

**ATTACHMENT A  
Corrective Action Plan Response Form**

**Plan Name: San Francisco Health Plan**



**Review/Audit Type:** DHCS A&I Medical Review Audit

**Review Period:** 1/1/2014 – 12/31/2014

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP via email in word format which will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require long term corrective action or a period of time longer than 30 days to remedy or operationalize, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

**CORRECTIVE ACTION PLAN FORMAT**

<b>Deficiency Number and Finding</b>	<b>Action Taken</b>	<b>Implementation Documentation</b>	<b>Completion/Expected Completion Date</b>	<b>DHCS Comments</b>
<b>1. Utilization Management</b>				
1.1.1 The Plan did not ensure consistent guideline application for utilization management by medical directors.	A. As submitted and approved in the 2014 DHCS Medical Review Audit Corrective Action Plan (CAP), SFHP has implemented an Inter-rater Reliability (IRR) process and contracted with McKesson to utilize a software program to ensure consistent application of review with regards to denials. SFHP has updated	1.1.1 MD 2014-IRR  1.1.1_UM-22_Authorization Requests_2015.09.14	Part A: Implemented in September 2014  Part B: Expected Implementation November 31,	<u>10/08/2015</u> - The plan has submitted evidence of their processes. The Plan expects full implementation of the actions necessary to completely address this deficiency to be completed in 2 stages. The Part B: Expected Implementation November 31, 2015 and the Part C:

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	<p>Internal policy, UM-22 Authorization Requests, to reflect this change. This met the SFHP UM Program annual requirement for evaluation of consistent application of UM criteria. All physicians passed the IRR assessment. Evidence of this process was provided to the Auditors while onsite; however, the audit findings were determined to be relevant to reviews provided before the CAP Implementation in September 2014. SFHP will continue this process. See attached results for CY 2015.</p> <p>B. Until Part C below is implemented, effective by 10/31/2015, the UM and Compliance Departments will implement a semi-annual file review of a random sample of Medical Directors' denials. File review results will be reviewed and discussed at the monthly Utilization Management (UM) Committee meeting following audit.</p> <p>C. In the 2015-2016 fiscal year budget, a Quality Management Nurse is scheduled to be hired. The primary responsibility of this position is to conduct first level review of selected medical denial files to ensure consistent application of criteria.</p>	<p>1.1.1 San Francisco Health Plan 2015-2016 Audit Work Plan</p>	<p>2015.</p> <p>Part C: Expected Full Implementation March 2016</p>	<p>Expected Full Implementation March 2016.</p> <p>To close this finding the MCP must provide evidence of the implementation of file review cited in Part B.</p> <p>Provisionally Closed</p> <p><u>11/17/15</u>- Per the SFHP Plan's response the Audit is currently in process. Expected Completion by 12/4/2015. QA nurse has been hired. Start date is 11/23/15.</p> <p><u>12/3/15</u>- The SFHP has submitted evidence of the completion of the UM Audit. Therefore this finding is closed.</p> <p><b>Closed</b></p>

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1.1.2 The Plan did not have systematic methods to detect over and under-utilization for populations, services, procedures, specialties, or providers.	<p>As implemented and approved by the 2014 DHCS Medical Review Audit CAP, the plan implemented a process to monitor overutilization of inpatient metrics by medical group and SPD/non-SPD population. The plan also reviews utilization of services with SFHN to identify trends and actionable items to ensure proper steerage of member in medical group for continuity of care. Evidence of this process was provided to the auditors; however, full implementation of this monitoring did not occur until December 2014. Although this finding had been corrected prior to the date of the onsite audit, the audit look-back period was 2014 and did not recognize corrected processes. SFHP will continue this process.</p> <p>In addition, SFHP has developed a Specialty Referral Monitoring process to identify and track all open and unused referrals. These are reviewed on a quarterly basis and feedback is provided to all Medical Groups. This process was implemented in December 2014 as presented and approved by MCQMD in the previous audit's Corrective Action Plan.</p>	<p>1.1.2 and 1.3.1 Q2-2015_SpecialtyRpt_Scrubbed_v8 17 15</p> <p>1.1.2 Executive Summary UM IP Trending Report_8 18 15</p> <p>1.1.2 UM_Utilization_Reports_201508_MG - with_MCX</p>	<p>Monitoring of overutilization of inpatient metrics implemented in December 2014</p> <p>Specialty referral tracking process was implemented in December 2014</p>	<p><u>10/08/2015</u>- The plan has submitted evidence of full implementation of the Monitoring of overutilization of inpatient metrics implemented in December 2014 and the Specialty referral tracking process that was implemented in December 2014.</p> <p><b>Closed</b></p>
1.1.3 The Plan did not have benchmarking for inpatient utilization.	A. As implemented and approved by the 2014 DHCS Medical Review Audit CAP, benchmarking criteria was developed and implemented by January 15, 2015. The benchmarking was developed and implemented according to SFHP's DHCS-approved Corrective Action Plan. Evidence of this process was provided to the auditors, however, full implementation of the monitoring	<p>1.1.3 BI_815_CHN OOMG Acute IP Admits and ED_updated_20150520</p> <p>1.1.3</p>	<p>Part A implemented January 15, 2015</p> <p>Part B to be implemented by 12/1/2015</p>	<p><u>10/08/2015</u>- The plan has submitted evidence of the full implementation of the monitoring that was not implemented until after the 2014 Audit period. Benchmarking criteria was developed and implemented by January 15, 2015. SFHP will continue this process.</p> <p><b>Closed</b></p>

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	<p>was not implemented until after the 2014 Audit period. SFHP will continue this process.</p> <p>B. In addition, Under-Utilization reports (including physician visits, and post-inpatient discharge visits) will be included in the current review process.</p>	<p>Benchmarks_06.23.15</p> <p>1.1.3 DRAFT_Reports Schedule_UMCommittee_v9.14.15</p>		
<p>1.2.1 The Plan did not ensure that PA decisions were based on consistent application of written utilization criteria, Medical guidelines and guidelines for acceptable medical care. Decisions were not always made by a qualified health care professional with expertise in the medical condition under consideration.</p>	<p>On an annual basis the Pharmacy and Therapeutics (P &amp;T) Committee reviews all medical necessity criteria. This was last done on January 21, 2015. SFHP will continue this process.</p> <p>A new process was developed to address the situation that occurs when there are medication requests for medication that does not have a P&amp;T-defined PA criteria and no available literature to form PA criteria, such as receiving an authorization for an off-label indication for which no peer-reviewed literature can be found. The SFHP medical director will review the pharmacist's recommendation for a denial. Medical Director will review and initiate third-party external specialty review when appropriate.</p> <p>Pharmacy Prior Authorization Policy (Pharm-02) is being updated to reflect this policy change and will be reviewed at the Q1-2016 QIC meeting.</p> <p>As of June 2015, all potential medical PA denials are reviewed by a Nurse Manager /</p>	<p>1.2.1 2.0_2015_01_21_P+T_minutes_signed –</p> <p>1.2.1 DTP_UM_Outpatient Authorizations_2014.10.15</p> <p>1.2.1 Criteria for non-specialty non-formulary or PA required medications without drug-specific criteria</p> <p>1.2.1 DTP_PHARM_Prior Auth_PBM_PA First Level Review Checklist_2015.0</p>	<p>A yearly evaluation of medical necessity criteria is conducted by the P &amp; T Committee- any evidence of evaluation in 2015</p> <p>Nurse Review implemented June 2015</p> <p>SFHP Policy Pharm-02 will be presented to January 2016 QIC</p> <p>Specialty referral workflow was developed with SFHN and OMC- implementation began in September 2015.</p>	<p><u>10/08/2015</u>- The plan has submitted evidence of their processes. The full implementation was not implemented until after the 2014 Audit period. SFHP will continue with these monitoring activities. To close this finding the MCP must submit an approved copy of P&amp;P Pharm-02 which is supposed to be completed by January 2016.</p> <p>Provisionally Closed</p> <p><u>12/10/2015</u>- Pharm-02, originally scheduled for presentation to QIC will be presented at the 12/10/15 QIC. Evidence of this policy will be submitted by 12/15/15, if approved by QIC.</p> <p><u>12/14/15</u>- The SFHP has submitted the Policy Pharm-02 which was approved for implementation by the Quality Improvement Committee (QIC) on December 10, 2015. Therefore this finding is closed. <b>Closed</b></p>

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	<p>Supervisor prior to sending cases to a Medical Director.</p> <p>SFHP will continue conducting an annual IRR with the Medical Directors and nurse staff, as introduced in 1.1.1. The IRR process was reviewed and approved by MCQMD as part of the 2014 Corrective Action Plan.</p> <p>Medical Directors review and initiate third-party external specialty review when appropriate. This process is outlined in SFHP Policy UM-22.</p> <p>A systematic list of services not requiring medical necessity review, e.g., colonoscopies, is integrated into the care management software workflow.</p> <p>The referral workflow was updated in June 2015 to include timely decision making, and appointment availability, for clinically urgent cases.</p> <p>Evidence of these processes was provided to the auditors; however, full implementation was not implemented until after the 2014 Audit period. SFHP will continue with these monitoring activities.</p>	<p>9.15</p> <p>1.2.1 PP_PHARM_(Pharm-02)_Pharmacy PA_2015.01.28</p> <p>1.2.1_UM-22_Authorization Requests_2015.0 9.14</p> <p>1.2.1 SFGH+Outpatient+Guideline_v3</p>		

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<p>1.2.2 Time frames for processing medical and expedited PAs were exceeded.</p>	<p>SFHP disagrees with this finding. It is unreasonable to conclude broadly that SFHP exceeded timeframes for processing routine and expedited medical PAs based on a review of 2 medical denials. The sample did not include PA approvals. A discussion of two medical denials is not indicative of widespread concern in SFHP's UM Program.</p> <p>As demonstrated in UM-22, SFHP maintains PA turnaround time standards that are compliant with both the DHCS contract and DMHC regulations.</p> <p>Beginning in 1/2015, PA turnaround time reports were reviewed on a monthly basis by the Clinical Operations Leadership team. These reports are currently reviewed and escalated to SFHP's UM committee if opportunities for improvement are identified.</p>	<p>1.2.2_UM-22_Authorization Requests_2015.09.14</p> <p>1.2.2 Monthly Coordinator Audit Tool</p>	<p>Implemented January 2015</p>	<p><u>10/08/2015</u>- The plan has submitted evidence, the UM-22 showing that the SFHP maintains PA turnaround time standards that are compliant with both the DHCS contract and DMHC regulations.</p> <p><b>Closed</b></p>
<p>1.2.3 Notice of Action (NOA) letters were not always translated to members' threshold language in medical PAs.</p>	<p>SFHP does not agree with this finding. It is unreasonable to conclude broadly that SFHP's NOA letters were not always translated to members' threshold languages. Moreover, SFHP has already completed this corrective action from the 2014 audit. As a direct result of the previous year's audit, full translation of NOA letters began in June 2014. Essette improvements, SFHP's system for authorizations, were implemented to allow for the auto-generation of NOA letters in members' threshold languages. This is an example of the need for DHCS to modify its audit process and timing of annual audits to acknowledge the</p>	<p>1.2.3 page 13 DTP_UM_Outpatient Nurse Review_2014.06.16</p>	<p>Completed in June 2014</p>	<p><u>10/08/2015</u>- As a direct result of the previous year's audit, full translation of NOA letters began in June 2014.</p> <p><b>Closed</b></p>

