MEDICAL REVIEW – NORTHERN SECTION I
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

San Francisco Health Authority
dba San Francisco Health Plan

Contract Number: 04-35400

Audit Period: March 1, 2016
Through
February 28, 2017

Report Issued: September 22, 2017

TABLE OF CONTENTS

I. INTRODUCTION

In 1994, the San Francisco City and County created the San Francisco Health Authority (SFHA) under the authority granted by the Welfare and Institutions Code Section 14087.36. The SFHA was established as a separate public entity to operate programs involving health care services including the authority to contract with the State of California to serve as a health plan for Medi-Cal members.

The Plan received a Knox-Keene Health Care Service Plan license in 1996.
On January 1, 1997, the State of California entered into a contract with the SFHA to provide medical managed care services to eligible Medi-Cal members as the local initiative under the name San Francisco Health Plan (SFHP).

The Plan contracts with eight medical entities and a health plan to provide or arrange comprehensive health care services. The Plan delegates a number of functions to these entities.

As of February of 2017, San Francisco Health Plan served 146,919 members through the following programs:

Line of Business	Membership
Medi-Cal	76,974
Healthy Kids	1,095
Healthy Workers	11,239
Medi-Cal Expansion (MCE)	57,611
Total	146,919

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of March 1, 2016 through February 28, 2017. The onsite review was conducted from March 20, 2017 through March 24, 2017. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference was held on July 25, 2017 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the exit conference. The results of our evaluation of the Plan's response are reflected in this report.

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

The prior DHCS medical audit (for the period of March 1, 2015 through February 29, 2016, with onsite review conducted from March 21, 2016 through April 1, 2016) was issued August 26, 2016. The corrective action plan (CAP) closeout letter was sent to the Plan on March 1, 2017. This audit examined documentation for compliance and to determine to what extend the Plan has implemented their CAP.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan's Utilization Management (UM) process utilizes licensed vocational nurses (LVN) to review, analyze, and interpret medical information related to medical prior authorization. LVNs must not be employed as independent practitioners or work outside of their scope of practice.

Category 3 – Access and Availability of Care

The Plan did not monitor whether providers returned members' calls.

Category 6 – Administrative and Organizational Capacity

The Plan is required to maintain a medical director who is a full time physician licensed by the Medical Board of California. The Plan's medical director's license was not valid during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The on-site review was conducted from March 20, 2017 through March 24, 2017. The audit include a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff. Prior findings for areas not reviewed in the 2017 audit will be reviewed in a future audit.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 15 medical and 15 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Category 3 – Access and Availability of Care

Appointment availability verification study: 21 providers from the Plan's six delegated entities and in-network providers of routine, urgent, specialty, and prenatal care were reviewed.

Category 4 – Member Rights

Grievance procedures: 45 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: San Francisco Health Authority dba San Francisco Health Plan	
AUDIT PERIOD: March 1, 2016 through February 28, 2017	DATE OF AUDIT: March 20, 2017 through March 24, 2017

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:
Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements…(as required by Contract)
2-Plan Contract A.5.2.A, B, D, F, H, and I.

Exceptions to Prior Authorization:
Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
2-Plan Contract A.5.2.G

Timeframes for Medical Authorization
Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto.
2-Plan Contract A.5.3.F

Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
2-Plan Contract A.5.2.H

Denial, Deferral, or Modification of Prior Authorization Requests:
Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.
2-Plan Contract A.13.8.A

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: San Francisco Health Authority dba San Francisco Health Plan	
AUDIT PERIOD: March 1, 2016 through February 28, 2017	DATE OF AUDIT: March 20, 2017 through March 24, 2017

SUMMARY OF FINDING(S):

1.2.1 Prior Authorization Processing

The Plan must ensure that the UM program includes qualified staff responsible for the UM program. The Contract defines a nurse as a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN). (*Contract A10, Exhibit A, Attachment 5, (1)(A), Exhibit E, Attachment 1, (81)*).

The Plan allowed licensed vocational nurses (LVN) to work outside of their scope of practice. LVN's had decision-making responsibilities in the prior authorization process.

The Plan must comply with all standards, requirements and responsibilities stipulated and agreed to in the Contract between the Plan and the Department of Health Care Services (DHCS) including administration/staffing (*CCR, Title 22 §53840 (b)(c)).*

DHCS described its policy regarding the role of LVNs in a policy letter about site reviews and medical record review. Policy Letter (PL) *14-004, Site Reviews, Facility Site Review and Medical Record Review* states, "State law stipulates that the LVN must perform only manual skills under the direction of a licensed physician or licensed professional nurse and perform only basic data collection (*B&P Code Section 2859*). The performance of manual skills or basic data collection does not include evaluation, analysis, interpretation, or synthesis of survey information or data or of making determinations about the information or data that was collected. Although an LVN may collect basic explicitly defined data, he or she is not qualified to evaluate or analyze the data."

Plan Policy and Procedure, *UM-22 Authorization Requests,* states that unlicensed UM staff (i.e. coordinators) are responsible to research authorization requests, collect data for authorization review, and refer cases to UM nurses for clinical review. UM nurses review and approve requests for medical necessity based on established criteria. The policy allowed credentials for a UM nurse to be a valid unrestricted registered nurse or a licensed vocational nurse license in the State of California.

The verification study showed that in four of fifteen cases an LVN made decisions about medical prior authorization requests.

- In one case, an LVN in the role of a UM nurse requested additional information, analyzed the information, and recommended denial for not meeting the Plan's surgical criteria.
- In a second case, an LVN in the role of a UM nurse reviewed medical records, recommended deferral for additional information, and ultimately recommended denial after not receiving the information.
- In a third case, an LVN in the role of a UM nurse requested and analyzed medical records, recommended deferral for additional supporting documentation, and then recommended denial for not receiving additional records.
- In a fourth case, an LVN in the role of a UM nurse analyzed medical information, referred to California Children's Services, independently performed an up-to-date search, and recommended denial for not meeting criteria.

