

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

**San Francisco Health Authority
dba San Francisco Health Plan**

Contract Number: 04-35400

Audit Period: December 1, 2012
Through
November 30, 2013

Report Issued: August 7, 2014

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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 Brown and Toland Physicians, Hill Physicians, Kaiser Permanente, North East Medical Services (NEMS), Chinese Community Health Care Association (CCHCA), Community Health Network (CHN), and UCSF Medical Group (UCSF) to provide or arrange comprehensive health care services.

As of December 1, 2013, SFHP had 81,754 Members of which 67,806 (82.93%) were Medi-Cal Members. The Plan also covers Healthy Families (3), Healthy Kids (2,236), and Healthy Workers (11,709).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of December 1, 2012 through November 30, 2013. The on-site review was conducted from March 3, 2014 through March 20, 2014. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on June 10, 2014 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, Members' Rights, Quality Management (QI), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan did not have a mechanism in place to ensure the consistent application of guidelines. There was no mechanism in place to ensure the consistency or appropriateness of denials made by medical directors. The Plan had no systematic method of detecting overall over-or under-utilization for populations, services, procedures, specialties or providers.

The Plan regarded the 24-hour time frame for authorization of pharmaceuticals as requiring a response instead of a decision and the majority of pharmacy prior authorizations did not meet the 24-hour time frame. The Plan denied prior authorization requests for medically necessary services that were possibly related to CCS eligibility, with no evidence of care coordination to ensure that all CCS and non-CCS services were provided to the member.

The Plan has not implemented a system to track prior authorization referrals to completion; **this is the third time this is noted as a repeat finding**. The Plan did not examine referral tracking mechanisms in delegated entities as part of its oversight activities.

The Plan inappropriately denied some appeals which were subsequently overturned. The Plan did not use the appeal system to update the Utilization Management (UM) program to reduce inappropriate denials.

Category 2 – Case Management and Coordination of Care

The Plan is required to ensure the provision of Comprehensive Medical Case Management Services to each Member. These services are provided through either Basic or Complex Case Management activities, based on the medical needs of the member.

The requirements for Basic Case Management include the provision of an Initial Health Assessment (IHA) for each new member within the required timeframes and coordination of carved-out and linked services. The IHA completion rates reported by the Plan for the audit period showed the requirement for timely completion for each new member was not met (see audit report section 2.4 for details). A review of coordination of care for members receiving California Children's Services and Golden Gate Regional Center services found that the Plan did not fully execute its Memoranda of Understanding (MOUs) with these programs (see audit report sections 2.2 and 2.3 for details).

According to the Contract, the Plan must be able to provide Complex Case Management defined as the management of acute or chronic illness by a multi-disciplinary team with intense coordination of services and care planning to ensure the eligible member regains optimal health or improved functionality. The requirements for Complex Case Management were not met as the Plan did not ensure that complex medical case management as defined by the Contract was available to members who required that level of service.

Category 3 – Access and Availability of Care

The Plan did not monitor waiting times to obtain the initial prenatal care appointment. Access to specialty services, telephone and wait times in provider offices were also not monitored. The Plan conducted an ICE Appointment Availability and a Third Appointment Availability surveys. These surveys were self-reported and the Plan did not conduct any studies to verify the accuracy of the answers.

The Plan did not review whether the 24/7 telephone triage lines used by delegated medical groups were answered by appropriate licensed professional as required by the Contract.

The Plan's monitoring did not determine and ensure whether existing 24-hour pharmacies in network were accessible and met members' after-hours pharmacy needs. **This is a repeat finding.**

Category 4 – Members’ Rights

The Plan did not capture all complaints and expressions of dissatisfaction as grievances. The Inquiry Log contained complaints and expressions of dissatisfaction but were not classified as grievances because the member declined to file a grievance. These were not reviewed or forwarded to the Plan’s quality assurance committee. The Plan lacked regular oversight to ensure appropriate classification of calls as grievances.

Category 5 – Quality Management

The Plan did not have well developed, effective monitoring and evaluation of programs. The Plan used the ICE self-reported survey tool, which they admitted is invalid, to report 100% compliance with timely access standards. Reports of access problems to the Quality Improvement Committee (QIC) resulted in no documented action. Although the Plan measured 3rd available appointment as part of its Practice Improvement Program, its interventions have been ineffective in bringing this measure into compliance with the Contract. The Plan relied on an e-referral program to ensure referrals for specialty care were reviewed by a qualified medical specialist. Those not seen within contractually required time frames were deemed to not require service within the standard. It did not monitor whether deferred care represented practice within acceptable standards of care.

The Plan delegated the majority of credentialing to medical groups. However, the Plan’s delegation agreements for credentialing did not contain remedies if delegated entities’ obligations are not met. For the providers that remained the Plan’s responsibility to credential, the Plan failed to recredential eight providers who needed recredentialing.

The QIC was not accountable for delegation oversight activities conducted by the Plan. **This is a repeat finding.**

Category 6 – Administrative and Organizational Capacity

Medical decisions were influenced by fiscal and administrative considerations.

The Plan’s delegation agreements for provider training do not contain remedies if delegated entities’ obligations are not met.

The Plan did not implement a more proactive fraud and abuse program as stated in their prior audit CAP. **This is a repeat finding.**

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 3, 2014 through March 20, 2014. 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.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 21 medical and 39 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Notification of Prior Authorization Denial, Deferral, or Modification: 60 denial and modification letters were reviewed for written notification requirements.

Appeal Procedures: 35 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): 10 medical records were reviewed for evidence of coordination of care between the Plan and CCS Providers.

Early Intervention Services and Developmental Disabilities: 10 medical records were reviewed for evidence of coordination of care between the Plan and Regional Centers.

Individual Health Assessment: 46 medical records were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Emergency Service Claims: 20 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 20 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Members' Rights

Grievance Procedures: 16 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

Medical Records: 46 medical records were reviewed for completeness.

Informed Consent: 3 informed consent records were reviewed.

Category 6 – Administrative and Organizational Capacity

New Provider Training: 2 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: December 1, 2012 through
November 30, 2013

DATE OF AUDIT: March 4 through March 20, 2014

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

Under- and Over-Utilization:

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:

The Plan was required by the Contract to consistently apply criteria or guidelines for Utilization Review. The Plan had the following statement in its 2013 Utilization Management (UM) Program:

"At least annually, the Plan or its delegates evaluates the consistency with which its reviewers apply utilization management criteria in decision-making (inter-rater reliability), and requires corrective action, if necessary"

The Plan did not conduct inter-rater reliability studies or have other mechanisms in place to ensure the consistent application of guidelines. There was no mechanism in place to ensure the consistency or appropriateness of denials made by medical directors.

The Plan was required have mechanisms within the UM Program to detect both under- and over-utilization of health care services. Although the Plan used review of individual cases to detect instances of over- and under-utilization, and to subsequently refer to case management, it had no systematic method of detecting overall over-or under-utilization for populations, services, procedures, specialties or providers. The Plan reported an average of 3.25 inpatient admissions per 1,000 members in 2013. This was well below the National Medicaid 10th percentile for General Hospital/Acute Care Discharges for Medicaid HEDIS, which was 4.98. There was no evidence of external benchmarking. For a Plan reporting an inpatient admission number that was far below benchmarks and potentially an indicator of under-utilization, it did not have a data driven explanation for this low number; it stated that low admissions were to be expected, given the ethnic makeup of the membership.