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	implementation of corrective action plans from a previous annual audit.			
1.2.4 The NOA letters to members were not always clear and concise in pharmacy and medical PA.	<p>SFHP disagrees with this finding. It is unreasonable to conclude broadly that SFHP's NOA letters were not always clear and concise in all medical PA cases when only one (1) medical PA NOA was cited. Furthermore, in SFHP's opinion, the NOA that was cited was clear and listed the criteria that the member needed to meet in order to receive the service. It is difficult to meet the requirement to be transparent about the medical criteria used and to convey medical criteria at a 6<sup>th</sup> grade reading level. SFHP believes that criteria were conveyed appropriately in the one case that was cited.</p> <p>Nevertheless, SFHP implemented the following processes for oversight of the NOA letter content:</p> <ul style="list-style-type: none"> <li>• The UM department will establish a quarterly audit process of denial letters.</li> <li>• The Compliance Department will conduct an audit of NOA letters every other month.</li> </ul>	1.2.4 San Francisco Health Plan 2015-2016 Audit Work Plan	Quarterly audits of NOA letters to begin by 11/30/2015.	<p><u>10/08/2015</u>- The SFHP plan has implemented the following processes for oversight of the NOA letter content:</p> <ul style="list-style-type: none"> <li>• The UM department will establish a quarterly audit process of denial letters.</li> <li>• The Compliance Department will conduct an audit of NOA letters every other month.</li> </ul> <p>The Quarterly audits of NOA letters to begin by 11/30/2015. The plan has yet to show prove of the implementation of these activities. To close this finding the MCP must submit evidence of the implementation of the cited quarterly audits</p> <p>Provisionally Closed</p> <p><u>11/17/15</u>- Per the SFHP Plan's response the audit is currently in process. Expected Completion by 12/4/2015.</p> <p><u>12/3/15</u>- The SFHP has submitted evidence of the completion of the UM Audit. Therefore this finding is closed.</p>

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				Closed
1.2.5 Documentation supporting medical PA denials contained minimal evidence of medical director involvement.	<p>SFHP does not agree with the finding that medical directors' involvement in reviewing medical PA denials was minimal during the 2014 audit period. The auditors appeared to believe that the extent of physicians' involvement in review of medical necessity cases is a statement, "I agree." It is not an accurate conclusion that medical director involvement was minimal because the documentation consisted of the physician reviewer's statement of "I agree." SFHP provided a desktop procedure and workflow which describe the step-by-step involvement of SFHP's physicians in the medical necessity review process. SFHP physicians have consistently been involved and are an integral part of the medical PA review process.</p> <p>Nevertheless, SFHP will execute the following processes by 11/30/15 to increase documentation of the physician's involvement:</p> <ul style="list-style-type: none"> <li>• Develop and execute Medical Director documentation standards in Essette for concurrent review, PA, and pharmacy reviews.</li> <li>• Create a desktop procedure of the standards.</li> </ul>		Development of Medical Director documentation standards, desktop procedure and training expected to be completed by 11/30/15	<p><u>10/08/2015</u>- The SFHP plan is expected to complete the development of Medical Director documentation standards, desktop procedure and training by 11/30/15. To close this finding the MCP must submit evidence of the referenced desktop procedures and training.</p> <p>Provisionally Closed</p> <p><u>11/17/15</u>- Per the SFHP Plan's response the audit is currently in process. Expected Completion by 12/4/2015.</p> <p><u>12/3/15</u>- The SFHP has submitted evidence of the implemented desktop procedure. Therefore this finding is closed.</p> <p><b>Closed</b></p>

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	<ul style="list-style-type: none"> <li>Conduct Medical Director training on the standards for Essette documentation.</li> </ul>			
<p>1.2.6 There was undue delay in a decision for a time sensitive medical condition.</p>	<p>An appropriately qualified physician needs sufficient clinical information to make an informed decision. With regard to the one pending case that was cited in this finding, the case was pending to allow time for the physician to receive sufficient clinical information in order to decide if authorization of out-of-network services was clinically appropriate. SFHP's current policies and procedures regarding authorization decision timeframes (UM-22) are compliant with both DHCS contractual and DMHC regulatory standards. As part of its current process, SFHP ensures that in-network services are available before denying authorizations to out-of-network services. Therefore, SFHP's processes are currently designed to ensure that there is no undue delay in decision-making for a time-sensitive medical condition.</p> <p>Monitoring of the timeliness of medical decisions is done via the review of Turn-Around-Time (TAT) reports for PAs. All clinically urgent PAs follow the DMHC/DHCS-compliant TATs.</p> <p>TAT reports are reviewed monthly by the</p>	<p>1.2.7 UM Report Card</p>	<p>Monitoring of TATs began in January 2015</p>	<p><u>10/08/2015</u>- The MCP submitted evidence of its monitoring of turnaround times for authorization decisions.</p> <p><b>Closed</b></p>

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	Clinical Operations Leadership. See attached UM Report Card as evidence of this process.			
1.3.1 The Plan has not operationalized a system to track Prior Authorization (PA) to completion.    	<p>As implemented and approved by the 2014 DHCS Medical Review Audit CAP, SFHP implemented a process to monitor and track Specialty Referrals. Evidence of this process was provided to the auditors; however, the process was not fully implemented until 2015, which was outside of the 2014 audit period. Although this finding had been corrected prior to the date of the onsite audit, the audit lookback period was 2014 and did not recognize corrected processes.</p> <p>The Provider Network Operations (PNO) Team, in 2015, completed the following monitoring activities of Delegated Medical Groups' (DMGs) Specialty Referrals:</p> <ul style="list-style-type: none"> <li>• 1/2015 – SFHP evaluated DMGs' reports from 7/1/2014 to 12/31/2014; results of the evaluation were presented to the Delegated Network Oversight Committee (DNOC). See Attachment 1 with DNOC Agenda, memo and meeting notes (page 3) regarding this item.</li> <li>• 12/2015 – SFHP is in the process of evaluating DMGs' reports from 7/1/2014 to 06/30/2014. Reports due</li> </ul>	1.1.2 and 1.3.1 Q2- 2015_SpecialtyR pt_Scrubbed_v8 17 15notes	See dates included in "Action Taken" column. Fully completed by 6/30/ <del>2016</del> 2015	<p><u>10/15/2015</u>- The SFHP plan implemented a process to monitor and track Specialty Referrals. However, the process was not fully implemented until 2015, which was outside of the 2014 audit period. To close this finding the MCP must submit evidence of the cited report analysis, which is expected to be completed by 6/30/<del>2016</del>2015.</p> <p>Provisionally Closed</p> <p><u>12/10/15</u>- The completion date has a typo. Per the SFHP plan these items were completed in June 2015. The SFHP plan has submitted evidence of implementation of the process to monitor and track Specialty Referrals. Therefore, this finding is closed.</p> <p><b>Closed</b></p>

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	<p>from Medical Groups by 10/2015. SFHP analysis available by 12/x/2015.</p> <ul style="list-style-type: none"> <li>Revised DMGs' Delegation Grids to include the required follow ups on the Specialty Referral reports. Revised Delegation Grids will be sent to the DMGs by 12/2015. DMGs' sign offs are expected by 6/2016.</li> </ul>			
<p>1.3.2 The Plan did not include referral tracking and adherence to referral time frames in its annual delegation oversight audits.</p>	<p>SFHP has developed referral tracking specifications that will be included in required reporting by the delegated medical groups. Please refer to the Attachment entitled, "Referral Tracking Notification to DMGs" for SFHP's notification to its delegated medical groups of these required specifications</p> <p>When the Referral Tracking Report is received from delegated medical groups, SFHP Delegation Oversight staff logs receipt of the report and forwards to the Director of Clinical Operations and the UM Program Manager for review. The Director of Clinical Operations and the UM Program Manager work with SFHP's Delegation Oversight staff to identify and request and corrective action from the delegated medical groups. All issues and/or corrective actions are logged in the delegated medical group's "Documents Log of Required Delegated Medical Group Reports" for monitoring purposes, as attached to this finding. Please refer to the Attachment entitled "Documents Log" for an example.</p> <p>Additionally, SFHP will revise its Oversight</p>	<p>1.3.2 - Documents Log of Required DMG Reports</p> <p>1.3.2 - Referral Tracking Notification to DMGs</p>	<p>- SFHP Policy DO-04 Oversight of Delegated Medical Functions to be completed by 12/01/2015</p> <p>- SFHP Oversight Process Flow to be completed by 12/01/2015</p>	<p><u>10/15/2015</u>- To close this finding the MCP must submit an approved copy of the referenced P&amp;P DO-04 and a copy of the referenced Oversight Process Flow.</p> <p>Open</p> <p><u>11/17/15</u>- Per the SFHP Plan's response the policy is scheduled to be presented to the QIC department on 12/10/15 and to the Policy and Compliance Committee on 12/17/15.</p> <p><u>12/10/15</u>- The SFHP plan has submitted evidence of the revised SFHP Policy DO-04 Oversight of Delegated Medical Functions and the SFHP Oversight Process Flow. Therefore, this finding is closed.</p> <p><b>Closed</b></p>

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	Process Flow and Policy DO-04 Oversight of Delegated Medical Functions, both of which will be available by December 2015 for DHCS review.			
1.4.1 Appeals data were not used to continuously update and improve the Utilization Management (UM) Program.	As of April 2015, SFHP commenced its monthly UM Committee review of overturned appeals, both medical and pharmacy. Two Medical Directors, UM staff, and Pharmacy staff participate on the UM Committee. From this process, the UM Committee discusses any UM process improvements, as needed, and UM staff executes appropriate improvements.	<p>1.4.1 Approved-UMCommitteeCharterFinal_v9.16.15</p> <p>1.4.1 August 2015 - UM Committee Agenda, Meeting Minutes, Action Items and Decisions, and Notes</p> <p>1.4.1 July 2015 - UM Committee Agenda Meeting Minutes, Action Items, Decisions, Notes</p> <p>1.4.1 June 2015 - UM Committee Meeting Agenda, Action Items, Decisions, and Notes</p>	Implemented in April 2015	<p>10/15/2015- The SFHP plan began its monthly UM Committee review of overturned appeals, both medical and pharmacy in April 2015. The MCP submitted copies of UM Committee meeting minutes which evidence the actions taken to address improvements to the UM program</p> <p><b>Closed</b></p>

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		1.4.2 Member Grievances and Appeal Policy		
1.4.2 Appeal decisions were made by the same medical director involved in the initial decision.	<p>The current version of SFHP's QI-06 P&amp;P regarding Member Grievances and Appeals states: "For clinical appeals, the reviewer must be a new physician or pharmacist who was not involved in the initial determination and who is not the subordinate of any physician or pharmacist involved in the initial determination."</p> <p>Furthermore, SFHP's Essette management system for tracking appeals and grievance documents the original physician or pharmacy appeal reviewer. SFHP staff are easily able to discern who the original reviewer was so that the grievance is not routed to the same physician for review.</p>	1.4.2_(QI-06) Member Grievances and Appeals_2015.09 .14	Implemented April 2015	<p>10/15/2015- The SFHP plan began using the Essette management system for tracking appeals and grievance that documents the original physician or pharmacy appeal reviewer. This way the staff is able to see who the original reviewer was and rout it to a different physician for review. The process was implemented April 2015.</p> <p><b>Closed</b></p>
1.4.3 A subcontractor resolved appeals without meeting Contract delegation requirements.	SFHP acknowledges that a delegated medical group, North East Medical Services (NEMS), resolved an appeal without meeting Contract delegation requirements. On 08/24/2015, SFHP staff members, including its Chief Medical Officer, met with NEMS' Medical Director and medical group staff and discussed this issue. SFHP reinforced the delegation requirement that SFHP must implement and maintain a process to resolve its Member appeals. Please refer to the Attachment,	<p>1.4.3 - Grievances and Appeals Memo to DMGs</p> <p>1.4.3 - NEMS Meeting Agenda and Notes</p>	Grievances and Appeals Memo to DMGs will be sent by 10/30/2015	<p>10/15/2015- The SFHP plan acknowledged the error and took action by meeting with the North East Medical Services (NEMS) who resolved an appeal without meeting Contract delegation requirements.</p> <p>SFHP will also send providers a semiannual reminder that all grievances and appeals must be sent to SFHP to process. Grievances and Appeals Memo to DMGs will be sent by 10/30/2015.</p>

