State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
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November 22, 2022

Nina Maruyama, Office of Compliance & Regulatory Affairs
San Francisco Health Plan
50 Beale St., 12th Floor
San Francisco, CA 94105

RE: Department of Health Care Services Medical Audit

Dear Ms. Maruyama,

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of San Francisco Health Plan, a Managed Care Plan (MCP), from March 5, 2018 through March 16, 2018. The audit covered the period of March 1, 2017 through February 28, 2018.

On September 19, 2022, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on September 21, 2018.

All items have been evaluated and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Overall effectiveness of the CAP will continue to be assessed, as well as, to what extent the MCP has operationalized proposed corrective actions on the subsequent audit. The enclosed report will serve as DHCS' final response to the MCP's CAP.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

If you have any questions, feel free to contact me at (916) 345-7942 or Daniel Park at (916) 345-8173.

Sincerely,

[Signature on file]

Oksana Meyer, MPA
Chief, CAP Compliance & FSR Oversight Section
Managed Care Quality & Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
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ATTACHMENT A
Corrective Action Plan Response Form

Plan: San Francisco Health Plan

Audit Type: Medical Audit **Review Period: 03/01/2017 – 02/28/2018**

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.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
1. Utilization Management				
1.1.1 Review, revise and implement plan UM policies to ensure consistency with current prior authorization processes for organ transplants.	The plan has updated CO-03 Organ Transplants to reflect current process. Policy was approved by Policy and Compliance Committee on 10/25/2018. Policy expected to be signed by 11/8/18.	CO-03	11/8/2018	**10/30/18** - The following documentation supports the MCP's efforts to correct this finding: - CO-03 was updated by the MCP reflecting its current prior authorization processes for organ transplants. **This finding is closed.**

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1.2.1 Revise policies and processes to ensure that a medical director modifies or denies retrospective requests and that UM processes are consistent with DHCS requirements.	(Leaving blank while MCQMD reviews finding to assist plan in appropriate CAP)			**12/7/20** – MCQMD Policy Clarification: -The MCP has established utilization management protocols for the receipt and review of retrospective authorization review requests. The MCP performs medical necessity reviews if request are submitted with 30 calendar days of service delivery. -The contract allows the MCP to establish reasonable administrative time limits for the receipt and review of retrospective authorization review requests. The imposition of an administrative time limit is not a contract violation. -MCP protocols involving provider disputes of claims denied for lack of prior authorization are forwarded to the MCP Claims Department for adjudication. -The contract allows the MCP to forego medical necessity reviews if the retrospective authorization review request is received after an established administrative time limit. **This finding is closed.**
1.2.2 Revise policies and processes to ensure PA requests for services that involve a medical necessity review can only be denied or modified by a qualified	The plan has updated CO-22 – Authorization Requests to reflect its new process for handling Out-of-Medical Group (OOMG) and Out-of-Network (OON) requests. All OOMG and OON requests will be reviewed for medical necessity and can only be denied by a qualified physician. The	CO-22	Process-10/01/18 Policy-11/8/2018	**10/30/18** - The following documentation supports the MCP's efforts to correct this finding: - CO-22 was updated by the MCP requiring out of network requests to be reviewed for medical necessity and all denials made by a qualified physician (page 18).

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physician.	process was implemented on 10/1/18. Policy was approved by PCC on 10/25/2018. Policy expected to be signed by 11/8/18.			**This finding is closed.**
1.2.3 Revise and implement policies to ensure the inclusion of clear and concise explanations of Plan decisions in its UM and Pharmacy NOA letters.	UM response: The plan will provide additional training to UM staff to ensure clear and concise explanations of UM decisions in NOA letters. UM will continue internal audits of UM NOA letters. Pharmacy Response: Denial rationale templates have been updated. A NOA letter audit process will be implemented as described in the NOA Letter Audit Process Document.	Pharm-02 Draft	UM Training by December 31, 2018 Pharm-02 will be presented to P& T Committee in January 2019 NOA Letter audit process will be implemented by November 20, 2018.	**10/30/18** - The following documentation supports the MCP's efforts to correct this finding: Policy Pharm-02 was updated by the MCP to institute monthly audits of PA denials to evaluate the contents including readability and accuracy of the rationale. (Page 6). **1/29/19** - The following additional documentation supports the MCP's efforts to correct this finding: 11.06.18_NurseMeetingAgenda1_30-2pm Castro lists Deferral/Denial NOA Letter "Clear and Concise" Training as agenda item number 2. - 6th Grade Denial Deferral Language Resource contains a glossary of types of services and how to say them in 6th grade language. - UM Adverse Decision Audit Report Q1 2018 and Draft UM Adverse Decision Audit Report Q2 2018 demonstrate that the MCP audits for clear and concise language. - NCQA 2018-19 UM 5B update w/CCRs denial letter process impacts Serves as evidence of training on denial language.

