

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: January 1, 2014
Through
December 31, 2014

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TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	EXECUTIVE SUMMARY	2
III.	SCOPE/AUDIT PROCEDURES	6
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 – Utilization Management	8
	Category 2 – Case Management and Coordination of Care	19
	Category 3 – Access and Availability of Care	26
	Category 4 – Member Rights	33
	Category 5 – Quality Management	40
	Category 6 – Administrative and Organizational Capacity	43

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 six medical groups and a health plan to provide or arrange comprehensive health care services. The Plan delegates a number of functions to these groups.

As of December 1, 2014, SFHP had 133,769 members of which 119,412 (89.27%) were Medi-Cal members. The Plan also covers 2,166 Healthy Kids (1.62%), and 12,191 Healthy Workers (9.11%)

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of January 1, 2014 through December 31, 2014. The on-site review was conducted from March 9, 2015 through March 20, 2015. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on June 4, 2015 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 finding. The Plan submitted supplemental information after the Exit Conference which is reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability to Care, Member Rights, Quality Management (QI), and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the period of December 1, 2012 through November 30, 2013, with onsite review conducted from March 3, 2014 through March 20, 2014) was issued August 7, 2014. The *corrective action plan* (CAP) closeout letter dated December 31, 2014 noted a number of previous findings as provisionally closed and suggested this audit examine cited documentation for compliance and to what extent the Plan has operationalized their CAP. The CAP did not address all of the previous audit findings. Overall, the Plan revised some of its policies and procedures but had not implemented much of the CAP as of this audit. **Repeat findings** were identified and appear in the body of the report.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan did not ensure consistent guideline application for utilization management decision-making by medical directors. The Plan did not have systematic methods to detect *over* and *under-utilization* for populations, services, procedures, specialties, or providers. The Plan did not have benchmarking for inpatient utilization.

The Plan issued denials not supported by accepted clinical guidelines for pharmacy and medical prior authorizations. Time frames for processing medical and expedited prior authorizations were exceeded. Prior authorization notice of action letters were not always translated into the member's threshold language or clear and concise. A medical necessity prior authorization denial was issued without documentation of participation by a qualified physician. There was limited medical director involvement in the medical prior authorization resolution process. There was undue delay in a decision for a time sensitive medical condition.

The Plan had not operationalized a system to track prior authorizations to completion. The Plan did not include referral tracking and adherence to referral time frames in its annual delegation oversight monitoring.

Prior authorization appeals outcomes were not used to continuously update and improve the utilization management program. Appeal decisions were made by the same medical director involved in the original decision. A medical group resolved appeals without proper delegation authority from the Plan.

The Plan did not execute all of the revised delegation agreements. Annual oversight monitoring did not include examinations of mechanisms for *over* and *under-utilization*, referral tracking, or medical director review of medical necessity denials. There were no reports of quality improvement activities by the delegated medical groups allowing the Plan to ensure accountability. There was no quality improvement committee review of delegated utilization management activities.

Category 2 – Case Management and Coordination of Care

The Plan used a methodology that was not tested for validity to monitor compliance with the requirement for *Initial Health Assessment*.

The Plan's methods for monitoring *coordination of care* for both California Children's Services and Early Intervention/Developmental Delay did not validate that policies and procedures were implemented within the delegated medical groups.

The Plan did not provide *complex case management* services during the audit year. The Plan did not conduct delegation oversight for *complex case management*.

Category 3 – Access and Availability of Care

The Plan's monitoring of access to routine, urgent, and specialty care appointments was not completed by the time of the audit. As a result, the Plan did not identify non-compliant providers for corrective action. DHCS' verification study shows providers not meeting timely access requirements for various appointments.

The Plan monitored waiting times of the initial prenatal care appointment but did not have a formal *corrective action plan* for non-compliant providers. The Plan did not monitor wait times at provider offices.

The Plan did not ensure providers answer member telephone calls or return the calls in a timely manner. The Plan did not continuously monitor member access and provider availability. The Plan did not ensure accurate provider listing as the *provider directory* did not accurately reflect the number of primary care providers and specialists available within the Plan's network.

The Plan did not monitor providers' compliance with telephone triage procedures and 24 hour availability and did not ensure 24/7 triage lines were answered by appropriately licensed professionals.

The Plan did not ensure members have access to medications prescribed in emergency situations to meet members' after-hours pharmacy needs. The Plan's new monitoring policy did not ensure members had access to a sufficient quantity of medication prescribed in emergency situations until the member can reasonably be expected to have a prescription filled.

Category 4 – Member Rights

The Plan did not ensure grievances were reported to the appropriate staff with authority to require corrective action. The Plan's grievance system did not log and report exempt grievances for quality improvement.

The Plan did not evaluate providers' delivery of appropriate cultural, linguistic, and interpreter services at all key points of contact. The Plan did not conduct an audit of cultural and linguistic services during the annual delegated medical group compliance audit for five of six medical groups. The Plan did not monitor the provision of cultural and linguistic services by non-delegated providers. The Plan did not address member concerns related to provider cultural, linguistic, and interpreter services or communicate with quality improvement committee for corrective action.

The Plan did not notify and report breach incidents to the DHCS information security officer.

Two delegated medical groups did not safeguard protected health information as thousands of members' records were compromised.

Category 5 – Quality Management

The Plan has not developed mechanisms for monitoring and evaluation of Plan quality improvement programs. The Plan did not document quality improvement in programs with objectively measured and recorded metrics. Resolutions for potential quality issues did not always ensure that members received acceptable medical care. Information from overturned grievances and appeals were not incorporated into the quality improvement system. The plan quality improvement committee did not review, and was not accountable for, delegation oversight activities conducted by the Plan. The governing board's late approval of the 2014 quality improvement plan did not demonstrate full governing board accountability for this Contract requirement.

Category 6 – Administrative and Organizational Capacity

Medical director participation in the Plan grievance process was limited. The Plan did not ensure all members received acceptable medical care. The Plan did not ensure that medical decisions were not unduly influenced by fiscal and administrative management.

The Plan did not review health education programs of delegated medical groups as part of the annual medical group audit. The Plan did not evaluate the performance of providers' health education services to ensure effectiveness.

The Plan developed and adopted but did not implement a proactive fraud and abuse program as part of the *corrective action plan* from the prior audit.

The Plan did not ensure covered services were prescribed or ordered by a provider in good standing with the Medi-Cal program.

A subcontractor service agreement did not include clauses regarding fraud and abuse reporting requirements. The Plan's pharmacy benefit management subcontractor reported a fraud and abuse incident to the Plan 25 working days after the incident occurred.

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 9, 2015 through March 20, 2015. The audit included 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.

Delegation Oversight: One medical group's utilization management and coordination of care policies, procedures, and practices were reviewed. Interviews with the group's administrators and staff were conducted; policies, procedures, and other documents were examined.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 25 medical and 25 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review. In addition, 20 medical prior authorizations for a delegated medical group were reviewed.

Notification of Prior Authorization Denial, Deferral, or Modification: 70 notification letters were reviewed for written notification requirements.

Appeal Procedures: 21 medical and 21 pharmacy prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 3 – Access and Availability of Care

Appointment Availability Verification Study: 15 providers from the Plan's five delegated medical groups and *in-network* providers of routine, urgent, specialty, and prenatal care were reviewed. The third next available appointment was used to measure access to care.

Emergency Service Claims: 14 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 19 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member Rights

Grievance Procedures: 48 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 6 – Administrative and Organizational Capacity

New Provider Training: 30 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1

UTILIZATION MANAGEMENT PROGRAM

Utilization Management (UM) Program Requirements:

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. ... (as required by Contract)

2-Plan Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

2-Plan Contract A.5.2.C

Review of Utilization Data:

Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.

2-Plan Contract A.5.4

SUMMARY OF FINDINGS:

1.1.1 The Plan did not ensure consistent guideline application by medical directors.

The Plan's 2014 Utilization Management (UM) Program stated that "at least annually, SFHP or its delegated medical groups evaluate the consistency with which its reviewers apply UM criteria in decision-making (inter-rater reliability), and requires corrective action, if necessary". Although associate medical directors participated in inter-rater reliability evaluations, this alone did not ensure complex decisions made by physicians were appropriate and consistent. Random samples of prior authorizations, appeals, and grievances done by the associate medical directors were not reviewed by the chief medical officer. Consistent guideline application was not ensured for the associate medical directors. **This is a repeat finding.**

1.1.2 The Plan did not have systematic methods to detect *over and under-utilization* for populations, services, procedures, specialties, or providers.