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	<p>“NEMS Meeting Agenda and Notes” to verify the 08/24/2015 meeting.</p> <p>SFHP will also send providers a semiannual reminder via the provider newsletter to reiterate the SFHP grievance and appeals process, and that all grievances and appeals must be sent to SFHP to process. Please refer to the Attachment entitled “Grievances and Appeals Memo to DMGs” to view SFHP’s current draft of semiannual reminder to DMGs.</p>			<p>To close this finding the MCP must submit a copy of the referenced Appeals Memo to DMGs</p> <p>Provisionally Closed</p> <p>11/16/15- The Plan has submitted evidence of the submission on 11/09 of the semiannual reminder to all the medical groups that all grievances and appeals must be sent to SFHP to process.</p> <p><b>Closed</b></p>
<p>1.5.1 The Plan did not execute all of the revised delegation agreements.</p>	<p>Three out of five delegation agreements were executed by March 2015, as provided to DHCS during the March 2015 audit. Please note that because delegation agreements are contractual documents, some delegates require a more exhaustive review by multiple levels within the organization that increases the execution timeline.</p> <p>The outstanding delegation agreement between SFHP and Kaiser Health Plan (Kaiser) is currently under review by both parties. The outstanding delegation agreement between SFHP and Hill Physicians Medical Group (Hill) is currently under review for requirements pertaining to Interpreter Services, Facility Site Review, and Referral Tracking. Although the Hill and Kaiser delegation agreements are not fully executed, the draft agreements between both delegates are operational as of 2015.</p>	<p>1.5.1 Sample Draft Delegation Agreement between SFHP and a Delegated Medical Group</p>	<p>Delegation agreements fully implemented into process, in March 2015.</p> <p>Outstanding signed Delegation Agreements are wholly dependent upon the Medical Group. Expected to be signed by June 2016.</p>	<p>10/15/2015- The SFHP plan implemented the Delegation Agreements in March 2015. The Outstanding Delegation Agreements are expected to be signed by June 2016 and are wholly dependent upon the Medical Group. To close this finding the MCP must provide evidence of the signed Delegation Agreements that are expected in June 2016.</p> <p><b>Provisionally Closed</b></p>

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	<p>Additionally, all of the Plan's delegation agreements have been amended to include remedies for non-performance of delegated functions. Please see the Attachment entitled, "Sample Draft Delegation Agreement between SFHP and a Delegated Medical Group", with specific attention to "Section 5. Health Plan Oversight".</p>			
<p>1.5.2 Annual oversight audits did not include: examination of mechanisms for over and under-utilization, referral tracking, or medical director review of medical necessity denials.</p>	<p>SFHP's delegated oversight audit criterion includes the SFHP Chief Medical Officer's (CMO's) review of medical denial logs and dashboards during monthly Utilization Management Committee (UMC) and Delegated Network Oversight Committee (DNOC) meetings. Additionally, the CMO conducts a random sampling review of delegated medical group medical denial cases, and may request additional information from delegated medical groups as necessary. The CMO may also request a plan for corrective action from delegated medical groups upon determining that medical denials were issued inappropriately.</p> <p>As of January 2015, SFHP's UMC has identified and approved under- and over-utilization benchmarks to include in the UM reporting suite. These benchmarks have been applied to delegated medical group dashboards that are reviewed by the UMC. SFHP's UMC will review delegated medical groups' referral tracking reports on a</p>	<p>1.5.2 - 06182015 DNOC Meeting Agenda and CMOs Review Report</p> <p>1.5.2 - 09162015 UM Committee Charter</p>	<p>Process fully implemented in June 2015.</p> <p>A Specialty Referral Tracking Report sample will be available by December 2015</p>	<p><u>10/15/2015</u>- The SFHP plan implemented the full process in June 2015.</p> <p><b>Closed</b></p>

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	<p>semiannual basis. Please refer to SFHP's corrective action item 1.3.2 for an outline of referral tracking review process.</p> <p>Please refer to the Attachment entitled, "UM Committee Charter" for the scope of the UM Committee's review, which includes review and monitor of delegated medical group utilization patterns and analysis to detect and recommend remediation of over/under or inappropriate utilization.</p>			
<p>1.5.3 No reporting of findings or actions by subcontractor; no continuous monitoring by Plan.</p>	<p>In accordance with SFHP policy and procedure DO-02 Oversight of Delegated Functions, SFHP's UM Committee formally adopted a routine schedule for delegated medical groups required reporting. SFHP receives encounter, claims, and UM authorization data at weekly, monthly, and quarterly intervals from its delegated medical groups. See the Attachment entitled, "DO-02 Oversight of Delegated Functions" for formalized reporting schedules to which SFHP's delegated medical groups must adhere. The first report to the UM committee will be December 17, 2015</p> <p>SFHP's Provider Network Operations team tracks the receipt of delegated medical groups' required reports to ensure timely report submissions as described in DO-02, Oversight of Delegated Functions. The delegated medical group reports are then sent directly to relevant SFHP business owners for review, comments, or requests for additional information or</p>	<p>1.5.3 - Delegation Oversight Annual Report - NEMS</p> <p>1.5.3 - Delegation Oversight Annual Report - Brown and Toland</p> <p>1.5.3 - Delegation Oversight Annual Report - CCHCA</p> <p>1.5.3 - Delegation Oversight Annual Report - Hill</p> <p>1.5.3 - Delegation Oversight Annual Report - NEMS</p>	<p>Tracking and reporting for Delegated medical Groups implemented in January 2015</p> <p>UM Committee Review of those results will be December 17, 2015.</p>	<p><u>10/15/2015</u>- The SFHP plan has submitted evidence of the implementation of the tracking and reporting for Delegated medical Groups in January 2015.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>corrective action. SFHP's need for additional information or corrective action from its delegated medical groups is noted in each delegated medical group's report.</p> <p>Please refer to the Attachment entitled, "SFHP Policy DRAFT PR-20 External Corrective Action Plans" for SFHP's corrective action plan procedures utilized by SFHP and its delegated medical groups.</p>	<p>1.5.3 - SFHP Policy DRAFT PR-20 External Corrective Action Plans</p> <p>1.5.3 September 2015 - UM Committee Agenda, Minutes, and Action Items</p>		
<p>1.5.4 There was no Quality Improvement Committee (QIC) review of delegated UM activities.</p>	<p>SFHP has designated the committees listed below as responsible for oversight of the following functions:</p> <ol style="list-style-type: none"> <li>1) Delegated Network Oversight Committee (DNOC): reviews all delegated oversight activities including UM, CM, QI, Credentialing Claims, and Member Grievances.</li> <li>2) UM Committee: reviews the results of delegated UM and CM Programs and File Review Audits.</li> <li>3) QI Committee: reviews the results of the QI Program, Member Grievances, Health Education, and Cultural and Linguistic audits.</li> </ol>	<p>1.5.4 - DNOC Meetings Calendar</p>	<p>- DNOC Final Audit Report of Delegated Medical Group's 2015 Audit will be available December 17, 2015.</p> <p>- UM Oversight Committee Final Audit Report of Delegated Medical Group's 2015 Audit will be available December 10, 2015.</p> <p>- QI Committee Final Audit Report of Delegated Medical Group's</p>	<p>10/23/2015- The SFHP plan is currently working on completing their final reports for the Delegated Network Oversight Committee (DNOC); UM Committee; and the QI Committee mid December 2015. To close this finding the MCP must provide evidence of the completion of their final reports.</p> <p>Open</p> <p><u>11/17/15</u>- Per the SFHP Plan's response the reports are scheduled to be finalized and presented to QIC at the 12/10/15 meeting.</p> <p><u>12/10/15</u>- The SFHP plan has submitted the summary of the results of the audits with their medical groups. Therefore, this finding is closed.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
			2015 Audit will be available December 15, 2015.	
1.5.5 The Plan did not ensure that a delegated medical group's UM program description met the standards set forth by the Contract.	SFHP disagrees with this finding. SFHP ensures that delegated medical groups meet the SFHP UM Program requirements by performing annual UM audits. In 2014, SFHP audited UM functions and requested a CAP from the delegated medical group NEMS. Please see the results of the NEMS 2014 UM audit, section UM 12: Emergency Services, Page 21, for the corrective action plan description, implementation dates, and SFHP comments indicating fulfillment of the CAP. Evidence of this process was provided to the auditors, both onsite and also in response to their draft findings. SFHP will continue this process.	1.5.5 - 2014 SFHP Annual Oversight Audit Results	Implemented prior to 2015 Audit	10/23/2015- The SFHP plan has submitted evidence of completion of the delegated medical group NEMS CAP that was implemented prior to the 2015 Audit. SFHP will continue this process.  <b>Closed</b>
<b>2. Case Management and Coordination of Care</b>				
2.2.1 The Plan's methods for monitoring coordination of care did not validate that policies and procedures were implemented within the delegated medical groups for CCS eligible members.	In May 2015, SFHP revised its Continuity and Coordination of Care Audit Tool, which is part of the annual delegated medical group audit tool, to ensure that coordination of care is occurring in delegated medical groups. SFHP is currently in the process of conducting an audit of its delegated medical groups' coordination of care activities, and will have results of this audit by December 1, 2015.	2.2.1 - 2015 Annual Oversight Audit Confirmation Letter - Brown and Toland  2.2.1 - 2015 Annual Oversight Audit	Revised oversight tool in May 2015. Results from the 2015 Coordination of Care Audit of delegated medical groups will be available by December 1, 2015.	10/23/2015- SFHP is currently in the process of conducting an audit of its delegated medical groups' coordination of care activities, and will have results of this audit by December 1, 2015. To close this finding the MCP must provide evidence of the completion of the audit with the delegated medical groups.  <b>Open</b>