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				This finding is closed.
1.2.4 Ensure that provider resources and written notifications contain current and consistent information about UM appeals.	Appeal information on fax cover sheet has been removed. SFHP website was updated regarding appeals information. Provider Manual was corrected in August 2018.	Updated fax cover sheet Link to Provider Manual online: https://www.sfhp.org/files/providers/NetworkOperationsManual.pdf	08/15/18	**10/26/18** – The following documentation supports the MCP's efforts to correct this finding: - Updated Fax Cover Sheet and Provider Manual (10/26/18) which has been amended to remove the appeal information on the Fax Cover Sheet and correct the appeal submission timeframe on the Provider Manual. The Provider Manual now reflects the correct time limit of 60 days from the date of the NOA letter to file an appeal. **This finding is closed.**
1.2.5 Revise and implement pharmacy policies to ensure that NOA letters consistently provide an easy method to contact the decision maker.	The issue of direct numbers of decision makers not being generated consistently was raised to the PBM on 08/06/2018. Upon the PBM's investigation, it was found that the PBM's Systems User Access Form, used for user setup, and was missing a field to designate the phone number to be used for the decision-maker in the NOA letter. The general number was listed for a few users/decision makers as a main contact number for the PBM and that was used for the configuration of decision makers' direct phone	PerformRx Systems User Access Request Form-Original (before change) PerformRx Systems User Access Request Form- Updated Draft of proposed changes to	Corrections to the configuration: 08/07/2018. Process implemented on 08/09/2018. Pharm-02 will be presented to P& T Committee in January 2019 NOA Letter audit	**11/16/18** – The following documentation supports the MCP's efforts to correct this finding: - Updated sample NOA letters, "Notice of Action - About Your Treatment Request" (11/16/18) which has been amended to include the decision maker's direct phone number. The NOA letters include the name and direct phone number with extension of the decision maker. - Updated form, "PerformRx System Access Request" (10/26/18) which has been amended to include a field for phone numbers to be used for NOA letters to ensure the appropriate phone number is generated for the letters moving forward.

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	numbers in the NOA letters. Corrections to the configuration were completed on 08/07/2018. The PBM has updated the form to include a field for phone numbers to be used for NOA letters to ensure the appropriate phone number is generated for the letters moving forward. Examples of this correction can be provided upon request. NOA Letter audit process will also help monitor and ensure that NOA letters consistently provided the direct phone number of the decision-maker.	Pharm-02.	process will be implemented by November 20, 2018.	**This finding is closed.**
1.2.6 Revise policies to include the sending of pharmacy deferral letters to members and providers as outlined in the contract and All Plan Letter 17-006.	Pharm-02 has been updated to reflect a change in policy to reduce the length of time on requests for information to 14 days. A deferral letter would be required if the review is extended an additional 14 days. SFHP has chosen not to allow for an additional extension, so a deferral letter would not be required.	Draft Pharm-02	Process already implemented. Pharm-02 will be presented to P& T Committee in January 2019	**10/26/18** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "Pharm-02: Pharmacy Prior Authorization" (10/26/18) which has been amended to reduce the length of time on requests for information to 14 days. Non-urgent requests are held open for no more than 14 calendar days from the date of the initial PA request (page 2). The plan has chosen not to allow for an additional extension, so a deferral letter would not be required. - An email (12/17/18) which includes a screen shot of cases being Request for Information (RFI) cases, which include an "RFI Time"