The Plan's 2014 UM Program stated that "the objectives of the UM program are measured through the SFHP Quality Improvement Program, using indicators for *over and under-utilization*, timeliness of UM decisions, member and provider satisfaction and *inter-rater reliability*..." According to the Plan's policy, "When problems are identified, the SFHP implements corrective actions and assures appropriate results are achieved". Though the infrastructure for new initiatives was being developed, this was not operationalized for the audit period. The Plan's capitated primary care providers were not monitored for *under-utilization*. The Plan did not have systematic methods for *over and under-utilization* service detection. **This is a repeat finding.**

1.1.3 The Plan did not have benchmarking for inpatient utilization.

The Plan's 2014 UM Program required mechanisms to detect *over and under-utilization* for Plan services, including inpatient utilization. There was no regional, state, or national benchmarking to detect *over or under-utilization*. The infrastructure needed was in development but not operationalized for the audit period. **This is a repeat finding.**

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

RECOMMENDATIONS:

- 1.1.1 Ensure consistent UM criteria guideline application by medical directors.
- 1.1.2 Operationalize comprehensive and systematic methods to detect *over and under-utilization* of services throughout the Plan.
- 1.1.3 Compare inpatient data and care patterns to available regional, state, and national benchmarks.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

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

SUMMARY OF FINDINGS:

1.2.1 The Plan did not ensure consistent application of utilization criteria based on sound medical evidence.

For medical and pharmacy PAs, the Plan is required to ensure use of a set of written criteria or guidelines for utilization review that are based on sound medical evidence, consistently applied, regularly reviewed, and updated (*Contract, Exhibit A, Attachment 5 (2)(C)*). According to Plan's *Policy #: Pharm-02, Pharmacy Prior Authorization*, guideline changes will be reviewed by SFHP's Pharmacy and Therapeutics Committee and be consistent with sound clinical principles. Plan's *Policy #: UM-22, Authorization Requests*, requires the Plan conducts Utilization Management by reviewing authorization requests and applying clinical criteria to make evidence-based decisions ensuring medical necessity of services provided to members.

Inconsistent application of sound medical evidence and guideline was illustrated by the following cases:

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

- Pharmacy PA Case #16 involved Invokana for treatment of diabetes. The member began Invokana as an add-on to four other diabetic medications several months before this request, with improvement in glycemic control and good tolerance. Pharmacist denied Invokana and recommended increased insulin dose instead, which would lead to increased appetite and weight gain. This medical decision was not made by a “qualified health care professional with appropriate clinical expertise in treating the condition and disease” (*Contract, Exhibit A, Attachment 5 (2)(A)*). Decision did not involve the Medical Director.
- Pharmacy PA Case #21 involved Amitiza for severe constipation. The request was denied for lack of sufficient documentation that multiple therapies were ineffective. The original PA request contained this information. The denial letter was not clear or concise and did not mention criteria used in the decision.
- Expedited Medical PA Case #16 involved a denial of electrophysiology (EPS) ablation of a dysrhythmic Supraventricular Tachycardia focus, though the EPS procedure and consultation were approved. Denial was for a “non-covered Medi-Cal benefit”. The ablation procedural code submitted to the Plan was discontinued and changed in January 2013 (CPT® 2014 Professional Edition). The request was not re-directed to the Provider for the proper coding. This denial would require an initial EPS study and then a second invasive study would be needed for the definitive ablation procedure, adding cost, risk, and inconvenience for the member.
- Expedited Medical PA Case # 17 involved denial of a request for a follow-up eye appointment at an *out-of-network* medical center the day after the member was seen in its emergency department for eye trauma and transient visual loss. The request was deferred for information as to why the appointment had to be *out-of-network*. The denial was issued after five business days and the delay in resolving this time sensitive medical need was not in the member’s best interest.
- Medical PA Case # 22 involved denial of a routine screening colonoscopy in a member over age 50 with average risk. The case was deferred for more information, which was not necessary as it is a generally medically accepted cancer screening tool (*California Health and Safety Code § 1367.665*).

The Plan did not ensure that PA decisions were based on consistent application of written utilization criteria, Medi-Cal guidelines and guidelines for acceptable medical care. Decisions were not always made by a qualified health care professional with expertise in the medical condition under consideration. **This is a repeat finding.**

1.2.2 Time frames for processing medical and expedited PAs were exceeded.

The Plan is required to ensure the time frames for medical and expedited authorizations are followed. Routine medical PAs should be completed within five working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from receipt and may be extended an additional 14 calendar days only when the member or provider make such request. Expedited prior authorizations require a decision no later than three working days after receipt of the request for services: the Plan may extend the three day period by up to 14 calendar days if the member requests an extension or if the Plan can justify that the extension is in the member’s best interest (*Contract, Exhibit A, Attachment 5 (3)(F), (G), and (H)*).

Time frames for medical PAs were exceeded for deferral and completion. For example, a case was deferred at 24 days and completed at 79 days; others were completed in 49 and 34 days. An expedited medical PA was not completed in three business days.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

1.2.3 **Notice of Action (NOA) letters were not always translated to members' threshold language in medical PAs.**

The Plan is required to provide linguistic services at no cost to Medi-Cal members including fully translated written informing materials which include NOA letters (*Contract, Exhibit A, Attachment 9 (14)(B)(2)*).

NOA letters reviewed were not consistently translated into the members' threshold language.

1.2.4 **The NOA letters to members were not always clear and concise in pharmacy and medical PA.**

The Plan is required to follow guidelines requiring that communications to members and providers "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" (*California Health and Safety Code § 1367.01(g) and (h)(4)*). For example, an NOA letter did not indicate a clear and concise explanation for the denial of one of three medications used in combination to treat a member with chronic Hepatitis C. Another example concerned a genetic lab screening for which the NOA letter did not provide a specific reason for the denial. The Plan did not follow guidelines requiring that communications with members and providers were clear and concise and contained guidelines and clinical reasons used in the decision.

1.2.5 **Documentation supporting medical PA denials contained minimal evidence of medical director involvement.**

The Plan is required to ensure that qualified health care professionals supervise decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity (*Contract, Exhibit A, Attachment 5 (2)(B)*). In medical PA Case #1 regarding genetic screening labs, a denial letter was sent based on lack of medical necessity and the letter was signed by the "Health Services Department", with no evidence of involvement by a qualified physician. Per review of 25 medical PA denials, there was consistent lack of medical director progress notes, discussions of case specifics, correspondence with staff members or evidence of independent research of medical issues. There was only a repeated statement at the end of each review, "I agree with the denial" and a signed denial letter. The Plan did not ensure a qualified physician was involved in denials related to lack of medical necessity. In each case, there was no documented involvement by the medical director in the PA denial process.

1.2.6 **There was undue delay in a decision for a time sensitive medical condition.**

The Plan is required to ensure that decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services (*Contract, Exhibit A, Attachment 5 (2)(F)*). Please refer to the summary of finding 1.2.1, medical PA Case #17, involving the expedited request for a follow-up evaluation subsequent to eye trauma and transient loss of vision. The Plan did not ensure that a time sensitive medical condition was expediently addressed.

RECOMMENDATIONS:

- 1.2.1 Ensure PA decisions are based on consistent application of written utilization criteria, Medi-Cal guidelines, and evidence-based medicine.
- 1.2.2 Follow all time frames for routine medical and expedited PAs.
- 1.2.3 Translate all written materials to members into the appropriate language.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

- 1.2.4 Implement procedures to ensure PA communications with members and providers are clear and concise and contain the guidelines and clinical reasons used in decision-making.
- 1.2.5 Ensure a qualified physician is involved in medical necessity denials and adequate involvement in the PA process is demonstrated via documentation.
- 1.2.6 Ensure decisions and appeals for time sensitive services are made in a timely manner.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

1.3

REFERRAL TRACKING SYSTEM

Referral Tracking System:

Contractor is responsible to ensure that the UM program includes: ... An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

2-Plan Contract A.5.1.F

SUMMARY OF FINDINGS:

1.3.1 The Plan has not operationalized a system to track Prior Authorization (PA) to completion.

As per *Contract, Exhibit A, Attachment 5 (1) and (5)*, “the Plan must ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring PAs through the Plan. The system shall include authorized, denied, deferred or modified referrals and the timeliness of referrals”. Though delegation agreements now contained PA referral tracking requirements and the previous *corrective action plan (CAP)* was being implemented, there was no objective evidence for 2014 to support operationalization of a referral tracking system meeting all requirements. **This is the fourth time this is noted as a repeat finding.**

1.3.2 The Plan did not include referral tracking and adherence to referral time frames in its delegation oversight monitoring.

According to the previous audit’s CAP, the Plan was required to perform a quarterly review of the logs of all specialty services for delegated medical groups requiring a PA and to provide feedback when the time frames were not met. Review of the delegation oversight monitoring reports for 2014 demonstrated minimal evidence of referral tracking and time frames. **This is a repeat finding.**

RECOMMENDATIONS:

1.3.1 Implement and maintain a system of PA tracking.

1.3.2 Include referral tracking and adherence to referral time frames in delegation oversight monitoring.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

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1.4

PRIOR AUTHORIZATION APPEAL PROCESS

Appeal Procedures:

There shall be a well-publicized appeals procedure for both providers and patients.
2-Plan Contract A.5.2.E

SUMMARY OF FINDINGS:

1.4.1 Appeals data were not used to continuously update and improve the Utilization Management (UM) Program.

The Plan is required to develop, implement, and continuously update and improve, a UM program that includes a process to integrate reports on review of the number and types of appeals (*Contract, Exhibit A, Attachment 5 (1)*).

The previous audit disclosed that the Plan repeatedly denied services, including when the same services were overturned on appeal. The *corrective action plan* was to discuss an enhanced Quality Improvement Committee (QIC) Grievance Report. The report was not produced upon request and not documented in the committee minutes during the audit period.