RECOMMENDATIONS:

- Establish a method to ensure consistent guideline application; including a method to ensure medical directors' denials are appropriate and consistent.
- Implement a systematic method of detecting over-and under-utilization for services across the population.
- Examine data and care patterns related to inpatient utilization, and compare to available regional, state and national benchmarks.

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1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements...(as required by Contract)

2-Plan Contract A.5.2.A, B, 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

Notification of Prior Authorization Denial, Deferral, or Modification:

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:

The Plan did not regard the 24-hour or one business day time frame for authorization of pharmaceuticals as requiring a decision, only a “response”. Twenty-four of the 39 pharmacy prior authorizations reviewed did not meet the 24-hour or one business day time frame.

During the audit period, the verification study included four cases where the Plan denied prior authorization requests for medically necessary services that were possibly related to California Children’s Services CCS eligibility, with no evidence of care coordination to ensure that all CCS and non-CCS services were provided to the member. The Plan stated that this process was changed in September 2013; however *Policy #: UM-22 Authorization Requests* (effective December 2013) still requires a CCS denial. No other CCS related denials were found in the verification study after September 2013.

The Plan issued inappropriate denials for both medical and pharmacy prior authorizations:

- Although the criteria for a tonsillectomy request were met, it was denied because it was requested together with an adenoidectomy which did not meet the criteria. The authorization was not modified to approve only the indicated procedure.
- Special formula for a premature infant was denied although it met Medi-Cal criteria for specialized infant formula.
- A colonoscopy was denied as not meeting the Plan’s criteria. The Plan received only two of the four pages of the medical record. The Plan’s medical reviewer would have no way of knowing whether the additional two pages contained information that allowed the member to meet the Plan’s criteria.
- Chimerism engraftment analysis on a bone marrow biopsy was denied for a post-transplant patient, as not a covered Medi-Cal benefit. The Plan maintained that this procedure was not made a covered benefit until January 2014 and submitted a Medi-Cal manual page dated December 2013 as evidence. However, an archived copy of the same Medi-Cal manual page from September 2012 shows that it was a benefit at that time.

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- A genetics consult was denied on a 20-month old developmentally delayed member with hypotonia and auditory neuropathy because the referring neurologist failed to provide “information on how the evaluation results will directly impact the treatment being delivered to the member or one of the member’s family members.” The failure to respond to this request was not a reasonable basis for denial. The purpose of the genetics consult was largely to determine whether the patient had an inherited condition that might have impacted care. It was inappropriate to require the referring doctor to speculate on all the possible genetic diseases, and corresponding therapeutic implications for this member. This represented a fundamental lack of knowledge on the part of the medical reviewer regarding the purpose of a genetics consult. The Contract requires that decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.
- Two members were required to receive a compounded product despite the availability of an FDA approved product and no medical indication for receiving a compounded product instead. The Plan stated that they discontinued this practice upon the receipt of Medi-Cal Managed Care Division (MMCD) Policy Letter 14-002.
- A member was denied off label ivermectin for Rosacea and substituted off label permethrin. Although both drugs are off label, a review of the literature disclosed published studies on the off label use of ivermectin for this member’s condition but none were discovered for permethrin. The Plan was unable to provide literature supporting this drug substitution.
- Five members were denied drugs with an FDA indication for musculoskeletal pain or fibromyalgia. These were modified to generic drugs such as gabapentin, venlafaxine and tricyclic antidepressants. Although many physicians may use these drugs for these indications, they do not have a labeled FDA indication. The Plan maintains that this mandatory step therapy was discussed at P& T and is supported by literature. Minutes submitted from P&T do not document discussion of mandating step therapy for unlabeled indications. An article submitted in support of this policy actually stated:

“Pregabalin is established as effective and should be offered for relief of PDN (Level A). Venlafaxine, duloxetine, amitriptyline, gabapentin, valproate, opioids (morphine sulfate, tramadol, and oxycodone controlled-release), and capsaicin are probably effective and should be considered for treatment of PDN”.

RECOMMENDATIONS:

- Respond with a decision for all pharmacy prior authorizations within 24 hours or one business day.
- Continue to approve medically necessary services that may be related to CCS conditions, providing care coordination to members as needed and revise Policy #: UM-22 to reflect the new process reported by the Plan as implemented in September 2013.
- Follow all Plan and Medi-Cal criteria when issuing denials.
- Modify requests to approve medically necessary services, when requests are for multiple services, and some did not meet criteria.
- Obtain complete relevant medical records before determining criteria for approval are not met.
- Use appropriate medical judgment when requesting information from referring providers; do not require referring doctors to speculate on the impact of specialist diagnoses or recommended treatments.
- Adhere to MMCD Policy Letter 14-002 and approve requests for FDA approved drugs instead of requiring compounded drugs where no medical indication exists.
- Approve drugs requested for FDA indications and not require step therapy through drugs being used off label unless published studies clearly establish therapeutic equivalence and the P&T Committee formally discusses and agrees.
- Involve professionals with appropriate clinical expertise in treating the member’s condition and disease before issuing a denial or substituting therapy.

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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:

The Plan has not implemented a system to track prior authorization referrals to completion; **this is the third time this is noted as a repeat finding**. The previous audit included implementation of Plan's Policy #: UM-19 as a Corrective Action Plan. *Policy #: UM-19, Standing Referral to Specialty Care*, states that the Plan:

"...has established a system to track and monitor specialty referrals requiring prior authorization," and that "SFHP UM is responsible for establishing a system to track and monitor specialist referrals requiring prior authorization by SFHP, including authorized, denied, deferred or modified referrals, and the timeliness of the referrals. Specialist referrals that require prior authorization are referrals made to specialists outside of the member's assigned group, for services not available within that medical group. SFHP is responsible to ensure that all contracting providers are aware of the referral process and tracking procedures."

However, Plan staff stated that they do not, in fact, track referrals. The Plan **has not implemented the CAP** outlined at the last audit.

Plan staff pointed to the e-referral system as intrinsically meeting the requirements of referral tracking. However, the e-referral system does not track timeliness of referrals, or track referrals to completion.

Plan staff also stated that they view referral tracking as part of the responsibility of the primary care provider. However, delegation agreements do not include referral tracking as a delegated activity. One delegated entity shared a referral log report and policy for which PCP's may elect time frames of up to one year with a three month default time frame - well in excess of the 15 days specified in the Contract. Delegated entity staff explained a 1-4 scale for rating the priority of referrals. Only priorities 1 and 2 are followed up; the amount of work to follow up on priorities 3 and 4 would be "too massive" according to delegated entity staff.

The Plan's oversight activities did not monitor delegated entities' tracking of referrals for adherence to contractual time frames for specialists' appointments, or their follow up on all referrals.

RECOMMENDATIONS:

- Implement Policy #: UM-19, as previously agreed to as part of a CAP, to establish and maintain a specialty referral system. Develop and produce semi-annual reports identifying unused referrals, as previously mentioned under the CAP.
- Include referral tracking as part of delegated activities, and conduct oversight to ensure delegated entities track referrals and adherence to contractual time frames for specialists' appointments.