Deficiency Number and Finding	Action Taken	Implementation on Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>Please refer to the attached Audit Confirmation Letters that were sent to SFHP's delegated medical groups. These letters demonstrate that SFHP's Annual Oversight Audit of its delegated medical groups includes monitoring of delegated medical groups' coordination of care policies and procedures.</p>	<p>Confirmation Letter CCHCA</p> <p>2.2.1 - 2015 Annual Oversight Audit Confirmation Letter Hill Physicians Group</p> <p>2.2.1 - Continuity and Coordination of Care Audit Tool</p>		<p><u>11/17/15</u>- Per the SFHP Plan's response the Delegated Audits are currently in process. Expected Completion by 12/1/2015.</p> <p><u>12/14/15</u>- The SFHP has submitted evidence of the completed audit with the delegated medical groups. Therefore, this finding is closed.</p> <p><b>Closed</b></p>
<p>2.3.1 The Plan's methods for monitoring coordination of care did not validate that policies and procedures were implemented within the delegated medical groups for ES eligible members.</p>	<p>SFHP monitors its delegated medical groups policies and procedures pertaining to Early Start (ES) eligible members. Please refer to SFHP Policy UM 44, and also the attached 2015 Annual Oversight Audit Confirmation Letters sent to each of SFHP's delegated medical groups, with specific attention to the Case Management and Coordination of Care sections.</p> <p>Evidence of this process was provided to the auditors; however, the process was not fully implemented until 2015, which was outside of the 2014 audit period. Although the process behind this finding had been corrected prior to the date of the onsite audit, the audit lookback period was 2014 and did not recognize corrected processes.</p>	<p>2.3.1 UM-44_Golden Gate Regional Center and Early Start</p> <p>2.3.1 2015 Annual Oversight Audit Confirmation Letter: Brown and Toland Physicians</p> <p>2.3.1 2015 Annual Oversight Audit Confirmation Letter: Chinese Community</p>	<p>-SFHP's 2015 Annual Oversight Audit Reports will be available by December 1, 2015</p>	<p>10/23/2015- The SFHP plan has submitted evidence of the full implementation of the process that monitors the plan's delegated medical groups policies and procedures pertaining to Early Start (ES) eligible members. The process was not fully implemented until 2015, which was outside of the 2014 audit period.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation on Documentation	Completion/ Expected Completion Date	DHCS Comments
		Health Care Association  2.3.1 2015 Annual Oversight Audit Confirmation Letter: Hill Physicians Medical Group		
2.4.1 The Plan used a methodology that was not tested for validity to monitor compliance with the requirement for Initial Health Assessment (IHA).	As part of the 2014 DHCS Medical Review Audit CAP, SFHP developed a review process, which was approved by MCQMD, to capture IHA completion. In lieu of guidelines from DHCS with regards to IHA procedures, SFHP developed this mechanism using methodology gathered from three other health plans. The Plan utilizes claims and encounter data for specific outpatient visits with a primary care provider in order to comply with the IHA requirement. This mechanism was determined to be invalid by the auditors. Without any clear industry or regulatory guidelines, the plan again revised the IHA reporting methodology based on input from other Plans. In addition, the Plan's Certified Medical Coders and Reporting Analyst researched and approved the new methodology. The Plan's Chief Medical Officer approved the new finalized IHA reporting methodology on (date). The Plan will monitor the network using this methodology on a quarterly basis beginning 11/30/15.	2.4.1 HE-02	11/30/15	10/23/2015- To close this finding the MCP must submit evidence of the referenced quarterly monitoring of IHA provision compliance.  Open  11/16/15- The SFHP has submitted evidence of the referenced quarterly monitoring of IHA provision compliance.  <b>Closed</b>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/Expected Completion Date	DHCS Comments
2.5.1 Complex case management services were not provided during the 2014 audit year.	<p>As of June 1, 2015 SFHP's Complex Medical Case Management (CMCM) Program implemented the following infrastructure:  A CMCM Team</p> <ul style="list-style-type: none"> <li>• Associate Medical Director, with oversight of the CMCM Program – hired 6/2015</li> <li>• CMCM Program Manager – hired 9/2015</li> <li>• CMCM Program Nurse – hired 2/2015</li> </ul> <p>The Essette web-based Care Management software was updated to manage and track the CMCM member case load.</p> <p>To date, 33 eligible member have been enrolled and engaged in CMCM program</p>	2.5.1 CMCM Criteria 2 Eligibility Report - Update 20150605	Implemented CMCM activities as of 2/2015 with full program operational as of 11/2015	<p><u>10/26/2015</u>- SFHP plan implemented Complex Medical Case Management (CMCM) activities as of 2/2015 with full program operational as of 11/2015. To close this finding the MCP must submit evidence of the operationalization of the referenced program.</p> <p>Provisionally Closed</p> <p><u>11/16/15</u>- The SFHPA has submitted evidence of the full program operational of the Complex Medical Case Management (CMCM)</p> <p><b>Closed</b></p>
2.5.2 The Plan delegated but did not monitor complex case management services within medical groups.	<p>In June 2015, SFHP implemented policy – DO-10 Oversight of CM Functions – to define the process and scope of SFHP's oversight of case management activities, including complex case management. This policy ensures compliance with applicable contract and ongoing monitoring of delegated case management activities. Please refer to the Attachment entitled, "SFHP Policy DRAFT DO-10 Oversight of CM Functions".</p> <p>Additionally as part of ongoing monitoring, SFHP has developed an audit tool for the evaluation of its delegated medical groups' Continuity and Coordination of Care policies, including complex case management. Please refer to the Attachment entitled, "SFHP Continuity and Coordination of Care Policies</p>	<p>2.5.2 - Attachment A DRAFT DO-10 Oversight of CM Functions</p> <p>2.5.2 -SFHP Continuity and Coordination of Care Policies Auditing Tool</p> <p>2.5.2 - SFHP Audit Tool for Complex Case Management</p>	Results from SFHP's Complex Case Management Audit will be available by December 1, 2015.	<p><u>10/26/2015</u>- The SFHP plan has submitted evidence of the full implementation of the process that monitors and audits its delegated medical groups' case management activities, including complex case management. The results from SFHP's Complex Case Management Audit will be available by December 1, 2015. To close this finding the MCP must provide evidence of the completion of the Audit.</p> <p>Open</p> <p><u>11/16/15</u>- The SFHPA has submitted evidence of the Delegated Audits are currently in process.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>Auditing Tool”.</p> <p>SFHP is also in the process of conducting an audit of its delegated medical groups’ case management activities, including complex case management. Please refer to the Attachment entitled, “SFHP Audit Tool for Complex Case Management”. Results from the audit will be available by December 2015.</p>			<p>Expected Completion by 12/1/2015.</p> <p><u>12/10/15</u>- The SFHP plan has submitted the summary of the results of the audits with their medical groups. Therefore, this finding is closed.</p> <p><b>Closed</b></p>
<b>3. Access and Availability of Care</b>				
<p>3.1.1 The Plan did not ensure providers met timely access requirements.</p>	<p>SFHP implemented the Access to Care Committee (ACC) to monitor and review timely access and network management data on a regular basis. Efforts of the ACC include:</p> <ul style="list-style-type: none"> <li>• Development of a dashboard that represents key access measures, particularly appointment access</li> <li>• Review of the dashboard quarterly to identify non-compliance with timely access regulations in the SFHP provider network</li> <li>• A request for proposals for a telemedicine contract to increase access to urgent care appointments</li> <li>• Development and distribution of a provider communication to remind providers about the access standards</li> </ul> <p>The ACC may request investigation and corrective action as a result of deficiencies identified in access data pursuant to PR-20.</p> <p>In 9/2015, SFHP revised QI-05, SFHP’s access policy, to indicate that timely access appointment wait times will be monitored using</p>	<p>3.1.1 Access to Care Committee Charter</p> <p>3.1.1 QI-13- Access to Care Committee</p> <p>3.1.1 QI-05 Monitoring Accessibility of Provider Services</p> <p>3.1.1 PR-07_Provider_Network_Membership_Ratios_Redlines Accepted</p> <p>3.1.1 PR-20_External_Corrective_Action_Plans</p>	<p>Finalization of Dashboard: 11/15/2015</p> <p>Request for proposals for telemedicine contract: 12/1/2015</p> <p>Development and distribution of provider communication regarding access standards by 1/31/2016</p>	<p><u>10/26/2015</u>- The SFHP plan has submitted evidence of the implementation of the Access to Care Committee (ACC) to monitor and review timely access and network management data on a regular basis. The efforts of the ACC will be completed from 11/15/2015 through 1/31/2016.</p> <p>To close this finding the MCP must provide evidence of the completion of the ACC.</p> <p>Provisionally Closed</p> <p><u>11/16/15</u>- Per the SFHP Plan’s response the evidence of ACC will be provided as soon as it’s completed.</p> <p><u>12/10/15</u>- The SFHP plan has submitted evidence of the implementation of the Access to Care Committee (ACC). Therefore, this finding is closed.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/Expected Completion Date	DHCS Comments
	<p>the Provider Appointment Availability Survey (PAAS). Various types of appointments will be reviewed including primary care, specialty, ancillary, etc. Any performance by a medical group that is below 80% in a given appointment type category will initiate investigation and possible corrective action pursuant to PR-20, SFHP's DRAFT policy regarding External Corrective Action Plans.</p> <p>The DHCS Audit Report provided a few examples of members' grievances regarding wait times at providers' offices received during the 2014 audit period. Since grievances represent a single occurrence and may or may not point to a system issue, it is unreasonable to conclude that single grievances definitely indicate a systemic problem. SFHP continues to monitor grievances related to wait times in provider offices in Grievance Review Committee (GRC). GRC is comprised of a team of SFHP staff members who review all grievance resolutions on a weekly basis. System grievances, defined as three or more grievances in three months in the same grievance category for the same provider site, are investigated further as potential trends. Based on individual grievances or indication of system issues. GRC may also initiate investigations and corrective action plans pursuant to PR-20.</p>	<p>3.1.1 MY2015_PAAS_Methodology_030215</p> <p>3.1.1 ICE_2015_DMHC_Access_Regulations_Appointment_Availability_Survey_FINAL</p> <p>3.1.1 ICE_2015_DMHC_Access_Regulations_Appointment_Availability_Survey_Ancillary_Final</p>		

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/Expected Completion Date	DHCS Comments
<p>3.1.2 No corrective action plan for non-compliant providers with the initial prenatal care appointment standard.</p>	<p>As described in the revised QI-05 (SFHP's access policy which, was revised in 9/2015) initial prenatal care appointment wait times during the 2015 calendar year will be monitored using the Provider Appointment Availability Survey (PAAS). Any performance by a medical group that is below 80% will initiate investigation and possible corrective action pursuant to PR-20, SFHP's DRAFT policy regarding External Corrective Action Plans.</p> <p>SFHP will also develop and distribute a provider communication to remind providers about the access standards. The provider communication will include information about what constitutes an "initial prenatal care visit" and also remind providers that initial prenatal care appointment must be provided within two weeks of the member's request.</p>	<p>3.1.2 QI-05 Monitoring Accessibility of Provider Services</p> <p>3.1.2 PR-20_External_Corrective_Action_Plans</p> <p>3.1.2 MY2015_PAAS_Methodology_030215</p> <p>3.1.2 ICE_2015_DMHC_Access_Regulations_Appointment_Availability_Survey_FINAL</p>	<p>Provider Appointment Availability Survey (PAAS) will be completed by the Industry Collaborative Effort (ICE) in late 2015; SFHP will complete analysis of PAAS survey results by 3/2016</p> <p>Development and distribution of provider communication regarding access standards by 1/31/2016</p>	<p><u>10/26/2015</u>- The SFHP plan has submitted evidence of the monitoring accessibility of provider services. Also, the development and distribution of provider communication regarding access standards will be completed by 1/31/2016. To close this finding the MCP must provide evidence of the completion of the provider communication regarding access standards, which is expected to be completed by 1/31/2016.</p> <p><b>Provisionally Closed</b></p>
<p>3.1.3 No monitoring of wait times at providers' offices.</p>	<p>SFHP performed dwell time studies for delegated medical groups and received data on a cycle time for non-delegated groups via a measure in the Pay for Performance Program for non-delegated groups. At the time of the onsite audit, the studies were not yet complete for review.</p> <p>SFHP recognized that the use of two methodologies did not allow SFHP to compare providers equally. In order to compare</p>	<p>3.1.3 QI-05 Monitoring Accessibility of Provider Services (Revised 9/2015)</p> <p>3.1.3 PR-20 External Corrective Actions (DRAFT)</p>	<p>Provider Appointment Availability Survey (PAAS) will be completed by the Industry Collaborative Effort (ICE) in late 2015; SFHP will complete analysis of PAAS survey</p>	<p><u>10/26/2015</u>- The SFHP plan has submitted evidence of the monitoring accessibility of provider services. Also, the development and distribution of provider communication regarding access standards will be completed by 1/31/2016. To close this finding the MCP must provide evidence of the completion of the provider communication regarding access standards, which is expected to be completed by 1/31/2016.</p>