The Plan has not used information from PA denials to improve the UM system. More than half of the appeals reviewed in the verification study were overturned, including three where no new medical information was requested. One overturned appeal was a screening colonoscopy for an adult over 50; the Plan continued to deny screening colonoscopies subsequently.

Health plans are required to provide generally medically accepted cancer screening tests (*California Health and Safety Code § 1367.665*). The American College of Gastroenterology 2008 guidelines recommend fecal immunochemical testing for colorectal cancer screening in patients who decline a colonoscopy but the preferred test is colonoscopy as it can both screen and *prevent* cancer. The National Comprehensive Cancer Network revised its screening guidelines for December 2013 recommend colonoscopy every 10 years as the preferred screening strategy.

Five requests for *out-of-network* services were denied and redirected *in-network*; however the requested services were unavailable *in-network*. Two Prior Authorizations (PAs) were denied even though all information used in the appeal overturn was present in the original PA submission. Two were overturned on receipt of medical records, but there was no documentation that records had been requested prior to the original denial. There was no evidence the overturned PA denials data were used as part of the Plan's Quality Improvement process to improve the PA procedure. **This is a repeat finding.**

1.4.2 Appeal decisions were made by the same medical director involved in the initial decision.

The Plan is required to implement and maintain a procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance (*Contract, Exhibit A, Attachment 14 (2)(G)*).

Although the Plan stated that the same medical director may not uphold a denial, but only overturn it, the Contract prohibits involvement of that person in any final decision. At times, medical and pharmacy appeals were resolved by the same physician issuing the original denial.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

1.4.3 A subcontractor resolved appeals without meeting Contract delegation requirements.

The Plan is required to maintain a system to ensure accountability for delegated activities including subcontractor's ability to perform the delegated activities (*Contract, Exhibit A, Attachment 4 (6)(B)*). The Plan is required to implement and maintain a process to resolve member appeals (*Contract, Exhibit A, Attachment 14 (5)(A)*).

Member appeals were resolved by a subcontractor without meeting the Contract's delegation requirements. According to interviews with the Plan, the Plan retains all responsibility for member appeals. However, the interview with the subcontractor indicated they processed the first level of member appeals filed by a provider. Our verification study showed the subcontractor also processed the second level review.

For example, an appeal initially denied by the subcontractor was submitted to the Plan. The Plan's response was for the subcontractor to make the final decision. The subcontractor's medical director upheld his original denial.

The process was not formally delegated, independent, or timely.

RECOMMENDATIONS:

- 1.4.1 Use information from appeals to continuously update and improve the UM Program.
- 1.4.2 Direct all appeals to a medical director not involved in the original denial.
- 1.4.3 Ensure appeals filed by providers on behalf of members are processed by the Plan, unless formally delegated.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

1.5

DELEGATION OF UTILIZATION MANAGEMENT

Delegated Utilization Management (UM) Activities:

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. 2-Plan Contract A.5.5

SUMMARY OF FINDINGS:

1.5.1 The Plan did not execute all of the revised *delegation agreements*.

The Plan is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. The Plan and delegated medical groups are required to include in their delegation agreements actions and remedies if delegated medical groups' obligations are not met (*Contract, Exhibit A, Attachment 4 (6)(A)(4)*).

The previous audit found the Plan's *delegation agreements* did not contain remedies for non-performance. Although the Plan drafted five revised *delegation agreements*, none were executed during the audit period, and three were executed as of the onsite review. **This is a repeat finding.**

1.5.2 Delegation oversight monitoring did not include: examination of mechanisms for *over and under-utilization*, referral tracking or medical director review of medical necessity denials.

The Plan is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors (*Contract, Exhibit A, Attachment 4 (6)(A)*) including: Utilization Management (UM) program mechanisms to detect both *over and under-utilization* of health care services (*Contract, Exhibit A, Attachment 5*); UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization through the Plan (*Contract, Exhibit A, Attachment 5 (1)(F)*); a qualified physician to review all denials that are made, whole or in part, on the basis of medical necessity (*Contract, Exhibit A, Attachment 5 (2)(B)*).

The Plan's delegation oversight monitoring documented deficiencies in the above UM activities. The Plan did not require these improvements as part of a *corrective action plan (CAP)*. The Plan's personnel indicated that because these are new items included in the oversight tools, these deficiencies were only cited as opportunities for improvement. **This is a repeat finding.**

1.5.3 No reporting of findings or actions by subcontractor; no continuous monitoring by Plan.

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities that at a minimum include the continuous monitoring, evaluation, and approval of the delegated functions (*Contract, Exhibit A, Attachment 4 (6)(B)*).

The Contract and delegation agreements require delegated medical groups to report findings and actions taken as a result of the quality improvement activities at least quarterly. The Plan is required to monitor these reports (*Contract, Exhibit A, Attachment 4 (6)(A)*).

The Plan's CAP included adopting Policy #: DO-02 to address these reporting requirements. The Plan confirmed that no reports were submitted during the audit period; 2015 was targeted for implementation of regular reporting. **This is a repeat finding.**

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

1.5.4 There was no Quality Improvement Committee (QIC) review of delegated UM activities.

The Plan Governing Body appoints an accountable entity or entities within the Plan to provide oversight of the Quality Improvement System (*Contract, Exhibit A, Attachment 4 (3)(B)*). The Plan is required to implement and maintain a QIC accountable to the Governing Body, who will report activities, findings, recommendations, and action to the Governing Body on a regular basis (*Contract, Exhibit A, Attachment 4 (4)(B)*).

The Plan's Policy #: DO-04 (adopted January 2, 2015) stated that on a quarterly basis, the QIC will review a summary of delegates' UM activities, findings, and recommendations for improvement.

Review of delegated UM activities was not documented in the QIC meeting minutes. Plan personnel indicated that a new committee, Delegation Network Oversight Committee (DNOC), would be responsible for this function. This committee did not meet during the audit period. An initial organizational meeting occurred after the audit period but did not document a review of delegated UM activities. **This is a repeat finding.**

1.5.5 The Plan did not ensure that a delegated medical group's UM program description met the standards set forth by the Contract.

The Plan is accountable for all quality improvement functions and responsibilities, such as Utilization Management and, if the Plan delegates these functions, it is responsible for oversight, monitoring, and evaluation of these processes (*Contract, Exhibit A, Attachment 4 (6)(A)(2)*). The Plan is required to maintain a system to ensure that delegated entities are accountable for the standards set forth by the Plan, which includes the continuous monitoring, evaluation, and approval of delegated functions (*Contract, Exhibit A, Attachment 4 (6)(B)(2) and (3)*).

A Plan delegated medical group's 2014 UM Program Description contained these statements: "Urgent services ordinarily require PCP authorization prior to treatment" and (for prior authorizations) "If additional clinical information is required, member and practitioner are provided at least 45 calendar days for submission of requested information".

Although the delegated medical group indicated that these statements did not reflect their actual UM operating procedures, the Plan did not oversee, monitor, and ensure that this delegated medical group's UM Program Description was consistent with Plan standards.

RECOMMENDATIONS:

- 1.5.1 Execute all of the revised delegation agreements.
- 1.5.2 Ensure delegation oversight monitoring includes an examination by medical directors of medical necessity denials, mechanisms of detecting *over and under-utilization*, and referral tracking.
- 1.5.3 Implement regular reporting and monitoring processes as currently outlined in the Plan's policies.
- 1.5.4 Ensure that the QIC or DNOC document oversight of delegated UM activities in committee minutes.
- 1.5.5 Ensure delegated medical groups' UM program descriptions are consistent with Contract standards.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.2

CALIFORNIA CHILDREN'S SERVICES (CCS)

California Children's Services (CCS):

Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program...(as required by Contract)

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program...for the coordination of CCS services to Members.

2-Plan Contract A.11.9.A, B

SUMMARY OF FINDING:

2.2.1 The Plan's methods for monitoring *coordination of care* did not validate that policies and procedures were implemented within the delegated medical groups.

The Plan is required to maintain procedures to monitor *coordination of care* provided to members, including but not limited to all *medically necessary services* delivered both within and outside the Plan's network. As part of *basic case management* services, this also includes coordination of *carved-out and linked services* (Contract, Exhibit A, Attachment 11 (1)(A) and (6)).

A review of the delegation agreements and grid indicated that the Plan delegated many of its functions including *coordination of care* for California Children's Services (CCS) to its medical groups. While *coordination of care* is a delegated function, the Plan has the responsibility to maintain oversight. The Plan's procedure to monitor *coordination of care* in its medical groups as it applies to CCS was to conduct annual audits on the medical groups' policies, procedures, and logs of members enrolled in CCS.

The Plan's 2014 annual delegation audit reports indicated that a medical group was deficient in the CCS requirement for *coordination of care*, but received a score of 100% irrespective of these findings and a *corrective action plan* was not required. When asked about this disparity, the Plan confirmed that auditing only for policies, procedures, and logs does not validate that *coordination of care* is occurring. The Plan acknowledged that their audit tool is insufficient to measure *coordination of care* and that they are revising their audit procedures.