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				that indicates the count down timer for each case that is due to be completed by 14 days. In addition, a description of the MCP's process for ensuring that a Pharmacy Prior Authorization decision does not go beyond 14 days: All cases have a timer within the processing system. If we request additional information it extends the time to 14 days from the date the request was submitted. The case is monitored in the work queue which has the timer and is completed before the end of the 14th day. If no additional information is received the determination is made based on what was given and it is noted that no additional information was received. - An email (01/08/19) which clarifies that the timer was previously set at 30 days for the two pharmacy cases that went beyond 14 days without notifying members, as referenced in the Medical Audit Report. The MCP changed the coding in the system so the timer is now 14 days. **This finding is closed.**
1.2.7 Consistently implement policy and criteria regarding prior authorization.	UM Response: UM will provide additional training to staff on how to apply appropriate criteria. UM will continue an internal audit to ensure criteria is applied appropriately. Pharmacy:	Oct P&T meeting agenda and materials. DTP_PHARM_ Prior Auth_PBM_PA	UM Training by December 31, 2018 Updated PA Criteria was reviewed and approved at October 17,	**10/29/18** – The following documentation supports the MCP's efforts to correct this deficiency: -P&T Meeting Agenda (10/17/18) which provides evidence of documented review and approval of interim prior authorization criteria. -Interim Prior Authorization Criteria Changes (October 2018) which provides evidence of newly adopted criteria based on

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	● Bullet 1: In response to the finding of outdated criteria used in a denial determination (Appeal Case #17), we acknowledge an opportunity to review all PA criteria to bring them up-to-date, including retiring outdated criteria. See Supporting Documentation. ● Bullet 2: In response to the Pharmacy PA Case #15, we updated the PA Desktop Procedure to include steps to ensure Continuity of Care requirements are assessed based on eligibility within the last 6 months. See Supporting Documentation. ●Bullet 3: In the finding of 3 pharmacy cases applying incorrect criteria (Pharmacy Case 17, 19, 22), we reviewed all PA criteria to bring them up-to-date, including retiring outdated criteria. See Supporting Documentation ●Bullet 5: In the finding of cases applying dosing criteria over the allowable amount (Pharmacy Case #26	First Level Review Checklist. (See pages 01 and 10) DTP_PHARM_ Prior Auth_PBM_PA First Level Review Checklist (See Page 09)	2018 P & T Committee meeting. New PA Criteria to be posted and implemented by November 20th 2018. PA DTP will be implemented by November 20th 2018.	specific regulatory requirements when handling requests determined to be for experimental or investigational use or terminal illness. Additionally, criteria was evaluated to check formulary status, clinical appropriateness and applicability. All updated criteria to be effective by 11/20/18. -Desktop procedure, SFHP Pharmacy Desktop Procedure (10/17/18) which describes key factors to consider in reviewing prior authorization requests, including guidance for review and requirements for communication and documentation (criteria, rationale and Medical Director consultation). **02/28/19** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Desktop procedure and audit tool – "Health Services Clinical and Pharmacy Denials and Appeals Audit (09/05/18) which indicates the MCP will conduct quarterly sample audits of prior authorization and appeals files relating to decision-making, timeliness, and communication. Audit report to be submitted to the Utilization Management Committee during quarterly meetings UM Training to be completed by 12/31/18. Request MCP to submit documented evidence of training (sign-in sheets, training schedules, dates of training, etc.) and training materials (desktop procedures, PowerPoint presentations, etc.) -UM training for staff on applicability of appropriate critieria.