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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:

The Plan had a well-publicized appeals process in place. There were only 35 appeals during the audit period. Ten of the 35 appeals were denied inappropriately – nine of which were overturned. The Plan had a contractual requirement to continuously update and improve the Utilization Management (UM) program. However, there was no evidence that the Plan used the appeal system to update the UM program to improve upon the denial rate. Examples of repeat overturned denials include:

- Requests for documentation that were not based on sound medical practice. One request for documentation of a therapy's effectiveness was inappropriate. The condition has an intermittent and unpredictable clinical course with no known biomarker for treatment response. The member had the FDA labeled indicated diagnosis for the therapy and was being treated by an appropriate specialist. Another request asked for evidence of how a genetic consultation would affect the patient's management. The purpose of the consultation was to ascertain whether any genetic conditions existed that would affect the patient's management.
- Requests for special infant formula for preterm infants were repeatedly denied even though they met Medi-Cal Provider Manual criteria.
- Multiple requests for medically necessary orthotics were overturned. The Plan cited an individual provider who often requested unnecessary orthotics. Nevertheless, each request must be individually considered; it is not acceptable to deny all such requests, and only differentiate medical necessity on appeal.
- The Plan reasonably denied out of network services, when they were available within a member's network. However, two appeals were overturned when it became apparent that the services were not actually available in-network. There was no documentation of a reasonable inquiry to determine whether the services were indeed available in-network before out of network services were denied.
- Services initially denied as being covered by a California Children's Services (CCS) diagnosis resulted in two overturned denials on appeal. The Plan stated that they have addressed this issue with a new process implemented in September 2013, to avoid denials for possible CCS services and make the Plan responsible for coordinating claims payment for medically necessary CCS and non-CCS services. However, *Policy #: UM-22, Authorization Requests*, (effective December 2013) still requires a CCS denial. No other CCS related denials were found in the verification study after September 2013.

RECOMMENDATIONS:

- Use information from overturned appeal denials to improve the prior authorization processes.
- Change guidelines and practices that result in inappropriate denials.
- Conduct thorough investigation of covered benefits, medical decision making and services available in network before issuing a denial for out of network services, rather than subjecting members to a "deny and appeal" process.

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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:

The Contract requires the Plan to include remedies if the Plan's delegated entities' obligations for delegated activities are not met. The Plan's delegation agreements did not contain remedies for failure to meet obligations.

The Contract requires the Plan to have a system to ensure the continuous monitoring, evaluation and approval of the delegated functions. The Plan's *Policy #: PR-12, Oversight of Functions Delegated to Medical Groups*, states:

“SFHP oversees these activities through interim reporting requirements and an annual oversight audit.”

No annual reports were produced for two entities during the audit period. Although the Plan stated that audits were conducted during the audit period, the reports were not completed until after the audit period.

Annual oversight audits that were conducted, with reports produced during the audit period, did not include an examination of mechanisms for over- and under-utilization or referral tracking as required by the Contract. The Plan was also required to have a qualified physician review all denials based, in whole or in part, on medical necessity and must ensure that appropriate processes were used to review and approve the provision of Medically Necessary Covered Services. The annual oversight audit did not include a review by the Plan's medical director for the appropriateness of medical necessity denials.

The Contract requires reporting of findings and actions taken by the delegated entities at least quarterly. Delegation agreements state that Utilization Management (UM) work plans must be submitted by delegated entities quarterly. UM denial logs are to be submitted semi-annually. However, quarterly and semi-annual reports were not submitted. The Plan's personnel stated that no reporting was done other than that required by the annual audit which is once per year. The Plan did not comply with a pre-audit request for denials by delegated medical group. The Plan was unable to produce a complete report until it had received data from all delegated medical groups, approximately 10 days after the completion of the DHCS' onsite audit.

The Quality Improvement Committee (QIC) was not accountable for delegation oversight activities conducted by the Plan. A single agenda item, sharing a five minute time slot in a QIC meeting with another item, was insufficient to constitute review and approval of UM delegation activities for the scope of activities delegated across five entities.

RECOMMENDATIONS:

- Include remedies in delegation agreements for delegated entities' failure to meet obligations.
- Complete all parts of an annual oversight audit, including the audit report, every 12 months.
- Include examination of mechanisms to detect over- and under-utilization in annual oversight audits.
- Include examination of referral tracking systems in annual oversight audits.
- Conduct a medical director review of a sample of medical necessity denials by the delegated entities for appropriateness.
- Require delegated entities to report on activities as specified in the Contract and delegation agreements.
- Review UM delegation oversight activities by the QIC at least annually as stated in *Policy #: PR-12, Oversight of Functions Delegated to Medical Groups*. Document reasonable time for discussion, comments and items for follow up by the QIC.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1

CASE MANAGEMENT AND COORDINATION OF CARE: WITHIN AND OUT-OF-PLAN

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.

2-Plan Contract A.11.1

Out-of-Plan Case Management and Coordination of Services:

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out of plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services...

2-Plan Contract A.11.5

SUMMARY OF FINDINGS:

The Plan is required to ensure the provision of Comprehensive Medical Case Management Services to each member. These services are provided through either Basic or Complex Case Management activities, based on the medical needs of the member.

The requirements for Basic Case Management include the provision of an Initial Health Assessment (IHA) for each new member within the required time frames and coordination of carved-out and linked services. The IHA completion rates reported by the Plan for the audit period showed the requirement for timely completion for each new member was not met (see audit report sections 2.4 for details). A review of coordination of care for members receiving California Children's Services and Golden Gate Regional Center services found that the Plan did not fully execute its Memoranda of Understanding (MOUs) with these programs (see audit report sections 2.2 and 2.3 for details).

According to the Contract, the Plan must be able to provide Complex Case Management defined as the management of acute or chronic illness by a multidisciplinary team with intense coordination of services and care planning to ensure the eligible member regains optimal health or improved functionality. The Contract states that these medical case management services, which also include psychosocial and emotional support, are to be provided through collaboration with the member and the Primary Care Physician (PCP) in the context of a multidisciplinary team.

Serving members in the Community Health Network (CHN) primary care clinics, the Plan's internal Complex Case Management program is called "CareSupport" and, according to *Policy #: CARE-01, CareSupport Policy*, represents a continuum of case management interventions from care coordination to Complex Case Management by a team that includes medical directors, nurses, and unlicensed care coordinators. According to interviews with Plan staff, the CareSupport program is staffed by unlicensed personnel who conduct the assessments, develop plans of care, and provide psychosocial case management to members.

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The CareSupport program was designed to provide psychosocial support and not the required medical case management. The program was available to qualified members in the CHN and University of California San Francisco (UCSF) clinics. The CareSupport Policy states that the members served have “complex needs which are compounded by outside health and social factors such as housing, food, substance use and/or mental health”. According to the *Policy #: CARE-01*, members are referred to the program by utilization management, the nurse advice line, customer service, and by their providers. Providers and staff interviewed within these clinics were not aware that Complex Case Management services were available through collaboration with the Plan’s CareSupport program.

The Plan’s *Policy #: Care-01* states that members outside the CHN or UCSF networks receive Complex Case Management through the delegated Medical Groups. Providers and staff who were interviewed in these clinics were able to identify members who might benefit from Complex Case Management but these interviewees were not aware that these services were available through collaboration with their Medical Group.

The requirements for Complex Case Management were not met as the Plan did not ensure that complex medical case management as defined by the Contract was available to members who required that level of service.