Deficiency Number and Finding	Action Taken	Implementation on Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>provider groups using the same methodology, wait times in provider offices during the 2015 calendar year will be monitored using the Provider Appointment Availability Survey (PAAS). Please refer to QI-05, SFHP's access policy which was newly revised in 9/2015. Any performance by a medical group that is below 80% will initiate investigation and possible corrective action pursuant to PR-20, SFHP's DRAFT policy regarding External Corrective Action Plans.</p> <p>SFHP will also develop and distribute a provider communication to remind providers about the access standards including SFHP's expectation that wait times in provider offices not exceed 30 minutes.</p> <p>The DHCS Audit Report provided a few examples of members' grievances regarding wait times at providers' offices during received during the 2014 audit period. Since grievances represent a single occurrence and may or may not point to a system issue, it is unreasonable to conclude that single grievances definitely indicate a systemic problem.</p> <p>SFHP continues to monitor grievances related to wait times in provider offices in Grievance Review Committee (GRC). GRC is comprised of a team of SFHP staff members who review all grievance resolutions on a weekly basis. System grievances, defined as three or more grievances in three months in the same</p>	3.1.3 PAAS Methodology and Survey Tool	<p>results by February 2016</p> <p>Development and distribution of provider communication regarding access standards by 1/31/2016</p>	<b>Provisionally Closed</b>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>grievance category for the same provider site, are investigated further as potential trends.</p> <p>Based on individual grievances or indication of system issues, GRC may also initiate investigations and corrective action plans pursuant to PR-20.</p>			
<p>3.1.4 The Plan did not ensure providers answer member telephone calls or return the calls in a timely manner.</p>	<p>SFHP conducted a statistically valid survey in February 2015 to assess telephone wait times. SFHP's survey to monitor wait times, which was provided during the onsite audit, found that calls were returned in a timely manner. The DHCS Audit Report stated that their survey results were discordant with grievances received during the 2014 audit period. Since grievances represent a single occurrence and may or may not point to a system issue, it is unreasonable to conclude that single grievances definitely indicate a systemic problem. Grievances are often outliers and not representative of all circumstances.</p> <p>SFHP will continue conducting statistically valid studies of providers' time to answer calls. As described in QI-05, SFHP will call a random sample of no less than 20 providers within each medical group to monitor both the time to answer and the time to return telephone calls on an annual basis. Any performance by a medical group that is below 80% will initiate</p>	<p>3.1.4 QI-05 Monitoring Accessibility of Provider Services (Revised 9/2015)</p> <p>3.1.4 PR-20 External Corrective Actions (DRAFT)</p> <p>3.1.4 DHCS Monitoring Wait Time Survey Memo</p>	<p>Survey completed in 2/2015. Next provider survey will be conducted in 1/2016.</p>	<p><u>10/26/2015</u>- The SFHP plan has submitted the DHCS Monitoring Wait Time Survey Memo that shows that For each medical group, a sample size of 20 was surveyed. The overall response rate for the survey was 89%. The next provider survey will be conducted in 1/2016.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/Expected Completion Date	DHCS Comments
	<p>investigation and possible corrective action pursuant to PR-20.</p> <p>SFHP continues to monitor grievances related to provider telephone calls in Grievance Review Committee (GRC). GRC is a team of SFHP staff members, including three physicians, who review all grievance resolutions on a weekly basis. GRC may also initiate investigations and corrective action plans pursuant to PR-20.</p>			
<p>3.1.5 The Plan did not continuously monitor member access and provider availability.</p>	<p>The DHCS contract does not specify the frequency that access studies should occur (including initial prenatal access, wait times in providers' offices, and telephone wait times). In the absence of contractually required frequency, SFHP had stated in its policies and procedures to perform a survey for initial prenatal care appointment every two years, dwell time studies of provider wait times in provider offices every three years, and a survey of providers regarding telephone calls and triage every two years. This proposal was accepted by DHCS MCQMD as part of the previous year's corrective action plan.</p> <p>Nevertheless, for the 2015 calendar year, SFHP will be monitoring initial prenatal access, wait times in providers' offices, and telephone wait times through the Provider Appointment</p>	<p>3.1.5 QI-05 Monitoring Accessibility of Provider Services (Revised 9/2015)</p> <p>3.1.5 PAAS Methodology and Survey Tool</p> <p>3.1.5 SFHP 2015-2015 Audit Work Plan</p> <p>3.1.5 2014 Provider Satisfaction Survey</p>	<p>Provider Appointment Availability Survey (PAAS) will be completed by the Industry Collaborative Effort (ICE) in late 2015; SFHP will complete analysis of PAAS survey results in early 2016</p> <p>Access Policy &amp; Procedure Audit will be performed by SFHP Compliance in</p>	<p><u>10/26/2015</u>- The SFHP plan has submitted evidence that they conducted a Provider Satisfaction Survey during the 2014 audit period and the survey is performed on an annual basis from January – March. In addition the Provider Appointment Availability Survey will be completed in late 2015 and the full analysis in early 2016.</p> <p>To close this finding the MCP must provide evidence of the completion of the survey, which is expected to be completed by March 2016.</p> <p><b>Provisionally Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>Availability Survey (PAAS). This survey is performed annually and SFHP will review the results annually.</p> <p>Overall network access monitoring, including monitoring of appointment waiting times, is the responsibility of SFHP—it is NOT delegated to the medical groups. When monitoring access at the medical group level, SFHP reviews medical groups’ policies and procedures to ensure medical groups’ compliance with access standards. SFHP’s Compliance Department will perform audits of both delegated and non-delegated provider groups’ access policies and procedures every year.</p> <p>Finally, the Audit Report states that a Provider Satisfaction Survey that gauges providers’ satisfaction with access was not performed during the audit period. SFHP did conduct a Provider Satisfaction Survey during the 2014 audit period and the survey is performed on an annual basis from January – March. SFHP provided the auditors with the survey report in the pre-audit document request and during the onsite audit. Although the report is titled “2013 Provider Satisfaction Survey,” the survey methodology states that the survey was performed during January to March 2014.</p>	<p>3.1.5 ICE_2015_DMHC_Access_Regulations_Appointment_Availability_Survey_FINAL</p> <p>3.1.5 SFHP_PSS_Final_Report (performed in 2014)</p>	<p>11/2015</p> <p>Provider Satisfaction Survey for 2014 was already performed during January – March 2014; 2015 survey was already performed during January – March 2015; 2016 survey will be performed during January – March 2016</p>	