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	and Appeal Case #21), we reviewed all PA criteria to bring them up-to-date, including retiring outdated criteria. See Supporting Documentation ● General Comment below bullets: In response to the comment where none of the pharmacy PAs cited documented a medical director review upon initial submission, we've updated our PA DTP to include documenting all MD consultations in PA notes.			**04/25/19** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Q3/Q4 Clinical Denials and Appeals Audit Report as evidence MCP conducts quarterly file reviews of concurrent and prior authorization, pharmacy and appeal (approval and denials) to ensure files are meeting statutory and regulatory requirements by DHCS, DMHC and NCQA. Q3/Q4 Audit Report was reviewed and approved at the Utilization Management Committee on 4/25/19. **This finding is closed.**
1.4.1 Develop and implement policies to ensure that the Plan provides clear and concise appeal resolution letters using the DHCS NAR template.	Updated Grievance and Appeal letter templates, including the NAR templates were submitted to DHCS for review on 10/26/2018. Compliance and QI will conduct resolution letter audit on quarterly basis. Plan intends to conduct member focus groups in fiscal year 19/20 to determine most effective wording and phrasing for appeal resolution letter.	Grievance Audit Tool	Implementation of updated templates will begin approximately 90 days after DHCS approval to allow for translation and configuration in care management system. First Audit: To be completed by 12/31/18	**11/01/18** – The following documentation supports the MCP's efforts to correct this deficiency: -MCP submitted revised NOA/NAR templates to MCOD on 10/26/18 for review and approval. Confirmed with MCOD that revised templates have been reviewed and approved (02/25/19). -Proposed quarterly audits pertaining to resolution letters. See excel spreadsheet. -Provided technical assistance to MCP regarding additional grievance templates potentially related to exempt grievances. Reminded MCP that they still need to make sure all expressions of dissatisfaction are logged, tracked and reviewed for potential quality of care issues. **02/27/19** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency:

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				-An email (02/27/19) which indicates all decline to file and withdrawn grievances are tracked and trended for quality issues. -Updated P&P, "QI – 06: Member Grievances and Appeals (05/31/18) that includes processes for reviewing potential quality issues. -Sample audit report, "Internal Grievance Audit Criteria" as evidence the MCP is conducting quarterly reviews relating to letters, documentation, and proper attachments. Audit checklist includes reviewing for error-free correspondence, proper regulatory notices, were all issues addressed, proper documentation, including are notices clear and concise. **This finding is closed.**
2. Case Management and Coordination of Care				
2.4.1 Implement policies and procedures to ensure documentation of all components of an IHA.	Revise policy to reflect procedures for documenting all components of an IHA Update Network Operations Manual to clarify procedures for documenting IHA Publish information in provider newsletter		Policy to be presented to PCC: 12/20/2018 Network Operations Manual update and messaging to providers to be complete by: 1/30/2020	**11/21/22** - The Plan lacked documented evidence that required components of a comprehensive IHA or preventive services were consistently provided or their current status documented. The Plan has proposed various corrective actions and been impacted by COVID, DHCS Guidance - Public Health Emergency, staff shortages, etc. In response to the COVID-19 pandemic, DHCS issued APL 20-004 which allowed plans to defer IHA completion until the emergency declaration was rescinded. IHA reinstatement occurred on 10/1/21. All of these issues have served as contributing factors for where the Plan stands today.

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				In response to the Emergency Guidance (APL 20-004) that resulted from the COVID-19 pandemic, the Plan was reminded of their responsibility to not only address newer member IHA requirements, but to be sure to address the backlog of members that did not receive or complete a comprehensive IHA during the emergency order. In addition to current new members, medical groups will receive lists of members who were not provided IHAs during their original onboarding. The backlog of members will be addressed through a phased in approach. The Plan is creating a dashboard to track adult preventive care and is creating a workgroup to identify opportunities to improve access to adult preventive care services. The Plan is currently in the process of soliciting members for the workgroup. Plan has identified members who have not received an IHA during the Public Health Emergency to current. Plan has identified members who have not received USPSTF A and B recommended preventive care. Dashboard will be used to identify providers who are not providing preventive care and identify which services are not being regularly provided. Planned outreach includes: Monthly reminders in the Provider Newsletter Letter campaign to adult members about the importance of completing an IHA Possible provider incentive program Catch-up Campaign for members that still need IHAs

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				Additional quarterly audits of providers based on dashboard The Plan has developed processes and protocols to address IHA requirements, while also addressing the backlog of members that did not receive an IHA while the emergency order was in effect. However, while the Plan has processes in place, increased emphasis will be placed on overall IHA implementation and compliance on the 2022 audit/CAP; including the following: • Timely completion of an initial comprehensive IHA within 120 calendar days of enrollment. • Ensure medical records demonstrate evidence/documentation age-appropriate preventive screenings were offered and/or declined OR consistently provided and/or status documented. • Evidence of implementation of previously proposed bi-annual audits surrounding documentation; including meeting the 120 day requirement, documenting all required components of an IHA, documenting the offer, provision, or current status of all age-appropriate preventive services. • Evidence the Plan is addressing the backlog after reinstatement of IHAs. **This finding is closed.**

