

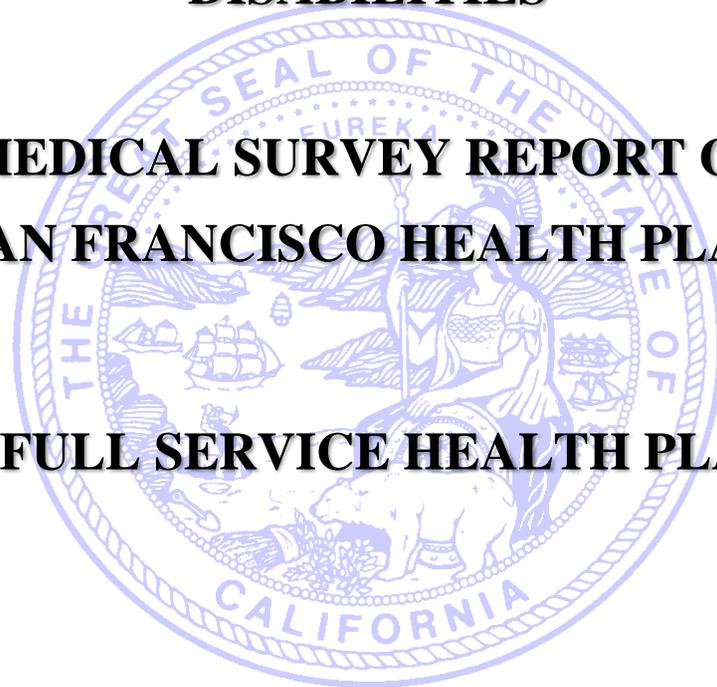
DEPARTMENT OF  
**Managed Health Care**  
**Help Center**

**DIVISION OF PLAN SURVEYS**

**1115 WAIVER SENIORS AND PERSONS WITH  
DISABILITIES**

**MEDICAL SURVEY REPORT OF  
SAN FRANCISCO HEALTH PLAN**

**A FULL SERVICE HEALTH PLAN**



**DATE ISSUED TO DHCS: February 3, 2016**

**1115 Waiver SPD Medical Survey Report  
San Francisco Health Plan  
A Full Service Health Plan  
February 3, 2016**

**TABLE OF CONTENTS**

EXECUTIVE SUMMARY .....	3
DISCUSSION OF POTENTIAL DEFICIENCIES .....	9
UTILIZATION MANAGEMENT .....	9
AVAILABILITY AND ACCESSIBILITY .....	19
MEMBER RIGHTS .....	31
QUALITY MANAGEMENT .....	48
APPENDIX A. MEDICAL SURVEY TEAM MEMBERS .....	57
APPENDIX B. PLAN STAFF INTERVIEWED .....	58
APPENDIX C. LIST OF FILES REVIEWED .....	59

## **EXECUTIVE SUMMARY**

The California Department of Health Care Services (“DHCS”) received authorization (“1115 Waiver”) from the federal government to conduct mandatory enrollment of seniors and persons with disabilities (“SPD”) into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The DHCS then entered into an Inter-Agency Agreement with the Department of Managed Health Care (the “Department”)<sup>1</sup> to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California’s strong patient-rights laws. Mandatory enrollment of SPDs into managed care began in June 2011.

On December 19, 2014, the Department notified San Francisco Health Authority, dba San Francisco Health Plan (the “Plan”), that its medical survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department’s medical survey team conducted the onsite portion of the medical survey from March 9, 2015 through March 13, 2015.

### **SCOPE OF MEDICAL SURVEY**

As required by the Inter-Agency Agreement, the Department provides the 1115 Waiver SPD Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the SPD population. This medical survey evaluated the following elements specifically related to the Plan’s delivery of care to the SPD population as delineated by the DHCS-SFHP Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations:<sup>2</sup>

#### **I. Utilization Management**

The Department evaluated Plan operations related to utilization management, including implementation of the Utilization Management Program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting under- and over-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

#### **II. Continuity of Care**

The Department evaluated Plan operations to determine whether medically necessary services are effectively coordinated both inside and outside the network, to ensure the coordination of special arrangement services, and to verify that the Plan provides for completion of covered services by a non-participating provider when required.

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<sup>1</sup> The Inter-Agency Agreement (Agreement Number 10-87255) was approved on September 20, 2011.

<sup>2</sup> All references to “Contract” are to the County Organized Health System, Geographic Managed Care, and Two-Plan contracts issued by the DHCS. All references to “Section” are to the Knox-Keene Act of the Health and Safety Code. All references to “Rule” are to Title 28 of the California Code of Regulations.

**III. Availability and Accessibility**

The Department evaluated Plan operations to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes, and are addressing reasonable patient requests for disability accommodations.

**IV. Member Rights**

The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for Primary Care Physician selection and assignment, and to evaluate the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

**V. Quality Management**

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care.

The scope of the medical survey incorporated review of health plan documentation and files from the period of January 1, 2014 through December 31, 2014.

**SUMMARY OF FINDINGS**

The Department identified **15** potential deficiencies during the current medical survey.

**2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES**

<b>UTILIZATION MANAGEMENT</b>	
<b>1</b>	<p><b>The Plan’s Notice of Action (NOA) denial letters do not consistently include:</b></p> <ul style="list-style-type: none"> <li>• <b>A clear and concise explanation of the denial;</b></li> <li>• <b>A description of the criteria or guidelines used to make the decision; and</b></li> <li>• <b>The clinical reasons for the decision regarding medical necessity.</b></li> </ul> <p>DHCS-SFHP Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures; DHCS-SFHP Contract, Exhibit A, Attachment 13 – Member Services, Provision 4(C) – Written Member Information; Section 1367.01(h)(4).</p>
<b>2</b>	<p><b>The Plan does not have adequate oversight mechanisms in place to ensure that delegated entities comply with the Plan’s contract with DHCS.</b></p> <p>DHCS-SFHP Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 4(D) – Contract Performance; DHCS-SFHP Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, and Provision 6(A)(1)-(4) and (B)(2)-(3) – Delegation of Quality Improvement Activities; Rule 1300.70(b)(2)(G)(5); Rule 1300.70(b)(2)(H)(1)-(2).</p>
<b>AVAILABILITY &amp; ACCESSIBILITY</b>	
<b>3</b>	<p><b>The Plan does not ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer members appointments that meet required appointment wait time standards. Specifically, the Plan does not have adequate compliance monitoring procedures in place and does not ensure that effective action is taken to improve care where deficiencies are identified.</b></p> <p>DHCS-SFHP Contract Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-SFHP Contract Exhibit A, Attachment 9 – Access and Availability, Provision 3 – Access Requirements, and Provision 4 – Access Standards; Rule 1300.67.2.2(c)(5); Rules 1300.67.2.2(d)(1)-(3); Rule 1300.70(a)(1) and (3).</p>
<b>4</b>	<p><b>The Plan did not report valid rates of compliance with appointment availability time elapsed standards for each of its contracted provider groups for Reporting Year 2014.</b></p> <p>DHCS-SFHP Contract Exhibit A, Attachment 9 – Access and Availability, Provision 3 – Access Requirements, and Provision 4 – Access Standards; Rule 1300.67.2.2 (d)(2); Rule 1300.67.2.2 (d)(3); Rule 1300.67.2.2.(g)(2)(B)-(C).</p>

5	<p><b>The Plan does not adequately oversee and monitor its 24 hours per day, 7 days per week, triage or screening services by telephone.</b>          DHCS-SFHP Contract Exhibit A, Attachment 9 – Access and Availability, Provision 3(D) and (E) – Access Requirements, and Provision 4 – Access Standards; Rule 1300.67.2(b) and (f); Rule 1300.67.2.2(c)(8).</p>
6	<p><b>The Plan’s Policy does not include written standards in the policy pertaining to physician-to-member ratios that are consistent with contractual requirements.</b>          DHCS-SFHP Contract Exhibit A, Attachment 6 –Provider Network, Provision 3(A)(1) and (2) – Provider to Enrollee Ratios.</p>
<b>MEMBER RIGHTS</b>	
7	<p><b>The Plan does not consistently process all expressions of dissatisfaction by enrollees as grievances to ensure adequate consideration and rectification when appropriate.</b>          DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System, and Provision 2(C) – Grievance System Oversight; Section 1368(a)(1); Rule 1300.68(a)(1) and (2).</p>
8	<p><b>The Plan does not have procedures in place to aggregate and analyze SPD-specific grievance data and use this analysis for quality improvement purposes.</b>          DHCS-SFHP Contract, Exhibit A, Attachment 13 – Member Services, Provision 3 – Call Center Reports; DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System, and Provision 2(C) – Grievance System Oversight; Rule 1300.68(b)(1).</p>
9	<p><b>The Plan does not consistently convey to its SPD members that language assistance services are provided at no cost to the member.</b>          DMHC-SFHP Contract Exhibit A, Attachment 9, Access and Availability, Provision 14. Linguistic Services.</p>
10	<p><b>The Plan does not adequately monitor and make modifications to its Language Assistance Program.</b>          DMHC-SFHP Contract Exhibit A, Attachment 4 – Quality Improvement System, Provision 7(F) – Written Description; DMHC-SFHP Contract Exhibit A Attachment 9 – Access and Availability, Provision 4 – Access Standards, and Provision 13(B)-(F) – Cultural and Linguistic Program; Rule 1300.67.2.2(c)(4).</p>
11	<p><b>The Plan does not ensure adequate consideration and rectification of SPD member grievances when appropriate.</b>          DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Section 1368(a)(1).</p>

<p>12</p>	<p><b>The Plan does not consistently include an application for independent medical review (IMR), an addressed envelope, and instructions in its responses to members’ grievances involving delay, modification, or denial of services based on a determination in whole, or in part, that the service is not medically necessary.</b>          DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System, and Provision 4(B)(2) – Notice of Action; Rule 1300.68(d)(4).</p>
<p>13</p>	<p><b>For complainants who file urgent grievances, the Plan does not provide immediate notification to the complainant of the right to contact the Department regarding the grievance.</b>          DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68.01(a)(1).</p>
<p>14</p>	<p><b>In its handling of potential quality issues, the Plan does not consistently document that the quality of care provided is being reviewed, that problems are being identified, and that effective action is taken to improve care where deficiencies are identified.</b>          DHCS-SFHP Contract Exhibit A, Attachment 4 –Quality Improvement System, Provision 1 – General Requirement, and Provision 7(D) – Written Description; Rule 1300.70(a)(1) and (3); Rule 1300.70(b)(1)(A)-(B); Rule 1300.70(b)(2)(A)-(B)(3).</p>
<p>15</p>	<p><b>The Plan’s quality assurance program does not ensure that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.</b>          DHCS-SFHP Contract Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, and Provision 7(D)(G)(H) – Written Description; Rule 1300.70(a)(1).</p>

## **OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD MEMBERS**

- The services developed for SPD members who transitioned in 2012 continue to exist for currently enrolled SPD members, e.g., the Provider Directory has a large-font section, and alternative formats in large font for other Plan materials are available upon request.
- Member Rights: The Plan established a dedicated phone line for SPD members, which is answered by a customer service representative. The Plan found no difference in call volume between SPD members vs. non-SPD Medi-Cal members.
- Continuity of Care: The Plan does not have separate programs for SPD members, but these members benefit from the Plan's monthly Health Services Grand Rounds. This is a case study format that includes an interdisciplinary team. The case presentation and the team discussion allows for input from all Plan departments. This is a unique approach to address the complex health care needs of Plan members, including the SPD population.

## DISCUSSION OF POTENTIAL DEFICIENCIES

### UTILIZATION MANAGEMENT

**Potential Deficiency #1: The Plan's Notice of Action (NOA) denial letters do not consistently include:**

- **A clear and concise explanation of the denial;**
- **A description of the criteria or guidelines used to make the decision; and**
- **The clinical reasons for the decision regarding medical necessity.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(D) – Pre-Authorizations and Review Procedures; DHCS-SFHP Contract, Exhibit A, Attachment 13 – Member Services, Provision 4(C) – Written Member Information; Section 1367.01(h)(4).