RECOMMENDATIONS:

- Develop and implement policies and procedures that reflect the contractual requirements for the provision of Complex Case Management.
- Develop and implement a program of Complex Case Management that includes medical case management.
- Conduct oversight of delegated case management services to ensure contractual requirements are met.
- Ensure primary care providers throughout all networks are aware of available Complex Case Management services.

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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 FINDINGS:

The Contract requires the Plan to execute a Memorandum of Understanding (MOU) with the local California Children's Services (CCS) program for the coordination of services to members. The Plan's Utilization Management (UM) staff had formal processes to ensure coordination of care for children whose diagnoses make them eligible for CCS and these processes were outlined in the Plan's policies and in its MOU with CCS. According to the MOU, the Plan will access the State's CCS Pediatric Electronic Data Interchange (PEDI) for "information on status of service requests and authorizations, denials and Notices of Action (NOAs)" and will request that the CCS program provide "CCS active and closed members including: name, CCS case number, CCS eligible diagnoses, date of eligibility, status, etc." from the state CCS database.

According to the Plan's *Policy #: UM-20, California Children Services*, the UM Nurse was responsible for "maintaining a database to track referrals to CCS and the status of CCS-enrolled children" in order to ensure coordination of care between Primary Care Physicians (PCP) and CCS. During an interview, the Plan's UM staff reported that they did not have a database maintained by the UM Nurse for coordination of care for CCS-enrolled members but rather processed linkage to CCS on a case-by-case basis using PEDI which provides the status of referrals.

The Plan provided a roster of newly enrolled members identified as CCS-enrolled but 55% of the members listed were ineligible as they ranged from 22 to 95 years of age. In a sample drawn from this roster, none were found listed as active CCS enrollees in the State's database.

The Plan's Quality Improvement (QI) Meeting minutes for December 2012 showed there were problems related to identification of CCS eligible members. A participating clinic physician was noted to suggest that the Plan should "improve identification of patients who are CCS eligible" and stated that he saw "no measurable improvements" in his clinic. In the "Action Items/Follow up" column of the minutes there was no analysis of this problem and there were no remarks about pending corrective action. A review of QI minutes throughout the audit period showed that the problem was not addressed again by the committee in subsequent meetings.

The requirement for the execution of the MOU with CCS was not met.

RECOMMENDATIONS:

- Develop and implement a monitoring system that ensures that data management results in enhanced communication and operational efficiency for PCPs, UM nurses, and the CCS program in the coordination of care for CCS eligible members.
- Develop and implement a monitoring system to ensure that the MOU with CCS is executed.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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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 FINDINGS:

The Contract requires the Plan to execute a Memorandum of Understanding (MOU) with the local Golden Gate Regional Center (GGRC) for the coordination of services to members. The Plan has an MOU between GGRC for the provision of developmental disability services to eligible members. According to the MOU, the Plan's Medical Director or designee will meet with GGRC designated staff on as needed basis to ensure continuous communication and to resolve operational, administrative and policy complications. The MOU requires that this meeting occur at least annually. The Plan provided an agenda for the July 18, 2013 meeting. The agenda contained three items: 1) Review MOU to "update and keep current"; 2) Early Start Upcoming Updates to discuss process and procedure challenges; and 3) Discuss and trouble shoot current procedural barriers. The Plan did not provide minutes of this meeting and no evidence was provided to show that the Plan reviewed and/or updated its MOU, discussed process challenges or procedural barriers. The MOU was last updated in 2011.

The requirement for the execution of the MOU with the local Regional Center for Services for Persons with Developmental Disabilities (DD) was not met.

RECOMMENDATION:

Develop and implement a monitoring system to ensure that the MOU with Golden Gate Regional Center is executed.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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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 60 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 FINDINGS:

The Contract requires the provision of an Initial Health Assessment (IHA) for each new member within stipulated timelines and reasonable attempts to contact a member to schedule an IHA be made and that all attempts be documented.

According to the Plan, welcome letters explaining IHA requirements are sent to new members to encourage initial appointments but the scheduling of IHAs is done by the primary care provider. During site visits staff and providers were interviewed with regard to the IHA scheduling process for newly enrolled members. The consistent practice of active encouragement for IHA appointments was not found. Attempts to contact newly enrolled members were not documented in most settings. When interviewed, several provider site staff reported they waited for new members to contact the office for an appointment.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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According to MMCD Policy Letter 08-003 (Initial Health Assessment), exemptions to the timeline requirements for completion of the IHA must be documented in the medical record. For example, when a newly enrolled member is exempt from an initial health assessment because the Primary Care Provider has performed or reviewed a recent IHA, the exemption must be documented in the medical record. Exemptions to IHA timeline requirements were not documented in existing medical records or provider office notes.

Although the Plan has multiple systems in place to support compliance with the IHA requirements, the Plan reported the completion rate was 45% for members who must have a completed IHA within 120 days of enrollment and 65% for members who must have a completed IHA within 60 days of enrollment. A verification study was conducted to determine compliance with IHA requirements and the findings for completion rates were consistent with those reported by the Plan.

According to the Plan's *Policy #: HE-02, Initial Health Assessment: Education and Follow-up*, the Plan used quality improvement strategies to improve the IHA completion rates. No quality improvement strategies were documented in the Quality Improvement Meeting minutes during the audit period.

The requirement for ensuring the provision of an Initial Health Assessment within required timelines for each new member was not met.

RECOMMENDATION:

Develop quality improvement processes to ensure the timely completion of the Initial Health Assessment for each new member as specified in the Contract.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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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

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:

The Plan did not monitor waiting times to obtain the initial prenatal care appointment. Through HEDIS, the Plan measured the percentage of women with live birth who had at least one prenatal care visit in their first trimester or within 42 days of enrollment with the health plan but not whether the first prenatal visit for pregnant members was available within two weeks upon request.

The Plan conducted an ICE Appointment Availability Survey by telephone from August to October of 2013. Providers were asked five questions with the option to answer either "YES" or "NO". Three out of 5 medical groups surveyed scored 100% compliant. The survey was self-reported and the Plan did not conduct any studies to verify the accuracy of the answers.

The Plan monitored appointment availability for non-urgent care through the Third Next Available Appointment under the Practice Improvement Program (PIP). Although it was a valid measure to monitor appointment availability, it was measured selectively. Only providers who volunteered to participate in PIP self-reported Third Next Available Appointment results to the Plan on a quarterly basis. Despite finding the majority of participating providers were not meeting the 10 days or less threshold, the Plan did not impose any corrective actions or propose any improvement plans.

Policy #: QI-05, Access Policy and Standards, specified that the Plan will monitor access to specialty services for the Community Health Network through regular reports on appointment wait times by specialty. However, the e-Referral Report submitted by the Plan did not include tracking of appointment wait times by specialty.

The Plan monitored waiting times for the Nurse Help Line through activity reports and statistics submitted from the subcontractor. However, the Plan did not monitor waiting times for providers to answer and/or return telephone calls at provider offices.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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The Plan required delegated medical groups to submit results of dwell/wait time studies to evaluate waiting times in providers' offices during the annual oversight audits. The Plan did not have standard procedures to monitor waiting times in the non-delegated medical group provider offices. The Plan stated they monitored waiting times in providers' offices through Patient Shadowing measure of the PIP but it was limited to providers who volunteered to participate in the program and no standard tool was used to conduct the measure.

