness, and compliance with BHT provision requirements.

Behavioral Health Treatment grievance: Three medical records for behavioral health were reviewed for response to complainants and submission to the appropriate level of review.

Continuity of Care (COC): 10 medical records were reviewed to confirm the performance of services.

Non-Emergency Medical Transportation (NEMT): 15 claims were reviewed to confirm compliance with Non-Emergency Medical Transportation requirements.

Non-Medical Transportation (NMT): 10 claims were reviewed to confirm compliance with Non-Medical Transportation requirements.

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

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

Appointment availability verification: 24 providers of routine, urgent, specialty and prenatal care from the Plan's directory were reviewed. The first next available appointment was used.

Emergency Services and Family Planning Claims: 16 emergency service claims and 10 family planning claims were reviewed for appropriate and timely adjudication.

### **Category 4 – Member's Rights**

Grievance Procedures: 56 grievances (35 standard, 10 exempt, and 11 expedited) were reviewed for timely resolution, response to complainant, and appropriate level of review and medical decision-making.

Confidentiality Rights: 14 Health Insurance Portability and Accountability Act (HIPAA) 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: 32 Newly contracted providers were reviewed to determine if they received Medi-Cal managed care program training.

Potential Quality of Care Issues: 20 Cases were reviewed for appropriate reporting, investigation and remediation.



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

Fraud and Abuse Reporting: Nine cases were reviewed for proper reporting of all suspected fraud and/or abuse to DHCS within the required timeframes.

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

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

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**CATEGORY 1 – UTILIZATION MANAGEMENT**

**1.1**

**DELEGATION OVERSIGHT**

**Delegated Oversight Activities:**

Contractor may enter into Subcontracts with other entities in order to fulfill the obligation of the Contract. Contractor shall evaluate the prospective subcontractor's ability to perform the subcontracted service, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracted requirements as stated in 42 CFR 438.230(b)(3), (4) and Title 22 CCR Section [53250]".

*2-Plan Contract A.6*

**MMCD All Plan Letter 17-004**

Subcontractor" means an individual or entity that has a subcontract with MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. Regardless of the relationship that the MCP has with a subcontractor, whether direct or indirect through additional layers of contracting or delegation, the MCP has the ultimate responsibility for adhering to, and fully complying with, all terms and conditions of its contract with the DHCS.

The MCPs has ultimately 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. MCPs must have in place policies and procedures to communicate these requirements to all subcontractor and delegated entities."

The MCPs shall alert their Managed Care Operations Davison (MCO) contract manager within three business days upon discovery that a subcontractor is out of compliance with [contract] requirements, and /or if a disclosure reveals any potential violation(s) of the ownership and control requirements.

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### **SUMMARY OF FINDINGS:**

#### **1.1.1 Delegation Oversight**

Pursuant to the Contract, Exhibit A, Attachment 6 states, “Contractor may enter into Subcontracts with other entities in order to fulfill the obligation of the Contract. Contractor shall evaluate the prospective subcontractor’s ability to perform the subcontracted service, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracted requirements as stated in 42 CFR 438.230(b)(3), (4) and Title 22 CCR Section [53250]”.

[2-Plan Contract A.6]

In addition, Contract exhibit E, attachment 2 states, the Plan agrees to “Any provision of the Contract which is in conflict with current or future applicable Federal or State laws or regulations is hereby 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 statutes 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.”

[2-Plan Contract E.2]

Furthermore, the Contract’s section related to Subcontract requirement states, “each Subcontract (as defined in Exhibit E, attachment 1, item 116) shall contain: 2) Specification that the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this Contract; 20) Subcontractor [agrees] to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program.”

[2-Plan Contract A.6.B (2) and (20)]

All Plan Letter 17-004 states, “Subcontractor” means an individual or entity that has a subcontract with the Managed Care Plan (MCP) that relates directly or indirectly to the performance of the MCP’s obligations under the contract with DHCS. Regardless of the relationship that the MCP has with a subcontractor, whether direct or indirect through additional layers of contracting or delegation, the MCP has the ultimate responsibility for adhering to, and fully complying with, all terms and conditions of its contract with the DHCS.”

In addition, APL 17-004 states, “[the Plans] are ultimately 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

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procedures to communicate these requirements to all subcontractor and delegated entities.”

Furthermore, “[the Plan] shall alert their Managed Care Operations Division (MCO) contract manager within three business days upon discovery that a subcontractor is out of compliance with [contract] requirements, and /or if a disclosure reveals any potential violation(s) of the ownership and control requirements.”

The section related to Monitoring Subcontracted and Delegated Functions of APL 17-004 states, “MCPs shall report any significant instances of non-compliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the contract with DHCS to their MCO contract managers within three business days of discovery or imposition.”

Additionally, section related to MCP Delegation and Subcontracting of APL 17-004 states, “If an MCP delegates any activity or obligation to subcontractor, whether directly or indirectly, the subcontract or written agreement shall contain the following:

- Specify any and all delegated activities, obligations, and related reporting responsibilities.
- Include the subcontractor’s agreement to perform the delegated activities and reporting responsibilities.
- Provide for revocation of the delegation of activities or obligations, or specify other remedies where DHCS or the MCP determines the subcontractor is not performing satisfactorily.

Furthermore, the MCP contract requires that subcontractors must agree to comply with all applicable Medicaid laws and regulations as well as applicable State and Federal laws. MCPs maintain the responsibility of ensuring that subcontractors are, and continue to be, in compliance with all applicable Medi-Cal, State and Federal laws, and contractual requirements.”