#### DHCS-SFHP Contract, Exhibit A, Attachment 5 – Utilization Management

##### 2. Pre-Authorizations and Review Procedures

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

D. Reasons for decisions are clearly documented.

#### DHCS-SFHP Contract, Exhibit A, Attachment 13 – Member Services

##### 4. Written Member Information

C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan Covered Services, processes and ensure the Member's ability to make informed health decisions.

#### Section 1367.01(h)(4)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(4) 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 the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a

physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification . . . .

**Documents Reviewed:**

- Utilization Management Program Description (2014)
- Plan Policy UM-22: Authorization Requests (12/02/14)
- Plan Policy UM-01: Utilization Management Notice of Action Letters (12/02/14)
- 10 SPD standard appeal files (01/01/14 – 12/31/14)
- 3 SPD expedited appeal files (01/01/14 – 12/31/14)

**Assessment:** DHCS-SFHP Contract, Exhibit A, Attachment 5, Provision 2(D) requires that “[r]easons for decisions are clearly documented.” DHCS-SFHP Contract, Exhibit A, Attachment 13, Provision 4(C) requires that all written member information is provided to members “at a sixth grade reading level,” or as determined appropriate through the Plan’s group needs assessment, and approved by the Department. The written member information must ensure members’ understanding of the Plan’s covered services and processes and ensure the member’s ability to make informed health decisions.

The Department conducted a random sample of both standard and expedited grievance files and isolated thirteen<sup>3</sup> appeals involving initial denials based in whole or in part on medical necessity. The Department’s review of these files determined that the Plan’s NOA denial letters do not meet contractual and regulatory requirements as follows:

***1. The Plan fails to consistently include a clear and concise explanation of the denial.***

Of the 13 medical necessity denial letters, nine<sup>4</sup> (9) (69%) failed to include a clear and concise explanation of the reasons for the Plan’s decision to deny or modify a requested service. The following are examples:

- *Expedited File #2:* This case involves a member who had been receiving treatment for sickle cell anemia (an inherited blood disorder) at UCSF, which is an out-of-network provider. The request was accompanied by supporting documentation from the physician for the necessity of continuing to receive this treatment at UCSF, i.e., SFGH could not treat her and consequently referred her to another facility. The denial letter states, “The request has been denied because this service is available at San Francisco General Hospital . . .”

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<sup>3</sup> The 13 medical necessity files review consisted of 10 standard appeals and 3 expedited appeals.

*Standard Appeal Files:* 9, 12, 17, 20, 28, 42, 45, 48, 53, 56

*Expedited Appeal Files:* 2, 3, 5

<sup>4</sup> *Standard Appeal Files:* 9, 17, 20, 28, 42, 45, 48, 56

*Expedited Appeal File:* 2

The NOA denial letter is unclear because it was not responsive to the request—it did not address the supporting argument for the request to receive services at UCSF. Nor did it explain the clinical reason for denying the OON follow-up.

- Standard File #9: This case involves a request for a bone scan and vascular flow imaging (a test to measure blood flow). The NOA denial letter states:

[The hospital] has asked San Francisco Health Plan (SFHP) to approve a Bone Scan and Vascular Flow Imaging. The request has been denied because it does not meet medical necessity as specified in InterQual.

The letter cited the name of the criteria used (InterQual); however, it failed to include the clinical reason or the rationale for the denial. Providing the name of the criteria and stating that the service requested does not meet medical necessity criteria does not explain why the service was not medically necessary.

- Standard File #42: This case involves a request for a medication for hepatitis. The NOA denial letter states:

Your [doctor] has asked San Francisco Health Plan to approve HARVONI. This request is denied due to lack of medical necessity. Per page 14 of the 2013-2014 Medi-Cal Evidence of Coverage, San Francisco Health Plan only covers services that are medically necessary. San Francisco Health Plan only covers treatment for Hepatitis C for F3 or F4 METAVIR score on liver biopsy or for advanced liver disease shown by one of the following: 1) physical exam findings (e.g. splenomegaly), platelets less than 100,000/mm<sup>3</sup> AND abdominal image findings (e.g. nodularity) OR 2) APRI score greater than 1.5, FIB-4 greater than 3.25, Fibrosure/Fibrotest greater than 0.58, Fibroscan greater than 9.5, AFRI greater than 1.75 or MRE greater than 6.47. Based on notes provided by your [doctor] your APRI score is 0.27 and Fibrosure fibrosis score is 0.18.

DHCS-SFHP Contract, Exhibit A, Attachment 13, Provision 4(C), requires that “all written Member information [be] provided to Members at a sixth grade reading level.” The technical terms used in this NOA letter are not at a sixth grade reading level.

- Standard File#48: In this case, the member’s request for continuation of a rental wheelchair (durable medical equipment) was denied. The NOA letter states:

[Medical Supply Company] has asked San Francisco Health Plan to approve the continued rental of a standard wheelchair. The request has been denied because it does not meet SFHP criteria for medical necessity as specified in the updated clinical

documentation dated April 16th, 2014, which states you are weight bearing bilaterally and walking with a cane.

The suggested criteria (e.g., weight bearing bilaterally, walking with a cane) are not only incomplete but also vague and unclear. A layperson would not understand what weight bearing bilaterally means. Nor does this address situations where an enrollee can only stand or bear weight for a few minutes or where an enrollee can walk only a small distance with a cane.

The remaining five NOA denial letters, in which the explanation for denial is not clear and concise, involved preauthorization review denials for durable medical equipment and non-formulary medications. These NOA denial letters stated similar unclear rationales, e.g., does not meet medical necessity.

**2. The Plan fails to consistently include the clinical reason and the criteria or guidelines used to make the decision.**

Of the 13 authorization denial letters reviewed for medical necessity, six (6)<sup>5</sup> (46%) did not contain a description of the criteria or guidelines used to make the decision. Seven (7)<sup>6</sup> files (54%) failed to include a clinical reason for the Plan's denial determination. The following are examples:

- **Standard File #56:** This case involves a request for ribavirin, a non-formulary medication used for anti-viral therapy for hepatitis C. The NOA denial letter states:

Your [doctor] has asked San Francisco Health Plan to approve RIBAVIRIN 200 MG CAPSULE. This request is denied due to lack of medical necessity. Per page 13-14 of the 2013-2014 Medi-Cal Evidence of Coverage, San Francisco Health Plan only covers services that are medically necessary. This request does not meet medical need based on review of medical notes provided by [your doctor]. If you still need RIBAVIRIN 200 MG CAPSULE, please ask your [doctor] to submit a new request with additional explanation why RIBAVIRIN 200 MG CAPSULE is needed.

The letter does not describe the criteria or guidelines used to make the decision; nor does this letter indicate the clinical reason for the denial.

- **Standard File #48:** As discussed above, the member's request for continuation of a rental wheelchair, i.e., durable medical equipment, was denied. The NOA letter states:

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<sup>5</sup> Standard Appeal Files: 9, 17, 20, 45, 48, 56

<sup>6</sup> Standard Appeal Files: 9, 17, 20, 45, 48, 56

Expedited Appeal File: 2

The request has been denied because it does not meet SFHP criteria for medical necessity as specified in the updated clinical documentation dated April 16th, 2014, which states you are weight bearing bilaterally and walking with a cane.

The Plan failed to describe the complete criteria used to make the denial decision. Ability to bear weight and walk with a cane does not necessarily disqualify the member from use of a medically necessary wheelchair. The ability to walk a certain distance without assistance or without falling must be assessed.

The NOA letters in the remaining four (4) files—(File #9, File #17, File #20, File #45—also failed to describe the criteria and guidelines used to make the decisions.

The requirement that the reason for the denial be “clear and concise” is consistent with Plan Policy *UM-01: Utilization Management Notice of Action Letters*, which states: “letters must include reasons for denial and modification written in clear, concise, consumer-friendly language, absent abbreviations, and technical terms.” This policy also states, “All NOA letters in English will be written at the sixth (6th) grade reading level.” However, the policy does not specifically require a description of the criteria or guidelines used or the “clinical reasons” for the decision regarding medical necessity.

**Conclusion:** The Plan’s written communications to members and health care providers to deny, delay, or modify requests for medical service, per its Notice of Action (NOA) denial letters, do not consistently contain “a clear and concise explanation of the reasons for the plan’s decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity,” as required in Section 1367.01(h)(4). This regulation is consistent with DHCS-SFHP Contract, Exhibit A, Attachment 5, Provision 2(C). Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

**TABLE 1**  
**UM Medical Necessity Denials**

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Utilization Management Files	13	Response includes a clear and concise explanation of the reasons for the plan’s decision	4	9
		Response includes a description of the criteria or guidelines used	7	6
		Response includes the clinical reasons for the decisions regarding	6	7

		medical necessity		
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**Potential Deficiency #2: The Plan does not have adequate oversight mechanisms in place to ensure that delegated entities comply with the Plan’s contract with DHCS.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 4(D) – Contract Performance; DHCS-SFHP Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, and Provision 6(A)(1)-(4) and (B)(2)-(3) – Delegation of Quality Improvement Activities; Rule 1300.70(b)(2)(G)(5); Rule 1300.70(b)(2)(H)(1)-(2).

DHCS-SFHP Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan

4. Contract Performance

Contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with Title 28 CCR Section 1300.67.3. Contractor shall ensure the following:

D. Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the Contractor’s business.

DHCS-SFHP Contract Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum:

- 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
- 2) Contractor’s oversight, monitoring, and evaluation processes and subcontractor’s agreement to such processes.
- 3) Contractor’s reporting requirements and approval processes. The agreement shall include subcontractor’s responsibility to report findings and actions taken as a result of the Quality Improvement activities at least quarterly.
- 4) Contractor’s actions/remedies if subcontractor’s obligations are not met.

B. Contractor shall maintain a system to ensure accountability for delegated Quality Improvement activities, that at a minimum:

- 2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
- 3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

Rule 1300.70(b)(2)(G)(5)

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the Plan and/or delegated providers.

Rule 1300.70(b)(2)(H)(1)-(2)

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements. In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(H) A plan that has capitation or risk-sharing contracts must:

(1) Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the plan shall have systems in place to monitor QA functions.

(2) Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible underutilization of specialist services and preventive health care services.

**Documents Reviewed:**

- Plan Policy: Delegated Network Oversight Committee (01/02/15)
- Plan Policy: DO-02, Oversight of Delegated UM Functions (11/01/14)
- Plan Policy: DO-04, Oversight of Delegated UM Functions (01/02/15)
- Delegated Medical Group Audit Results 2013 (audit dates September 24 and October 2, 2013; reported January 2014)
- QIC Minutes (February 2014, April 2014, June 2014, August 2014, October 2014, and December 2014)

**Assessment:** The contracted provider groups are delegated to perform utilization management functions (e.g., authorization and tracking utilization) according to the utilization management standards established by the Department and the Plan. These standards are set forth in DHCS-SFHP Contract, Exhibit A, Attachment 4, Provision 6(A) and (B). Quality improvement activities included in the contract are “oversight, monitoring, and evaluation processes”;

“reporting requirements and approval processes”; and “actions/remedies.” Provision 6 of the contract requires the Plan to maintain a system of accountability for delegated quality improvement activities that, at a minimum, ensures that the subcontractors/health networks meet Department and Plan standards and includes continuous monitoring, evaluation, and approval of the delegated functions.

DHCS-SFHP Contract, Exhibit A, Attachment 4, Provision 1 requires the Plan to “implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Rule 1300.70(b)(2)(G) mandates that the Plan “retain responsibility for reviewing the overall quality of care delivered to plan enrollees” and that the Plan ensure that each contracted provider group or other provider entity “has the capability to perform effective quality assurance activities.” Rule 1300.70(b)(2)(H)(1) requires a plan that has capitation or risk-sharing contracts to “ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations.” Rule 1300.70(b)(2)(H) also requires the Plan to “have systems in place to monitor QA functions.”

The Department found that the Plan does not have adequate oversight mechanisms to ensure that delegated entities meet the requirements of its contract with DHCS. The following evidence supports this finding:

**1. Quality Improvement Committee**

*A review of the Quality Improvement Committee (QIC) Meeting Minutes for 2014 revealed no active discussion regarding oversight of delegated groups. Delegate utilization data was not presented, reviewed, or discussed. A delegated medical group audit was conducted in 2013. The audit included a variety of operational areas, such as credentialing, utilization management, health education, culture and linguistics, facility sites, timely access, and claims. The results, dated January 27, 2014, were presented in the June 2014 meeting of the QIC. However, the minutes do not show that there was any discussion regarding the results of the audit.*

**2. Staff Interviews**

Plan staff stated in interviews that the Plan has just begun, in recent months, laying the foundation for a more responsive delegation oversight— admittedly in large part because of the corrective activities required by the Department. Plan staff stated that no Delegation Oversight Committee existed prior to December 2014. Plan staff cited high staff turnover as a complicating factor to inadequate delegation oversight.