Deficiency Number and Finding	Action Taken	Implementation on Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>3.1.6 The Plan did not ensure accurate provider listing.</p>	<p>SFHP will review the records of a sample of 30 providers per medical group each quarter. The first review of 30 providers will be completed by 9/30/2015.</p> <p>SFHP receives, reviews, and enters updates of provider rosters from medical groups on a regular basis. Upon notification of an update or correction to the provider's listing, SFHP Provider Network Operations staff inputs the update or correction into the SFHP database. The online provider search tool is updated within 1 business day of that update or correction. PR-18, a DRAFT policy, reflects the current process for provider data maintenance.</p> <p>SFHP continues to monitor grievances related to access to providers in Grievance Review Committee (GRC). GRC is comprised of a team of SFHP staff members, including Provider Network Operations staff, who review all grievance resolutions on a weekly basis. GRC may also initiate investigations and corrective action plans pursuant to PR-20.</p>	<p>3.1.2 ICE_2015_DMHC_Access_Regulations_Appointment_Availability_Survey_FINAL</p> <p>PR-20_External_Corrective_Action_Plans</p>	<p>First quarterly review of provider records will be completed 10/1/2015</p>	<p><u>10/26/2015</u>- The SFHP plan has submitted the Provider Data Maintenance Policy and Procedure that confirm that the plan receives, reviews, and enters updates of provider rosters from medical groups on a regular basis. Upon notification of an update or correction to the provider's listing, SFHP Provider Network Operations staff inputs the update or correction into the SFHP database. SFHP monitors the data provided by the network</p> <p><b>Closed</b></p>
<p>3.3.1 The Plan monitored Nurse Advice Line (NAL) but not all 24/7 telephone triage services.</p>	<p>As described in QI-05 (SFHP's access policy which was revised in 9/2015), providers' compliance with after-hours telephone triage or screening services during the 2015 calendar year will be monitored using the Provider Appointment Availability Survey (PAAS). The survey will assess 24/7 availability of screening or triage services by an appropriately licensed professional and whether telephone wait times</p>	<p>3.3.1 QI-05 Monitoring Accessibility of Provider Services (Revised 9/2015)</p> <p>3.3.1 ICE After Hours</p>	<p>After Hours Survey will be completed 12/31/2015; SFHP will perform analysis of results in early 2016</p> <p>Access Policy &amp;</p>	<p><u>10/26/2015</u>- The SFHP plan has submitted evidence that they will be conducting an After Hour Survey, which should be completed by 12/31/2015. The analysis of the results will be performed in early 2016. To close this finding the MCP must provide evidence of the completion of the results of the survey, will be completed</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>exceeded the 30-minute standard. Any performance by a medical group that is below 80% will initiate investigation and possible corrective action pursuant to PR-20, SFHP's DRAFT policy regarding External Corrective Action Plans.</p> <p>SFHP's Compliance Department will perform audits of both delegated and non-delegated provider groups' access policies and procedures every year.</p> <p>SFHP continues to monitor grievances related to triage and screening wait times in Grievance Review Committee (GRC). GRC is a team of SFHP staff members, including three physicians, who review all grievance resolutions on a weekly basis. GRC may also initiate investigations and corrective action plans pursuant to PR-20.</p>	<p>Methodology and Survey Tool</p> <p>3.3.1 SFHP 2015-2015 Audit Work Plan</p> <p>3.3.1 PR-20 External Corrective Actions (DRAFT)</p> <p>3.3.1 QI-05</p>	<p>Procedure Audit will be performed by SFHP Compliance in 11/2015</p>	<p>12/31/2015.</p> <p><b>Provisionally Closed</b></p>
<p>3.3.2 The Plan did not ensure 24/7 triage lines were answered by appropriately licensed professionals.</p>	<p>As described in QI-05 (SFHP's access policy which was revised in 9/2015), providers' compliance with after-hours telephone triage or screening services will during the 2015 calendar year will be monitored using an after-hours survey tool and methodology developed by the Industry Collaborative Effort (ICE). The survey will assess 24/7 availability of screening or triage services by an appropriately licensed professional and whether telephone wait times exceeded the 30-minute standard. Any performance by a medical group that is below 80% will initiate investigation and possible corrective action pursuant to PR-20, SFHP's</p>	<p>3.3.2 MY_2015_ICE After Hours Survey Methodology_Final_v2</p> <p>3.3.2 2015 ICE After Hours Survey Methodology and Tool</p> <p>3.3.2 PR-</p>	<p>After Hours Survey will be completed 12/31/2015; SFHP will complete analysis of results in 2/2016</p> <p>Access Policy &amp; Procedure Audit will be performed by SFHP Compliance in</p>	<p><u>10/26/2015</u>- The SFHP plan has submitted evidence that they will be conducting an After Hour Survey, which should be completed by 12/31/2015. The analysis of the results will be performed in early 2016. SFHP's Compliance Department has committed to perform audits of procedures regarding staffing of 24/7 triage lines by appropriately licensed professionals. To close this finding the MCP must provide evidence of the completion of the results of the survey, will be completed</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/Expected Completion Date	DHCS Comments
	<p>DRAFT policy regarding External Corrective Action Plans.</p> <p>SFHP's Compliance Department will perform audits of both delegated and non-delegated provider groups' access policies and procedures every year, including procedures regarding staffing of 24/7 triage lines by appropriately licensed professionals.</p>	<p>20_External_Corrective_Action_Plans</p> <p>3.3.2 QI-05 Monitoring Accessibility of Provider Services</p> <p>3.3.2 SFHP 2015-2015 Audit Work Plan</p>	11/2015	<p>12/31/2015</p> <p><b>Provisionally Closed</b></p>
<p>3.6.1 The Plan did not ensure provision of sufficient supply of drugs prescribed in emergency situations.</p>	<p>"Emergency situations" are a distinct subset of prescriptions written in conjunction with emergency room visits. The latter are made for a range of conditions, many of which are not medical emergencies (i.e. acute sinusitis). Prescriptions for these latter diagnoses are not emergencies. While the plan can track prescriptions dispensed to members within 5 days of ER visits the plan has no means to differentiate (based on pharmacy data) these prescriptions from those targeting true emergency situations. The availability of 24 hour pharmacies within acceptable geographic proximity of emergency rooms makes it possible for emergency prescriptions to be accessible to members. Based on this definition, as part of the 2014 DHCS Medical Review Audit CAP, SFHP developed a review process, which was approved by MCQMD, to capture and track the provision of drugs post-emergency room visits. Evidence of this</p>	<p>3.6.1 Pharm-13 After-Hours Pharmacy Access</p>	<p>Pharm-13 will be submitted to QIC 10/15/2015</p>	<p><u>10/26/2015</u>- The SFHP plan has submitted evidence that shows that the plan monitors and reviews a quarterly report to track:</p> <ul style="list-style-type: none"> <li>a) Number of prescription claims processed within 72 hours of ER visits</li> <li>b) Number of prescriptions claims in part (a) processed at a 24-hour pharmacy location</li> <li>c) Quantity and day supply dispensed for prescription claims ( with associated ED visit)</li> <li>d) Time which prescription claims (with associated ED visit) were processed</li> </ul>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/Expected Completion Date	DHCS Comments
	<p>process was provided to the auditors onsite, but this mechanism was determined to be invalid by those auditors.</p> <p>In response, SFHP revised Policy Pharm-13 to include, 1) definition of 'sufficient' quantity and day supply, 2) reference of Pharm-07 and member's access to non-formulary medications in emergency circumstances outside of normal business hours, and 3) a new parameter in quarterly report to capture time at which prescriptions were processed by claim processor. These modifications will address the definition of 'sufficient' quantity and day supply in emergency circumstances. New language states: "Quantity and day supply will be processed and dispensed according to prescriber's written prescription and amounts sufficient to last until a member can reasonably be expected to have the prescription filled will be at the discretion of the prescriber."</p> <p>In circumstances where the written prescriptions include medications and quantity outside of formulary limit, elements in Pharm-07 will ensure members have at least 5-day supply until a prior authorization request can be submitted. In addition, the time parameter to be added to quarterly report will serve as an indicator that these processed prescriptions will be available for pick up by members, any time thereafter, at the 24-hour pharmacy location. Submitted to Q3-2015 (October) QIC meeting for formal approval.</p>			<p>at the pharmacy</p> <p>SFHP Pharmacy Services Department reviews a quarterly report of network pharmacies to ensure that there is an in-network 24-hour pharmacy location available within three (3) miles of ER locations. The quarterly report shall also be submitted and reviewed by the Quality Improvement Committee (QIC) for any need for corrective action.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<b>4. Members' Rights</b>				
<p>4.1.1 The Plan did not ensure grievances were reported to the appropriate staff with authority to require corrective action.</p>	<p>SFHP implemented the following process during 2015 to document physician involvement reviews of grievances:</p> <p>The Grievance Review Committee (GRC) meets weekly to review and discuss all grievance resolutions. The GRC committee consists of the following SFHP staff:</p> <ul style="list-style-type: none"> <li>• Grievance and Appeal Staff</li> <li>• Chief Medical Officer</li> <li>• Associate Medical Director</li> <li>• SFHP Physician consultant</li> <li>• Health Improvement Director, or delegate</li> <li>• Provider Network Operations representative</li> <li>• Member Services Manager, or delegate</li> <li>• Officer, Compliance &amp; Regulatory Affairs</li> <li>• Regulatory Affairs Program Manager</li> </ul> <p>The GRC ensures that grievances are reported and escalated to the appropriate staff. All grievance resolutions are discussed by the GRC, including input and questions by SFHP</p>	<p>4.1.1 Grievance Review Committee Charter</p> <p>4.1.1 PR-20_External_Corrective_Action_Plans</p>	<p>Grievance Review Committee was implemented 6/23/2015</p>	<p><u>10/26/2015</u>- The SFHP plan has submitted evidence of the implementation of the Grievance Review Committee on 6/23/2015.</p> <p>The committee reviews individual member grievances and works as a team to ensure that all the components of the grievances have been resolved.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>physicians. The GRC ensures that all member issues and components of grievances have been addressed. Discussions that take place at GRC are documented within each grievance in SFHP's Essette system. Grievance and Appeal staff and/or Provider Network Operations representatives may be called upon to request responses from providers and key partners in SFHP's provider network, including Medical Directors, Associate Medical Directors and/or the Quality Directors, as appropriate. The Associate Medical Director reviews all grievances to determine if a Potential Quality Issue (PQI) exists. The Associate Medical Director also reviews each case to ensure appropriate documentation is entered into Essette. The GRC may request investigations and/or external corrective action plans pursuant to PR-20.</p>			
<p>4.1.2 The Plan's grievance system did not log and report exempt grievances for quality improvement.</p>	<p>As stated in 28 CCR Section 1300.68(d)(8), grievances are "exempt" from the requirement of sending written acknowledgment and resolution letters to the member when the grievance: 1) is NOT a coverage dispute or about disputed health care services involving medical necessity or experimental/ investigational treatment AND 2) are resolved by the close of the next business day. In order to more effectively track grievances that have these specific characteristics, SFHP will develop and provide a training for Customer Service representatives about categorization and documentation of complaints that are resolved by the end of a member call. SFHP</p>		<p>Provide training to Customer Service Representatives by 10/31/2015</p> <p>Implement changes in Essette system by 11/30/2015</p> <p>Revise QI-06 as appropriate to reflect updated processes by 11/30/2015</p>	<p><u>10/27/15</u>- The SFHP plan has committed to provide training to Customer Service Representatives about categorization and documentation of complaints that are resolved by the end of a member call by 10/31/2015. In addition, the plan will make the appropriate updates in their systems to identify grievances that are resolved by the next business day.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	will also implement changes in the Essette system to efficiently identify grievances that are not about coverage, medical necessity or experimental/ investigational treatment and are resolved by the next business day. The Grievance Oversight Committee will review exempt grievances data on at least a quarterly basis to ensure the grievances were correctly categorized as exempt grievances and to identify whether any corrective actions are necessary..			
4.2.1 The Plan did not monitor delegated medical groups' provision of cultural and linguistic services.	SFHP is in the process of conducting its annual audit of delegated medical groups' Cultural and Linguistic Services. Results will be available by December 2015. Upon completion of this audit, SFHP will evaluate whether improvements are necessary in its delegated medical groups' delivery of culturally and linguistically appropriate services. Any deficiencies will be corrected in accordance with SFHP's Policy DRAFT PR-20 External Corrective Action Plans, as noted in corrective action section 1.5.3. Please note that SFHP Policy PR-20 External Corrective Action Plans was created to formalize corrective action processes already in place through SFHP's Delegation Agreements.	4.2.1 - Cultural and Linguistic Audit Tool  4.2.1 PR-20_External_Corrective_Action_PlansPlans	Results from the 2015 Cultural and Linguistic Services audit of delegated medical groups will be available by December 30, 2015.	<p><u>10/27/15</u>- The SFHP plan is in process of conducting its annual audit of delegated medical groups' Cultural and Linguistic Services. The results from the 2015 Cultural and Linguistic Services audit of delegated medical groups will be available by December 30, 2015. Any identified deficiencies will be corrected according to the submitted SFHP Policy. To close this finding the MCP must provide evidence of the completion of the Audit.</p> <p>Provisionally Closed</p> <p><u>11/17/15</u>- Per the SFHP plan's response the Delegated Audits are currently in process. The report will be submitted as soon as it's available. Expected Completion by 12/1/2015.</p> <p><u>12/10/15</u>- The SFHP plan has submitted evidence of completion of the audit of</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				<p>delegated medical groups' Cultural and Linguistic Services. Therefore, this finding is closed.</p> <p><b>Closed</b></p>
<p>4.2.2 The plan did not monitor non-delegated providers' provision of cultural and linguistic services.</p>	<p>By 11/30/15, SFHP will implement the following items:</p> <ul style="list-style-type: none"> <li>• A standard audit tool for delegated and non-delegated groups that includes: 1) availability and confidentiality of interpreter services 2) linguistic competency of clinical and non-clinical staff and 3) cultural competency training requirements.</li> <li>• A new process by which SFHP will request a language assessment at the time of initial credentialing. Revise CLS-02 policy to reflect the new process. Recommend the use of the of the ICE tool.</li> <li>• Revise policy to recommend that new non-clinical staff complete a language self-assessment survey when they begin working at the practice/clinic.</li> <li>• Conduct an audit of SFHN and UCSF interpreter services.</li> </ul>	<p>4.2.2 - Cultural and Linguistic Audit Tool</p> <p>4.2.2 Employee Language Self Assessment</p>	<p>Complete assessment and audits due by 11/30/15</p>	<p><u>10/27/15</u>- The SFHP plan is in process of completing the assessment survey for linguistic services to SFCCC and other independent clinics, and complete the audit by 11/30/2015. To close this finding the MCP must provide evidence of the completion of the Audit.</p> <p>Provisionally Closed</p> <p>11/17/15- Per the SFHP plan's response the audit is currently in process. Expected Completion by 12/15/2015.</p> <p><u>12/3/15</u>- The SFHP has submitted evidence of the completion of the Audit Summary. Therefore this finding is closed.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/Expected Completion Date	DHCS Comments
	<ul style="list-style-type: none"> <li>Send assessment survey for linguistic services to SFCCC and other independent clinics. Completed survey due by 11/30/15.</li> </ul>			
4.2.3 The Plan did not assess members' concerns regarding providers' interpreter services.	<p>On 7/1/2015, SFHP developed and implemented a new Appeals and Grievances (A&amp;G) process (see A&amp;G process) for Health Education Cultural and Linguistic Services (HECLS) to ensure all members' concerns regarding cultural and linguistic services are reviewed and resolved by the appropriate clinical staff and the Project Manager (PM) of HECLS. SFHP will internally revise P&amp;P CLS 02 by 10/30/15.</p> <p>The PM HECLS will review A&amp;G and attend Grievance Committee and/or Grievance Oversight Committee, as needed.</p> <p>The PM HECLS will also provide resolution for A&amp;G and set criteria for investigation and/or implementation/monitoring of corrective action plans by 10/30/15.</p>	4.2.3 Visio – HECLS A&G Process	CLS-02 P&P to include new A&G process by 10/30/2015	<p><u>10/27/15</u>- The SFHP plan implemented a new Appeals and Grievances process for Health Education Cultural and Linguistic Services to ensure all members' concerns regarding cultural and linguistic services are reviewed and resolved. This process will be reviewed by 10/30/2015. To close this finding the MCP must provide evidence of the completion of the new Appeals &amp; Grievances process.</p> <p>Provisionally Closed</p> <p>11/17/15- The SFHP has submitted evidence of the new Appeals &amp; Grievances process that was reviewed and approved on 11/10.</p> <p><b>Closed</b></p>
4.3.1 The Plan did not notify and report breach incidents to the Department of Health Care Services (DHCS) Information Security Officer.	SFHP failed to notify the DHCS Information Security Officer, and only notified the DHCS Contract Manager and DHCS Privacy Officer. SFHP will notify and report all breach incidents to DHCS Information Security Officer, in addition to the DHCS Privacy Officer, as documented in SFHP Policy CRA-07 PHI	4.3.1 CRA-07	Implemented March 2015	<u>10/27/15</u> - The SFHP plan has committed to report all breach incidents to DHCS Information Security Officer, in addition to the DHCS Privacy Officer, as documented in SFHP Policy CRA-07 PHI Breach Notification.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/Expected Completion Date	DHCS Comments
	Breach Notification.			<b>Closed</b>
4.3.2 The Plan did not ensure medical groups notify the Plan upon discovery of breach incidents within the required time frame.	SFHP does ensure that the medical groups notify SFHP within 24 hours of discovery of breach incidents. It is clearly defined in the SFHP provider contracts. In this incident, the medical group was not in compliance with the contract. SFHP has implemented a policy PR-20, External Corrective Action Plans to address the need to develop Corrective Action Plans when a provider or medical group does not satisfy contractual requirements.	4.3.2 PR-20_External_Corrective_Action_Plans	October 15, 2015	<p><u>10/27/15</u>- Based on the occurred incident the SFHP has developed and implemented a policy PR-20, External Corrective Action Plans. The execution of the policy was expected by October 15, 2015.</p> <p>To close this finding the MCP must provide evidence of the completion of the new policy PR-20.</p> <p>Provisionally Closed</p> <p>11/17/15- The SFHP has submitted evidence of the new policy PR-20 which was approved and fully implemented on 11/19.</p> <p><b>Closed</b></p>
4.3.3 Two of the Plan's delegated medical groups did not safeguard PHI.	While it is true that two medical groups had breach incidents during the audit period, it is difficult to develop a corrective action plan when SFHP took appropriate actions with each case once they were reported to SFHP. Corrective Action Plans were developed with these medical groups after each breach was reported. SFHP will continue to respond appropriately to breach reports.	4.3.3 CRA-07		<p><u>10/27/15</u>- The MCP reports it initiated CAPs with the medical groups that had PHI breaches once it learned of the incidents. Additionally the MCP submitted a copy of an approved P&amp;P regarding PHI safeguarding and breaches.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<b>5. Quality Management</b>				
<p>5.1.1 The Plan has not developed mechanisms for monitoring and evaluation of quality improvement programs.</p>	<p>SFHP disagrees with this finding. The quality improvement programs are evaluated on an annual basis. SFHP provided auditors with the 2014 Quality Improvement program and evaluation of our QI program and objectives. SFHP believes the evidence of the QI evaluation provided to the auditors during pre-audit survey request and onsite audit sufficiently describes the mechanisms in place to evaluate the quality improvement programs. The implementation and evaluation of the QI program was developed as submitted in 2014 DHCS Medical Review Audit CAP, which was approved by MCQMD. The evaluation of the 2014 quality improvement program is clearly identified as an evaluation and is a complete evaluation of the QI program.</p> <p>For 2015, SFHP's Quality Improvement (QI) Evaluation includes a comprehensive assessment of the QI Plan (see 2014 attached). The 2015 QI Evaluation will be presented to the Board January 6, 2016.</p> <p>SFHP's 2015 Quality Improvement Plan</p>	<p>5.1.1 2014 SFHP NCQA QI Plan pg 19-23</p> <p>5.1.1 2014 SFHP QI Program Evaluation_final_f or State Review</p> <p>5.1.1 Q2 2015 QI Workplan Scorecard Summary_7 24 15</p>		<p><del>10/28/2015-</del> The SFHP plan has submitted evidence of the 2014 Quality Improvement Program which goal is to assure that SFHP provides high-quality care and services to members. The 2015 QI Evaluation will be presented to the Board January 6, 2016.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	includes a QI Work Plan. In 2015, the work plan has been modified to create a QI Dashboard for monitoring of quality improvement programs. The dashboard is shared quarterly with the QIC (sample attached).			
5.1.2 The Plan did not document quality improvement in programs with objectively measured and recorded metrics.	<p>SFHP disagrees with this finding. SFHP submits for review the 2014 SFHP NCQA QI Plan. The implementation of the QI program was developed as submitted in 2014 DHCS Medical Review Audit CAP, which was approved by MCQMD. SFHP developed a comprehensive QI Program and evaluation that includes the outcomes of measure and metrics. SFHP believes these documents sufficiently demonstrate documentation of quality improvement in programs with objectively measured and recorded metrics.</p> <p>In the exit conference, the auditor stated that interviews with staff indicated that quality infrastructure was not in place. SFHP believes statements were taken out of context without full consideration of the documents provided. SFHP submits the 2014 SFHP QI Plan to MCQMD as evidence that this program was developed prior to the audit and sufficiently meets the requirement.</p> <p>For 2015, SFHP's Quality Improvement (QI) Evaluation includes a comprehensive assessment of the QI Plan (see 2014 attached). The 2015 QI Evaluation will be presented to the Board January 6, 2016.</p>	5.1.2 2014 SFHP QI Program Evaluation_final_f or State Review		<p><u>10/28/2015</u>- The SFHP plan has submitted evidence of the implementation of the 2014 SFHP NCQA Quality Improvement (QI) Program. SFHP developed a comprehensive QI Program and evaluation that includes the outcomes of measure and metrics The 2015 QI Evaluation will be presented to the Board January 6, 2016.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/Expected Completion Date	DHCS Comments
	SFHP's 2015 Quality Improvement Plan includes a QI Work Plan. In 2015, the work plan has been modified to create a QI Dashboard for monitoring of quality improvement programs. The dashboard is shared quarterly with the QIC (sample attached).			
5.1.3 Resolutions for Potential Quality Issues (PQIs) did not always ensure members received acceptable medical care.	<p>SFHP disagrees with this finding. It is unreasonable to base a finding of “not ensuring member’s received acceptable medical care” based on a PQI investigation, which typically happens after the provision of care. A confirmed PQI, by definition, involves situations in which the member did not receive acceptable medical care, which results in an investigation. In the PQI case cited in this finding, the Plan’s clinical staff immediately escalated the case to Medical Director, the hospital’s risk manager, and there was a peer-to-peer discussion between the Plan’s Medical Director and the hospital’s Medical Director.</p> <p>A corrective action plan cannot “ensure acceptable medical care to this member” since, by definition of a PQI, the member did not receive acceptable medical care. A corrective action plan is warranted if the PQI investigation involves identification of systemic issues that render subsequent members at risk for deviations from acceptable standards of medical care. A corrective action plan is not warranted when investigation does not identify a systemic issue but rather that an individual practitioner deviated from accepted standards</p>			<p>11/19/15- The chart reviewed in the audit did evidence missteps in a PQI chart review. However, the final audit report notes that no corrective actions are recommended. Therefore, DHCS deems this issue to be non-systemic and this deficiency is closed.</p> <p>In addition the SFHP plan has submitted evidence that they resolved the PQI inquiry and that they sent SFMH a resolution letter.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>of practice or institutional policies. Such individual deviations are addressed through the peer review process and, if of sufficient severity, may impact the physician's credentialing status and require notification of appropriate regulatory bodies.</p> <p>In the final investigation of this PQI the CMO for the facility communicated that it is hospital policy that inter-facility transfers require physician-to-physician communication from both facilities and transfer of the patient by appropriately staffed ambulance.</p> <p>The PQI investigation also involved reviewed of the RN discharge note from the involved facility which documented that the patient was clinically stable. Additionally the hemoglobin on the morning of discharge was acceptable.</p> <p>This documentation is at variance with the DHCS statement that this PQI involved the transfer of an "acutely ill and medically unstable" patient in 6.1.3. SFHP disagrees with the general statement in this audit report finding.</p> <p>Additionally, SFHP would also refer DHCS to its status as being among the top three Medi-Cal managed care plans for aggregated HEDIS scores for the past 8 years as evidence of its commitment to ensuring that its members receive appropriate care.</p>			