The contract between the Plan and the delegated entity states, “[delegated entity] shall not delegate the performance of any Delegated Activities to any organization or entity without the prior written consent of [the Plan]. Notwithstanding the preceding, [delegated entity] may delegate to or involve [sub-delegated entity], which perform administrative management on behalf of [delegated entity] in portions of its Delegated Activities so long as [delegated entity] retains ultimate responsibility for the performance of such Activities.”

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During the interview, the Plan's staff disclosed that the Plan has delegated the claims processing function to one of their delegate entities. However, the Plan did not disclose to DHCS that the delegated entity had subcontracted with another entity to perform claims processing. Based on an inquiry with the DHCS Managed Care Operations Division (MCO), the delegated entities list provided could not trace beyond the first line of delegated entities. Once the Plan became aware of this situation, it self-reported to DMHC in concert with Knox-Keene regulatory requirements, but not to DHCS despite contractual obligations to do so.

During the separate interview with the delegated entity staff, it was not disclosed to DHCS that the delegate had subcontracted with yet another entity for claims processing even though the delegate was well aware of its additional layers of contracting relationships. According to the Plan's delegation contract, its delegate is required to obtain written consent from the Plan prior to entering into subcontractual agreements.

Furthermore, review of the post audit documents revealed three additional issues. First, the delegated entity failed to disclose an additional three subdelegated entities to the Plan. This was out of compliance with the contract between the Plan and its delegate.

Second, review of the contract between the delegate and subcontractor mentions HIPAA requirements; however, it does not provide guidance to subcontractor on how to handle and report breaches based on the DHCS Contract requirements, State and Federal regulations, and other DHCS guidance including, but not limited to, APLs.

Lastly, the Plan created an attestation tool to address the above concerns, but it primarily reflects Medicare requirements rather than the Medi-Cal Managed Care Contract and APL directives.

The Plan failed to comply with contract requirements to monitor its delegated entity's subcontracting activities. The Plan did not ensure that their delegate's oversight included a comprehensive review and identification of specific problems.

The Plan's failure to fully monitor its delegate's administrative activities could have adverse effects on service delivery to Plan members. In addition, the Plan's non-disclosure of the delegate entity's contract violation to the Managed Care Operations Division (MCO) was noncompliant with DHCS Contract requirements.

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**RECOMMENDATIONS:**

- 1.1.1 Develop policies and procedures to ensure the Plan's delegate oversight includes comprehensive review and identification of specific items requiring correction when a delegate does not comply with regulatory and contractual requirements. In addition, the Plan shall report to DHCS contract managers any significant instances of non-compliance or corrective action pertaining to their obligation under the Contract.

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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, C, D, F, and I.*

**Exceptions to Prior Authorization:**

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

*2-Plan Contract A.5.2.G*

**Timeframes for Medical Authorization**

Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto.

*2-Plan Contract A.5.3.F*

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

*2-Plan Contract A.5.3.G*

**Denial, Deferral, or Modification of Prior Authorization Requests:**

Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.

*2-Plan Contract A.13.8.A*

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### **SUMMARY OF FINDINGS:**

#### **1.2.1 Written Notification to Providers for Prior Authorization**

Pursuant to the Contract, Exhibit A, Attachment 5, Provision 2 states, “the Plan must notify the requesting provider or Member of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.”

[2-Plan Contract A.5.2]

Title 42 of the Code of Federal Regulations (CFR), Section 438.210 Coverage and authorization of Services states, “Each contract must provide for the Managed Care Organization to notify the requesting provider and give the [member] written notice of any decision to deny a service authorization request, or to authorized a service in an amount, duration, or scope that is less than request.”

California Health & Safety Code, Section 1367.01(h)(3) and (4) states, “Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision... Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated ... to providers initially by telephone or facsimile... and then in writing...”

In addition, All Plan Letter (APL) 17-006 states, “decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing.”

The Plan’s Procedure HS.01.01 Prior Authorization and Organization Decisions Notification to requesting provider section states, “(1) Routine standard decisions are sent to the requesting provider via fax, (2) Expedited and urgent decisions are communicated to the individual or provider submitting the requested service via phone followed by a written notification within 3 calendar days.”

The Plan’s Procedure PH.03.01 Prior Authorization Notification section states, “All decisions shall be communicated to the requesting prescriber by telephone, facsimile, or electronic mail within 24 hours of the decision followed by written notification.”



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The Plan did not consistently notify the provider of a pharmacy prior authorization decision. The verification study disclosed that the Plan failed to notify prescribing physicians in two pharmacy prior authorization samples due to facsimile failure. The Plan acknowledged that for two samples, provider notification did not occur due to unsuccessful facsimile communication. In addition, the Plan failed to implement a quality assurance process in monitoring for unsuccessful provider notification via facsimile communication. An informal procedure existed which the Plan considered reliable but was determined to be ineffective. The Plan did not have a written procedure and monitoring mechanism in place to ensure successful fax transmissions to providers.

Unsuccessful or inefficient transmission of information from the Plan to provider concerning members' prior authorization denials can lead to inadvertent omission of or delay in receipt of medically necessary services and thus result in potentially adverse outcomes.

### **1.2.2 Inconsistent Application of Medical Necessity Criteria for Pharmacy Prior Authorization**

Contract, Exhibit A, Attachment, 5 Utilization Management, 1. Utilization Management Program states, "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."

[2-Plan Contract A.5.1]

Contract, Exhibit A, Attachment, 5 Utilization Management, 2. Pre-Authorizations and Review Procedures, Section C states, "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]

California Health & Safety Code, Section 1367.01(b) states, a health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.

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The Plan's Pharmacy Prior Authorization policy, effective March 15, 2018, Section II.B states, "[the Plan] defines how prior authorization procedures and processes address the adoption of review criteria, application of criteria, and review of consistency of applying the criteria."