RECOMMENDATION:

2.2.1 Develop and implement monitoring procedures to ensure CCS requirements are being met within the Plan's network of primary care providers including within delegated medical groups.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

2.3

EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

Services for Persons with Developmental Disabilities:

Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers... for the coordination of services for Members with developmental disabilities.

2-Plan Contract A.11.10.A, C, E

Early Intervention Services:

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program... Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

2-Plan Contract A.11.11

SUMMARY OF FINDING:

2.3.1 **The Plan's methods for monitoring *coordination of care* did not validate that policies and procedures were implemented within the delegated medical groups.**

The Plan is required to maintain procedures to monitor *coordination of care* provided to members, including but not limited to all *medically necessary services* delivered both within and outside the Plan's network. As part of *basic case management* services, this also includes coordination of *carved out* and *linked* services (*Contract, Exhibit A, Attachment 11 (1)(A) and (6)*). The Plan is required to oversee and remain accountable for any functions and responsibilities delegated (*Contract, Exhibit A, Attachment 6 (14)*).

A review of the delegation agreements and delegation grid indicated that the Plan delegated many of its functions including *coordination of care* for Early Start (ES) to its medical groups. While *coordination of care* is noted to be a delegated function, the Plan has the responsibility to maintain oversight. The Plan's procedure to monitor *coordination of care* in its medical groups as it applies to ES was to conduct annual audits on the medical groups' policies, procedures, and logs of members enrolled in ES.

The Plan's 2014 annual audit reports indicated that a medical group was deficient in the ES requirement for *coordination of care*, but received a score of 100% irrespective of these findings and a *corrective action plan* was not required. When asked about this disparity, the Plan confirmed that auditing only for policies, procedures, and logs does not validate that *coordination of care* is occurring. The Plan acknowledged that their audit tool is insufficient to measure *coordination of care* and that they are revising their audit procedures.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

RECOMMENDATION:

- 2.3.1 Develop and implement monitoring procedures to ensure ES requirements are being met within the Plan's network of primary care providers including within delegated medical groups.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

2.4

INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21

For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

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

2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

- 1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
- 2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
 - a) blood pressure,
 - b) height and weight,
 - c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
 - d) clinical breast examination for women over 40,
 - e) mammogram for women age 50 and over,
 - f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
 - g) chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
 - h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
 - i) health education behavioral risk assessment.

2-Plan Contract A.10.6

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

2-Plan Contract A.10.3.D

SUMMARY OF FINDING:

2.4.1 The Plan used a methodology that was not tested for validity to monitor compliance with the requirement for *Initial Health Assessment (IHA)*.

The Plan is required to cover and ensure the provision of an IHA to each new member within 120 calendar days of enrollment (*Contract, Exhibit A, Attachment 10 (3)(A)*) and to have procedures for monitoring IHA completion (*MMCD Policy Letter No. 08-003 Initial Comprehensive Health Assessment*).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

According to Plan *Policy #: HE-02, Initial Health Assessment: Education and Follow-up*, the Plan monitored its overall compliance with IHA requirements by analyzing encounter data submitted by clinics and delegated medical groups. The Plan defined IHA encounters (office visits) with primary care providers (PCPs) by using a select set of billing and encounter codes. According to interviews with Plan staff, the extent to which these codes represented completed IHAs (or documented IHA exceptions) was untested and so the IHA monitoring methodology's validity was not established. Without evidence of valid methodology, the Plan's duty to monitor and ensure IHA completion could not be verified.

RECOMMENDATION:

2.4.1 Ensure procedures for monitoring IHA compliance are based on validated methodology.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

2.5

COMPLEX CASE MANAGEMENT

Case Management and Coordination of Services:

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

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

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

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

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

2-Plan Contract A.11.1

SUMMARY OF FINDINGS:

2.5.1 *Complex case management services were not provided during the 2014 audit year*

The Plan is required to ensure the provision of *complex case management services (Contract, Exhibit A, Attachment 11 (1)(B)(1), (2), (3), and (4))*.

The Plan's case management program, "Care Management", provided extensive psychosocially based care coordination but the medical case management component for *complex case management* was not in place. This was confirmed through review of a program description, draft policies and procedures, two weekly "clinical team meeting" minutes, notes and agendas from two "grand rounds" sessions, a narrative response to pre-audit document request, review of prior year audit corrective action plan, and interviews with members of the Care Management clinical team, case management leadership, and delegation oversight staff.

The Plan's case management leadership staff explained in interviews and a written pre-on-site audit narrative that complex case management services that meet the contract requirement for a program of medical case management would not be implemented until the program was fully staffed with an interdisciplinary team. At the time of the audit, one of five planned medical case management team members had been hired and was in orientation. The Plan's corrective action to address the need for interdisciplinary team involvement in complex case management was to develop and implement grand rounds as what it termed a "platform" for its interdisciplinary team to address the complicated medical and psychosocial needs of its complex members while the complex case management program was being implemented. At the time of the audit, two of these sessions had taken place (October and November 2014). One of the 106 members listed on the complex case management roster had been reviewed during grand rounds. The Plan could not confirm during the audit that grand rounds continued into 2015. Provision of complex case management as contractually defined was not evident. **This is a repeat finding.**

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

2.5.2 The Plan delegated but did not monitor *complex case management* services within medical groups.

The Plan is accountable for all coordination of care functions and responsibilities, such as *complex case management* and, if the Plan delegates these functions, it is responsible for oversight, monitoring, and evaluation of these processes (*Contract, Exhibit A, Attachment 6 (14)*).

The Plan delegated *comprehensive case management* services to its medical groups during 2014. According to document review and interviews with the Plan's compliance and delegation staff, no oversight was conducted for the *complex case management* requirement in 2014. Representatives from a delegated medical group confirmed that *complex case management* services were not monitored through the Plan's delegation oversight audit process. **This is a repeat finding.**

RECOMMENDATIONS:

- 2.5.1 Implement policies and procedures for the provision of *complex case management*.
- 2.5.2 Conduct oversight of delegated *complex case management* services to ensure continuous monitoring, evaluation, and approval of delegated activities or functions.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

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 FINDINGS:

3.1.1 The Plan did not ensure providers met timely access requirements.

The Plan is required to develop, implement, and maintain a procedure to monitor the time to obtain various types of appointments indicated in (*Contract, Exhibit A, Attachment 9 (3)(A) and (C)*). The Plan is required to communicate, enforce, and monitor providers’ compliance with timely appointments standards (*Contract, Exhibit A, Attachment 9 (3)*).

The Plan monitored appointment wait times for routine, urgent, and specialty care appointments through the Industry Collaborative Effort (ICE) Appointment Availability Survey for 50 providers sampled from five delegated medical groups. The Plan monitored non-delegated providers using the same survey in-house. Since the Plan was in the process of analyzing the results, the survey results were not available at the time of the audit.

These factors indicate providers were not in compliance with timely access requirements:

- The Plan’s Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results showed low scores with composite “Top Box” scores of 71% for getting needed care and 72% for getting care quickly. Respondents reported they did not obtain an appointment for health care as soon as they thought they needed. They did not receive urgent care as soon as they needed it and it was often not easy to obtain appointments with specialists.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

- Over 20 grievances were related to access issues including grievances not categorized as access. For instance, a grievance was filed by a new member who was put on a six week waiting list to schedule an appointment. A member was put on a three month waiting list to see a specialist and the member's mother called several providers to find suitable treatment for her son and found only one provider who accepted the Plan.
- The Plan's inquiry log showed members' access concerns were not addressed by the Plan. For instance, a member was unable to schedule an appointment or be seen by a primary care provider (PCP) for six months.
- The DHCS medical audit included an appointment availability verification study. The study to verify member wait times to obtain appointments for routine, urgent, specialty, and prenatal care illustrated providers' non-compliance with access standards. Fifteen providers sampled from the Plan's five delegated medical groups and *in-network* providers were reviewed. The *third next available appointment* was used to measure access to care. The verification study found a total of eight providers non-compliant with access standards.

The results of the verification study are as follows:

Provider Type	Contract Standards	Average Third Next Available Appointment
Non-urgent primary care	within ten business days of request	15.2 days
Urgent care for services without prior authorization	within 48 hours of a request	6.4 days
Specialty care	within 15 business days of request	23.6 days new patient 19.4 days established patient
First prenatal visit for a pregnant member	within two weeks upon request	17.6 days

- According to Plan staff, their 2014 Appointment Availability Survey included review of three types of specialists in Dermatology, Cardiology, and Allergy based on the recommended survey methodology. The Plan also monitors specialist turnaround 72-hours to track how PCPs communicate with specialists to expedite the referral process. Providers interviewed by DHCS auditors at provider sites consistently reported difficulties accessing specialty care providers, e.g., gastroenterologists, endocrinologists, and nutritionists.