RECOMMENDATIONS:

- Monitor waiting times to obtain appointments for first prenatal visit, non-urgent care, and specialty referral.
- Monitor waiting times for providers to answer and/or return telephone calls.
- Develop and implement a procedure to monitor waiting time in the non-delegated medical group provider offices.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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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:

The Plan's *Policy #: QI-05, Access Policy and Standards*, established access standards and monitoring procedures for telephone triage procedures and after-hours care. Providers' compliance with telephone triage procedures and 24-hour availability was to be reviewed through Facility Site and Medical Record Reviews, and Annual Oversight Audits of Medical Groups.

The Timely Access section of the Annual Oversight Audits included a verification of 24/7 telephone triage lines used by the five medical groups, whether they use their own 24/7 triage line or the Plan's Nurse Help Line (NHL). Three of five used their own 24/7 triage line. The Plan did not review whether 24/7 telephone triage lines used by medical groups were answered by appropriate licensed professionals as required by the Contract.

RECOMMENDATION:

Develop and implement procedures to monitor that appropriate licensed professional will be available for after-hour calls through 24/7 telephone triage line used by delegated medical groups.

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3.4

SPECIALISTS AND SPECIALTY SERVICES

Specialists and Specialty Services:

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with Title 22 CCR Section 53853(a) and W & I Code Section 14182(c)(2) 2-Plan Contract A.6.6

Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined Medically Necessary. 2-Plan Contract A.9.3.F

SUMMARY OF FINDINGS:

The Plan's *Policy #: PR-07, Provider Network Membership Ratios*, stated that review of member and provider grievances regarding access to specialty care is used to assess adequacy of the number of specialists. Three out of 16 member grievances reviewed were related to specialty care access but were neither addressed in resolution letters nor forwarded to Quality Improvement or Provider Relations.

A routine specialty care access standard stated in *Policy #: QI-05, Access Policy and Standard*, the Provider Manual and in the Evidence of Coverage (EOC) were not consistent. Providers were informed that routine specialty care must be scheduled within 15 days of request while members were informed that they can schedule an appointment for specialty care within 14 days.

RECOMMENDATIONS:

- Ensure grievances with access to specialty services issues are communicated to appropriate department or committee.
- Implement and provide consistent access standards for routine specialty care to providers and members. Revise EOC to be consistent with *Policy #: QI-05*.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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3.5

EMERGENCY SERVICE PROVIDERS (CLAIMS)

Emergency Service Providers (Claims):

Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the plan.

2-Plan Contract A.8.13.A

Contractor shall pay for emergency services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge....

2-Plan Contract A.8.13.C

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

2-Plan Contract A.8.13.D

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D). 3

2-Plan Contract A.8.13.E

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section...Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.

2-Plan Contract A.8.5

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.

2-Plan Contract A.9.7.A

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

The Plan did not process all claims timely as indicated in its *Policy #: CL-02, Interest Calculation for Late Payment of Claims*, with system errors identifying California Children's Services (CCS) conditions causing incorrect denials. The Plan was required to reimburse providers within 45 working days unless the claim or portion thereof was contested by the Plan in which case the claimant shall be notified, in writing, that the claim was contested or denied, within 45 working days after receipt of the claim by the health care service plan.

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Twenty out-of-network emergency service claims were reviewed for appropriate and timely payment:

- 3 of 20 claims were not processed within 45 working days of receipt by the Plan.
- 2 of 20 claims were incorrectly denied due to CCS condition. Per Plan's representative, this was an issue of incorrect information in one of their Desk Top Procedures for the Claims Examiners (incorrect remit message).

RECOMMENDATIONS:

- Ensure claims are processed within 45 working days after receipt.
- Ensure claims staff is trained on claims procedures and that system edits for CCS members are appropriately applied.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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3.6

FAMILY PLANNING (PAYMENTS)

Family Planning: (Payment):

Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate....(as required by Contract)

2-Plan Contract A.8.9

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section...Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.

2-Plan Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

The Plan incorrectly denied claims due to the payment system not being updated timely with new covered benefits and changes in payment rates. In addition, the Plan incorrectly denied claims from eligible members due to claims staff use of incorrect information.

Twenty out-of-network Family Planning Services claims were reviewed for appropriate and timely payment:

- 2 of 20 claims with covered services were improperly denied due to codes not being configured in the payment system.
- 2 of 20 claims for members over 21 years old were improperly denied due to California Children's Services (CCS) condition. Per Plan's representative, this was an issue of incorrect information in one of their Desk Top Procedures for the Claims Examiners (incorrect remit message).
- 3 of 20 claims were paid the incorrect rate. Providers disputed and the Plan later paid the corrected amount with interest.

RECOMMENDATIONS:

- Ensure payable service codes are uploaded timely and claims are paid at the correct rate.
- Ensure claims staff is trained on claims procedures and that system edits for CCS members are appropriately applied.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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3.7

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 FINDINGS:

The Plan's contracted Emergency Rooms (ER) did not provide after-hours pharmacy services. Members had the option to get their prescription filled at any of the three 24-hour pharmacies in the pharmacy network. Two pharmacies were located in the Castro District (central part of San Francisco) and one in the Marina District (northern part of San Francisco).

The Pharmacy and Therapeutics Committee was responsible for reviewing and updating the Plan's formulary and pharmacy services. Monitoring of pharmacy usage is limited to review of monthly cost and utilization reports. The Plan's *Policy #: Pharm-05, Emergency Department Medication Supply*, stated that the Pharmacy Services Department will track and trend prescription fills for members who have ER claims/encounters. The Emergency Supply Policy Monitoring Reports submitted by the Plan contained no information of members who have ER claims/encounters and prescription drugs dispensed to them. The Plan did not monitor whether members were able to have drugs filled prescribed after-hours in emergency circumstances. The Plan's monitoring did not determine and ensure whether existing 24-hour pharmacies in network were accessible and met members' after-hours pharmacy needs. **This is a repeat finding.**

RECOMMENDATION:

Implement policies and procedures for monitoring whether the pharmacy network adequately meets members after-hour pharmacy needs.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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CATEGORY 4 – MEMBERS’ 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:

The Plan did not capture all complaints and expressions of dissatisfaction. The Inquiry Log’s listing of complaints and expressions of dissatisfaction were not classified as grievances unless members explicitly stated they would like to file a grievance. Fourteen complaints and expressions of dissatisfaction were identified as an inquiry where the member declined to file a grievance even though these were grievances. They were not reviewed nor forwarded to the Plan’s quality assurance committee. According to the Plan, clinical component reviews of these inquiries began in 2014; however, the procedure was not detailed and approved in the Plan’s Members Grievances and Appeals Policy and Procedure.

Members commonly addressed complaints and dissatisfaction to the Customer Service Department. Customer Service Representatives categorized calls into 23 categories, including grievances. However, review of the Customer Service Call Log for the third and fourth week of October 2013 found 12 of 176 calls were obvious expressions of dissatisfaction that were not categorized as grievances. The Plan lacked regular oversight to ensure appropriate classification of calls as grievances. According to the Grievance Coordinator & Member Services Supervisor, recorded customer service calls were reviewed but not regularly. Analysis and comparison of total number of calls classified as grievance among Customer Service Representatives to determine any outliers was not conducted.