The Plan failed to ensure that pharmacy prior authorization decisions are consistent with criteria or guidelines that are supported by clinical principles and processes. In the verification study review, the Plan failed to apply medical necessity criteria consistently in two pharmacy prior authorization denials.

Two root causes contributed to this issue. The Plan's clinician failed to pre-approve formulary drug with prior authorization criteria when evaluating a request for a non-formulary drug of the same therapeutic drug class. In addition, the Plan's quality assurance process (or inter-rater reliability (IRR) reviews) did not adequately address the inconsistencies identified in this audit.

The Plan failed to apply medical necessity criteria consistently in pharmacy prior authorization decisions. This caused an unnecessary delay for the member to get medically necessary drug therapy.

### **RECOMMENDATIONS:**

- 1.2.1 Update and implement procedures to ensure that the Plan meets all contractual requirements and regulatory requirements for timely notification.
- 1.2.2 Provide training to the clinical pharmacists for making pharmacy prior authorization decisions that are consistent with medical necessity criteria. Furthermore, the Plan should develop and implement a more robust quality assurance process for ensuring accurate and consistent application of medical necessity criteria.

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

**2.1**

**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 shall ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

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

*2-Plan Contract A.10.5A and 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,

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**2.1**

**INITIAL HEALTH ASSESSMENT**

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 (IHEBA).

*2-Plan Contract A.10.6.A*

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

*2-Plan Contract A.10.3.D*

**SUMMARY OF FINDINGS:**

**2.1.1 Lack of Initial Health Assessment Completion by Primary Care Provider**

Pursuant to the Contract, the Plan shall cover and ensure the provision of an Initial Health Assessment (IHA) (comprehensive history and physical examination) in conformance with CCR, Title 22, Section 53851 (b)(1) and 53910.5 (a)(1) to each new member within 120 calendar days of enrollment. The Plan shall make reasonable attempts to contact a member to schedule an IHA and all attempts shall be documented. Documented attempts that demonstrate the Plan's unsuccessful efforts to contact the member to schedule an IHA shall be considered evidence in meeting this requirement.

[2-Plan Contract A.10.3.A]

The Plan's Procedure QI.10.01 Initial Health Assessment Validation explains the Plan's IHA identification methodology. In addition, Procedure QI.10.02 Initial Health Assessments and Staying Healthy Assessment addresses how the Plan trains the providers regarding requirements and oversight and monitoring of IHA completion.

The Plan did not meet the contractual requirements of an IHA completion within 120 calendar days of a member's enrollment. The verification study showed that for six members there was no documentation showing that an IHA was completed. The Plan was not aware of this until Department of Health Care Services (DHCS) requested medical records for review.

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A review of the medical records demonstrated that the primary care physicians (PCPs) did not document attempts to contact members to schedule IHA. In addition, the Plan was not aware of its members who did not receive the IHA within 120 days of enrollment.

When the Plan does not ensure provision of an IHA to each new member within 120 calendar days of enrollment, the member may have poor health outcomes related to the lack of diagnosis of health problems leading to delay or nonoccurrence of treatment.

**RECOMMENDATIONS:**

2.1.1 Revise monitoring and oversight process and ensure timely IHA completion.

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**2.2**

**COMPLEX CASE MANAGEMENT**

**Case Management and Coordination of Services:**

Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

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

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

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

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

*2-Plan Contract A.11.1.B and C*

**SUMMARY OF FINDINGS:**

**2.2.1 Lack of Primary Care Physician Participation**

Contract states, "Complex Case Management Services are provided by the primary care provider, in collaboration with the Plan, and shall include...(4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually."

[2-Plan Contract A.11.1.B]

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Plan's Policy QI.13 Comprehensive Case Management (CCM) indicates the structure is organized to promote quality case management, client satisfaction and cost efficiency through the use of collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes for members with multiple or complex conditions.

The Plan's 2018 Comprehensive Case Management Program Description indicates that "[it was] established to provide case management processes and procedures that help members with multiple or complex conditions to obtain access to care and services, and the coordination of the appropriate care and resources".

A review of medical records demonstrated that the primary care providers (PCPs) did not participate in the development of five care plans. According to the Plan, their PCPs do not participate and provide input in the development of care plans. The Plan's case managers develop the care plans with input from members. Once the care plans are completed, the Plan sends a copy to the members and their PCP.

The Plan does not have procedures in place to ensure PCP's participation and input in the development of members' care plans. The Plan's Policy QI.13 and Plan's 2018 Complex Case Management Program Description did not indicate the role of PCP in the development of members' care plans.

Without the PCP input in the development of a member's care plan, not all health conditions of the member may appear in the care plan to guide prioritization of goals and interventions.

**RECOMMENDATIONS:**

- 2.2.1 Revise and implement the Plan's policy and procedure to ensure that the member's PCP participates and provides input in developing care plan for eligible members.

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**2.3**

**BEHAVIORAL HEALTH TREATMENT**

**Services for Members under Twenty-One (21) Years of Age**

Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.

**EPSDT Supplemental Services for Members under 21 years of age**

Contractor shall provide or arrange and pay for EPSDT supplemental services, including case management and supplemental nursing services, as defined in Title 22 CCR Section 51184.

Contractor shall determine the Medical Necessity of EPSDT supplemental services using the criteria established in Title 22 CCR Sections 51340 and 51340.1.

EPSDT supplemental services include targeted case management services designed to assist children in gaining access to necessary medical, social, educational and other services.