Deficiency Number and Finding	Action Taken	Implementation on Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>5.1.4 Information from overturned grievances and appeals were not incorporated into the Quality Improvement System (QIS).</p>	<p>SFHP disagrees with the finding that SFHP did not incorporate information from overturned grievances and appeals into the QIS. SFHP did review appeals and grievances during the 2014 audit period and provided an analysis and next steps to improve the UM process. This is evident in the attached UM Appeals Report.</p> <p>Nevertheless, SFHP's Utilization Management (UM) Committee continues to conduct monthly review of overturned appeals. Improvements to UM processes are identified during this review and implementation plans are discussed at committee meetings.</p> <p>The Grievance Review Committee reviews all grievances on a weekly basis. Potential Quality Issues (PQIs) are discussed during committee meetings, including analysis and next steps.</p> <p>The Grievance Oversight Committee reviews improvements to grievance system processes when identified during this review and implementation plans are discussed at committee meetings.</p>	<p>5.1.4 UM Appeals Report Q1 2014</p> <p>5.1.4 UM Appeals Report Q2 2014</p> <p>5.1.4 - Approved-UM Committee Charter</p> <p>5.1.4 Grievance Review Committee Charter</p> <p>5.1.4 Grievance Review Committee Process Map</p>		<p><u>10/28/2015</u>- The SFHP plan has submitted evidence of the implementation of the Grievance Oversight Committee whose purpose is to ensure that all the components of the grievances have been resolved. Monthly reviews of the overturned appeals are conducted on a monthly basis and weekly reviews are conducted of all grievances.</p> <p><b>Closed</b></p>
<p>5.1.5 The Plan QIC did not review, and was not accountable for, delegation oversight activities conducted by the Plan.</p>	<p>SFHP has designated the committees listed below as responsible for oversight of the following functions:</p> <ol style="list-style-type: none"> <li>1) Delegated Network Oversight Committee (DNOC): reviews all delegated oversight activities including</li> </ol>	<p>5.1.5 - DNOC Meetings Calendar</p>	<p>- DNOC Final Audit Report of Delegated Medical Group's 2015 Audit will be available December 17,</p>	<p><u>10/28/2015</u>- The SFHP plan has created committees responsible for oversight of the activities including UM, CM, QI, Credentialing Claims, and Member Grievances. Also a committee that reviews the results of delegated UM and CM Programs and File Review Audits and</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>UM, CM, QI, Credentialing Claims, and Member Grievances.</p> <p>2) UM Oversight Committee: reviews the results of delegated UM and CM Programs and File Review Audits.</p> <p>3) QI Committee: reviews the results of the QI Program, Member Grievances, Health Education, and Cultural and Linguistic audits.</p>		<p>2015.</p> <p>- UM Oversight Committee Final Audit Report of Delegated Medical Group's 2015 Audit will be available December 10, 2015.</p> <p>- QI Committee Final Audit Report of Delegated Medical Group's 2015 Audit will be available December 15, 2015.</p>	<p>the results of the QI Program, Member Grievances, Health Education, and Cultural and Linguistic audits.</p> <p><b>Closed</b></p> <p><u>11/17/15</u>- Per the SFHP plan's response the Reports are scheduled to be finalized and presented to QIC at the 12/10/15 meeting.</p>
<p>5.1.6 The Governing Board's late approval of the 2014 Quality Improvement Plan (QIP) did not demonstrate full Governing Board accountability for the Plan QIP.</p>	<p>The QI Program was finalized after the completion of the QI Program evaluation. SFHP believes the evaluation provides direction for the subsequent year's program. Due to this timing, the QIP plan was presented after the start of the calendar year, in September of 2014. The 2015 QI program was presented for approval in March of 2015, but due to suggestions by the Board, it was presented again with Board-suggested changes for improved clarity in May 2015.. The 2016 QI Program is scheduled to be presented to the Quality Improvement Committee in December 2015 and will be</p>		<p>The 2016 QI Program will be presented to QIC in December 2015. If approved, it is scheduled to be presented to the Board in January 2016.</p>	<p><u>10/28/2015</u>- The SFHP plan presented the 2015 final QIP plan in May 2015. The 2016 QI Program is scheduled to be presented to the Quality Improvement Committee in December 2015 and will be presented to the Board in January 2016.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/Expected Completion Date	DHCS Comments
	presented to the Board in January 2016.			
<b>6. Administrative and Organizational Capacity</b>				
6.1.1 Medical directors' participation in the Plan grievance process was limited.	<p>SFHP does not agree with the finding that medical directors' participation in the grievance process was limited during the 2014 audit period. SFHP employs a physician Associate Medical Director whose responsibilities include responding to quality-related grievances. Non-physician staff members do not "resolve" clinical grievances. The staff composes the grievance resolution letter in consultation with the Medical Director and then updates the letter after discussion of the resolution with the Medical Director. A "general statement of agreement with the resolution letters drafted by non-clinical Plan staff" in the case notes is not indicative of limited physician involvement with grievances. SFHP physicians are integral in the grievance system.</p> <p>Nevertheless, SFHP implemented the following processing during 2015 to increase documentation of physician involvement reviews of grievances:</p> <ul style="list-style-type: none"> <li>The Grievance Review Committee (GRC) meets weekly to review and discuss all grievance resolutions. The GRC committee is a team that consists of the following SFHP staff:</li> </ul>	<p>6.1.1 Grievance Review Committee Charter</p> <p>6.1.1 Grievance Review Committee Process Map</p>	Grievance Review Committee was implemented on 6/23/2015	<p><u>10/28/2015</u>- The SFHP plan has submitted evidence of the creation of the implementation of the Grievance Oversight Committee whose purpose is to ensure that all the components of the grievances have been resolved.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<ul style="list-style-type: none"> <li>○ Grievance and Appeal Staff</li> <li>○ Chief Medical Officer, Associate Medical Director, and physician consultant</li> <li>○ Health Improvement Director, or delegate</li> <li>○ Provider Network Operations representative</li> <li>○ Member Services Manager, or delegate</li> <li>○ Officer, Compliance &amp; Regulatory Affairs</li> <li>○ Regulatory Affairs Program Manager</li> <li>● The GRC ensures that grievances are reported and escalated to the appropriate staff.</li> <li>● All grievance resolutions are discussed by the GRC, including input and questions by SFHP physicians. The GRC ensures that all member issues and components of grievances have been addressed.</li> <li>● Discussions that take place at GRC are documented within each grievance in SFHP's Essette system.</li> <li>● Grievance and Appeal staff and/or Provider Network Operations representatives may be called upon to request responses from providers and key partners in SFHP's provider network, including Medical Directors, Associate Medical Directors and/or the Quality Directors, as appropriate.</li> <li>● The Associate Medical Director reviews all grievances to determine if a Potential</li> </ul>			