3.1.2 **No corrective action plan for non-compliant providers with the initial prenatal care appointment standard.**

The Contract (*Exhibit A, Attachment 9 (4)*) requires the Plan to establish acceptable accessibility standards in accordance with *California Code of Regulations, Title 28, § 1300.67.2.2 (d)(3)* which states "Plans are required to implement prompt investigative and corrective action for non-compliant Providers with timely access standards to bring its network into compliance; and give advance written notice to the Providers affected by the corrective action that includes a description of the identified deficiencies, and the rationale for the corrective action." The Plan's *Policy #: QI-05, Access Policy and Standards*, requires provider or medical groups found to be out of compliance to submit a *corrective action plan* to the Plan for approval and monitoring.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

The Plan monitored initial prenatal care appointment waiting times through survey of seven high-volume OB/GYN providers in January 2015. The average initial prenatal appointment wait time was 12.4 days across the Plan's network. Two providers did not meet the two weeks appointment standard, the wait times were several weeks to a month. The Plan did not have a formal *corrective action plan* for the two groups that exceeded the standard. There was no follow-up by the Plan to verify the providers corrected the deficiencies. The Director of Health Improvement stated they collaborated with the Provider Network Operations department for outreach and notified the providers and educated them on access standards. The Plan has not required any *corrective action plan* in the past from a provider for access non-compliance.

3.1.3 No monitoring of wait times at providers' offices.

The Plan is required to monitor waiting times in the providers' offices (*Contract, Exhibit A, Attachment 9 (3)(c)*). *Policy #: QI- O5, Access Desktop Procedure*, states waiting times in the provider office for delegated medical groups would be monitored by dwell time studies and for non-delegated medical groups through collection of patient visit cycle time (the time between a member enters and exits the practice) data collected through the Plan's Pay-for-Performance Program.

The Plan's policy and procedure to monitor wait times at providers' offices was not implemented.

- The Plan did not conduct dwell time studies for delegated medical groups during the audit period. The Plan conducted the dwell time studies in 2013 for three of the six medical groups.
- The Plan incorporated a cycle time measure in the Practice Improvement Program for all non-delegated medical groups. According to Plan staff, this monitoring procedure was not performed during the audit period; the data collection started in the second quarter of 2015.

Long wait times for scheduled appointments at provider offices were also reflected in Plan's member grievances. For instance, a member experiencing extreme abdominal pain had to wait four hours; this member had another appointment two weeks later and had another four hour wait. Another member waited six to eight hours to be seen at an urgent care facility. **This is a repeat finding.**

3.1.4 The Plan did not ensure providers answer member telephone calls or return the calls in a timely manner.

Contract, Exhibit A, Attachment 9 (3) requires the Plan to establish acceptable accessibility requirements in accordance with *California Code of Regulations, Title 28, § 1300.67.2.1*. The Plan is required to monitor providers to answer and return telephone calls (*Contract, Exhibit A, Attachment 9 (3)(c)*).

The Plan monitored waiting time for member telephone calls and triage screening at provider offices through its *monitoring wait time survey* of providers in February 2015. The Plan sampled 20 providers from each of the six provider networks for both primary and specialty care. The survey reported the average wait times for the call to be answered was less than five minutes. The Plan concluded phone wait times remain low and no additional improvement was required. The Plan's wait time survey did not accurately represent provider accessibility because it excluded providers who did not answer the phone during the survey.

Evidence of provider phone accessibility deficiencies not detected by the Plan's survey includes:

- Members filed grievances because they were unable to speak to a person at provider offices, and providers not returning member calls timely. For instance, a member with severe rash, tried to call PCP ten times but the call went to voicemail. Another member was unable to reach a specialist provider to schedule an appointment since calls were not answered during normal business hours and the provider responded in 12-24 hours.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

- The Plan's fourth quarter 2014 Grievance & Appeals Report to the Quality Improvement Committee identified three access grievances associated with a provider whose roll over line, a message service that responds to calls when the main number is busy, was not in service.
- The DHCS' verification study also found provider offices that did not answer without any option for voicemail. DHCS Auditor experienced long hold times of up to 15 minutes.

3.1.5 The Plan did not continuously monitor member access and provider availability.

The Plan is required to establish acceptable accessibility requirements in accordance with *California Code of Regulations, Title 28, § 1300.67.2.1 (Contract, Exhibit A, Attachment 9 (3))*. *Contract, Exhibit A, Attachment 9 (3)(C)* requires the Plan to 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 indicated in *Contract, Exhibit A, Attachment 9 (A)*. *Policy #: QI-05, Access Policy and Standards*, includes a Desktop Procedure as a companion document for measuring member access to maintain compliance with DMHC and DHCS regulatory requirements.

The Plan did not monitor continued access non-compliance as evidenced by the following:

- The Plan's Desktop Procedure states the Plan monitors prenatal care through survey of higher-volume OB/GYN providers for the initial prenatal care appointment every two years. The Plan monitors waiting times in the provider offices for delegated medical groups by dwell time studies every three years. The Plan monitors waiting time for member telephone calls and triage screening through a random sample survey of providers every two years.
- The Plan's Desktop Procedure states the annual delegated medical groups audit includes timely access requirements compliance by medical groups, including corrective actions for any policies and procedures that do not align with timely access requirements. This audit was not conducted during the audit period. The manager for Delegation Oversight and Credentialing stated access was not part of the Plan's 2014 delegated medical group oversight audits because audits of access policies and procedures are conducted every other year.
- The Plan's Desktop Procedure specified the Plan conducts a comprehensive Provider Satisfaction Survey that addresses access requirements to gain provider perspective. *Policy #: QI-05, Access Policy and Standards*, further indicates the Plan conducts Provider Satisfaction Survey on annual basis to monitor Providers' access standard compliance. However, the Plan did not conduct a Provider satisfaction survey during the audit period.

3.1.6 The Plan did not ensure accurate provider listing.

The Plan is required to ensure that each member has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned member when medically required. Contract requires the Plan to ensure member access to specialists for Medically Necessary Covered Services (*Contract, Exhibit A, Attachment 9 (1)*).

Policy #: CS-04, Member Notification Regarding PCP Terminations, states in the event that an individual practitioner or clinic terminates their affiliation with the Plan network and when a medical group terminates its participation, affected members are notified at least 60 days in advance, and re-assigned to a PCP. The Provider Relations Department updates the Plan Provider Database, and makes the termination effective as of the first day of a month, allowing for at least 60-calendar days to notify members by mail.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

The Plan's Provider Directory and Plan's list of contracted specialists did not accurately reflect the number of PCPs and specialists available within the Plan's network. The DHCS' verification study found two PCPs and seven specialists listed in the Plan's Provider Directory were no longer active in the Plan's provider network. The Plan staff stated the printed version of the Provider Directory is updated twice a year and the online database on a weekly basis. However, providers who left the network for more than a year were still listed. The DHCS' verification study also found the Plan was not aware of a specialty practice provider who stopped taking member appointments for two months.

These access findings were also reflected in member grievances. Members were unable to see their PCPs and specialists because they were not accepting members from the Plan. For example, a member was unable to make an appointment with an assigned PCP because the assigned PCP was not accepting members from the Plan.

RECOMMENDATIONS:

- 3.1.1 Ensure provider compliance with all access standards.
- 3.1.2 Develop and implement *corrective action plans* for providers who do not comply with prenatal care access standards.
- 3.1.3 Develop and maintain a system to monitor wait times at providers' offices.
- 3.1.4 Ensure providers answer and return member calls in a timely manner.
- 3.1.5 Monitor access and availability of care on a routine basis.
- 3.1.6 Ensure an accurate provider listing.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

3.3

TELEPHONE PROCEDURES / AFTER HOURS CALLS

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.

2-Plan Contract A.9.3.D

Contractor shall maintain the capability to provide Member services to Medi-Cal Members or potential members through sufficient assigned and knowledgeable staff

2-Plan A.13.2.A

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 after-hours calls.

2-Plan Contract A.9.3.E

SUMMARY OF FINDINGS:

3.3.1 The Plan monitored *Nurse Advice Line (NAL)* but not all 24/7 telephone triage services.

The Plan is required to ensure providers maintain a procedure for triaging members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters (*Contract, Exhibit A, Attachment 9 (3)(D)*).

Providers have the option of using the Plan's NAL or employing and overseeing licensed clinicians providing 24-hour coverage to ensure members have access to after-hours care. The Plan's *Policy #: QI-05, Access Policy and Standards*, requires telephone triage or screening wait time within 30 minutes and providers must maintain standard protocols and guidelines for processing member calls that include telephone triage and after-hour availability. This policy did not state how non-NAL triage services would be monitored. The Plan did not monitor whether non-NAL providers arrange or provide 24/7 triage services with a screening wait time within 30 minutes.

3.3.2 The Plan did not ensure all 24/7 triage lines were answered by appropriately licensed professionals.

The Contract requires the Plan to ensure that a physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls (*Contract, Exhibit A, Attachment 9 (3)(E)*).

Providers have the option of using the Plan's NAL or employing and overseeing licensed clinicians providing 24-hour coverage to ensure members have access to after-hours care. *Policy #: QI-05, Access Desktop Procedure*, states that the Plan monitors after-hours care through ensuring appropriate policies and procedures exist for delegated medical groups, and *in-network* providers. The Plan's staff stated this monitoring procedure was not performed. The Plan has no established monitoring procedures for 24/7 triage line for delegated and non-delegated medical groups. The Plan did not review whether all providers' 24/7 telephone triage lines were answered by appropriately licensed professionals. **This is a repeat finding.**

RECOMMENDATIONS:

3.3.1 Develop and implement a system to monitor providers' compliance with 24/7 telephone triage services.

3.3.2 Develop and implement procedures to ensure 24/7 telephone triage lines are answered by appropriately licensed professionals.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

3.6

ACCESS TO PHARMACEUTICAL SERVICES

Pharmaceutical Services and Prescribed Drugs:

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.