In these four cases, the LVNs reviewed, analyzed, and interpreted information. Once this step was completed, they forwarded the cases with recommendations to defer, refer or deny to the medical director who made the final review.

Allowing LVNs to work outside of their scope of practice can lead to incorrect clinical decisions, which can lead to adverse health outcomes for the Plan's members.

RECOMMENDATION(S):

1.2.1 Revise Plan policy and procedure regarding clinical personnel qualifications and duties so that staff members do not work outside of their scope of practice.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: San Francisco Health Authority dba San Francisco Health Plan	
AUDIT PERIOD: March 1, 2016 through February 28, 2017	DATE OF AUDIT: March 20, 2017 through March 24, 2017

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

Appointment Procedures:
Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
2-Plan Contract A.9.3.A

Members must be offered appointments within the following timeframes:
3) Non-urgent primary care appointments – within ten (10) business days of request;
4) Appointment with a specialist – within 15 business days of request;
2-Plan Contract A.9.4.B

Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.
2-Plan Contract A.9.3.B

Monitoring of Waiting Times:
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments…
2-Plan Contract A.9.3.C

SUMMARY OF FINDING(S):

3.1.1 Procedures to monitor whether member calls are returned

The Plan is required to develop, implement, and maintain a procedure to monitor telephone call answer and return times (*Contract A10, Exhibit A, Attachment 9 (C)).*

Plan policy*, QI-5 Monitoring Accessibility of Provider Services,* states the Plan will call a random sample of providers within each medical group, monitoring both the time to answer and the time to return the telephone call.

The Plan's *Provider Time to Answer Survey's* methodology states that "for each unique number, SFHP calls and records the wait time for office staff to answer the phone. Next, SFHP staff alert office staff that they are conducting an SFHP access compliance survey

and inquire regarding wait time to hear back from a provider, average wait time in the provider office, and availability of language interpretation for appointments. Four elements determine time to answer compliance:

a) Functioning phone number
b) Phone call answered within 10 minutes of start of call
c) Provider is available to return call
d) Return call is stated to be within 30 minutes of the end of call.

The Plan did not initiate and implement the steps to monitor whether providers returned members' calls in the 2015 or in the 2016 Telephone Time to Answer Surveys. The Plan's survey did not include results of whether member calls were returned within 30 minutes of the end of call as stated in its policy.

Failure to return member calls timely can potentially delay coordination of their care and have detrimental impacts on members' health.

RECOMMENDATION(S):

3.1.1 Implement policy and procedures to monitor providers' return of members' telephone calls.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: San Francisco Health Authority dba San Francisco Health Plan	
AUDIT PERIOD: March 1, 2016 through February 28, 2017	DATE OF AUDIT: March 20, 2017 through March 24, 2017

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.1	MEDICAL DIRECTOR AND MEDICAL DECISIONS

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

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

2-Plan Contract A.1.6

Medical Decisions:
Contractor shall ensure that medical decisions, including those by sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management.
2-Plan Contract A.1.5

SUMMARY OF FINDING(S):

6.1.1 Medical Director Qualifications

The Plan shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857. A physician means a person duly licensed as a physician by the Medical Board of California (*Contract A10, Exhibit A, Attachment 1 (6), Exhibit E, Attachment 1, (86)*).

Plan Policy, *UM 22 Authorization Requests,* states that the minimum required staff credentials for a medical director are a M.D. or D.O. degree from an accredited program, board certification, and a valid unrestricted license to practice medicine in the State of California.

The medical director's medical license had expired on April 30, 2016 and was not valid during the audit period. The Plan confirmed that they were not aware of the expired

license. Since then, the license has been renewed. The medical director submitted a copy of the renewed medical license to the reviewer on March 21, 2017 showing that it had been reinstated. The reviewer also verified this via the California Department of Consumer Affairs (DCA) BreEZe online services, which is DCA's licensing and enforcement system. A Review of sample prior authorizations, grievances and appeals records from the audit period revealed that the medical director made decisions that met standards for acceptable medical care.

Unlicensed medical directors may not be qualified to fulfill the responsibilities of the position, which may lead to potential harm to the Plan's members.

RECOMMENDATION(S):

6.1.1 Develop and implement a system to ensure that licensing and certification for all Plan medical directors is up to date.

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

San Francisco Health Authority
dba San Francisco Health Plan

Contract Number:	03-75800 State Supported Services
Audit Period:	March 1, 2016 Through February 28, 2017
Report Issued:	September 22, 2017

TABLE OF CONTENTS

I. INTRODUCTION

This report was created for informational purposes. Department of Health Care Services (DHCS) did not conduct a review of the San Francisco Health Authority dba San Francisco Health Plan (SFHP) state supported services contract No. 03-75800. The State Supported Services contract covers contracted abortion services with SFHP. Prior findings for State Supported Services not reviewed in the 2016 audit will be reviewed in a future audit.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: San Francisco Health Authority dba San Francisco Health Plan	
AUDIT PERIOD: March 1, 2016 through February 28, 2017	DATE OF AUDIT: March 20, 2017 through March 24, 2017

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion *Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services: Current Procedural Coding System Codes*: 59840 through 59857 HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336* **These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.* *State Supported Services Contract Exhibit A.1*

SUMMARY OF FINDING:

DHCS did not conduct a review of the San Francisco Health Authority dba San Francisco Health Plan (SFHP) State Supported Services contract No. 03-75800.

RECOMMENDATION:

N/A