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	<p>Quality Issue (PQI) exists. The Associate Medical Director also reviews each case to ensure appropriate documentation is entered into Essette.</p> <ul style="list-style-type: none"> <li>The GRC may request investigations and/or external corrective action plans pursuant to PR-20.</li> </ul>			
<p>6.1.2 The Plan did not ensure all members received acceptable medical care.</p>	<p>SFHP disagrees with this finding. The auditors cite one pended denial and one PQI investigation to include the broad, general finding that the Plan did not have the administrative and organizational capacity to ensure that all members receive acceptable medical care. SFHP would also refer DHCS to its status as being among the top three Medical managed care plans for aggregated HEDIS scores for the past 8 years as evidence of its commitment to ensuring that its members receive appropriate care. With respect to UM, SFHP's Chief Medical Officer is responsible for assuring that UM criteria and decisions are consistent with professionally accepted standards of practice. SFHP maintains a full-time physician as Chief Medical Officer and a 0.8 FTE physician as Associate Medical Director to perform these functions.</p> <p>In practice, some UM decisions are not criteria-based, but rather involve whether a proposed service is experimental/ investigational or whether the proposed service must be provided out-of-network. An appropriately qualified physician needs sufficient clinical information to make an informed decision in</p>		<p>10/31/15 – interim process to review UM decision files by SFHP RN.</p> <p>Expected Implementation March 2016 for QM Nurse Reviewer</p>	<p><u>11/20/15</u>- Based on the conversation with the SFHP the plan will provide evidence from the Chief Medical Officer (CMO).</p> <p><u>12/15/15</u>- The MCP provided satisfactory explanation of the two incidents the auditors cited to support this finding. The MCP has also creating a QM reviewer position and is in the process of hiring a nurse to fill the position. Until the QM nurse is hired, effective by 10/31/2015, a UM RN will implement a semi-annual file review of a random sample of Medical Directors' denials. We are requesting evidence of the cited review process.</p> <p><u>12/16/15</u>- Per today's conference call with the SFHP, the plan has committed to update the UM-48 policy to state that only a clinician is authorized to approve the transfer of a patient from a facility to another. The plan will follow up in a timely manner.</p> <p><u>12/16/2015</u>- The SFHP plan has submitted the UM- 48 policy that clearly stated that the member must be</p>

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	<p>such cases. The case is pended to allow additional time to gather more clinical information and/or perform research. With regards to the pended case, the case was pended to allow time for the reviewing physician to receive sufficient clinical information about an authorization to out-of-network services.</p> <p>In the cited PQI case, the auditor inaccurately stated that the member was medically unstable. The out-of-network physician indicated that the member was stable for transfer in clinical documentation. As discussed in the audit interviews, the member would not have been transferred to an in-network hospital if services were not available at the in-network hospital. Moreover, SFHP was not involved in the decision to transfer the member from an out-of-network hospital to an in-network hospital. SFHP requires a physician-to-physician hand-off when transferring patients.</p> <p>Nevertheless, in addition to the full-time Chief Medical Officer's oversight of UM decisions (which includes oversight of the Associate Medical Director's PQI decisions), SFHP is in the process of hiring for a Quality Management (QM) nurse, who will have the following responsibilities:</p> <ul style="list-style-type: none"> <li>• Reviews, tracks, documents, and manages clinical appeals and grievances.</li> <li>• Ensures compliance with clinical appeal</li> </ul>			<p>determined to be medically stable for transfer by the transferring physician. Therefore this finding is closed.</p> <p><u>12/17/2015-</u> In addition the SFHP plan has submitted as evidence the summary of the internal execution of PQI and Quality Improvements.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>and clinical grievance standards</p> <ul style="list-style-type: none"> <li>• Conducts quarterly review of internal UM and CM cases and provides opportunities for improvement to leadership</li> <li>• Facilitates the Inter-rater Reliability program</li> <li>• Participates in the Quality Improvement Committee and UM Committee</li> </ul> <p>Results of the QM nurse activities will be presented to the UM Committee.</p> <p>Until the QM nurse is hired, effective by 10/31/2015, a UM RN will implement a semi-annual file review of a random sample of Medical Directors' denials. File review results will be reviewed and discussed at the monthly Utilization Management (UM) Committee meeting following audit.</p>			
<p>6.1.3 The Plan did not ensure that medical decisions, including those by sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management (Contract, Exhibit A, Attachment 1 (5) and (6)(A)(2)).</p>	<p>SFHP disagrees with this finding. The Audit Report did not define "undue influence." Affordability is part of the health care industry goal of the Institute for Healthcare Improvement's Triple Aim and one of DHCS' expectations of the Medicaid managed care plans. The UM Programs in general and UM criteria are influenced by some degree of financial considerations—this is part of a DHCS contractor's fiduciary responsibility in the provision of Medi-Cal services. In fact, DHCS regulations require consideration of the lowest cost solution (e.g., power wheelchair requirements, Title 22 California Code of</p>	<p>6.1.3 - Approved-UM Committee Charter</p>		<p><u>11/19/15</u>- The SFHP has submitted their Utilization Management Committee procedure as evidence that the plan's UMC is not directly or indirectly unduly influenced by fiscal and administrative management in its utilization management decisions.</p> <p><b>Closed</b></p>

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	<p>Regulations §51303). DHCS has not cited any evidence that SFHP nurses or physicians receive any financial incentive or reward for making adverse determinations, not does any financial incentive exist. SFHP acknowledges that the auditors disagreed with the Plan's UM policy for colonoscopy versus FIT testing, one decision regarding one non-formulary medication request, one out-of-network specialty visit request, and one PQI case, but no evidence was cited that indicated that SFHP's decisions were unduly influenced by financial considerations. This finding is an assertion based on opinion, not evidence, and it overlooks the fact that the majority of UM decisions result in approvals of the service(s) requested. SFHP staff members do not receive any financial incentives related to UM decision.</p>			
<p>6.2.1 The Plan did not evaluate the performance of providers' delivery of health education services.</p>	<p>SFHP is in the process of conducting an audit of its delegated groups' Health Education services, which began in June of 2015. Audit results will be available by 11/30/2015.</p> <p>SFHP will develop a desktop process to ensure that the health education list of classes on SFHP's website a) has health education class options available to all members and b) classes are free to members. A list meeting these requirements will be completed and posted on the SFHP website by 11/30/2015.</p>	<p>6.2.1 - Audit Tool Attachment A</p>	<p>Audit results will be available by 11/30/2015</p> <p>Desktop procedure for monitoring external health education classes will be available by 10/30/2015</p>	<p><u>10/28/2015</u>- The SFHP plan is in process of conducting an audit of its delegated groups' Health Education services, which began in June of 2015. Audit results will be available by 11/30/2015. In addition, the SFHP plan will create a desktop process to provide health education classes to all members. The desktop process containing a list of educational health classes will be available by 10/30/2015</p> <p>To close this finding the MCP must provide evidence of the completion of the results of the Audit and the desktop process.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/Expected Completion Date	DHCS Comments
				<p>Provisionally Closed</p> <p>11/17/15- The SFHP plan has submitted evidence of the completion of the results of the Audit and the desktop process. The audit is still in process.</p> <p><u>12/3/15</u>- The SFHP has submitted evidence of the completion of the Audit Summary. Therefore this finding is closed.</p> <p><b>Closed</b></p>
6.3.1 The Plan's proactive Anti-Fraud program was not operational.	As submitted and approved by the 2014 DHCS Medical Review Audit CAP, the plan implemented an Anti-Fraud Work Plan. During the audit period, pharmacy anti-fraud reports were active, claims audit monitoring was active, and the training portion of the anti-fraud program was active. Evidence of the operational workplan was submitted to the auditors; however, because the majority of the plan was implemented in 2015, after the 2014 audit period, the auditors did not accept the evidence as operationalized during the audit period. SFHP plans to continue the Anti-Fraud Work Plan.	6.3.1 2015-2016 SFHP Anti-Fraud Work Plan		<p><u>10/28/2015</u>- The SFHP plan has submitted evidence of the implemented in 2015 Anti-Fraud Work Plan. The purpose of this Anti-Fraud Work Plan is to specifically address identified risks within the 2015-2016 Anti-Fraud Program by outlining the current year's actionable goals, planning, and implementation of anti-fraud projects. SFHP plans to continue the Anti-Fraud Work Plan.</p> <p><b>Closed</b></p>
6.3.2 The Plan did not report a suspected fraud and abuse case to the Department of Health Care Services (DHCS) within the required time frame.	As stated during the audit interview, the specific case was not reported to DHCS because the details of the report could not be substantiated before the member was disenrolled from the plan. As required by SFHP Policy CRA-08, SFHP will report all	6.3.2 CRA-08 Fraud and Abuse Prevention and Investigation		<p><u>10/28/2015</u>- As required by SFHP Policy CRA-08, SFHP will report all suspected fraud and abuse cases to DHCS within 10 working days.</p> <p><b>Closed</b></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	suspected fraud and abuse cases to DHCS within 10 working days.			
6.3.3 The Plan did not ensure covered services were prescribed or ordered by a provider in good standing with the Medi-Cal program.	<p>SFHP disagrees with this finding. The requirement of the contract is that we do not pay providers that are ineligible or suspended. SFHP is in compliance with ensuring SFHP does not pay providers that are ineligible or suspended.</p> <p>The specific requirement stated in the audit report that plans must ensure providers that prescribe or order are in good standing with Medi-Cal is not stated in the DHCS contract. Contract requirement only states that the plan not have a contract with nor pay any ineligible or suspended provider. Evidence was provided during audit that SFHP monitors, on a monthly basis, the suspended and ineligible provider list to verify payments are not made to the ineligible or suspended providers. The auditors cite a provision of CCR, Title 22, 51303(k), which states that “services prescribed or ordered by a provider suspended from participation in the Medi-Cal program shall not be covered by the program while the suspension is in effect...” SFHP does not pay or contract with any suspended provider that orders or prescribes a service. Operationally, it is impossible for the Plan to identify, and refuse to pay, for services that are ordered by a</p>			<p><u>12/16/2015</u>- Per today’s conference call with the SFHP the plan will add a disclaimer in provider directory stating that a non-SFHP provider can’t benefit from Medi-Cal funds if they are not eligible. The plan will follow up with an update regarding the disclaimer in a timely manner.</p> <p><u>12/17/2015</u>- The SFHP plan has submitted a proposed corrective action plan. That included that they will develop a report to provide the Compliance Department with every claim and encounter submitted in the previous quarter with a provider name in field 17 of the CMS 1500 Claim Form (Name of Referring Provider or Other Source.) On a quarterly basis, SFHP will audit the referring providers against the Medi-Cal Ineligible and Suspended Provider List. If any ineligible or suspended providers are identified, the rendering provider will be notified that they accepted an order from a provider that was ineligible to do business with the Medi-Cal Program. In addition, the Medical Group will be notified that the identified provider is</p>

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	provider that is not billing for the service.			<p>ineligible to conduct business with the Medi-Cal Program.</p> <p>Report Development: By January 25, 2016 Inaugural Audit: February 1, 2016</p> <p><b>Provisionally Closed</b></p>
6.3.4 Subcontractor service agreement did not include clauses regarding fraud and abuse reporting requirements.	The Pharmacy Benefit Management subcontractor agreement does contain a clause requiring that suspected fraud and abuse is reported to the plan. The agreement does not specify a timeframe for reporting; however, the agreement does state that they will follow SFHP's operational policies. SFHP will conduct a review of the PBM's Fraud and Abuse Reporting Policies to ensure that the policies are consistent with SFHP's own Fraud and Abuse reporting requirements.		Perform review of PBM's Fraud and Abuse reporting policies by 10/30/2015	<p><u>11/17/15</u>- Upon review of the PerformRX Policies, it was determined that the subcontractor policies do not meet the required time frames for fraud and abuse notification. SFHP is working with PerformRX to Amend the contract to require compliance with SFHP and DHCS fraud and abuse notification requirements. Expected Completion Date: 12/30/2015.</p> <p>Provisionally Closed</p> <p><u>12/3/15</u>- The SFHP plan has submitted evidence of the amendment of the contract with PerformRX that requires compliance with SFHP and DHCS fraud and abuse notification requirements. Therefore this finding is close.</p> <p><b>Closed</b></p>

**Submitted by: Nina Maruyama**  
**Title: Officer of Compliance and Regulatory Affairs**

**Date: 9/30/2015**