*2-Plan Contract A.10.5 and 5(F)*

**All Plan Letters 15-025 and 18-006 Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder**

The MCP is responsible for the provision of EPSDT supplemental services to include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions that develop or restore, to the maximum extent practicable, the functioning of a member with Autism Spectrum Disorder (ASD). The MCP must ensure all children, including children with ASD, receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening exam indicates the need for further evaluation of a child's health, the child must be referred for medically necessary diagnosis and treatment without delay. The MCP is required to:

1. Inform members that EPSDT services are available for members under 21 years of age
2. Provide access to comprehensive screening and prevention services in accordance with the most current Bright Futures periodicity schedule
3. Provide access to comprehensive diagnostic evaluation based upon recommendation of a licensed physician and surgeon or a licensed psychologist for treatment of ASD including all medically necessary services, including but not limited to, BHT services



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**BEHAVIORAL HEALTH TREATMENT**

4. Ensure appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the contract
5. Ensure coverage criteria for BHT are met

For individuals diagnosed with ASD who are under the age of three with a rule out or provisional ASD diagnosis, or those diagnosed with an intellectual disability, the MCP must ensure appropriate referrals are made to the Regional Center and Special Education Local Plan Area (SELPA) for Regional Center services and supports and/or special education services, respectively.

**MCP Approved Treatment Plan – (APL 15-025)**

MCPs must ensure that BHT services are medically necessary and are provided and supervised under an MCP-approved behavioral treatment plan developed by a contracted (or other form of agreement between the MCP and provider) and MCP-credentialed “qualified autism service provider,” as defined by H&S Code Section 1374.73(c)(3) and the MCQMD All Plan Letter 18-006: Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder.

BHT services must be provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific beneficiary being treated and developed by a qualified autism service provider. The behavioral treatment plan must be reviewed, revised and/or modified no less than once every six months by a qualified autism service provider. **(APL 18-006)**

**Continuity of Care (APL 15-025 and 18-006)**

MCPs must ensure continuity of care in accordance with existing contract requirements, All Plan Letter 15-025 and 18-006, 18-008, and Health & Safety Code Section 1373.96 for the provision of BHT services.

**Delegation Oversight (APL 15-025 and 18-006)**

The MCP must ensure that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and DHCS guidance, including APLs, Policy Letters for the provision of BHT services.

**SUMMARY OF FINDINGS:**

**2.3.1 Policy and Program Description do not Reflect APLs 15-025 and 18-006**

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### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements**

The Contract exhibit A, attachment 10(5) states, “The Plan shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services. In addition the Plan shall ensure that appropriate diagnostic and treatment are initiated as soon as possible.” [2-Plan Contract A.10(5)]

All Plan Letter (APL) 15-025 effective February 1, 2016 states “Plan is responsible for the provision of EPSDT services for members under 21 years of age”.

APL18-006 effective July 1, 2018, states “Plan is responsible for the provision of EPSDT services for members under 21 years of age.” In addition, Behavioral Health Treatment (BHT) services must be provided, observed and directed under approved behavioral treatment plan. The approved behavioral treatment plan must meet the the following 13 criteria:

- Be developed by a BHT Service Provider
- Description of the patient referral information
- Person centered individualized care plan with measurable goals and timeline
- Treatment plan to address the behaviors
- Identify measurable long, intermediate and short term goals and objectives
- Include outcome measurement assessment criteria
- Include the current level, date of introduction, estimated date of completion and outcome
- Utilize evidence-based BHT services
- Clearly identify the services with the frequency at which the member’s progress is measured and reported with transition and crisis plan
- Consider the members’ age, school attendance requirements and other activities when determining the number of service hours
- Deliver BHT services in a home or community-based setting, clinics and school if clinically indicated
- Include an exit plan/criteria

Furthermore, The Plan is responsible for providing medically necessary BHT services for all members that meet the eligibility criteria even without a diagnosis of Autism Spectrum Disorder (ASD) based upon medical necessity as determined by a licensed physician and surgeon or a licensed psychologist.

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The Plan's Policy QI.17 Behavioral Health Care Coordination states, "Early Periodic Screening, Diagnostic and Treatment (EPSDT) services for members 0 to 21 years of age which includes medically necessary Behavioral Health Treatment (BHT) services with or without an Autism diagnosis and other evidence based behavioral intervention services that develop or restore functioning..."

The Plan's policy QI.17 Behavioral Health Care Coordination did not list elements of EPSDT requirements for BHT. In addition, the Plan did not update its BHT Program to reflect the APL 18-006 requirements to include BHT.

The Plan was aware of the APL 18-006 requirements; however, the Plan did not update its policy for the BHT program to reflect the current APL guidelines. The Plan acknowledged that they are still working on finalizing the policy and the program.

Delay in timely implementation of the APL 18-006 requirements for BHT may result in members being delayed in receiving care and the Plan being noncompliant with the contract requirements.

**RECOMMENDATIONS:**

- 2.3.1 Update the Plan's policy QI.17 and ensure members receive Behavioral Health Treatment services as required by the APL.

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2.4

**NON-EMERGENCY MEDICAL TRANSPORTATION/  
NON-MEDICAL TRANSPORTATION**

**Non-Emergency Medical Transportation** means ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51323, 51231.1 and 51231.2 rendered by licensed providers.

*2-Plan Contract A11. Exhibit E.1*

The Contractor is required to cover and pay for all Medically Necessary Covered Services for the Member, including all non-emergency medical transportation services, as provided for in Title 22, CCR Section 51323, required by members to access Medi-Cal covered services.

*2-Plan Contract A11.10.8(e)*

The Member Services Guide ... shall include the following information: ...12) Procedures for obtaining any transportation services to Service Sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available.

*2-Plan Contract A11.13.D.12*

**Non-Emergency Medical Transportation Requirements**

NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when it is prescribed in writing by a physician, dentist, or podiatrist. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 1250.