2-Plan Contract A.10.8.G.1

SUMMARY OF FINDING:

3.6.1 The Plan did not ensure provision of sufficient supply of drugs prescribed in emergency situations.

The Plan is required to arrange for pharmaceutical services to be available during regular business hours, and to ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the member can reasonably be expected to have the prescription filled (*Contract, Exhibit A, Attachment 10 (8)(G)(1)*).

The Plan did not ensure members have access to medications prescribed in emergency circumstances to meet members' after-hours pharmacy needs. Members have access to 24-hour pharmacies for after hour or emergency situations. The Plan's corrective action did not correct the deficiency identified in the prior DHCS audit. The Plan implemented a new *Policy #: Pharm-13, After Hours Pharmacy Access*, on October 31, 2014, which stated the Plan Pharmacy Department would review a quarterly report to track the number of prescription claims within 72 hours of Emergency Department (ED) visits and the number of prescription claims filled at a 24-hour pharmacy location to monitor emergency medication supplies; this report would be submitted and reviewed by the Delegated Provider Oversight Committee for any need of corrective action. The Plan's current method of monitoring did not ensure members have timely access to sufficient supply of emergency medications. The monitoring report was for claims within 72 hours and did not capture services that may not have met the 72-hour requirement. The monitoring report showed the total number of prescription claims associated with ED visits and the total number of prescriptions filled at 24-hour pharmacies for the third quarter of 2014. The Compliance and Regulatory Affairs Officer stated the report did not differentiate between medication dispensed during normal business hours and after-hours. There was no indication in the report (e.g., no *days-supply* field) that assured members had access to a sufficient quantity of medication prescribed for an emergency medical condition or as a result of emergency medical services until the member can reasonably be expected to have a prescription filled. **This is the second time this is noted as a repeat finding.**

RECOMMENDATION:

3.6.1 Develop and implement a system to monitor and ensure the provision of prescribed drugs dispensed in emergency situations meet timeliness and sufficiency requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

CATEGORY 4 – MEMBER RIGHTS

4.1

GRIEVANCE SYSTEM

Member Grievance System and Oversight:

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-Plan Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858....(as required by Contract)

2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

2-Plan Contract A.14.3.A

SUMMARY OF FINDINGS:

4.1.1 The Plan did not ensure grievances were reported to the appropriate staff with authority to require corrective action.

The Plan is required to ensure that the grievance submitted is reported to an appropriate level, and the participation of individuals with authority to require corrective action (*Contract, Exhibit A, Attachment 14 (2)*).

Review of grievance files showed cases that were not completely investigated or reported to the appropriate level. Examples include but were not limited to:

- Alleged use of instruments with expired sterilization
- Acceptance of provider explanation without independent investigation
- Alleged 53 days delay in mailing a Notice of Action (NOA) letter

4.1.2 The Plan's grievance system did not log and report exempt grievances for quality improvement.

A grievance is defined as a written or oral expression of dissatisfaction. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance (*California Code of Regulations, Title 28, § 1300.68 (a)(1)*).

Grievances received over the telephone that do not involve medical necessity and that are resolved by the close of the next business day are exempt from the requirement to send a written acknowledgment and response. The Plan is required to maintain a detailed log of exempt grievances to be periodically reviewed by the Plan (*California Code of Regulations, Title 28, § 1300.68 (d)(8)*).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

According to interviews with Plan personnel, the Plan does not categorize or log expressions of dissatisfaction as exempt grievances. For example, a member contacted the Plan because the member could not obtain an appointment with a provider. The customer service representative helped the member obtain an appointment and the call was not classified as an exempt grievance. In some cases, members were asked if they wished to file a grievance. When they declined, their calls were classified as inquiries and letters acknowledging members' expression of dissatisfaction were sent. The Plan did not provide evidence that these grievances were classified, tracked, and continuously reviewed for quality improvement. **This is a repeat finding.**

RECOMMENDATIONS:

- 4.1.1 Ensure grievances are reported to the appropriate staff with authority to require corrective action.
- 4.1.2 Develop and implement procedures to ensure expressions of dissatisfaction are classified, logged, and reported as grievances.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

4.2

CULTURAL AND LINGUISTIC SERVICES

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...

2-Plan Contract A.9.13

Contractor will assess, identify and track the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical).

2-Plan Contract A.9.13.B

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.

2-Plan Contract A.9.13.F

Linguistic Services:

Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, 45 C.F.R. Part 80) that prohibits recipients of Federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

2-Plan Contract A.9.12

Contractor shall comply with Title 22 CCR Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact...either through interpreters, telephone language services, or any electronic options...

2-Plan Contract A.9.14.A

Types of Linguistic Services:

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...
- 3) Referrals to culturally and linguistically appropriate community service programs.
- 4) Telecommunications Device for the Deaf (TDD).

2-Plan Contract A.9.14.B

Key Points of Contact Include:

- 1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care providers including pharmacists.
- 2) Non-medical care setting: Member services, orientations, and appointment scheduling.

2-Plan Contract A.9.14.D

SUMMARY OF FINDINGS:

4.2.1 The Plan did not monitor delegated medical groups' provision of cultural and linguistic services.

The Plan is required to ensure members receive 24-hour oral interpreter services at all key points of contact (*Contract, Exhibit A, Attachment 9 (14)(A)*).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

The Plan is required to assess the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program (*Contract, Exhibit A, Attachment 9 (13)(F)*). The Plan is required to monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services (*Contract, Exhibit A, Attachment 9 (13)*).

The Plan's policy to monitor and evaluate the cultural and linguistic services of delegated medical groups was not implemented. The Plan delegates the responsibility of providing cultural and linguistic (including interpreter services) at all key points of contact to its delegated medical groups; and the responsibility of providing cultural awareness trainings to their staff. *Policy #: CLS-02, Use of Interpreter Services and Bilingual Staff*, specified the Plan conducts an audit of linguistic services as part of the annual oversight audit and discusses findings with medical groups and Plan health services staff, but the Plan did not include cultural and linguistic services in the oversight audits of five of six delegated medical groups. The reviewed medical group received 100% score even though it was noted that many employees did not complete cultural awareness training. The Plan did not monitor or evaluate whether improvement was needed in the delivery of culturally and linguistically appropriate services.

4.2.2 **The plan did not monitor non-delegated providers' provision of cultural and linguistic services.**

The Plan is required to ensure members receive 24-hour oral interpreter services at all key points of contact (*Contract, Exhibit A, Attachment 9 (14)(A)*).

The Plan is required to assess the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program (*Contract, Exhibit A, Attachment 9 (13)(F)*). The Plan is required to monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services (*Contract, Exhibit A, Attachment 9 (13)*).

The Plan did not monitor non-delegated providers to assess the performance of individuals who provide cultural and linguistic services. The Plan requires non-delegated providers to arrange for interpreter services to non-English speaking or LEP members on a 24-hour basis. The Plan staff stated providers receive education materials and that providers' cultural and linguistic services were evaluated during Facility Site Review/Medical Record Review. However, this review occurs every three years. The last time the Plan conducted an interpreter services survey was in 2012 for 15 providers. The Plan did not have any other established procedures in place to monitor and evaluate these requirements.

4.2.3 **The Plan did not assess members' concerns regarding providers' interpreter services.**

The Plan is required to ensure all monolingual, non-English-speaking, or limited English proficient (LEP) members and potential members receive 24-hour oral interpreter services at all key points of contact. The Plan is required to ensure lack of interpreter services does not impede or delay timely access to care (*Contract, Exhibit A, Attachment 9 (14)(A)*).

The Plan did not monitor the effectiveness of the linguistic services program. Grievances regarding communication or language problems and assessment of member satisfaction with the quality and availability of interpreter services were not included in Plan's linguistic services program monitoring. *Policy #: CLS-02, Use of Interpreter Services and Bilingual Staff*, states the Plan Project Manager of Health Education and Cultural and Linguistic Services (HECL) assists in addressing grievances related to cultural and linguistic issues both medical and non-medical, investigates and intervenes as needed when applicable, and discusses relevant issues raised as grievances with medical group and Plan health services staff. The Plan QI Committee reviews grievance trends and suggests additional corrective actions.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

Grievances related to cultural and linguistic services were not reviewed by the Project Manager of HECL and QI as stated in Policy #: CLS-02. The Plan's cultural and linguistic staff members were not aware of grievances related to culture and linguistic services during the audit period. Examples include:

- A grievance alleged that a member waited all day in a hospital waiting room to see a provider since there was no one who spoke Spanish. When the member received interpretation services the member's words were incorrectly translated.
- Another grievance was reported by a member's relative who called a provider to make an appointment. The appointment was not made because the office staff stated, "You don't know how to speak English, you need to learn to speak a line or two...call us when you do".