File review of 16 grievances found:

- Eight of 16 Acknowledgment and Resolution Letters were not fully translated into the members’ preferred languages. Details of the members’ complaint and the Plan’s resolution were in English while the rest of the letters were in the members’ preferred languages. The Plan stated there was a statement on top of each Acknowledgment and Resolution Letter that translation service is available by calling a specific number. The Contract requires the Plan to provide fully translated written informing materials, including grievance acknowledgement and resolutions letters.
- Four of 16 grievances had inadequate responses and not all issues raised were addressed.
- Two of 16 grievance files did not have all pertinent medical records and documents which the Plan relied on in reaching its decision.

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RECOMMENDATIONS:

- Monitor Customer Service Department staff to ensure proper classification of calls.
- Train Customer Service Representatives to appropriately classify calls and identify grievances.
- Develop and implement procedures to capture all complaints and expression of dissatisfaction including those where a member declined to file a grievance and where a member did not explicitly state they want to file a grievance.
- Fully translate acknowledgement and resolution letters for members with threshold languages other than English.
- Obtain, review, and maintain all pertinent medical records and documents used to reach the Plan's decision.
- Ensure resolution letters address all issues raised in the grievance.

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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

SUMMARY OF FINDINGS:

The Plan devoted a considerable amount of resources to Quality Improvement (QI). Staffing, incentive programs, outreach and training were prevalent. Effective monitoring and evaluation of programs were not well developed. While the Plan's reporting process has resulted in consistently high Healthcare Effectiveness Data and Information Set (HEDIS) scores, its current interventions have not resulted in continued substantial improvements. Its satisfaction scores, measured by the Consumer Assessment of Health Plan Satisfaction Survey (CAHPS), were poor and its actions were equally ineffective at improving these. The Plan cited adverse selection as the primary reason for low satisfaction, maintaining that the demographics of their population lead to poor scores.

The Plan has a contractual requirement to have a QI System that includes methods to ensure that members are able to obtain appointments within established standards. Low satisfaction survey scores pointed to poor access as a contributor. The Plan used the ICE self-reported survey tool, which they admitted is invalid, to report 100% compliance with timely access standards. Reports of access problems to the Quality Improvement Committee (QIC) resulted in no documented action. Although the Plan measured 3rd available appointment as part of its Practice Improvement Program, its interventions have been ineffective in bringing this measure into compliance with the Contract.

Access to specialty care was also a problem. The Plan relied on an e-referral program to ensure referrals were reviewed by a qualified medical specialist. Those not seen within contractually required time frames were deemed to not require service within the standard. The Plan did not monitor whether deferred care represented practice within acceptable standards of care.

The Plan's contractual requirement for an annual quality improvement report states that it should include a comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements. Although the Plan had wide ranging activities within the community and particularly in partnership with Public Health Clinics, it did not demonstrate, through measurement, a comprehensive assessment of the effect of these interventions on quality of care or service parameters. Instead of addressing needed improvements through new or retooled initiatives, the Plan used post hoc subgroup analysis and secondary endpoint improvement when primary measures failed to show improvement in response to an initiative.

The Plan used measures to demonstrate success in a program that were indirect and more related to the satisfaction and perception of program participants than to any real improvements in care or service.

- The Rapid Dramatic Performance Improvement Program showed improved no show rates and cycle times; however, no impact was documented on compliance with contractually mandated appointment standards.
- The Provider-Patient Communication Series was measured entirely by provider feedback. Although providers report their patients had a better understanding of their health conditions, no measurement was made of the patients' perception.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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- The San Francisco Quality Culture Series was measured on the basis of attendee satisfaction, not on any resultant improvements in areas such as access or communications.
- The Building Blocks Practice Coaching Program was characterized as having an impact based on interviews with clinic staff; objective milestones have not been measured.

While the Plan's Strength in Numbers program had shown some improvements, the Plan did not differentiate between improvements that reflected the implementation of measurement from those resulting from improvement efforts.

The Plan cited its website's educational efforts in its QI Program Evaluation. The website had only 11 hits per day to its Health Education Materials section; this represented daily access by only 0.01% of enrollees. Although the Plan stated it intends to expand its web offerings, there is no evidence that it has recognized or addressed the low penetration of web based interventions.

RECOMMENDATIONS:

- Focus efforts on key service and quality metrics for its membership, including primary care and specialty access. Devote sufficient resources to a prioritized set of activities and continue to evaluate and modify those activities until they result in significant improvement in measures defined in advance as meaningful.
- Monitor e-referral systems to ensure that specialty visits not seen within required time frames meet an acceptable standard of care.
- Use valid measures to monitor and evaluate whether new or continuing QI efforts result in actual improvement in care and service. Regard lack of improvement as information to guide further activity rather than as an indication to engage in post hoc subgroup analysis or the use of secondary measurement to create an appearance of improvement.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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November 30, 2013

DATE OF AUDIT: March 4 through March 20, 2014

5.2

PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:

Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.

Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

2-Plan Contract A.4.12

Provider Participation:

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered....Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

2-Plan Contract A.4.12.A

Delegated Credentialing:

Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities...

2-Plan Contract A.4.12.B

Disciplinary Actions:

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.

2-Plan Contract A.4.12.D

SUMMARY OF FINDINGS:

The Plan delegated credentialing to four delegated medical groups and a subcontracted Plan. The Plan also delegated credentialing to UCSF and San Francisco General Hospital. The Plan's contract states that if they delegate quality improvement functions (including credentialing) the subcontract must include Contractor's actions/remedies if delegated entities' obligations are not met. The Plan's delegation agreements for credentialing did not contain remedies if delegated entities' obligations are not met.

For the providers that remained the Plan's responsibility to credential, the Plan failed to recredential the providers up for renewal. It did not recredential providers in 2013. Although 29 providers left the network in 2014, eight providers who needed recredentialing were not recredentialled. This was discovered in late 2013. The credentialing system did not identify these providers proactively. The Plan stated that they have since credentialed affected providers as new and remedied the system to prevent future omissions.

The Plan did not follow its *Policy #: PR-12, Oversight of Functions Delegated to Medical Groups*, by having the SFHP Physician Advisory / Credentialing / Peer Review Committee (PAC) review a summary of the Plan's credentialing / recredentialing activities at least annually.

RECOMMENDATIONS:

- Add remedies for non-performance to delegation agreements if delegated entities' obligations are not met.
- Recredential all providers in a timely fashion. Maintain systems that identify providers due for recredentialing.
- Follow all Plan policies, including annual review of oversight activities by the PAC.

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5.3

QUALITY IMPROVEMENT PROGRAM DESCRIPTION AND STRUCTURE

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:

The Plan was required to have a Quality Improvement Committee (QIC) that meets at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee must be reported to the governing body in writing on a scheduled basis. The Plan submitted six sets of minutes for QIC meetings that occurred during the audit period. The minutes lacked evidence of follow up, action items or implemented corrective actions. Although the Chief Medical Officer (CMO) issued memos regarding "Old Business" for the QIC, the separation of this documentation from the QIC minutes did not allow for follow up on all action items. Items from the "Old Business" memos were listed as deferred to future QIC meetings and never appeared to be discussed again. Because action items were not carried forward within the agenda of subsequent QIC meetings, the QIC was not accountable for the adequacy of the follow up activities, or whether an action item had been thoroughly addressed. **This is a repeat finding.** The Plan previously agreed to a Corrective Action Plan, for the QIC to identify and document detailed recommendations and proposed actions, in response to problems or issues discussed. The Plan **failed to fully implement its Corrective Action Plan** from the previous audit.