**NEMT Physician Certification Statement Forms**

MCPs (Medi-Cal managed care health plans) and transportation brokers must use DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the

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NON-MEDICAL TRANSPORTATION**

authorization.

*MMCD All Plan Letter 17-010*

**Non-Medical Transportation** means transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.

*2-Plan Contracts E.1 Definitions*

**Non-Medical Transportation Requirements**

NMT has been a covered benefit when provided as an EPSDT service. Effective July 1, 2017, NMT is a Medi-Cal managed care benefit for all members to obtain medically necessary covered services. Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver.

*MMCD All Plan Letter 17-010*

**Non-Medical Transportation Authorization**

MCPs may authorize NMT for each member prior to the member using NMT services. The MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter.

**Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards**

MCPs are contractually required to meet timely access standards (Title 28 CCR Section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)). MCPs that

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**2.4**

**NON-EMERGENCY MEDICAL TRANSPORTATION/  
NON-MEDICAL TRANSPORTATION**

have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.

**Conditions for Non-Medical Transportation Services:**

- MCP may use prior authorization processes for approving NMT services and shall re-authorize services every 12 months when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
- With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- NMT does not cover trips to a non-medical location or for appointments not related to medically necessary covered Medi-Cal benefits.
- For private conveyance, the member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
  - Has no valid driver's license.
  - Has no working vehicle available in the household.
  - Is unable to travel or wait for medical or dental services alone.
  - Has a physical, cognitive, mental, or developmental limitation.

*MMCD All Plan Letter 17-010*

**SUMMARY OF FINDINGS:**

**2.4.1 Lack of Oversight on Transportation Delegates**

Contract Exhibit A, Attachment 10 part 8(e) states, "the Plan is required to cover and

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pay for all Medically Necessary Covered Services for the Member, including all non-emergency medical transportation services, as provided for in Title 22, CCR Section 51323, required by members to access Medi-Cal covered services.”  
[2-Plan Contract A.10.8(e)]

All Plan Letter (APL) 17-010 states, “Managed Care Plans (MCPs) are responsible for ensuring that 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, “MCPs must timely communicate these requirements to all delegated entities and subcontractors in order to ensure compliance.”

CCR, Title 28 Section 1300.67.2.2(c) (1) states, “Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.”

The Plan's Procedure HS.01.08 part (H) states, “[the Plan] monitors compliance such as driver attitude, timelines, riding experience through grievance tracking and the Member Satisfaction process detailed in Member Satisfaction.”

The Plan's Procedure CS.14.01 related to Reporting and Monitoring states, “on a daily basis, the Transportation Specialists and Customer Service Supervisor monitor the requests and coordinate transportation to ensure timely access standard of transportation is met.”

The Plan's Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) delegates did not consistently provide members with transportation services in a timely manner. The verification study disclosed that members did not receive transportation services as scheduled in two cases. In addition, a review of two grievance cases indicated that members missed their appointments because drivers did not show up.

During the interview, the Plan stated that they monitored their delegates through the grievance and customer satisfaction surveys. The Plan relies on their delegates to provide services to their members based on the terms of their written agreement. The Plan acknowledged that their existing monitoring system was not sufficient because they did not address their delegate's non-compliance.

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When the Plan does not monitor their transportation delegates, the delegates will not comply with all applicable federal and state laws and regulations governing NEMT and NMT; as a result, it may affect members' quality of care and service.

**RECOMMENDATIONS:**

- 2.4.1 Develop procedures to effectively monitor transportation delegates and to ensure compliance with all oversight and transportation requirements.



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**2.5**

**CONTINUITY OF CARE**

The Contactor shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96.

*2-Plan Contract A.9.16(B)*

Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with state law and the MCP contract. All MCP members with pre-existing provider relationships who make a continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services that have been receiving through Medi-Cal FFS or through another MCP.

MMCD APL 15-019 and 18-008

**MCP Process**

Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to an MCP for continuity of care. When this occurs, the MCP must begin to process the request within five working days following the receipt of the request. However, the request must be completed in three calendar days if there is risk of harm to the member. The continuity of care process begins when the MCP starts the process to determine if the member has a pre-existing relationship with the provider.

MCPs must accept requests for continuity of care over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, the MCP may take any necessary information from the requestor over the telephone.

MCPs shall accept and approve retroactive requests for continuity of care that meet all continuity of care requirements noted above and in 1-3 below. The services that are the subject of the request must have occurred after the member's enrollment into the MCP, and the MCP must have the ability to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment into the MCP. MCPs shall only approve retroactive requests that meet the following requirements:

1. Have dates of services that occur after the effective date of this APL;

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2. Have dates of services within 30 calendar days of the first day of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement; and
3. Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested.

The MCP should determine if a relationship exists through use of data provided by DHCS to the MCP, such as Medi-Cal FFS utilization data.

Each continuity of care request must be completed within the following timeline:

- Thirty calendar days from the date the MCP received the request;
- Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is risk of harm to the member.

A continuity of care request is considered completed when:

- The member is informed of his or her right of continued access;
- The MCP and the out-of-network FFS or prior MCP provider are unable to agree to a rate;
- The MCP has documented quality of care issues; or
- The MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

Upon approval of a continuity of care request, the MCP must notify the member of the following within seven calendar days:

- The request approval;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the member's care at the end of the continuity of care period; and
- The member's right to choose a different provider from the MCP's provider network.