RECOMMENDATIONS:

- 4.2.1 Monitor delegated medical groups' provision of appropriate cultural and linguistic services (including interpreter services) at all key points of contact.
- 4.2.2 Develop and implement procedures to monitor non-delegated providers' delivery of appropriate cultural and linguistic services (including interpreter services) at all key points of contact.
- 4.2.3 Assess and include members' concerns in the cultural and linguistic services program and report to the Quality Improvement Committee for corrective action.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

4.3

CONFIDENTIALITY RIGHTS

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

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

2-Plan Contract A.13.1.B

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

Business Associate agrees:

Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

2-Plan Contract G.III.C.2.

Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

- 1. Notice to DHCS.** (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.
- 2. Investigation and Investigation Report.** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
- 3. Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

2-Plan Contract G.III.J

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

SUMMARY OF FINDINGS:

4.3.1 The Plan did not notify and report breach incidents to the Department of Health Care Services (DHCS) Information Security Officer.

Upon discovery of any breach or security incident, the Plan is required to notify and report to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer (*Contract, Exhibit G (J)*).

The Plan's *Policy #: C&RA-06, Breach Investigation and Report*, also requires the Plan to notify and report breach incidents to the DHCS Information Security Officer.

Interview with Plan representatives and review of documents confirmed the Plan notified and reported breach incidents to the DHCS Program Contract Manager and the DHCS Privacy Officer, but not the DHCS Information Security Officer.

4.3.2 The Plan did not ensure medical groups notify the Plan upon discovery of breach incidents within the required time frame.

The Plan is required to notify DHCS immediately upon the discovery of a breach of unsecured Protected Health Information (PHI) or Personal Information (PI) if it was, or is reasonably believed to have been, accessed or acquired by an unauthorized person (*Contract, Exhibit G (III) (J)(1)*). The Plan is required to impose the same security and breach notification requirements on its subcontractors (*Contract, Exhibit G (III) (E)(1)*). If the cause of a breach of PHI or PI is attributable to the Plan or its subcontractors, the Plan is responsible for all required reporting of the breach (*Contract, Exhibit G (III) (J)(5)*).

According to Plan staff and review of documents, several medical groups did not immediately report breach incidents to the Plan. One medical group did not report a breach incident to the Plan. The Plan discovered the breach through the national news media.

4.3.3 Two of the Plan's delegated medical groups did not safeguard PHI.

The Plan is required to ensure that "Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network" (*Contract, Exhibit A, Attachment 13 (1)(B)(1)*).

Two delegated medical groups' unencrypted computers containing PHI were burglarized. Thousands of members' records were affected.

RECOMMENDATIONS:

4.3.1 Notify and report breaches or security incidents to the DHCS Information Security Officer.

4.3.2 Impose the same Contract breach notification requirements on the Plan's subcontractors.

4.3.3 Ensure delegated medical groups implement technical safeguards to protect PHI consistent with the Contract requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

CATEGORY 5 – QUALITY MANAGEMENT

5.1

QUALITY IMPROVEMENT SYSTEM

General Requirements:

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.

2-Plan Contract A.4.1

Written Description: Contractor shall implement and maintain a written description of its QIS [Quality Improvement System]...(as required by Contract)

2-Plan Contract A.4.7.A-I

Accountability: Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted physicians and contracted providers in the process of QIS development and performance review. Participation of non-contracting providers is discretionary.

2-Plan Contract A.4.2

Governing Body: Contractor shall implement and maintain policies that specify the responsibilities of the governing...(as required by Contract)

2-Plan Contract A.4.3.A-D

Provider Participation: Contractor shall ensure that contracting physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.

2-Plan Contract A.4.5

SUMMARY OF FINDINGS:

5.1.1 The Plan has not developed mechanisms for monitoring and evaluation of quality improvement programs.

According to *Contract, Exhibit A, Attachment 4 (1)*, the Plan is required to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering service on its behalf, in any setting.

Since the 2014 audit, the Plan was working on the *corrective action plan (CAP)* and developing the necessary infrastructure for effective program monitoring and evaluation. The Plan's 2014 quality improvement plan describes the mechanism to evaluate the quality improvement program. This infrastructure was not developed at the time of this review. **This is a repeat finding.**

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

5.1.2 **The Plan did not document quality improvement in programs with objectively measured and recorded metrics.**

The Plan is required to develop an annual quality improvement report which includes a comprehensive assessment of the quality improvement activities undertaken, evaluation of areas of success and needed improvements in services including the collection of aggregate data on utilization, and review of the quality of services rendered (*Contract, Exhibit A, Attachment 4 (8)(A)*).

According to the 2014 Plan Quality Improvement Program, all health services interventions focused on improvement of clinical quality and practice improvement were evaluated annually through data analysis to ensure that the interventions were effective and had impact on quality improvement.

Since the 2014 audit, the Plan was developing the necessary infrastructure for effective use of metrics for objective assessment of quality improvement from various interventions. **This is a repeat finding.**

5.1.3 **Resolutions for Potential Quality Issues (PQIs) did not always ensure members received acceptable medical care.**

The Plan is required to ensure that acceptable medical care standards are adhered to and that medical protocols and rules of conduct are followed (*Contract, Exhibit A, Attachment 1 (6)*).

The Plan's *Policy #: UM-56, Potential Quality Issues*, effective after the audit period (February 12, 2015), ensures that all Plan members receive quality medical care services from providers in a safe, appropriate, and regulatory compliant environment.

The Plan determined a PQI to have no quality of patient care issues and no potential for patient harm although missteps in clinical management, transfer protocols, and care coordination were noted. No corrective actions were recommended. The Plan acknowledged that a higher risk score would have been in order if it was reassessed. Failure to assign proper risk to this PQI and enact a *corrective action plan* with the involved entities did not ensure acceptable medical care for this member or future members under similar circumstances.

5.1.4 **Information from overturned grievances and appeals were not incorporated into the Quality Improvement System (QIS).**

The Plan is required to ensure that the UM activities are integrated into the QIS, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff (*Contract, Exhibit A, Attachment 5 (1)(G)*).

According to the 2014 Quality Improvement Plan, the Plan Manager of Clinical Quality oversaw the member grievance staff and all activities related to clinical Healthcare Effectiveness Data and Information Set and health education program improvement. The Quality Management Specialist managed member grievances, ensuring grievances were resolved in a timely fashion and tracked appropriately and reported quarterly to QIC.

Information derived from overturned grievances and appeals, when analyzed and tracked, is an objective source to be used for improving the QIS. The Plan did not evaluate, track, and trend information on overturned grievances and appeals and use this information to benefit the QIS.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

5.1.5 **The Plan QIC did not review, and was not accountable for, delegation oversight activities conducted by the Plan.**

The Plan Governing Body is required to designate a QIC with oversight and performance responsibilities for Plan activities (*Contract, Exhibit A, Attachment 4 (2)*). The Plan is accountable for all quality improvement functions and responsibilities, such as UM and credentialing, which is delegated to subcontractors and is responsible for the monitoring of such delegated functions (*Contract, Exhibit A, Attachment 4 (6)(A)*).

The Plan's 2014 Quality Improvement Plan stated the QIC was responsible for review and approval of the Plan's UM and Quality Improvement Programs and for review and approval of activities pertaining to the oversight of delegated entities. Review of QIC meeting minutes did not demonstrate discussion or actual oversight of delegated activities, including utilization management. **This is a repeat finding.**

5.1.6 **The Governing Board's late approval of the 2014 Quality Improvement Plan (QIP) did not demonstrate full Governing Board accountability for the Plan QIP.**

The Plan is required to implement and maintain policies that specify the responsibilities of the Governing Body, including approval of the overall Quality Improvement System (QIS) and the annual report of the QIS (*Contract, Exhibit A, Attachment 4 (3)(A)*).

The Plan's *Policy #: QI-10, Governing Board's Role in SFHP Quality Improvement Program*, stated that the Governing Board was responsible for approving the QIP annually and directing the QIC in the QIP's implementation.

The Governing Board did not approve the 2014 QIP until September 2014 thus the Plan did not implement an approved QIP for two-thirds of the year. The Plan is reworking its procedures to ensure earlier annual approval of the QIP. **This is a repeat finding.**

RECOMMENDATIONS:

- 5.1.1 Develop and implement mechanisms for the effective monitoring and evaluation of Plan programs to ensure quality care by all providers.
- 5.1.2 Fully develop Plan program metrics to objectively demonstrate that interventions improve the quality of care provided.
- 5.1.3 Ensure PQI resolutions are consistent with acceptable medical care.
- 5.1.4 Integrate information derived from analysis of overturned grievances and appeals into the QIS.
- 5.1.5 Ensure and document oversight of delegated entities by the QIC.
- 5.1.6 Establish a process to ensure the annual QI Plan is approved by the Governing Board prior to its planned implementation.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

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 FINDINGS:

6.1.1 Medical directors' participation in the Plan grievance process was limited.

The Plan is required to maintain a full time physician as medical director whose responsibilities include actively participating in the functioning of the plan grievance procedures (*Contract, Exhibit A, Attachment 1 (6)*).

Documentation of physician involvement in grievances was often limited to a general statement of agreement with grievance resolution letters drafted by non-clinical Plan staff. Plan's medical directors could not describe and outline their role in the grievance system. There was limited evidence of independent grievance analysis, research, or root cause analysis of the grievance medical issues.