### **3. Plan Policy: Oversight of Delegated UM Function**

Plan Policy *DO-02, Oversight of Delegated UM Functions*, effective November 1, 2014, outlines the Plan's monitoring of delegated entities. Plan policy *DO-04, Oversight of Delegated UM Functions*, effective January 2, 2015, replaced this policy. However, Plan policy *DO-04, Oversight of Delegated UM Functions*, was the policy effective during the survey review period of January 1, 2014 – December 31, 2014 and states:

MONTHLY AND QUARTERLY MONITORING: SFHP receives encounter data, prior authorization data, UM, and CM reports. SFHP staff reviews and processes the data and reports, and provide feedback or request additional information or corrections from the delegate as needed.

During interviews, Plan staff stated that this policy was implemented after the 2013 delegated medical group audit.

### **4. Delegation Agreements**

The Plan created Delegation Agreements after the 2013 delegated medical group audit and will be upgrading them as the Plan communicates with providers on how to proceed with corrective action plans.

### **5. Delegates' Utilization Management Data**

The Plan delegates UM functions to five provider groups. Policy *DO-04, Oversight of Delegated UM Functions*, describes the mechanisms used by the Plan to oversee the delegates:

- (1) Review and evaluation of monthly or quarterly reports and data submission;
- (2) Annual audits;
- (3) A combination of monthly or quarterly reviews in addition to an in depth review at the annual audit; and
- (4) Review of referral logs, denial logs, evaluation of trends, determination of the appropriateness of referrals and denials, and providing feedback when timeframes are not met.

However, the Plan concedes that they are just beginning to undertake these activities. Plan staff stated that delegates' UM data was reviewed for only the first time in 2014. The Plan will begin reviewing delegates' UM data at least twice a year, including UM denials.

## **6. Interrater Reliability Assessment among Staff**

Interrater reliability (IRR) assessment among delegated providers' authorization reviewers and quality improvement/assurance auditors is a mechanism widely used in the health care industry to promote consistent application of standards set by health plans. Plan staff conceded that the Plan has not conducted any IRR assessment among its auditors who conduct delegate audits. Nor had the Plan investigated whether delegates conduct IRR assessment among their own nurse and physician reviewers. Plan staff stated that while it confirms that delegates have IRR policies and procedures in place, it does not review delegates' IRR assessment results.

## **7. Monitoring of Under- and Over-Utilization**

Rule 1300.70(b)(2)(H)(1)-(2) requires plans that have capitation or risk-sharing contracts to "have systems in place to monitor QA functions" and to "[h]ave a mechanism to detect and correct under-service by an at-risk provider ..., including possible underutilization of specialist services and preventive health care services." Rule 1300.70(b)(2)(G)(5) requires plans "[e]nsure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice ..." The Plan conducts HEDIS audits and it measures emergency room readmission rates on an annual basis, as required by the Department. When queried what other mechanisms were in place to monitor under- and over-utilization of services at the delegate level, Plan staff stated that the Plan is currently developing these mechanisms as part of monitoring activities it will undertake. Plan staff further stated that referral tracking is under "exploratory review."

**Conclusion:** DHCS-SFHP Contract, Exhibit A, Attachment 4, Provision 6(A) and (B)(2)-(3) requires plans to be "accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors." DHCS-SFHP Contract, Exhibit A, Attachment, Provision 4(D) requires that plans "maintain the organization and staffing," for "implementing and operating" its contract with DHCS, including "staffing in medical and other health services." These contractual requirements are consistent with Rule 1300.70(b)(2)(G)(5) and Rule 1300.70(b)(2)(H)(1)-(2), which require the Plan to establish adequate oversight mechanisms to ensure that delegated entities meet the requirements of the Knox Keene Act and the standards set forth by the Plan. The Plan does not have adequate oversight mechanisms to ensure that delegated entities meet the requirements of the Knox Keene Act and the standards set forth by the Plan.

The Plan conceded that the Plan's delegation oversight was inadequate—monitoring of delegated functions was not active, even though delegation audits were conducted; data was not reviewed, analyzed, and acted upon; and monitoring of under- and over-utilization of services, including review of delegates' utilization management data, was not fully developed and operational. The Plan also acknowledged that it had staffing turnover issues, which contributed to the inadequate oversight mechanisms during the review period. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

**Potential Deficiency #3: The Plan does not ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer members appointments that meet required appointment wait time standards. Specifically, the Plan does not have adequate compliance monitoring procedures in place and does not ensure that effective action is taken to improve care where deficiencies are identified.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-SFHP Contract Exhibit A, Attachment 9 – Access and Availability, Provision 3 – Access Requirements, and Provision 4 – Access Standards; Rule 1300.67.2.2(c)(5); Rules 1300.67.2.2(d)(1)-(3); Rule 1300.70(a)(1) and (3).

DHCS-SFHP Contract Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

DHCS-SFHP Contract Exhibit A, Attachment 9 – Access and Availability

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

A. Appropriate Clinical Timeframes

Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.

B. Standards for Timely Appointments

Members must be offered appointments within the following timeframes:

1. Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
2. Urgent appointment for services that do require prior authorization – within 96 hours of a request;
3. Non-urgent primary care appointments – within ten (10) business days of request;

4. Appointment with a specialist – within 15 business days of request;
5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

Rule 1300.67.2.2(c)(5)

(c) Standards for Timely Access to Care.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G);

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (G);

(C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (G) and (H);

(D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (G) and (H);

(E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in (G) and (H);

(F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in (G) and (H);

Rules 1300.67.2.2(d)(1)-(3)

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers...

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all contracted providers affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

Rules 1300.70(a)(1) and (3)

(a) Intent and Regulatory Purpose.

(1)The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.  
(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.”

**Documents Reviewed:**

- Plan Policy QI-05: Access Policy and Standards (11/25/14)
- Timely Access Report 2013 Appointment – Availability
- Timely Access Report 2013 Provider Report Rate of Compliance
- Timely Access Report 2013 Medical Group Audit Findings
- Timely Access Report 2013 Ancillary
- Comparison of Third Next Available Appointment Between 2014 and 2015
- Quality Improvement Committee meeting minutes (02/13/14, 04/10/14, 06/12/14, 08/14/14, 10/09/14)

**Assessment:** The Plan gathered and reported access data, which did not meet timely access standards; however, no corrective action was taken by the Plan to address the identified deficiencies.

**1. The Plan’s contracted provider medical groups/provider network are not consistently meeting timely access standards for primary care and specialty appointments.**

The Plan is required to “ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 ...” pursuant to DHCS-SFHP Contract Exhibit A, Attachment 9, Provision 4. Rule 1300.67.2.2(c)(5) requires plans ensure “that its contracted provider network has adequate capacity and availability of licensed health care providers to offer members appointments that meet” specific timeframes. Rule 1300.67.2.2(d)(1) requires each plan have “written quality assurance systems, policies and procedures designed to ensure that the plan’s provider network is sufficient to provide accessibility, availability and continuity of covered health care services ...” Such systems are required to include “compliance monitoring policies and procedures ...” pursuant to Rule 1300.67.2.2(d)(2). Rule 1300.67.2.2(d)(3) requires the Plan “implement prompt investigation and corrective action when compliance monitoring discloses that the plan’s provider network is not sufficient to ensure timely access ...”

The Plan presented a document, *Third Next Available Appointment Data for 2014*,<sup>7</sup> which demonstrated that during the survey period, the average wait time for the Plan was 32 days. The report broke down wait times for the various medical groups/provider networks that serve the

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<sup>7</sup> Third Next Available Appointment is a method of assessing appointment availability. The Plan asks providers for not the first or second available appointment but the third available appointment. The rationale behind this survey method is that it mitigates randomness to some degree, in that the first available appointment (or even the second) may just have been available by a chance cancellation. Data resulting from this method is not directly comparable with the design of surveys used by most other California plans.

Plan's members. Based on these reported wait times, timely access standards were not being met in three (3) out of five (5) (60%) Plan provider networks:

- Pursuant to Rule 1300.67.2.2(c)(5)(C) "Non-urgent appointments for primary care" must be offered "within ten business days of the request for appointment." Two Plan provider networks had average Primary Care Provider (PCP) wait times of 11.1 and 14.6 days; another two provider networks had *average wait times of 30 and 38.3 days*.
- Rule 1300.67.2.2(c)(5)(D) "Non-urgent appointments with specialist physicians" must be offered "within fifteen business days of the request for appointment." One network had an *average specialist wait time of 66.3 days*. Plan specialist data is aggregate data, not broken out by specialty; therefore, it is not possible to ascertain which specific specialties have significant access issues in order that corrective actions can be targeted effectively.

**2. The Plan fails to implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access.**

Rule 1300.67.2.2(d)(3) requires each plan to "implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access ..." DHCS-SFHP Contract Exhibit A, Attachment 9, Provision 3 states that the Plan shall "...communicate, enforce, and monitor providers' compliance with these requirements." Rule 1300.70(a)(1) requires, "that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated" and subsection (3) requires, the Plan to "address service elements, including accessibility, availability, and continuity of care." A plan's QA program must also monitor whether the "provision and utilization of services meets professionally recognized standards of practice" pursuant to Rule 1300.70(a)(3).

Plan policy, *QI-05, Access Policy and Standards*, confirms the requirement to implement corrective actions to address identified compliance issues, stating:

If a provider or medical group is found to be out of compliance the following actions will be taken:

- The provider or medical group will be required to submit a corrective action plan to SFHP for approval and monitoring.
- QIC will be notified.
- Efforts will be made by SFHP to review network adequacy and ensure appropriate service levels.

The Plan gathered and reported access data, which as noted above, did not meet timely access standards; however, no corrective action was taken. This outcome was confirmed during interviews in which Plan staff stated that "access was an issue and an area needing improvement" and confirmed that they had never issued a Corrective Action Plan (CAP) for access to care. *QIC Committee Minutes* did not document discussion of access or related corrective actions.

**3. The Plan fails to monitor timely access for mental health providers.**

Rule 1300.67.2.2(c)(5) and (d)(2) require the Plan monitor timely access. DHCS-SFHP Contract Exhibit A, Attachment 9, Provision 3 states that the Plan shall "...communicate, enforce, and monitor providers' compliance with these requirements." Provision 4 states, "Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers' compliance with these standards."

In the follow-up access interview, the Plan was asked for data related to mental health provider availability and wait times. Plan staff stated that they did not have data for mental health provider availability and wait times, indicating that the Plan does not monitor mental health appointment availability.

**Conclusion:** Rule 1300.67.2.2(d)(3) requires each plan to "implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access ...". The Plan's monitoring showed that two provider networks had average PCP appointment wait times of 30 and 38.3 days and one network had an average specialist wait time of 66.3 days – all significantly above the maximum timeframes permitted by the Plan's contract of 10 business days of request for non-urgent primary care appointments and within 15 business days of request for specialists. Committee minutes and interviews with Plan staff revealed that no corrective action plans were implemented for these deficiencies. The Plan fails to monitor appointment availability for mental health providers and take effective action to improve timely access to primary care and specialty care providers, in violation of Rules 1300.67.2.2(c)(5) and (d)(2) and DHCS-SFHP Contract Exhibit A, Attachment 9, Provisions 3 and 4. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

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**Potential Deficiency #4: The Plan did not report valid rates of compliance with appointment availability time elapsed standards for each of its contracted provider groups for Reporting Year 2014.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract Exhibit A, Attachment 9 – Access and Availability, Provision 3(A) – Access Requirements, and Provision 4(A) and (B) – Access Standards; Rule 1300.67.2.2 (d)(2)-(3); Rule 1300.67.2.2 (d)(3); Rule 1300.67.2.2.(g)(2)(B)-(C).