An example of the QIC not demonstrating follow up on findings related to the items brought forward by Plan members who were on the QIC. Issues of access raised by the Plan's members did not result in any action items or identified follow up in subsequent meetings. Although Plan staff stated that they resolved these members' individual access issues "offline", the identification of larger system issues, and the implementation of corrective action directed at identified issues, was not performed by the QIC in response to access issues identified by its members.

The Plan's Quality Improvement (QI) Program Description contained specific language regarding the QIC's Role in Delegation Oversight:

"It reviews and approves the Plan's utilization management and case management policies, its preventive care guidelines and studies, and the activities of all entities delegated for utilization management services."

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The June 2013 minutes had as the second to last agenda item: "Provider Relations", which included Provider Satisfaction Survey Results and Medical Group Audit results (for delegated activities). Five minutes was scheduled for both of these items. While there were 17 lines of comments for the Provider Satisfaction Survey, there were no comments, questions, action items, or follow up related to delegation oversight.

The QIC was not accountable for delegation oversight activities conducted by the Plan. A single agenda item, sharing a five minute time slot in a QIC meeting with another item, was insufficient to constitute review and approval of delegation activities for the scope of activities delegated by the Plan across the number of delegated entities. The Plan fully delegated Utilization Management (UM), Case Management, Provider Training, Cultural and Linguistics, Facility Site Reviews, Grievances, Appeals and Credentialing to another Plan. The Plan delegated UM, Credentialing, Case Management, Provider Training, Cultural and Linguistics, Facility Site Reviews, Credentialing and Claims Payments to four separate groups, and delegated credentialing to two additional groups. It was not possible to read the summary of delegation oversight activities within the allocated annual five minute time slot, even if it were to be fully devoted to the topic. The lack of any discussion demonstrated that no meaningful oversight of delegated activity was taking place at the QIC.

The Contract requires goals and objectives which are approved by the Contractor's governing body. The Plan's *Policy #: QI-10*, defines the roles of the Governing Board in QI. As part of the consent calendar, the Board's meeting minutes did demonstrate review and approval of the QIC minutes. The Board reviewed and approved the 2012 QI Program Evaluation at its May 2013 meeting. The Board did not review or approve the 2013 QI Program until its September 4, 2013 meeting. The Plan's management stated that the 2013 Program covers the 2013 calendar year but the program description was not ready for Board approval until late in the year. The lack of Board approval of the 2013 QI Program until September 2013 demonstrated a lack of Board accountability for the QI Program for 2/3 of the audit period.

RECOMMENDATIONS:

- Revise the format of QIC meeting minutes to allow for follow up by the entire committee on identified action items. Fully implement the CAP previously agreed to by the Plan in response to the last DHCS Audit:

"SFHP will ensure that this "Identified Action" column will always reflect recommendations and actions identified by QIC for follow-up"

- Demonstrate action and follow up by the QIC in response to issues raised by the QIC members.
- Perform oversight of delegated entities at the QIC level. Devote sufficient time and discussion to allow for meaningful analysis, issue identification and action planning in response to delegation oversight activities.
- Align the calendar of QI Planning with Board meetings and the calendar year to allow the Board to be accountable for the QI Program before most of the year has already passed.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2

MEDICAL DECISIONS

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:

The Plan's bylaws stated that:

“The medical director shall be responsible for the quality of patient care, clinical outcomes, and appropriate utilization and management of services, and shall exercise authority separate and independent from administrative management such that the Medical Director will not be unduly influenced by fiscal and administrative decisions.”

However, the audit revealed areas in which fiscal and administrative considerations influenced medical decisions.

Two instances were identified of the Plan's Pharmacy prior authorization processes denying an FDA approved and manufactured drug, substituting a compounded product that was a preferred formulary alternative. No medical indication existed for the use of compounded drugs. Medi-Cal Managed Care Division (MMCD) Policy Letter 14-002 notes:

“Routine use of compounded alternatives to FDA approved drugs not only poses a risk to the patient's health, but also places DHCS at risk . . .”

The Plan maintained that they have discontinued this practice after MMCD Policy Letter 14-002 was issued but provided no justification for this medical decision. This practice was not only not medically justified, but is also a violation of California Code of Regulations, Title 16 §1735(c):

“‘Compounding’ does not include, except in small quantities under limited circumstances as justified by a specific, documented, medical need, preparation of a compounded drug that is commercially available in the marketplace or that is essentially a copy of a drug product that is commercially available in the marketplace.”

After the exit conference the Plan stated that MMCD Policy Letter 14-002 required FDA approved drug products to be used in place of compounded products, asking that this finding be removed. This finding has not been removed. This policy letter summarized existing law, emphasizing reports of untoward quality and adverse effects of compounded products. It did not endorse previous practices that influenced medical decisions with fiscal considerations.

The Plan did not cover the routine use of colonoscopy for colon cancer screening. It covered fecal occult blood testing and reserved colonoscopy for those with positive occult blood tests or other symptoms.

The Plan quoted the use of United States Preventive Services Task Force (USPSTF) Recommendation Statement and the American Society of Gastrointestinal Endoscopy Appropriate Use of GI Endoscopy Guidelines 2012 as sources, but misrepresented their content.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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It omitted the statement from the American Society of Gastrointestinal Endoscopy Appropriate Use of GI Endoscopy Guidelines 2012:

“Colonoscopy is generally indicated in the following circumstances :
D. Screening and surveillance for colonic neoplasia:
1. Screening of asymptomatic, average-risk patients”

The Plan guidelines also ignored statements from the USPSTF Guidelines regarding the variable acceptability of various screening tests, with the ideal of shared decision making between clinicians and patients, and the greater specificity and sensitivity of colonoscopy as compared with fecal testing, and the statement:

“Colonoscopy is a necessary step in any screening program that reduces mortality from early cancer.”
Since the term “screening” implies testing of asymptomatic individuals at average risk, the Plan essentially only covered diagnostic colonoscopy, and not screening colonoscopy. This violates California Health and Safety Code §1367.665:

“Every Individual or group health care service plan contract, except for a specialized health service plan contract, that is issued, amended, delivered or renewed on or after July 1, 2000 shall be deemed to provide coverage for all generally medically accepted cancer screening tests, subject to all terms and conditions that would otherwise apply.”

The Plan stated that the current criteria of not covering routine screening colonoscopy was developed at the request of contracted capitated gastroenterologists who were unable to provide timely access to screening colonoscopy with their current capacity.

The decision to issue Plan criteria limiting screening colonoscopy to high risk individuals was without medical justification and made purely on the basis of fiscal and administrative considerations.

The Plan delegated and capitated medical services to designated medical groups. One of the medical groups sent welcome letters to new members stating:

“Please call us for all of your medical care. In particular, be sure to call if you need urgent or emergency care.”

It closed with the repeat statement:

“Again, please call us at any time for your medical concerns, especially if you need any emergency care.”

While coordination of care between emergency and primary care providers is desirable, and fragmentation of care by providing non-emergent care in the Emergency Department is undesirable, there was no medical justification for telling members with medical emergencies to first contact their primary care provider. Since health plans are responsible for all Emergency Room (ER) claims, following the prudent layperson standard, there was, however a fiscal consideration in reducing ER usage.