6.1.2 The Plan did not ensure all members received acceptable medical care.

The Plan is required to maintain a full time physician as medical director whose responsibilities include ensuring that all Plan members receive acceptable medical care (*Contract, Exhibit A, Attachment 1 (6)*).

Medical decisions were not overseen to ensure Utilization Management (UM) decisions were consistent with acceptable medical care.

Examples of UM decisions that were inconsistent with acceptable medical care include:

- A member with eye trauma and transient blindness seen in the Emergency Department of an *out-of-network* facility. An expedited Prior Authorization (PA) request was placed for a next day eye clinic evaluation at this same facility. The request was delayed for documentation as to why the service had to be done *out-of-network* and then denied at 7 calendar days when no information arrived. This time sensitive medical need was not addressed within a time frame consistent with acceptable medical care.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

- A Potential Quality Issues (PQIs) was generated when a member was repatriated from an out of network to an in network inpatient facility. A member with ongoing blood loss deemed unstable for discharge was transferred in a taxi to an *in-network* facility accompanied by the Plan's non-clinical care manager. According to an interview with Plan leadership, Care Management staff members are not qualified to make these decisions. The Plan's *repatriation* policy (#: *UM-48*) at the time of the incident did not specify who was qualified to determine what "level of ambulance will be required for the transfer (Basic Life Support/BLS, Advanced Life Support/ACLS, or Critical Care Transfer/CCT)". After the member arrived at the *in-network* facility, the care needed was not available, thus prompting another transfer. After a six month period, the Plan determined that this PQI had no merit and involved no quality or patient harm issues. No *corrective action plans* were issued.

6.1.3 The Plan did not ensure that medical decisions, including those by sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management (*Contract, Exhibit A, Attachment 1 (5) and (6)(A)(2)*).

The prior DHCS medical audit's CAP included a directive, to ensure the Plan does not adopt medical policies driven by cost saving strategies, to be inserted into a variety of UM materials and remind and educate staff about the directive. Based on our review, this directive was not implemented. The Plan's delay, denial, and repatriation of essential medical services, contrary to clinical indications, are indications of medical decisions, including those by sub-contractors and rendering providers, that were influenced by financial and administrative considerations. For example:

- Screening colonoscopies were denied until mid-way through the audit period when this practice was discontinued. Health plans are required to provide generally medically accepted cancer screening tests such as colonoscopies for members (*California Health and Safety Code § 1367.665*).
- The Plan enforced restrictions on branded medications, even in the absence of medical justification or indication. A diabetic on multiple medications, including insulin, demonstrated a good response to a non-formulary medication. The Plan denied the request to continue the drug. A Plan pharmacist without clinical knowledge of the member denied the drug and recommended an increased dose of insulin. This clinical decision was made without medical director involvement. This was a cost savings decision without clinical support.
- An expedited PA for a next day eye evaluation after eye trauma and loss of vision was delayed seven days in an attempt to redirect the visit to an *in-network* provider. The PA was denied for failure to justify an *out-of-network* visit, thus not meeting a time sensitive need for this member. These decisions to delay and deny time sensitive care had no identified medical benefit.
- A member with significant ongoing medical issues and deemed unstable for hospital discharge was repatriated from an *out-of-network* hospital to an *in-network* hospital, accompanied by a non-clinical Plan care coordinator via taxi transportation. It was then determined that there was no accepting attending physician and special services required by the member were not available at the *in-network* hospital. Repatriation of this member was without identifiable medical benefit.

This is a repeat finding.

RECOMMENDATIONS:

- 6.1.1 Ensure medical directors' independent involvement in the grievance process is documented.
- 6.1.2 Implement active monitoring of UM processes to ensure medical care delivered is of acceptable quality.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

- 6.1.3 Ensure medical decisions, including those by sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative considerations.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

6.2

HEALTH EDUCATION PROGRAM

Health Education:

- 1) Contractor shall implement and maintain a health education system that include programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members.
- 2) Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator.
- 3) Contractor shall provide health education programs and services at no charge to Members directly and/or through Subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Member population.
- 4) Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health.
- 5) Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.
- 6) Contractor shall maintain a health education system that provides educational interventions...
- 7) Contractor shall ensure that Members receive point of service education as part of preventive and primary health care visits. Contractor shall provide education, training, and program resources to assist contracting medical providers in the delivery of health education services for Members.
- 8) Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to ensure effectiveness.
- 9) Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements...(as required by Contract)

2-Plan Contract A.10.8.A

SUMMARY OF FINDING:

6.2.1 The Plan did not evaluate the performance of providers' delivery of health education services.

The Plan is required to maintain health education policies and procedures, standards, and guidelines. The Plan is also required to conduct appropriate levels of program evaluation and monitor performance to ensure effectiveness of providers who are contracted to deliver health education services (*Contract, Exhibit A, Attachment 10 (8)(A)(8)*).

The Plan delegated health education services to medical groups and contracted providers. *Policy #: CLS-05, Health Education Standards*, states the Plan monitors its provider network through annual review of health education programs as part of the delegation oversight audit. The Plan did not conduct health education review for five of six medical groups as part of the delegation oversight audit.

Policy #: CLS-05, Health Education Standards, states the health educator provides education, training, and program resources to assist contracted providers in the delivery of health education services for members. The Plan's *in-network* clinics and contracted medical groups offer health education classes. The Plan did not verify members may attend these education classes or evaluate the classes for any needed improvements. The Plan staff stated member service staff called to validate if the classes were offered. The Plan did not evaluate health education classes and programs offered by *in-network* providers.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

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The Plan provided a Healthier Living/Chronic Disease Self-Management Program directly to members to help members with chronic conditions with self-management tools. Five rounds of six weeks training was provided; a total of 35 members participated in the program. However, there were no attendance records. The Plan did not track the participants since it did not require members to sign-in for the training.

RECOMMENDATION:

6.2.1 Evaluate the performance of providers' health education services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

6.3

FRAUD AND ABUSE

Fraud and Abuse Reporting

Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse....

- 1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
- 2) Contractor shall provide effective training and education for the compliance officer and all employees.
- 3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
- 4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity....
- 5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs....

2-Plan Contract E.2.26.B

SUMMARY OF FINDINGS:

6.3.1 The Plan's proactive Anti-Fraud program was not operational.

The Plan is required to make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines (*Contract, Exhibit E, Attachment 2 (26)(B)(3)*).

Prior year audit report recommended the Plan to implement procedures to undertake a more proactive fraud and abuse detection and intervention program. The Plan adopted the *Anti-Fraud Work Plan* in response; however it was not yet operational at the time of onsite review. **This is the second time this is noted as a repeat finding.**

6.3.2 The Plan did not report a suspected fraud and abuse case to the Department of Health Care Services (DHCS) within the required time frame.

The Plan is required to conduct, complete, and report to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse is within ten working days of the date the Plan is aware of such activity (*Contract, Exhibit E, Attachment 2 (26)(B)(4)*).

The Plan notified DHCS of a suspected fraud and abuse incident, but did not complete a preliminary investigation and report the results to the DHCS within ten working days.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Francisco Health Plan

AUDIT PERIOD: January 1, 2014 through December 31, 2014

DATE OF AUDIT: March 9, 2015 through March 20, 2015

6.3.3 **The Plan did not ensure covered services were prescribed or ordered by a provider in good standing with the Medi-Cal program.**

The Plan is prohibited from employing, contracting, or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs (*Contract, Exhibit E, Attachment 2 (5)*). The Plan is required to maintain sufficient claims processing, tracking, and payment systems to comply with applicable State and Federal law (*Contract, Exhibit A, Attachment 8 (5)(D) and Attachment 10 (8)(G)(1)*). "Services prescribed or ordered by a provider suspended from participation in the Medi-Cal program shall not be covered by the program while the suspension is in effect...." (*California Code of Regulations, Title 22, § 51303(k)*)

The Plan tracked prescribing providers within its network against federal and state suspended and ineligible provider list. However the Plan did not track prescribing providers for out-of-network provider claims.

6.3.4 **Subcontractor service agreement did not include clauses regarding fraud and abuse reporting requirements.**

The Plan is required to conduct, complete, and report to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse is within ten working days of the date the Plan is aware of such activity (*Contract, Exhibit E, Attachment 2 (26)(B)(4)*).

Delegation of any obligation or requirement to a subcontractor by a plan shall not release the plan from the responsibility to discharge any obligation or comply with any requirement contained in the contract between the plan and the Department (*California Code of Regulations, Title 22, § 53867*).

The Plan's contracted Pharmacy Benefit Management (PBM) reported a fraud and abuse incident to the Plan 25 working days after the incident occurred. The PBM service agreement did not include fraud and abuse reporting requirements.

RECOMMENDATIONS:

- 6.3.1 Operationalize the Anti-Fraud Work Plan to initiate a more proactive fraud and abuse detection and intervention program.
- 6.3.2 Ensure all incidents of suspected fraud and abuse are reported to DHCS within ten working days of the date the Plan is aware of such activity.
- 6.3.3 Ensure covered services are prescribed or ordered by a provider in good standing with the Medi-Cal program.
- 6.3.4 Ensure subcontractor service agreements are consistent with contract requirements.