DHCS-SFHP Contract Exhibit A, Attachment 9, Access and Availability

**3. Access Requirements**

Contractor shall establish acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2 and as specified below. DHCS will review and approve standards for reasonableness. Contractor shall ensure that Contracting Providers offer hours of operation similar to commercial s or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal s. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

#### A. Appointments

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

##### (1) Appropriate Clinical Timeframes:

Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.

##### (2) Standards for Timely Appointments:

Members must be offered appointments within the following timeframes:

- a) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
- b) Urgent appointment for services that do require prior authorization – within 96 hours of a request;
- c) Non-urgent primary care appointments – within ten (10) business days of request;
- d) Appointment with a specialist – within 15 business days of request;
- e) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illnesses, or other health condition – within 15 business days of request.

#### DHCS-SFHP Contract Exhibit A, Attachment 9, Access and Availability

##### 4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

##### A. Appropriate Clinical Timeframes

Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.

##### B. Standards for Timely Appointments

Members must be offered appointments within the following timeframes:

1. Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
2. Urgent appointment for services that do require prior authorization – within 96 hours of a request;
3. Non-urgent primary care appointments – within ten (10) business days of request;
4. Appointment with a specialist – within 15 business days of request;
5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

#### Rule 1300.67.2.2(d)(2)-(3)

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers ...

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all contracted providers affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

Rule 1300.67.2.2(g)(2)(B)-(C)

(g) Filing, Implementation and Reporting Requirements.

(2) By March 31, 2012, and by March 31 of each year thereafter, plans shall file with the Department a report, pursuant to subsection (f)(2) of Section 1367.03 of the Act, regarding compliance during the immediately preceding year. The first reporting period shall be the calendar year ending December 31, 2011. The reports shall document the following information:

(B) The rate of compliance, during the reporting period, with the time elapsed standards set forth in subsection (c)(5), separately reported for each of the plan's contracted provider groups located in each county of the plan's service area. A plan may develop data regarding rates of compliance through statistically reliable sampling methodology, including but not limited to provider and enrollee survey processes, or through provider reporting required pursuant to subsection (f)(2) of Section 1367.03 of the Act;

(C) Whether the plan identified, during the reporting period,

(1) any incidents of noncompliance resulting in substantial harm to an enrollee or

(2) any patterns of non-compliance and, if so, a description of the identified non-compliance and the plan's responsive investigation, determination and corrective action.

**Documents Reviewed:**

- Plan Policy QI-05: Access Policy and Standards (11/25/14)
- Timely Access Report (Reporting Year 2014)

**Assessment:** The Plan is required to "ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 ..." and to "monitor providers' compliance with these standards" pursuant to DHCS-SFHP Contract Exhibit A, Attachment 9, Provision 4. The Plan is required by Rule 1300.67.2.2(g)(2) to annually submit the *Timely Access Report*, a report of its access monitoring results, to the Department. Rule 1300.67.2.2(g)(2)(B) requires this report include the Plan's "rate of compliance during the reporting period with the time elapsed standards set forth in subsection (c)(5), separately reported for each of the plan's contracted provider groups ..." The Plan's measurements are required to "accurately measure the accessibility and availability of contracted providers" pursuant to Rule 1300.67.2.2(d)(2). DHCS-SFHP Contract Exhibit A, Attachment 9, Provision 4(A) states that the Plan must "ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition," and Provision 4(B) further delineates specific timeframes for types of appointments.

The Plan was unable to report valid rates of compliance for its contracted provider groups for 2014 reporting year because it provided erroneous sampling data to the vendor that conducted its appointment availability survey. This error resulted in the Plan receiving an inadequate number of survey responses to create valid rates.

The Plan described its intended approach to monitoring compliance with appointment availability time elapsed wait time standards in *Plan Policy QI-05: Access Policy and Standards Plan policy*:

SFHP monitors providers compliance with urgent PCP and Specialty appointments (with and without prior authorization), and non-urgent ancillary care standards through the administration of the ICE [Industry Collaborative Effort] Provider Availability Tool annually. In cases where this function is delegated, Medical Groups are required to use the ICE Provider Availability Tool, or a tool, which at a minimum, includes questions similar to those in the ICE survey. Medical Groups are required to conduct this evaluation annually, and to report results to SFHP annually, by the date set by SFHP.

The Plan submitted its annual *Timely Access Report* for the 2014 reporting year to the Department's web portal. The Plan reported, consistent with its *Plan Policy QI-05 Access Policy and Standards*, that it attempted to conduct its annual appointment availability survey by working through ICE. ICE and its vendor administered the Department's *Model Provider Appointment Availability Survey* for PCPs and three specialties identified by the Department for focus in 2014. However, the Plan reported issues that invalidated the results of its survey. The Plan described the issues in its submission as follows:

SFHP provided a list of SFHP-contracted providers to ICE, including an oversample of 20 providers. In turn, ICE contracted with a call center vendor to implement the survey. ICE utilized the appointment availability survey recommended by DMHC. SFHP encountered several issues with the survey administration in 2014. First, SFHP misinterpreted the survey sample size requirement and submitted an incorrect sample of providers to the call center vendor resulting in an adequate sample for the entire network, but SFHP did not follow the sampling size requirement correctly by provider group. As a result, SFHP provided incorrect sample sizes for each provider group within the network. Secondly, the survey results were provided to SFHP by the survey vendor approximately four weeks past the due date. Late receipt of the results did not allow sufficient time for SFHP to recognize the sampling error and SFHP was not able to make corrections for the survey sample in time.

In comparison with the sample sizes needed for valid reporting, as specified in the Department's *Model Provider Appointment Availability Survey Methodology*, the number of providers the Plan identified to the vendor for each provider group and the number of responses the Plan ultimately received were far below the minimums needed in nearly every provider-by-specialty category (see Table 2).

**TABLE 2**  
**Comparison of Sample Sizes Needed, Number of Providers the Plan Identified to the Survey Vendor, and Number of Responses Received**

Provider Group	# of Providers	PCP	Allergists	Dermatologists	Cardiologists
A	# Needed for Sample	49	2	7	14
	# Identified to Vendor	7	3	8	14
	# Responded to Survey	5	1	6	3
B	# Needed for Sample	47	1	4	6
	# Identified to Vendor	31	1	4	17
	# Responded to Survey	31	1	4	17
C	# Needed for Sample	28	1	6	0
	# Identified to Vendor	28	1	5	9
	# Responded to Survey	2	1	2	1
D	# Needed for Sample	45	6	38	19
	# Identified to Vendor	34	3	5	1
	# Responded to Survey	8	2	3	1
E	# Needed for Sample	57	13	44	45
	# Identified to Vendor	115	13	47	5
	# Responded to Survey	4	3	3	1

Upon review of this data, the Department finds that the sample sizes were insufficient for determining compliance with wait time standards at a Plan-wide level or for individual provider groups. In its report submission, the Plan concurred with the Department’s assessment that the survey results were not useable for determining compliance, stating that, “... due to the insufficient sample sizes for each provider group, the number of returned surveys was too small to deliver results that could be used to determine non-compliance. These factors led to low response rates for each provider group and survey results with questionable validity.”

This survey is the Plan’s primary means for assessing compliance with wait time standards. As a result the Plan was unable to effectively pinpoint access problems (e.g., by provider or specialty) and ensure that it had identified and reported “any patterns of non-compliance and, if so, a description of the identified non-compliance and the Plan’s responsive investigation, determination and corrective action,” as required by Rule 1300.67.2.2(g)(2)(C)(2). The Plan identified only one potential problem for further investigation: Provider Group B showed that 0% of the sample (17 providers) offered urgent appointments that require prior authorization within the required 96-hour timeframe. The Plan stated “all other results had questionable validity due to response sizes of 1, 2 or 3 in most cases.” Further, because the Plan could not ensure that it had identified all existing access problems, it in turn could not ensure that such problems were addressed through “prompt investigation and corrective action ... taking all

necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance,” as required by Rule 1300.67.2.2(d)(3).

The Plan was unable to correct its reporting problem during the 2014 reporting year. In an effort to improve response rates for measurement year 2015 and future surveys, the Plan stated in its report submission that it would:

1. Ensure SFHP staff have a correct understanding of the survey requirements prior to implementing the survey with the vendor.
2. Follow the DMHC methodology requirements to segment provider data by provider group to ensure a meaningful sample sizes for each.
3. Oversample primary and specialty care to account for physician office refusal to participate in the survey.
4. Monitor ICE-contracted survey vendor weekly to remediate potential low response rates, identify any issues, and allow sufficient time for analysis.

**Conclusion:** Because the Plan provided erroneous sampling data to the vendor that conducted its appointment availability survey, it was unable to submit a valid rate of compliance with time elapsed appointment wait time standards for each of its contracted provider groups in its annual *Timely Access Report* as required by Rule 1300.67.2.2(g)(2)(B) and Rule 1300.67.2.2(d)(2). The Plan could not ensure that it had identified and reported any patterns of non-compliance because it lacked valid data on appointment wait times, as required by DHCS-SFHP Contract Exhibit A, Attachment 9, Provision 3 and Rule 1300.67.2.2(g)(2)(C)(2). As a result of this failure, the Plan was unable to implement prompt investigation and corrective action as required by Rule 1300.67.2.2(d)(3). Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

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**Potential Deficiency #5: The Plan does not adequately oversee and monitor its 24 hours per day, 7 days per week, triage or screening services by telephone.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract Exhibit A, Attachment 9 – Access and Availability, Provision 3(D) and (E) – Access Requirements, and Provision 4 – Access Standards; Rule 1300.67.2(b) and (f); Rule 1300.67.2.2(c)(8).

DHCS-SFHP Contract Exhibit A, Attachment 9 – Access and Availability

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers’ compliance with these requirements.

D. Telephone Procedures

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

E. After Hours Calls

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

#### 4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

##### Rule 1300.67.2(b) and (f)

(b) Hours of operation and provision for after-hour services shall be reasonable;

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

##### Rule 1300.67.2.2(c)(8)

(c) Standards for Timely Access to Care.

(8) Plans shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined at subsection (b)(5).

#### **Documents Reviewed:**

- Plan Policy CS-03: Monitoring of Telephone Calls (05/20/14)
- Plan Policy QI-05: Access Policy and Standards (11/25/14)
- Network Operations Manual
- Clinic Template 2009
- Med Group Template 2010

**Assessment:** The Plan does not monitor to ensure the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone.

The Plan is required to “ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 ...” and to “enforce and monitor providers' compliance with these standards” pursuant to DHCS-SFHP Contract Exhibit A, Attachment 9, Provision 4. DHCS-SFHP Contract Exhibit A, Attachment 9, Provision 3(E) states that “a physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls.” Rule 1300.67.2(b) requires that “provision for after-hours services shall be reasonable” and Rule 1300.67.2.2(c)(8) further specifies that each plan shall, “provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone ...”

The Plan provides a Nurse Advice Line to assist with after-hours questions and concerns. Additionally, as explained in the Responsibilities section of the Provider Manual entitled, *Network Operations Manual PCP*, the Plan assigns PCPs the responsibility for “assuring reasonable access and availability to primary care services,” “providing access to urgent care,” and “providing 24-hour coverage for advice and referral to care.” The Plan's contract with its medical groups confirms this requirement, stating, “Emergency Services and telephone advice

and referral will be available, as Medically Necessary, twenty-four (24) hours a day, seven (7) days per week.”

The Plan does not have a documented system for monitoring and evaluating accessibility of triage services, including a system for addressing problems that develop. Rule 1300.67.2(f) requires that “each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems ...” DHCS-SFHP Contract Exhibit A, Attachment 9, Access and Availability, Provision 3. Access Requirements, requires the Plan to “communicate, enforce, and monitor providers compliance” with this regulation.

The Plan’s policy, *QI-05: Access Policy and Standards*, states that the Plan monitors access via “Facility Site Review and Medical Record Reviews, through annual oversight audits ... and member and provider surveys.” These monitoring approaches do not adequately address triage services. Facility site reviews are conducted only every three years, and therefore, are insufficient for monitoring ongoing performance. The Plan’s member and provider surveys do not directly address after-hours care. During interviews, Plan staff stated that they do not conduct after-hours calls to monitor answering and triage services. The Plan’s policies and procedures also do not outline a documented system for monitoring and evaluating accessibility of care with regard to triage.