The MCP must notify the member 30 calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. This process includes engaging with the member and

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provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

*MMCD All Plan Letter 18-008*

MCPs must provide continuity of care with an out of network provider when:

1. MCP is able to determine that the beneficiary has an existing relationship with the provider;
2. The provider is willing to accept the higher of the MCP's contract rates or Medi-Cal FFS rates;
3. The provider meets the MCP's applicable professional standards and has no disqualifying quality of care issues;
4. The provider is a California State Plan approved provider;
5. The provider supplies the MCP with all relevant treatment information for the purposes of determining medical necessity ...

Additional requirements pertaining to continuity of care are set forth in Health and Safety Code (HSC) Section 1373.96 and require health plans in California to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under HSC Section 1373.96, health plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by the MCP..."

*MMCD APL 15-019 and 18008*

**SUMMARY OF FINDINGS:**

**2.5.1 Continuity of care during pregnancy**

Contract states, "the MCP shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96."

[2-Plan Contract A.9.16(B)]

Health and Safety (H & S) Code, Section 1373.96 requires all health care service plans in California to provide covered services set for under this section at the request of a member. The Plan shall provide covered services for the following conditions: acute, serious chronic, pregnancy, terminal illness, and care of a newborn child between birth

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and age 36 months and surgery or other procedures that are authorized by the Plan. Furthermore, H & S Code, Section 1373.96 defines a pregnancy as “the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.”

All Plan Letters (APLs) 15-019 effective August 26, 2015 and 18-008 effective July 1, 2018 states, “under Section 1373.96, health plans are required to complete services for the following conditions; acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and surgery and [other authorized procedures].” In addition, “MCPs must allow for the completion of these services for certain timeframes which are specific to each condition and defined under H & S Code Section 1373.96.”

The Plan Procedure HS.01.05 related to Out of Area/Continuity of Care part II (A)(2) states, “the requests for Continuity of Care services may be authorized through the Utilization Management or Case Management process for the following conditions: acute episode of care, care for defined chronic condition, terminal illness, newborn care ages birth to 36 months for up to 12 months after first enrolled and surgeries.” However, Procedure HS.01.05 did not reflect the requirement that covered services be provided for the duration of three trimesters in cases of pregnancy.

The Provider Manual states, “if a member is in the second or third trimester of pregnancy, treatment may extend through the post-partum period.” However, the Provider Manual did not indicate that the Plan provides the complete covered services for the duration of the three trimesters of pregnancy.

The Plan did not comply with continuity of care requirements for the provision of covered services throughout the duration of three trimesters in cases of pregnancy.

When the member is not able to receive continuity of care by an out-of-network provider for entire duration of the pregnancy, members may experience delays and interruptions in receiving medically necessary services during their pregnancy.

### **2.5.2 Continuity of Care for members with pre-existing provider relationships**

Contract states “the [Plan] shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96.”

[2-Plan Contract A.9.16(B)]

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All Plan Letters (APLs) 15-019 effective August 26, 2015 and 18-008 effective July 1, 2018 states, “all Managed Care Plan (MCP) members with pre-existing provider relationships who make a continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal Fee for Services (FFS) or through another MCP.”

The Plan’s desktop resource for continuity of care screening includes the following: acute condition, serious and chronic condition, pregnancy and postpartum period, care of a newborn child between birth and age of 36 months, surgery or other authorized procedures and terminal illness. However, the Plan’s desktop resource did not mention that members with pre-existing provider relationship could continue to see the current provider.

When the Plan does not have updated desktop resources for continuity of care by an out-of-network provider to a member, members may experience delays and interruptions in receiving medically necessary services and may potentially have poor health outcomes as a result.

**RECOMMENDATIONS:**

- 2.5.1 Update procedure and provider manual to reflect continuity of care requirements in cases of pregnancy.
- 2.5.2 Update the desktop resource and train the staff to allow continuity of care in accordance with requirements.

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**CATEGORY 4 – MEMBER’S RIGHTS**

**4.1**

**GRIEVANCE SYSTEM**

**Member Grievance System:**

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). Contractor shall resolve each Grievance and provide notice to Members as quickly as the Member’s health condition requires, within 30 calendar days from the date Contractor receives the Grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

*2-Plan Contract A.14.1*

**Member Grievance Oversight:**

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.

*2-Plan Contract A.14.2*

**Grievance Log an Quarterly Grievance Report:**

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*

(g) Each plan shall adhere to the following requirements and time frames in processing member grievances:

- (1) Member grievances shall be resolved within thirty days of the member’s submittal of a written grievance or if they grievances is made verbally, it shall be resolved within 30 days of the written record of the grievance.
- (2) In the event resolution is not reached within thirty days, the member shall be notified in writing by the Plan of the status of the grievance and shall be provided with an estimated completion date of resolution.

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**GRIEVANCE SYSTEM**

**Grievance and Appeals Requirements and Revised notice Templates and “Your Rights” Attachment:**

Effective July 1, 2017, All Plan Letter (APL) 17-006, provides Medical Managed Care Health Plans (MCPs) with clarification and guidance regarding the application of new federal (42 CFR, Section 438.408 Subpart F) and existing state regulations for processing Grievances and appeals.

**Grievance Timeframes for Filing:**

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

**Appeal Timeframes for Filing:**

Timeframes for requesting Appeals are delineated in the DCHCS contracts and in both federal and state regulations. Existing, federal regulations allows beneficiaries 90 days from the date of the Notice of Action (NOA) to file an Appeal. However, new federal regulation requires beneficiaries to file an Appeal within 60 calendar days from the date of NOA. MCPs shall adopt the 60 calendar day timeframe in accordance with the new federal regulations. Beneficiaries must also exhaust the MCP’s Appeal process prior to requesting State Fair Hearing.