RECOMMENDATIONS:

- Adhere to MMCD Policy Letter 14-002; cover FDA approved medications where medically necessary, and not substitute compounded drugs without a medical indication.
- Cover all generally medically accepted cancer screening tests, including colonoscopy for routine screening of asymptomatic adults over age 50. Support shared decision making by clinicians and members in determining a choice of colon cancer screening method.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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- Perform oversight of delegated groups to detect and correct any member education or information that informs them to first call their primary care provider when experiencing a medical emergency.
- Refrain from adopting medical policies or implementing procedures designed solely as cost saving strategies without a concomitant medical justification.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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6.4

PROVIDER TRAINING

Medi-Cal Managed Care Provider Training:

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

2-Plan Contract A.7.5

SUMMARY OF FINDINGS:

Provider training was delegated to six medical groups and one plan. Oversight of provider training requirements was done annually through the credentialing review.

The Plan's delegation agreements for provider training did not contain remedies if delegated entities' obligations were not met.

Contracts with two medical groups did not include provider training as one of the delegated functions. Annual oversight review of one delegated medical group showed that 100% of the providers received the training; however, it was provided outside of the 10 working day time frame.

The Plan did not conduct a provider training review of the delegated plan in 2012 and 2013. The Plan stated that 2012 was the first year the subcontracting plan was NCQA accredited and therefore was exempt from the Credentialing audit. The Plan had yet to establish a different process for auditing provider training on subcontracting plan that were NCQA accredited.

There were two new providers during the audit period and one was not trained by the Plan within 10 working days as required by the Contract.

RECOMMENDATIONS:

- Directly ensure provider training is performed for all groups that do not have a formal delegation agreement.
- Execute formal delegation agreements with delegated medical groups and plan to whom the Plan delegates provider training.
- Add remedies for non-performance to delegation agreements if delegated entities' obligations are not met.
- Ensure delegated medical groups' and plan's compliance with provider training requirement during annual audits.
- Annually audit provider training on subcontracting plan that is NCQA accredited.
- Ensure that all new providers are trained within 10 working days after being placed on active status as required by the Contract.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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6.5

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:

The prior audit report recommended that the Plan develop and implement procedures to monitor and identify potential or suspected fraud and abuse committed by members and providers. The Plan's Corrective Action Plan (CAP) proposed that the Compliance Committee be reinstated to review and revise the Plan's Fraud and Abuse Prevention and Detection Compliance Program. In addition, a position of Contracts and Audit Manager was created to conduct internal audits to detect any incidents of suspected fraud and to report results to the Plan's Executive Team and to regulatory agencies.

While the Plan's Policy and Compliance Committee met on a monthly basis, the focus of the meetings was on general policy and procedure reviews and follow-ups on prior audits conducted by external agencies such as the Department of Managed Health Care (DMHC). During the audit period, there were no discussions to review the Fraud and Abuse program or to make recommendations for improvement. The position of Contracts and Audit Manager has been vacant since the prior manager left in 2012. The Plan conducted no fraud and abuse detection audits during the audit period.

The Plan reported one incident of potential fraud to the Department of Justice (DOJ) but it did not report the incident to the Department of Health Care Services (DHCS) within 10 working days as required by the Contract and by the Plan's *Policy #: CRA-08, Fraud and Abuse Prevention and Investigation*.

The Plan did not implement a more proactive fraud and abuse program as stated in their prior audit CAP. **This is a repeat finding.**

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RECOMMENDATIONS:

- Implement procedures to undertake a more proactive fraud and abuse detection and intervention program as stated in the prior CAP.
- Ensure that all incidents of potential fraud and abuse are reported to DHCS within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity.

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

**San Francisco Health Authority
dba San Francisco Health Plan**

Contract Number: 03-75800
State Supported Services

Audit Period: December 1, 2012
Through
November 30, 2013

Report Issued: August 7, 2014

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INTRODUCTION

This report presents the audit findings of San Francisco Health Authority dba San Francisco Health Plan (SFHP) State Supported Services contract No. 03-75800. The State Supported Services contract covers contracted abortion services with SFHP.

The onsite audit was conducted from March 3, 2014 through March 20, 2014. The audit period is December 1, 2012 through November 30, 2013 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

An Exit Conference was held on June 10, 2014 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. No additional information was submitted following the Exit Conference.

COMPLIANCE AUDIT FINDINGS

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion

Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes*: 59840 through 59857
HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.
State Supported Services Contract Exhibit A.1*

SUMMARY OF FINDINGS:

The Plan's documents did not agree in their descriptions of the availability of abortion services from non-contracted providers. The Plan's 2011-2012 Evidence of Coverage (EOC) was not consistent with the Plan's Network Operations Manual and the Plan's *Policy #: UM-06, Abortion Services*. EOC informed members that "Abortion services do not require pre-approval but must be provided by an SFHP provider contracted with your medical group." However, the Network Operations Manual stated that members are encouraged to receive abortion services from a provider within their medical group but may self-refer to any provider that is contracted with their medical group or outside of their medical group. But the Plan's *Policy #: UM-06, Abortion Services*, stated that Medi-Cal members may self-refer to any Medi-Cal provider for an outpatient abortion without a prior authorization. **This is a repeat finding.**

The delegated plan's EOC for Plan members stated "We cover abortions at no charge when we arrange for the services. Your PCP (Primary Care Provider) does not have to authorize these services". The EOC did not inform members of their right to self-refer abortion services to any Medi-Cal Provider, in or out-of-network, without prior authorization as required by the Contract and the Plan's *Policy #: UM-06*.

The Plan's EOC, Network Operations Manual and delegated plan's EOC incorrectly stated that minors age 12 or older do not need parental approval to get abortion services. Minors of any age may consent for the performance of an abortion in California. In 1987, the California Legislature enacted a law which prohibited minors from consenting to having an abortion in non-emergency situations, unless the minor had the consent of one parent, or had received permission from the juvenile court. (Fam. Code, § 6925; Health & Safety Code, § 123450 (a).) However, this law was found to violate the state constitutional right to privacy in *American Academy of Pediatrics v. Lungren*, (1997) 16 Cal.4th 307. This information is correctly stated on the Plan's *Policy #: UM-06*.

The Customer Service Inquiry Log documented a call from a member asking whether prior authorization was needed for abortion services. The customer service representative advised the member to contact her delegated medical group. Since abortion services are available to all members without prior authorization regardless of their medical group, the representative should have advised the member of this coverage.

RECOMMENDATIONS:

- Ensure all Plan documents are consistent with their descriptions of the availability of abortion services from non-contracted providers.
- Ensure that delegated medical group's policy and procedures regarding access to abortion services are consistent with the Plan's policies and the Contract.
- Revise EOC language to reflect consistent instructions for Plan's coverage of abortion services.
- Revise delegated plan's EOC to inform members that abortion services may be obtained from any Medi-Cal Provider and are not restricted to in-network providers or SFHP contracted Providers.
- Revise the Plan's EOC and Network Operations Manual and ensure that the delegated plan's EOC is revised to state minors of any age may consent for the performance of an abortion.
- Ensure customer service staff receives training on the Plan's policies and procedures for abortion services.