**Conclusion:** Rule 1300.67.2.2(c)(8) requires the Plan to, “provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone ...” Rule 1300.67.2(f) requires the Plan to, “have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.” Because the Plan has not established a system for monitoring triage and after-hours services, it cannot ensure the provision, 24 hours per day, 7 days per week, of triage services. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

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**Potential Deficiency #6: The Plan’s policy does not include written standards in the policy pertaining to physician-to-member ratios that are consistent with contractual requirements.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract Exhibit A, Attachment 6 –Provider Network, Provision 3(A)(1) and (2) – Provider to Enrollee Ratios.

DHCS-SFHP Contract Exhibit A, Attachment 6 – Provider Network

3. Provider to Member Ratios

A. Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:

- 1) Primary Care Physicians 1:2,000
- 2) Total Physicians 1:1,200

**Documents Reviewed:**

- Plan Policy QI 05: Access Policy and Standards (11/25/14)

**Assessment:** Plan policy, *QI 05: Access Policy and Standards*, does not include written standards in the policy pertaining to physician-to-member ratios that are consistent with contractual and statutory requirements. The PCP to member ratio and the specialist to member ratio are written incorrectly as follows:

**1. Primary Care Physician-to-Member Ratio**

DHCS-SFHP Contract Exhibit A, Attachment 6. Provider Network, Provision 3(A)(1) requires one full-time equivalent primary care physician for each two thousand (2,000) members. Plan policy states “Primary care provider to Member ratio does not exceed 1 PCP: 2000 members.” [Emphasis added.] It would actually be advantageous for members if that ratio exceeded 1:2000; the policy should instead state that the Plan has sufficient PCPs such that there are never fewer than one PCP per 2,000 members.

**2. Specialist-to-Member Ratio**

DHCS-SFHP Contract, Exhibit A, Attachment 6, Provision 3(A)(1) requires one full-time equivalent physician for each two thousand (2,000) members. Plan policy states “Specialist to Member ratio does not exceed 1 PCP: 2000 members.” [Emphasis added.] It would actually be advantageous for members if that ratio exceeded 1:2000; the policy should instead state that the Plan has sufficient physicians (specialists and PCPs combined) such that there are never fewer than one physician per 2,000 members.

**Conclusion:** The Plan’s *QI 05: Access Policy and Standards* is incorrectly written in terms of its standard for physician-to-member ratios and does not, therefore, conform to DHCS-SFHP Contract Exhibit A, Attachment 6, Provision 3(A)(1) and (2). Therefore, the Department finds the Plan in violation of this contractual requirement.

**MEMBER RIGHTS**

**Potential Deficiency #7: The Plan does not consistently process all expressions of dissatisfaction by enrollees as grievances to ensure adequate consideration and rectification when appropriate.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System, and Provision 2(C) – Grievance System Oversight; Section 1368(a)(1); Rule 1300.68(a)(1) and (2).

DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System

**1. 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 the Member 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. Grievance System Oversight

Contractor shall implement and maintain procedures as described below 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.

C. Procedure for systematic aggregation and analysis of the grievance data and use for Quality Improvement.

### Section 1368(a)(1)

(a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

### Rule 1300.68(a)(1) and (2)

(1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

(2) "Complaint" is the same as "grievance."

### **Documents Reviewed:**

- Plan Policy QI-06: Member Grievances and Appeals (04/28/14)
- Plan 2014 Inquiry Log
- Updated 2014 Inquiry Log (Plan submitted post onsite identifying grievances filed by SPD members and enrollees of Healthy Kinds/Healthy Workers program)
- 84 "Decline to File Grievance" letters from the survey period (01/01/14 – 12/31/14)
- Member Handbook, 2014
- MediCal Evidence of Coverage and Disclosure Form (2013 – 2014)

**Assessment:** Section 1368(a)(1) requires the Plan to establish and maintain a grievance system that provides reasonable procedures ensuring adequate consideration of enrollee grievances and rectification when appropriate. Rule 1300.68(a)(1) indicates that a "grievance" means a written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

The Plan submitted as part of the pre-onsite request, a universe of 204 standard grievances and appeals filed by members during the review period. However, the Plan did not produce a separate log of "exempt" grievances, or grievances that were resolved by the close of the next

business day and were not coverage disputes or disputed health care services involving medical necessity, or experimental or investigational treatment. Therefore, to ensure that the Plan is capturing all expressions of dissatisfaction, during its onsite review, the Department reviewed the Plan's 2014 *Inquiry Log*. The *Inquiry Log* contained 84 telephone complaints, 40 of which were submitted by SPD members. The Department's review of the 40 cases revealed the following:

- All 40 cases met the definition of grievance which is defined as an "oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance" under Rule 1300.68(a)(1) .
- All callers expressed dissatisfaction about the Plan or the provider for care or services received or not received.
- Plan staff offered each of the complainants the option to file a grievance during the phone call and all declined.
- The Plan sent a letter to each caller acknowledging receipt of the member's expression of dissatisfaction and indicating that that the member did not want to file a grievance. All letters were sent within the close of next business day of receipt.
- There was no evidence that the Plan provided written resolution to complainants of the problems presented during the phone call.

The Plan's policy *QI-06 I: Member Grievances and Appeals* does incorporate procedures to follow when members decline to file grievances. On page 4, it states:

If a member or his/her representative calls the SFHP Customer Service Department with a complaint or an expression of dissatisfaction regarding the plan and/or provider, and the member declines to file a grievance, SFHP will perform the following procedure:

- Customer Service Representative will notify Utilization Management (UM) RN, Customer Service Manager and Grievance Coordinator
- UM RN reviews member's statement for any clinical and/or Potential Quality Issues (PQI) components (clinical or non-clinical)
- If the complaint or expression of dissatisfaction is determined to be non-clinical, Customer Service records this information into department's non-clinical grievance log and sends a letter to the member
- ***Next steps are case by case scenario if the issues are determined to be clinical:*** If there is a potential quality issue, the Grievance Coordinator will log the appropriate information into the PQI log and notify the PQI RN

The Plan's policy indicates that although these complaints by members were not classified and handled as formal grievances, the Plan does maintain a separate log and the Customer Service Manager and Grievance Coordinator are notified. However, it is unclear whether information within this log is reviewed periodically for systematic aggregation and analysis for quality improvement as required by DHCS-SFHP Contract, Exhibit A, Attachment 14, Provision 2(C).

Furthermore, despite the member's decision not to file a grievance, there is no indication that the issues presented by the member were ever adequately considered, investigated, or resolved, as required by 1368(a)(1). For example:

- *Inquiry #23*: Notes from the inquiry log made by a Plan customer service representative (CSR) are as follows:

Member called to change PCP to [to another doctor] because she was unhappy with her current PCP ... . She said the medication [her doctor] prescribed [to] her triggered allergic reaction and her condition was not improved. She was then admitted to ER [at the hospital] today due to that. Member refused to file grievance. I changed her PCP [to another doctor] as of July 1 2014.

The letter sent to the member stated:

You are not satisfied with the services provided by [your doctor] because you were prescribed with medication that triggered allergic reaction which also did not improve your condition and lead to your ER visit at [the hospital] today.

The Department requested clarification from the Plan regarding the activities that transpired following the call. The Plan did not identify staff in the log in terms of title, position, or Department affiliation. There was no evidence provided to the Department that the CSR or anyone else reviewed the "no clinical component" designation in these cases. There were no notes pertaining to investigation of the member's allegation that her prescription medication triggered an allergic reaction, which did not improve her condition, and led to an emergency room visit. Even if the member did not want the case to be investigated, there is no documentation to substantiate that the Plan tracked this complaint to identify trends for this particular provider.

**Conclusion:** Section 1368(a)(1) requires the Plan to establish and maintain a grievance system under which enrollees may submit their grievances to the Plan. DHCS-SFHP Contract, Exhibit A, Attachment 14, Provision 1 requires the Plan to implement and maintain a Member Grievance System in accordance with Rule 1300.68. Section 1300.68(a)(1) and (2) indicate that a "grievance" is a written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care concerns. The Plan must also provide reasonable procedures to ensure adequate consideration of enrollee grievances and rectification when appropriate. The Department's review of 40 inquiries indicates that all 40 members expressed dissatisfaction to the Plan but declined to file formal grievances. Although the Plan did send out letters to members, acknowledging the complaint and providing the member with further opportunity to file a grievance, there was no documentation to substantiate that these issues received further follow-up. In addition, the Plan did not provide evidence that this data received systematic aggregation and analysis for quality improvement as required by DHCS-SFHP Contract, Exhibit A, Attachment 14, Provision 2(C). Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

**Potential Deficiency #8: The Plan does not have procedures in place to aggregate and analyze SPD-specific grievance data and use this analysis for quality improvement purposes.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract, Exhibit A, Attachment 13 – Member Services, Provision 3 – Call Center Reports; DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System, and Provision 2(C) – Grievance System Oversight; Rule 1300.68(b)(1).

DHCS-SFHP Contract, Exhibit A, Attachment 13 – Member Services

3. Call Center Reports

Contractor shall report quarterly, in a format to be approved by DHCS, the number of calls received by call type (questions, grievances, access to services, request for health education, etc.); the average speed to answer Member services telephone calls with a live voice; and the Member services telephone calls abandonment rate.

DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System

1. 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).

2. Grievance System Oversight

C. Procedure for systematic aggregation and analysis of the grievance data and use for Quality Improvement.

Rule 1300.68(b)(1)

(b) The plan's grievance system shall include the following:

(1) An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

**Documents Reviewed:**

- Quality Improvement Committee Meeting Minutes (February 13, 2014; April 10, 2014; June 12, 2014; August 14, 2014; October 9, 2014)
- Plan 2014 Inquiry Log with 84 grievances (SPD members filed 40 of the 84 grievances.)

**Assessment:** The Department's review found no evidence that the Plan collects, reports, and analyzes grievance data for its SPD population. In interviews, Plan staff confirmed that no SPD-specific reports or trend and pattern analysis pertaining to member grievances have been

generated or reported to Plan management, including the Quality Improvement Committee and the Governing Board.

The Plan's *Inquiry Log* contains 84 telephonic complaints recorded during the period January through December 2014. Of these 84 cases, enrollees from the Healthy Kids and Healthy Workers Programs filed 7; SPD members filed 40; and non-SPD Medi-Cal members filed the remaining 37.

As discussed in Potential Deficiency #7, the Plan did not recognize these telephonic complaints as grievances because the members declined to file a grievance after their initial call expressing dissatisfaction. The Plan did not respond to the Department's question as to where these cases were recorded and counted because they were not part of the Plan's grievance system. The Plan also did not respond to the Department's question whether these cases were reported to the Quality Improvement Committee, the Board, or other monitoring body. Because these cases were not considered grievances, the Plan may have under-reported the volume of grievances in the Plan's quarterly reports to the Department, the Quarterly Grievance Report for Medi-Cal Members, and the Quarterly Call Center Report to DHCS. The Call Center Report requires the reporting of the number of calls received by call type (questions, grievances, access to services, request for health education, etc.); the average speed to answer member services telephone calls with a live voice; and the member services telephone calls abandonment rate.

**Conclusion:** The Plan is required to "implement and maintain a Member Grievance System in accordance with [Rule] 1300.68," pursuant to DHCS-SFHP Contract, Exhibit A, Attachment 14, Provision 1. Rule 1300.68(b)(1) requires a plan to have an officer designated as having primary responsibility for its grievance system, and the officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include reporting procedures in order to improve plan policies and procedures. Without reports or any analysis pertaining to SPD-specific member grievances, the Plan and its officials cannot review the operation of the grievance system to identify any emergent patterns of grievances and implement improvements. DHCS-SFHP Contract, Exhibit A, Attachment 14, Provision 2(C), requires procedures for systematic aggregation and analysis of grievance data and use for quality improvement. The Plan failed to meet this requirement as it did not conduct any SPD-specific systematic aggregation and analysis of the grievance data and use it for quality improvement. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

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**Potential Deficiency #9: The Plan does not consistently convey to its SPD members that language assistance services are provided at no cost to the member.**

**Contractual/Statutory/Regulatory Reference(s):** DMHC-SFHP Contract Exhibit A, Attachment 9 – Access and Availability, Provision 14(B)(1) and (2) – Linguistic Services.