**State Fair Hearing Timeframes for Filing:**

New federal regulation (42 CFR, Section 438.408 F) requires beneficiaries to request a State Fair Hearing within 120 calendar days from the date of the Notice of Appeal Resolutions (NAR), which informs the beneficiary that the Adverse Benefits Decision has been upheld.

*MMCD All Plan Letter 17-006.*

An enrollee may request a State Fair Hearing only after receiving notice that MCO,PIHP,PAHP is upholding the adverse benefit determination and the enrollee is deemed to have exhausted the MCO,PIHP,PAHP’s appeal process.

*42 CFR, Section 438.408 Subpart F*

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**GRIEVANCE SYSTEM**

Policy Letter means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division (MMCD), provides clarification of Contractor’s obligations pursuant to the Contract, and may include instructions to the Contractor regarding implementation of mandated changes in State or Federal statutes or regulations, or pursuant to judicial interpretation.

Any provision of the Contract which is in conflict with current or future applicable Federal or State laws or regulations is hereby 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 statutes 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.

*2-Plan Contract A11 Exhibit E attachments 1 and 2*

**SUMMARY OF FINDINGS:**

**4.1.1 Inclusion of a State Fair Hearing Option in Grievance Resolution Letter to Members**

Contract exhibit E, attachment 2 states, the Plan agrees to “Any provision of the Contract which is in conflict with current or future applicable Federal or State laws or regulations is hereby 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 statutes 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.”

[2-Plan Contract E.2]

Title 42 of the Code of Federal Regulations, Section 438.408, Subpart F requires the member to exhaust the Managed Care Organization’s (MCO’s) appeal process before they can request a State Fair Hearing.

All Plan Letter (APL) 17-006 states that the terms “Grievance” and “Appeal” are separately defined. A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. A complaint is the same as a grievance. In addition, it requires beneficiaries to exhaust the Managed Care Plan’s (MCP’s) internal appeal process and receive a Notice of Resolution (NAR) indicating that the



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Adverse Benefit Determination has been upheld prior to requesting a State Fair Hearing.

The Centers for Medicare and Medicaid Services (CMS) Final Rule states, "...grievances do not progress to the level of a state fair hearing...Once the single level appeal process is exhausted, the member would be able to request a state fair hearing." The verification study files for the audit period indicated that in 26 grievance resolution responses to members, the Plan included an option for members to request a State Fair Hearing. However, a State Fair Hearing may only be requested if the Plan's internal appeals process has been exhausted and a NAR is issued.

During the interview and in a subsequent written statement, the Plan acknowledged that this was due to loss of an experienced Grievances and Appeals supervisor as a primary reason for untimely recognition and implementation of all grievance related changes specified in APL 17-006.

A beneficiary's receipt of incorrect information concerning a Plan-determined grievance resolution can cause confusion, resulting in an unpleasant and frustrating experience as well as a potential delay in care.

**RECOMMENDATIONS:**

- 4.1.1 Develop and implement procedures to ensure the grievance system and processes comply with requirements and provide accurate information to members.

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**4.3**

**CONFIDENTIALITY RIGHTS**

**Members' Right to Confidentiality**

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

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

*2-Plan Contract A.13.1.B*

**Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:**

Contract may use or disclose PHI pertaining to Members only to perform functions, activities or services specified in this Contract provided that such use or disclosure is for purposes directly connected with the administration of the Medi-Cal program.

**Responsibilities of Contractor:**

Contractor agrees:

Safeguards: To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI that it creates, receives, maintains, uses or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as per Contract. Contractor shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and nature and scope of its activities.

*2-Plan Contract G.2A and 3B.*

Contractor's agents including subcontractors but excluding providers of treatment services, to whom Contractor provides PHI received from or created or received by Contractor on behalf of DHCS, agree to the same restrictions and conditions that apply to Contractor with respect to PHI; and to incorporate, when applicable the relevant provision of contract into each subcontract or subaward to such agents or subcontractors.

*2-Plan Contract G.3.D.*

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**4.3**

**CONFIDENTIALITY RIGHTS**

**Breaches and Security Incidents.**

During the term of this Agreement, the Contractor agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

- 1. Discovery of Breach:** To notify DHCS immediately by telephone call plus email or fax upon the discovery of a breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been accessed or acquired by an unauthorized person; or within 24 hours by email or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of the Contract, or potential loss of confidential data affecting the Contract.

Notification shall be provided to the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and DHCS Information Security Officer.

- 2. Investigation of Breach:** To immediately, investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS, MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer.

*2-Plan Contract A.G.III*

- 1. Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

*MMCD APL 09-014*

**SUMMARY OF FINDINGS:**

**4.3.1 Privacy Information Reporting Requirements**

The Contract requires the Plan to immediately investigate a security incident, breach, or unauthorized use or disclosure of PHI or confidential data when there is such an occurrence. The Plan shall notify to the Department of Health Care Services (DHCS), Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer within 72 hours of the discovery. [2-Plan Contract A.G.III]

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All Plan Letter 09-014 states that the Plan is required to notify by email or fax any suspected security incidents, intrusions, or unauthorized use or disclosure of Personal Health Information (PHI) in violation of the Contract to DHCS within 24 hours. Also, the Plan is required to immediately investigate and report within 72 hours of the discovery addressing the elements stated in Provision 3(H)(2) which can enable DHCS and the entity reporting the breach to determine how serious the breach is and to initiate actions to mitigate possible harm as soon as possible.” Furthermore, a full investigative report is required within 10 working days after the discovery of the incident.

The Procedure CP20.01 part 15 of the Health Information Privacy indicates that the Plan investigates a breach, or unauthorized use or disclosure of Protected Health Information (PHI), and provides an updated “Privacy Incident Report (PIR)” of the investigation to the DHCS Privacy Officer within 72 hours of the discovery. A complete report of the investigation will be sent to the DHCS Contract Manager, DHCS Privacy Officer and DHCS Information Security Officer within 10 working days of the discovery of the breach or unauthorized use or disclosure.