DHCS-SFHP Contract, Exhibit A, Attachment 9 – Access and Availability

14. Linguistic Services

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

- 1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those that speak the threshold or concentration standards languages.
- 2) Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor’s Service Area, and by the Contractor in its group needs assessment.

**Documents Reviewed:**

- Plan Policy QI-06: Member Grievances and Appeals (04/28/14)
- Plan 2014 Inquiry Log
- Updated Inquiry Log (The log contains 84 telephonic grievances. SPD members filed 40 of the 84 grievances)
- 84 “Decline to File Grievance” letters from the survey period (01/01/14 – 12/31/14)
- MediCal Evidence of Coverage and Disclosure Form (2013 – 2014)

**Assessment:** The Plan’s grievance and appeals resolution letters do not indicate that translation services are free as required by DMHC-SFHP Contract Exhibit A, Attachment 9, Access and Availability, 14. Linguistic Services. Several key Plan documents offer interpreter services free of charge (e.g., the Member Handbook correctly states, “You have a right to interpreter services at no charge, and may use one whenever you get medical care”). However, the Department found that during the review period, the Plan’s grievance acknowledgement and resolution letters included the following statement at the top of the page: “If you need assistance to translate this letter in another language, please contact San Francisco Health Plan at (800)288-5555.” This statement does not indicate that these services are free. The Plan noted that beginning September/October 2014, the resolution letter started to be translated into the member’s preferred language.

**Conclusion:** DMHC-SFHP Contract Exhibit A, Attachment 9, Provision 14(B), requires plans to “provide ... linguistic services at no cost to Medi-Cal Members or potential members.” The Plan does not consistently indicate that language assistance services are provided free of charge. Therefore, the Department finds the Plan in violation of this contractual requirement.

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**Potential Deficiency #10: The Plan does not adequately monitor and make modifications to its Language Assistance Program.**

**Contractual/Statutory/Regulatory Reference(s):** DMHC-SFHP Contract Exhibit A, Attachment 4 – Quality Improvement System, Provision 7(F) – Written Description; DMHC-SFHP Contract Exhibit A Attachment 9 – Access and Availability, Provision 4 – Access Standards, and Provision 13(B)- (F) – Cultural and Linguistic Program; Rule 1300.67.2.2(c)(4).

DMHC-SFHP Contract Exhibit A, Attachment 4 – Quality Improvement System

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

DHCS-SFHP Contract Exhibit A, Attachment 9 – Access and Availability

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

13. Cultural and Linguistic Program

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

B. Linguistic Capability of Employees

Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and nonclinical).

E. Cultural Competency Training

Contractor shall provide cultural competency, sensitivity, or diversity training for staff, providers and subcontractors at key points of contact. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with providers and the health care structure; traditional home remedies that may impact what the provider is trying to do to treat the patient; and, language and literacy needs.

F. Program Implementation and Evaluation

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

Rule 1300.67.2.2(c)(4)

4) Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. This subsection does

not modify the requirements established in Section 1300.67.04, or approved by the Department pursuant to Section 1300.67.04 for a plan's language assistance program.

**Documents Reviewed:**

- Plan Policy CLS-02: Use of Interpreter Services and Bilingual Staff (09/09/14)
- Plan Policy CLS-04: Health Education and CLS Group Needs Assessment (06/19/14)
- Plan Policy CLS-06: Cultural Awareness Trainings (04/30/14)
- Plan Policy PR-03: New Provider Training (02/10/2015)
- Health Education and Cultural and Linguistic Group Needs Assessment 2011 (with updates through 2014)
- Monitoring Call Guide Line
- October – December 2014 Calls Monitoring – Need Improvement Log

**Assessment:** The Plan does not adequately monitor language and interpreter services and ensure interpreter services are coordinated with scheduled appointments. DMHC-SFHP Contract Exhibit A, Attachment 9, Provision 13 requires plans to “monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services.” The following describes key aspects of the Plan's Language Assistant Program that demonstrates the Plan's failure to monitor or otherwise comply with the regulations.

**1. Language Assistance/Cultural Awareness Training**

In Plan policy *PR-03 (New Provider Training)*, the Plan describes its requirements for language assistance/cultural awareness training as follows:

- This training must be completed by all contracted providers on an annual basis.
- This training must be completed by all office staff working with contracted providers.
- Proof of training completion is demonstrated by signing the training attendance sheet verified by vendor report of completed trainings.

While the Plan requires that this annual training be verified through sign-in sheets, it was not able to provide the Department verification for all providers and provider staff. Plan staff conceded in interviews that it had not received verification of training from all its providers. Of additional concern, Plan staff confirmed that no corrective actions were implemented for individual providers who did not undergo training in 2013 and 2014. DMHC-SFHP Contract, Exhibit A, Attachment 9, Provision 13, requires plans to “provide cultural competency, sensitivity, or diversity training for staff, providers and subcontractors at key points of contact.”

## **2. Language Assistance Services provided by Plan Call Center Staff**

DMHC-SFHP Contract Exhibit A Attachment 9, Access and Availability, Provision 13(B) specifically requires plans to “assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and nonclinical).”

The Plan’s Customer Service Call Center staff includes individuals who have been tested and identified as proficient in several languages, including Chinese, Spanish, Vietnamese, Russian, and Burmese. These individuals provide customer service in the member’s preferred language. The Plan has also contracted with an interpretation service, which is available to Call Center staff when a member contacts the Call Center and there is no staff person available who speaks the member’s preferred language.

In pre-onsite materials and onsite interviews, the Plan offered no evidence that it monitors the performance of Call Center staff providing services directly in a member’s preferred language or working with an interpreter. Upon the Department’s request, the Plan provided the document, *Monitoring Call Guide Line*, a list of elements assessed during the Plan’s periodic internal monitoring of customer service representatives’ performance. The list included the following items: offer accurate information, polite and courteous, and enter accurate note in QNXT/OEA data system. However, no item specifically addressed language assistance: identification of caller language assistance needs when indicated; provision of service in a language other than English (for those representatives classified as having a skill in a language other than English); arranging for, and working with, an interpreter when indicated; or any other aspect of language services.

The Department also confirmed during interviews that the Plan does not use any alternate approach for assessing Call Center staff performance in addressing language assistance needs (e.g., post-call member satisfaction surveys).

## **3. Oversight of Language Assistance Services by Providers**

The Plan did not regularly perform monitoring activities regarding providers’ language assistance services (e.g., reports on volume/timeliness of interpretation requests, satisfaction surveys of members and providers who have used interpretation surveys). Nor did the Plan require such monitoring by delegates and receive resulting reports from delegates regarding use/provision of these services.

A serious problem with the Plan’s oversight of language assistance services provided by delegates is the lack of consistent Plan policies on how often the Plan monitors its delegates. For example, Plan policy *CLS-02 (Use of Interpreter Services and Bilingual Staff)* states:

The SFHP Project Manager of HECLS conducts an audit of linguistic services as part of the *annual Medical Group Compliance Audit*. [Emphasis added.]

This policy conflicts with the response to an item in the Culture and Linguistic Program Questionnaire: “How does the Plan ensure interpreter services are available at key points of contact?” The Plan responded: “Audits conducted *every other year* with contracted medical groups—interpreter services is a delegated function.” [Emphasis added.]

Plan staff stated in interviews that some documents need to be corrected. Operationally, the audits are currently conducted every other year, and only one delegate was audited during the survey period.

Further, the Department reviewed the Plan’s audit tool and found that the assessment during these audits is limited to review of language assistance policies and procedures. The Plan does not review—either as part of its delegate audits or periodically between audits—evidence to demonstrate that policies and procedures have been consistently and effectively implemented by the delegates.

#### **4. Coordination of Language Assistance Services with Scheduled Appointments**

Providers are advised in provider training and in the Provider Manual that in-person and phone interpretation services are available for limited English proficient members. However, the Plan has conducted no study, nor has it established a monitoring policy and procedure, to assess whether providers are consistently identifying members in need of interpreter services and whether the providers are consistently arranging for provision of these services at scheduled appointments. Rule 1300.67.2.2(c)(4) requires that interpreter services “be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.”

**Conclusion:** Rule 1300.67.2.2(c)(4) requires that interpreter services “... shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.” The Plan does not monitor language and interpreter services and ensure interpreter services are coordinated with scheduled appointments. Therefore, Department finds the Plan in violation of these contractual and regulatory requirements.

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#### **Potential Deficiency #11: The Plan does not ensure adequate consideration and rectification of SPD member grievances when appropriate.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Section 1368(a)(1).

##### DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System

###### 1. 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 the Member 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.

Section 1368(a)(1)

(a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

**Documents Reviewed:**

- 43 standard grievance/appeal files from the survey period (01/01/14 to 12/31/14)

**Assessment:** The Department reviewed 43 grievance/appeal files. Out of the 43 grievances, five (5) (12%), failed to demonstrate adequate consideration and rectification of member grievances. The following are examples of this failure:

- File #11: The member, who has primary pulmonary hypertension, contacted the Plan with concerns about his new provider group, which became effective on March 1, 2014. His grievance involved the length of time it took for his enrollment to be activated in the provider group's system, alleged lack of follow through by provider staff, being told by one staff member that she "did all that she could do" to assist, and his continued inability by March 24, 2014, to schedule an urgent appointment with a pulmonary specialist. The following are the Plan's notes:

He wants us to talk to [the provider] to ask them why did they not assist him and why did they keep telling him he was not in their system as active. He would like for us to find him a pulmonary specialist and assistance in getting his medications, since he only has 4 days left worth of medications.

The Plan's resolution letter sent three days later, on March 27, 2014, stated: "Since you are a XXX member, grievances need to be directly filed to them. To file a grievance, please call XXX's member services at (800) 464-4000."

Although grievance handling is delegated to the provider, Plan staff failed to promptly notify the member of this information and/or intervene *to facilitate the scheduling of an urgent appointment for his life threatening condition.*

- File #15: The member complained that the number of diabetic test strips the physician approved was inadequate, and the physician never followed through with obtaining a prior authorization for more than a five-day supply of Oxycontin. The member requested assistance with getting these medications refilled as soon as possible.

When the Plan attempted to investigate, their notes show: “PCP did not respond via fax. We have no e-mail contact for this provider, and the phone number above has been disconnected. No information from provider for resolution.” The Plan’s resolution letter stated: “We have forwarded your case to [doctor’s name], your primary care physician, for review and investigation.”

The member was also directed back to a doctor with a disconnected phone, who failed to respond to during the investigation, for documentation of medical necessity for additional diabetic test strips and, either a prescription for a preferred medication, or submission of a request for a non-formulary medication. While the resolution letter does state, “you have the right to change your primary care physician,” the notes do not reflect any effort to assist with a timely transition and ensure the provision of appropriate medical treatment.

- *File #38*: The member stated that upon filling a prescription, the pharmacy advised the medication was not covered by insurance. The member contacted the Plan and was told that the prescription was covered if billed to Medi-Cal FFS. However, when the pharmacy attempted to do so, it was unable to process the claim. Additionally, pharmacy staff reportedly offended the member by saying that they would just pay for it if they were in a similar circumstance. With the assistance of the Plan, the pharmacy was subsequently able to fill the prescription.

The member requested that the Plan “ensure the pharmacy knows how to fill the medication and the hassle won’t happen next time.” He stated that he was not comfortable being told to pay out of pocket because his medications were taking a long time, “especially when the pharmacy doesn’t know how to submit a claim to FSS MC. Since the pharmacy is contracted with SFHP, the pharmacy should have proper training.”

The Plan’s resolution letter, stated, “While San Francisco Health Plan does not cover these prescription drugs, if you have trouble picking them up in the future please be aware that they should be billed directly to Fee-for-Service (Regular) Medi-Cal.” The notes do not reflect any investigation or resolution related to the member’s concerns about training of pharmacy staff or the alleged offensive comment.

- *File #39*: The member appealed the denial of a request for an out-of-network physician to perform gender reassignment surgery. The member stated s/he was “not comfortable with in-network physician and that the scheduled surgery had been delayed on two occasions. The Plan’s notes state that the member “Would like to request for an IMR and whatever we can do to help him get his surgery.”

The denial was upheld by the Plan on the basis that services were available in-network. Despite the member’s specific request for an IMR, the Plan’s note do not show that the member was informed that she could file one at any time, *and the resolution letter failed to contain an application packet*, as required by Rule 1300.68(d)(4). The Plan also did not document any investigation into the member’s discomfort with the in-network MD or the two previous surgery postponements.

**File #40:** The member contacted the Plan to complain that she was “dropped” by her physician because of too many cancelled appointments. The member alleged that this was due to a wrong telephone number that automatically canceled scheduled appointments. The member also stated that at the last visit, she was assured a female provider would see her, but instead, she was seen by a male provider. The member described the encounter as “sexual assault.”

The Plan’s investigation found that the member had canceled and/or failed to show for multiple appointments, and that she had received several warning letters from the physician’s office prior to termination. However, the resolution letter, *sent the following day*, and the Plan’s notes, failure to show evidence of an investigation into the member’s allegations about the wrong telephone number or “sexual assault.”

**Conclusion:** The Plan is required to “implement and maintain a Member Grievance System in accordance with [Rule] 1300.68,” pursuant to DHCS-SFHP Contract, Exhibit A, Attachment 14 Provision 1. Section 1368(a)(1) requires that the Plan, “ensure adequate consideration of enrollee grievances and rectification when appropriate.” In 5 of 43 files reviewed, the documentation did not reflect adequate investigation of member concerns and rectification of the issues raised by the member. Therefore, Department finds the Plan in violation of these contractual and regulatory requirements.

**TABLE 3**  
**Standard Grievances**

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Grievance/Appeal	43	The Plan ensures adequate consideration and rectification of member grievances.	38	5

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**Potential Deficiency #12: The Plan does not consistently include an application for independent medical review (IMR), an addressed envelope, and instructions in its responses to members’ grievances involving delay, modification, or denial of services based on a determination in whole, or in part, that the service is not medically necessary.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System, and Provision 4(B)(2) – Notice of Action; Rule 1300.68(d)(4).

DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System

1. 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 the Member 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.

4. Notice of Action

B. If a Member receives a NOA, the Member has three options:

2) Members may request an Independent Medical Review (IMR) regarding the NOA from the Department of Managed Health Care (DMHC). An IMR may not be requested if a State Fair Hearing has already been requested for that NOA.

Rule 1300.68(d)(4)

(d) The plan shall respond to grievances as follows:

(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

**Documents Reviewed:**

- Plan Policy QI-06: Member Grievances and Appeals (04/28/14)
- 43 standard grievance/appeal files from the survey period (01/01/14 – 12/31/14),

**Assessment:** The Department reviewed 43 standard grievance/appeal files, including 12 appeals of denied services. Of the 12 appeals, 10 of the initial denials were upheld upon the Plan's review of the appeals. The DHCS-SFHP Contract, Exhibit A, Attachment 14, Provision 4(B)(2) indicates that if a member receives a Notice of Action (NOA), the member has the option to request an IMR. Of the 10 upheld denials, nine (9) included NOAs. The Department's review of these nine (9) files found that the Plan grievance resolution letters included a form to file for State Hearing. However, there is no evidence that an IMR application, instruction, and addressed envelope were provided to the members as required by Rule 1300.68(d)(4).

**TABLE 4**  
**Upheld Denials**

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Upheld Denial involving NOAs	9	Evidence of inclusion of an IMR application, instruction and envelope with the member's resolution letter	0	9

Plan policy *QI-06 (Member Grievances and Appeals)*, Section V. 16. Grievance Process, pertaining to mailing of grievance resolution letters, states: “For grievances involving a denial of medical services, the Clinical Quality Coordinator *includes an IMR form to the DMHC and a return envelope.*” [Emphasis added.] In interviews, Plan staff stated that it is a general practice that an IMR application and a return envelope are included in the mailing of applicable grievance resolutions; however, there is no evidence that this had been done.

**Conclusion:** The Plan is required to “implement and maintain a Member Grievance System in accordance with [Rule] 1300.68,” pursuant to DHCS-SFHP Contract, Exhibit A, Attachment 14, Provision 1. Rule 1300.68(d)(4) requires that the Plan include an Independent Medical Review form and return envelope with the Plan’s response to grievances involving medical necessity. The Plan failed to comply with these requirements as well as its own policy on the same subject matter. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

**Potential Deficiency #13: For complainants who file urgent grievances, the Plan does not provide immediate notification to the complainant of the right to contact the Department regarding the grievance.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68.01(a)(1).

DHCS-SFHP Contract, Exhibit A, Attachment 14 – Member Grievance System

1. 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 the Member 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.

Rule 1300.68.01(a)(1)

(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function (“urgent grievances”). At a minimum, plan procedures for urgent grievances shall include:

(1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.

**Documents Reviewed:**

- Plan Policy QI-06: Member Grievances and Appeals (04/28/14)
- 11 expedited grievances selected for review from the survey period (01/01/14 – 12/31/14)

**Assessment:** Rule 1300.68.01(a)(1) as well as the Plan’s policy indicate that the Plan must notify the member by telephone of the right to for an expedited review by the Department:

- Rule 1300.68.01(a)(1) requires that “grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function,” i.e., urgent grievances, be given “expedited review.” Among other steps, the Plan must serve “immediate notification to the complainant of the right to contact the Department regarding the grievance.”
- *Plan Policy QI-06 (Grievances and Appeals)*, Section VII. Expedited Review, states, “the Clinical Quality Coordinator informs the member of his/her right to concurrently notify the DMHC about the expedited grievance ... The initial notification need not be in writing and can be accomplished by a documented telephone call ...”

The Department reviewed all 11 expedited grievances identified by the Plan during the review period. Of the 11 expedited grievances reviewed, the Department found no evidence of documented phone calls or other methods of communication in any case files demonstrating that the Plan immediately notified the members of their right to contact the Department regarding the grievance.

**Conclusion:** The Plan does not provide immediate notification to members who file urgent grievances that they have the right to contact the Department regarding the grievance, which is required by Rule 1300.68.01(a)(1). Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

## QUALITY MANAGEMENT

**Potential Deficiency #14: In its handling of potential quality issues, the Plan does not consistently document that the quality of care provided is being reviewed, that problems are being identified, and that effective action is taken to improve care where deficiencies are identified.**

**Contractual/Statutory/Regulatory Reference(s):** DHCS-SFHP Contract Exhibit A, Attachment 4 –Quality Improvement System, Provision 1 – General Requirement, and Provision 7(D) – Written Description; Rule 1300.70(a)(1) and (3); Rule 1300.70(b)(1)(A)-(B); Rule 1300.70(b)(2)(A)-(B)(3).

### DHCS-SFHP Contract Exhibit A, Attachment 4 – Quality Improvement System

#### 1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting.

#### 7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

D. A description of the system for provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.

### Rule 1300.70(a)(1) and (3)

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

### Rule 1300.70(b)(1)(A)-(B)

(b) Quality Assurance Program Structure and Requirements.

(1) Program Structure. To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

(A) A level of care which meets professionally recognized standards of practice is being delivered to all enrollees;

(B) Quality of care problems are identified and corrected for all provider entities.

Rule 1300.70(b)(2)(A)-(B)

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(A) There must be a written QA plan describing the goals and objectives of the program and organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.

(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

**Documents Reviewed:**

- San Francisco Health Plan 2014 Quality Improvement Program
- Plan Policy UM-56: Potential Quality Issues
- Plan Policy QI-12: Peer Review Process (10/03/14)
- 9 PQI files from the survey period (01/01/14 – 12/31/14)
- PQI File Review Worksheet

**Assessment:** The Plan's *Quality Improvement Program* document describes potential quality issues (PQIs) as "incidents outside the standard of care that put members at risk of harm, or when medical errors caused harm." In its review of nine (9) of the Plan's PQIs files during the survey period, the Department found that the Plan does not ensure that "problems are being identified, that effective action is taken to improve care where deficiencies are identified" as required by Rule 1300.70(a)(1). The Department identified the following concerns with the Plan's handling of PQIs:

**1. Lack of clear, detailed procedures for reviewing PQIs**

The Department found that the Plan has not established a clear and detailed set of reasonable procedures to guide its review of PQIs. Rule 1300.70(b)(2)(A) requires that each plan have "a written QA plan describing ... the methodology for on-going monitoring and evaluation of health services ...." Rule 1300.70(c) requires that each plan "design and implement *reasonable procedures* for continuously reviewing the performance of health care personnel .... The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department." [Emphasis added.] DHCS-SFHP Contract Exhibit A, Attachment 4, Provision 7(D) requires that the Plan "implement and maintain a written description of its QIS that shall include ... A description of the system for provider review of QIS findings."

The Plan's *Quality Improvement Program* states:

SFHP UM and Pharmacy staff is trained to identify Potential Quality Incidents (PQIs) and refer them to the Chief Medical Officer (CMO) to review. PQIs are incidents outside the standard of care that put members at risk of harm, or when medical errors caused harm. SFHP has a PQI process that ensures that PQIs are evaluated first by the CMO, and then brought to the Physician Advisory Committee for peer review and scoring.

There is no further description of the PQI process in that document. Thus, the Plan's peer review policy provides a broad outline of the process, stating:

CMO or physician designee (MD) determines if there is a potential issue. If a quality of care issue is identified, the CMO prioritizes SFHP's actions. The CMO sends a written notice of the investigation to the practitioner (and medical group if appropriate). The practitioner is asked to provide any information that may assist in a full investigation ...

However, this policy focuses on the Peer Review Committee's role and does not detail the initial PQI investigation process. During the survey period, the Plan had no additional policy or document to detail the full PQI process. Thus, the Plan failed to produce any documentation to identify:

- (1) The multiple sources for identifying PQIs;
- (2) The role of the nurse reviewers;
- (3) The process for requesting medical records;
- (4) The timeframes for conducting review;
- (5) The criteria for elevating a case from physician level review to full committee review;
- (6) The guidelines for classifying and reporting on cases; and
- (7) The guidelines for recommending and tracking corrective actions.

In interviews, Plan staff recognized the need for a formal document to ensure consistency and effectiveness of the PQI process and had drafted a policy; however, this document was not implemented until February 2015, after the review period.

Further, the Plan's operation of its PQI process was inconsistent with Plan Policy *QI-12 Peer Review Process* which states, "all potential quality issues are investigated by SFHP staff and brought to the Peer Review Committee for objective review and scoring." However, the Department found that while all nine (9) SPD PQI cases handled during the survey period were reviewed by a physician, none were elevated to full committee review.

## **2. Failure to identify problems and implement corresponding corrective actions**

The Plan identified nine (9) PQI cases during the review period. The Department determined that all nine (9) cases were properly identified as PQIs. However, the Department found that in

two (2) of the nine (9) cases it reviewed, the Plan failed to identify problems that should have resulted in corrective/educational actions, as required by Rule 1300.70(a)(1) "... effective action is taken to improve care where deficiencies are identified" and Rule 1300.70(b)(1)(B) "problems are identified and corrected for all provider entities." Rule 1300.70(b)(1)(A) requires that "a level of care which meets professionally recognized standards of practice is being delivered to all enrollees." These requirements are confirmed by DHCS-SFHP Contract Exhibit A, Attachment 4, Provision 1.

The two (2) cases in which the Plan failed to identify problems that should have resulted in corrective/educational actions are as follows:

- *File #2:* This case was identified through a member grievance. The member experienced a significant three-month delay in breast cancer care. Follow-up was needed in order to determine if further treatment or adjuvant therapy was required, but the Plan's medical group did not get the member in for timely follow-up care. Lung metastasis was diagnosed at the time the member was finally seen. The case was assigned a severity level of 1B (minor quality of care issues with complications due to treatment; untoward surgical or post-surgical events that are not due to negligence or poor technical ability/minor complications or harm to member), and as a result of this low dispensation, no corrective action was requested.

Given that such a delay in care has a potential to impact a patient's likelihood of survival, corrective action was appropriate as a mechanism to prevent recurrence of the problem. The Plan's investigation of the case took over seven months. Although the Plan assigned no corrective action, the delay in completing its review of the case necessarily delays the implementation of corrective action. Failure to investigate and impose corrective action in a timely manner does not ensure corrective action is "effective" or ensure care rendered by the provider in the meantime meets professional standards of practice, as required by Rule 1300.70(a)(1) and (b)(1)(A).