The verification study disclosed that the Plan did not submit a PIR to DHCS within 72 hours of the discovery for five files.

During the interview, the Plan acknowledged that they had identified gaps in the oversight process of reporting PIR to DHCS during the audit period. The Plan did not monitor and provide appropriate training to the compliance staff; as a result, staff misunderstood the PIR reporting timeline requirement of 72 hours.

When the Plan submits the DHCS PIRs in a timely manner, the Plan helps to safeguard the members’ protected health information. It also allows DHCS to take prompt and appropriate actions.

**RECOMMENDATIONS:**

- 4.3.1 Develop and implement procedures to ensure PIR submission to DHCS within the required timeframe.

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**CATEGORY 5 – QUALITY MANAGEMENT**

**5.2**

**PROVIDER QUALIFICATIONS**

**Medi-Cal Managed Care Provider Training:**

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

*2-Plan Contract A.7.5*

**SUMMARY OF FINDINGS:**

**5.2.1 Plan’s Policies related to New Provider Training**

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

[2-Plan Contract A.7.5]

Policy PS025-025 related to New Provider Orientation training states, “The plan will conduct a provider orientation training to newly contracted providers within ten (10) days of their effective date”.

Policy PS010-08 related to Provider Training and Communications states, “the Provider Services Department schedules and conducts initial orientation training with newly contracted providers no later than 10 calendar days after the effective date of participation”.

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The Plan's Policies P025-05 and PS010-08 related to new provider training did not specifically state that new providers must complete the new provider training within 10 working days from the Contract effective date based on contract requirements. A review identified eight new providers that did not complete the training within 10 working days.

During the interview, the Plan's staff acknowledged that they were aware of inconsistency of 10 days and 10 calendar days on the Plan's policies. However, they thought that as long as policies stated 10 days the Plan's policies were satisfactory. The Plan is in the process of revising these policies to match the contract requirements.

Without updated policies, the Plan is noncompliant with the contract requirements, which can delay new providers in receiving the training in a timely manner, which can result in a delay in their appropriately providing services to members.

### **5.2.2 Plan's Oversight for the New Provider Training**

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

[2-Plan Contract A.7.5]

The Plan delegates the new provider training to delegate entities. The delegate entities did not consistently provide training to new providers within 10 working days. The verification study disclosed that a delegated entity did not provide the new provider training within 10 working days in eight sampled files. The Plan was not aware that its delegated entity failed to train new providers in a timely manner as required by the Contract.

In addition, for 32 sampled files the Plan could not provide documents such as sign-in sheets to verify new provider training attendance within the required 10 working days. According to the Plan's staff, the Plan did not mandate that its delegate entities keep records demonstrating that their new providers took the training.

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The Plan did not have an adequate quality assurance process and proper oversight of its delegated entities to ensure timely new provider training. In addition, the Plan failed to address the inadequate maintenance of records regarding new provider training. This may result in providers being unaware of Medi-Cal covered services, which may delay the delivery of contractually required services to members.

**RECOMMENDATIONS:**

- 5.2.1 Revise and implement policies PS025-05 and PS010-08 to match contract requirements.
- 5.2.2 Develop a quality assurance process to monitor and to maintain records for completion of new provider training.

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

**SANTA CLARA FAMILY HEALTH PLAN**

Contract Number: 03-75802  
State Supported Services

Audit Period: April 1, 2018  
Through  
February 28, 2019

Report Issued: July 11, 2019



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## **INTRODUCTION**

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

The onsite audit was conducted from March 18, 2019 through March 29, 2019. The audit covered the review period from April 1, 2018 through February 28, 2019 and consisted of document reviews and interviews with the Plan staff.

An Exit Conference was held on June 13, 2019 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings; however, there were no deficiencies found for the review period for the Plan's State Supported Services.

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

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**STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS**

**Abortion**

Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:

Current Procedural Coding System Codes\*: 59840 through 59857

HCFA Common Procedure Coding System Codes\*: X1516, X1518, X7724, X7726, Z0336

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

State Supported Services Contract Exhibit A.1

**SUMMARY OF FINDINGS:**

Abortion is a sensitive service covered by the Medi-Cal program without prior authorization for outpatient abortions. The Plan is required to ensure 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 in-patient abortions.

All Plan Letter (APL) 15-020 states Medi-Cal Managed Care Health plans' responsibility is to provide their beneficiaries timely access to abortion services. All Medi-Cal Managed Care Health Plan's providers who provide physician services must not require medical justification and/or prior authorization for outpatient abortion services.

The Member Evidence of Coverage listed the following family planning services offered to members: pregnancy testing, family planning visits, All Food and Drugs Administration (FDA) approved contraceptive birth control drugs, surgical birth control, outpatient abortion, including minors of their rights to pregnancy termination services and to receive services outside of their health plan's network without a referral.

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

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The Plan's policies and procedures indicate that the Plan ensures that neither medical justification nor prior authorization for outpatient abortion services is required. However, requests for inpatient abortion does require prior authorization.

The Plan maintains a list of Current Procedural Terminology (CPT) codes for procedures and services, which are exempt from prior authorization for the Plan's Claims department to use in automatic payment. The Plan's claims system does not require prior authorization for payment. The billing codes for sensitive services, which are exempt from prior authorization, include CPT codes: 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S0199 (Medically Induced Abortion Services), S0190 (Mifepristone 200 mg), S0191 (Misoprostol 200 mcg) and A4649.

Based on the 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.

**RECOMMENDATIONS:**

None