- *File #3:* The case was identified through a member grievance filed with the Plan. The member was transitioning between health plans and did not receive medication for pulmonary hypertension (a potentially life-threatening condition that requires treatment with medication or the heart will not be able to pump blood out into the lungs for oxygenation) in a timely manner from the member's assigned medical group. It was the medical group's responsibility to ensure that the member received the medication, but it failed to do so.

The Plan initially assigned this case a severity level of 2B (moderate quality of care issue/minor complications or harm to member); however, when the case was closed, the Medical Director dropped the severity level to 0A (no quality of care/clinical judgment issue/no injury or harm to member with no detailed rationale except that the patient did not experience complications). While the member experienced no physical harm as a result, the issue was a moderate quality of care issue because lack of access to a life sustaining medication poses a significant health risk. The Plan should have requested corrective action from the medical group in order to improve the process for dispensing potentially life-sustaining medication. The Plan's investigation of the

case took eight months. The Plan's delay in completing the review of the case would have delayed the implementation of corrective action, had such action been prescribed by the Plan. Failure to investigate and impose corrective action in a timely manner does not ensure corrective action is "effective" or ensure that care rendered by the provider in the meantime that meets professional standards of practice, as required by Rules 1300.70(a)(1) and (b)(1)(A).

### **3. Delays in review of PQIs**

Failure to investigate and impose corrective action in a timely manner does not ensure corrective action is "effective" or ensure that care rendered by the provider in the meantime that meets professional standards of practice, as required by Rule 1300.70(a)(1) and Rule 1300.70(b)(1)(A). The Plan must ensure that its review and corrective action process operate without unreasonable delays so that non-compliant behavior is not permitted to continue or recur. The Department found that the Plan did not ensure that its PQI process operates without undue delays in two (2) of the nine (9) cases described below:

- ***File #9:*** This case was identified by a provider, who reported that a member was admitted with anoxic brain damage and intubated (insertion of a tube to assist with breathing). The member was declared brain dead and transferred to the network hospital so an extubation (removal of the breathing tube) could be performed. This transfer was not medically necessary as the patient was determined to be brain dead prior to the transfer. The transfer resulted in a delay of the extubation. The Plan's review of the case took 17 months. Although the Plan's final determination that no quality problem existed was appropriate, the delay in review was inappropriate. Excessive delays may allow care that does not meet professional standards of practice to be provided during this delay.
- ***File #4:*** A member complaint about delays in access to care, took four months to complete from time of referral to the quality department until completion of the investigation.

**Conclusion:** As evidenced by the PQI files the Department reviewed, cases containing quality of care concerns are not consistently reviewed in a timely manner, and problems are not consistently identified and addressed through corrective actions. Contributing to these inconsistencies, the Plan did not have a policy to guide its PQI review activities. The Plan's failure to ensure timely and adequate investigation of PQIs and effectively implement corrective actions where concerns are confirmed may enable problems to continue or recur among its providers, negatively impacting the quality of care delivered to members. Rule 1300.70(a)(1) requires the Plan to document that "... problems are being identified, that *effective action* is taken to improve care where deficiencies are identified." [Emphasis added.] Rule 1300.70(b)(1)(B) and DHCS-SFHP Contract Exhibit A, Attachment 4, Provision 1 also contain this requirement. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

**Potential Deficiency #15: The Plan’s Quality Assurance Program does not ensure that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.**

**Statutory/Regulatory Reference(s):** DHCS-SFHP Contract Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, and Provision 7(D)(G)(H) – Written Description; Rule 1300.70(a)(1).

DHCS-SFHP Contract Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care....

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

D. A description of the system for provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.

G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that Members are able to obtain appointments within established standards.

H. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.

Rule 1300.70(a)(1)

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

**Documents Reviewed:**

- San Francisco Health Plan 2014 Quality Improvement Program
- HEDIS results – DHCS Data Submission Template Full Scope MCPs 2014 F2 SFHP auditor approval
- Plan Policy QI-04: Quality Improvement HEDIS, CAHPS, and QIP Procedures (05/06/13)
- Quality Improvement Committee minutes (02/13/14, 04/10/14, 06/12/14, 08/14/14, 10/09/14)
- Practice Improvement Program Guides – Community Clinics, Clinical Practice Groups, Medical Groups, NEMS and CCHA, UCSF Medical Group (2014)
- Emergency Supply Policy Monitoring Report Quarterly 2014 (summary and detail)

**Assessment:** The Plan has not implemented a Quality Improvement Program that confirms a quality of care monitoring cycle as described by Rule 1300.70(a), “that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.” This rule is supported by DHCS-SFHP Contract Exhibit A, Attachment 4, Provision 1: The Plan must “monitor, evaluate, and take effective action to address any needed improvements in the quality of care ...”

### **1. Quality of care is not being adequately reviewed**

With the exception of HEDIS and DHCS-mandated data (e.g., ER readmission rates), the Plan produces few reports to assist it in overseeing/detecting problems in quality, utilization, and timeliness of services it provides. The Plan conceded during interviews that it had not implemented the full battery of reports that were specified in the Quality Improvement Program and various Plan policies. For example, the Plan does not consistently produce (or receive from its delegates) and assess:

- *Analysis reports for patterns and trends in PQIs (e.g., by topic, condition, care setting and/or provider):* Such reports would assist the Plan in identifying problems indicating a need for provider education or delivery changes.
- *Reports breaking down appointment wait time by specialty:* Survey data and other appointment wait time measures by specialty would assist the Plan in identifying recruitment needs or other specialty-specific corrective actions.
- *Monitoring reports for under- and over-utilization:* These reports would help the Plan detect and correct underservice by an at-risk provider, including possible under-utilization of specialist services and preventive health care services. When queried what mechanisms were in place to monitor under- and over-utilization of services at the delegate level, Plan staff stated that the Plan is currently developing them as part of its planned monitoring activities.
- *Referral tracking reports:* Plan staff stated that referral tracking is under “exploratory review.” Referral reports would assist the Plan in identifying patient service needs and provider recruitment needs.
- *Provider-specific reports:* With the exception of HEDIS/CAHPS reporting, interviews with the Plan medical director and staff indicated that there are no provider-specific reports on the quality of care provided.
- *Pharmacy tracking:* Two reports (Emergency Supply Policy Monitoring Report Quarterly 2014 Summary and Emergency Supply Policy Monitoring Report Quarterly 2014 Detail) provide an example of the detailed tracking and trending, summary data and analysis that is helpful for analyzing quality. These reports address a small segment of the population who use emergency medications. Expansion of similar reporting to the broader member population to assess pharmacy use by member and provider, including number of prescriptions, age of member, category of medication, and the associated diagnosis would assist the Plan to evaluate if members receive appropriate treatment.

In addition to creating such reports, it is of key importance that detailed reports be elevated to, reviewed, and discussed in detail at QIC meetings. Given that the Plan delegates care to medical groups, reports by provider group are essential to conducting oversight. With the exceptions noted above, committee minutes do not reveal regular review and discussion of detailed reports at the group or provider level.

**2. The Plan cannot document that problems are not being identified**

DHCS-SFHP Contract Exhibit A, Attachment 4, Provision 7(G) requires plans to “implement and maintain a written description of its QIS” which includes a “description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services.” Provision 7(D) additionally requires a “description of the system for provider review of QIS findings” and Provision 7(H) requires “a [d]escription of the quality of clinical care services provided.” Given the absence of detailed reports for the Department’s review, it is difficult to identify specific problems the Plan has missed; however, file review of PQIs provides an example of these problems. The Plan’s failure to track and trend PQI case closure time led to the Plan not being aware that a significant number of cases took more than 60 days to close. Such delays in completing PQI review results in delay in sending an educational letter or implementing other corrective actions to address the confirmed quality of care issue. The poor quality of care may, therefore, have reoccurred or continued while the Plan was investigating the case.

**3. Effective action is not taken to improve care where deficiencies are identified with follow-up to ensure that corrective actions are effective**

The Plan does not consistently implement corrective actions for problems that have been confirmed. The following are examples:

- The Plan identified significant deficiencies in wait times for access to appointments (see Potential Deficiency #3). Plan staff confirmed in interviews that no corrective action plans had been implemented.
- The Plan participated in the 2014 All Cause Readmission Study. There was an analysis of readmission causes. However, there is no record in the minutes that the analysis was presented to the QIC for discussion, and there was no implementation of a corrective action plan to address the issues identified in the study.
- The Practice Improvement Program (PIP) Advisory Committee worked on identifying quality problems for improvement, specifically improving HEDIS and CAHPS scores and incentivizing providers. Although the committee conducted discussions about identifying problems and improving care, there was no action plan developed and implemented during 2014.

**Conclusion:** The Plan produces and reviews an inadequate number of reports to assist it in overseeing/detecting quality of care problems; the Plan does not investigate problems it does identify in a timely manner; and when problems are confirmed, the Plan does not consistently implement corrective actions. These issues with the Plan’s Quality Assurance Program result in failure to ensure that the quality of care provided is being reviewed, that problems are being

identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated, as required by DHCS-SFHP Contract Exhibit A, Attachment 4, Provision 1 and Rule 1300.70(a)(1). Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

**APPENDIX A. MEDICAL SURVEY TEAM MEMBERS**

<b>DEPARTMENT OF MANAGED HEALTH CARE</b>	
Jennifer Friedrich	Medical Survey Team Lead
Cindy Liu	Attorney
<b>MANAGED HEALTHCARE UNLIMITED, INC.</b>	
Dawn Wood, MD	Quality Management /Continuity of Care Surveyor
Bernice Young	Member Rights Surveyor
Rose Leidl, RN	Utilization Management Surveyor
Senia Vitale, PhD	Utilization Management Surveyor
Madeline Hommel, MPH	Availability and Accessibility Surveyor

**APPENDIX B. PLAN STAFF INTERVIEWED**

<b>SAN FRANCISCO COMMUNITY HEALTH AUTHORITY</b>	
Llendl Aquino	Practice Improvement Specialist
Rebecca Au, Pharm. D.	Clinical Pharmacist
Monical Baldzikowski, RN	Manager, UM Outpatient
Odalis Bigler	Manager, Delegation Oversight and Credentialing
Matija Cale, RN	Manager, UM Outpatient
Emily Coriale, Pharm.D.	Director of Pharmacy
Betty DeLos Reyes	Regulatory Affairs Program Manager
Sean Dongre	Supervisor, Provider Network Operations
Collin Elane, RN	Director, Clinical Operations
Crystal Garcia	Compliance Program Manager
Jim Glauber, MD	Chief Medical Officer
Courtney Gray	Senior Manager, Care Coordination
Anna Jaffe	Director, Health Improvement
Perla Kempis	Senior Claims Analyst
Regina Leung, RN	Clinical Quality and Outreach Nurse
Nina Maruyama	Officer, Compliance and Regulatory Affairs
Valerie Miller	Director of Marketing and Communications
Daniel Moore, RN	Complex Medical Case Management
Olga Mostovetsky	Clinical Pharmacist
Adam Sharma	Manager, Practice Improvement
Jim Soos	Medical Policy Administrator
Tony Tai	Manager, UM Coordinators
Terence Ung	Manager, Customer Service
Sari Weis	Manager, Clinical Quality
Nicole Ylagan	Quality Management Specialist
Mimi Zou	Project Manager, Clinical Improvement

**APPENDIX C. LIST OF FILES REVIEWED**

*Note: The statistical methodology utilized by the Department is based on an 80% confidence level with a 7% margin of error. Each file review criterion is assessed at a 90% compliance rate.*

<b>Type of Case Files Reviewed</b>	<b>Sample Size (Number of Files Reviewed)</b>	<b>Explanation</b>
<b>Standard Grievances &amp; Appeals</b>	43	The Plan identified a universe of 204 files during the review period. Based on the Department’s File Review Methodology, a random sample of 43 files were reviewed.
<b>Expedited Grievances &amp; Appeals</b>	11	The Plan identified a universe of 11 files during the review period. Based on the Department’s File Review Methodology, all 11 files were reviewed.
<b>Inquiries</b>	40	The Plan identified a universe of 84 files during the review period. The Department reviewed all 40 SPD files.
<b>Potential Quality Issues</b>	9	The Plan identified a universe of 9 files during the review period. Based on the Department’s File Review Methodology, all 9 files were reviewed.