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3. Access and Availability of Care				
3.1.1 Develop and implement policies and procedures to monitor return calls by providers.	This is a continuation from the 2017 Audit. As part of the corrective action plan from the 2017 audit, the implementation period would extend through the 2018 Survey period. We committed to adding the appropriate questions, after working with our provider groups, to establish an appropriate and measureable threshold. The question was added to the Daytime Survey, which began 10/8/18.	Daytime Survey (2018)	Survey kick-off 10/08/18. Survey completion 02/28/2019.	MCQMD acknowledges that the proposed 2017 CAP for this finding required long term corrective action. MCP has submitted concrete milestones for implementation and DHCS is assured of MCP's commitment towards remediating this finding. DHCS will continue to monitor full implementation of this CAP through the subsequent medical audit. **02/11/19** – The MCP submitted the following documentation to support its efforts to correct this finding: - "SFHP 2018 Daytime Survey" demonstrates that MCP has updated the Survey to comply with contractual requirement. (Page 1, 1A & 1B) - "Provider Daytime Survey Methodology" that describes MCP's procedures for administering Daytime Survey, aggregation of survey results and the requirement for corrective action for non-compliant providers. - "Results: Time to Return Telephone Calls" demonstrate results for 2018 Daytime Survey for 13 provider groups and 10 Independent Clinics and San Francisco Consortium of Community Clinics. - MCP's written response (via e-mail 02/11/19) confirming the completion of the survey, the actual raw results and a commitment to follow up with non-compliant providers by issuance of the Corrective Action Plan (CAP) request.

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				03/13/19 - The following additional documentation submitted supports the MCP's efforts to correct this deficiency: - MCP's written response (via e-mail 03/13/19) confirming that the CAP requests were sent to non-compliant providers on March 1, 2019. - A sample of three CAPs issued to a non-compliant providers. "Beacon Access", "Brown & Toland Physicians "and "Mission Neighborhood Health Center"(Request date 03/01/19). "Beacon Access Results and CAP" is demonstrating that The Plan conducts internal monitoring and has surveyed this provider for the time it took to return member phone calls (non-triage). (Page 2) **This finding is closed.**
3.1.2 Develop and implement policies and procedures to update provider directory to reflect accurate and complete information.	System improvements have been put into place to correct inaccuracies. System improvements include maintaining a log to demonstrate the corrections have been made.	Provider Inaccuracy Log	May 2018	**10/16/18** – The following documentation supports the MCP's efforts to correct this finding: - "Provider Inaccuracy Log" tracks and monitors reported Provider Directory inaccuracies. This log captures resolution date, investigation outcome and tracks the changes made. - Plan Policy PR-21 "Data Maintenance for Providers Participating in SFHP" stated, upon receipt of reports of potential provider directory inaccuracies, SFHP either verifies the accuracy of the provider directory or updates the provider directory within 30 business days following receipt of the report of potential inaccuracy. SFHP documents the receipt and outcome of each report including:

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				(1) Provider's name and location; (2) Description of SFHP's investigation; (3) Outcome of the investigation; and (4) Any changes or updates made to the provider directories. **This finding is closed.**
4. Members' Rights				
4.1.1 Develop and implement policy and procedures to capture all grievances.	SFHP Grievance Policy (QI-06) was updated to clarify the medical groups' role in the Grievance Process. Publish article to provider newsletter reminding providers to that members have right to file grievance with their health plan.	QI-06	Policy updated 05/31/18 Provider Newsletter tentatively scheduled for January 2019.	**10/16/18** – The following documentation supports the MCP's efforts to correct this finding: - SFHP P&P "QI-06 Member Grievances and Appeals" (revision date 05/31/18) clarifies the role of the medical groups in the Grievance Process. It also requires the delegated medical groups to report all grievances to the MCP (QI-06, Section XVII and Section XVIII). **05/21/19** - The following additional documentation submitted supports the MCP's efforts to correct this deficiency: - MCP's written response (05/21/19) confirmed that the following language will be added to the distribution of "June Provider Update" to all providers on 06/01/19. "Member Grievances. San Francisco Health Plan (SFHP) considers all expressions of dissatisfaction made by SFHP members to be Grievances. Please use the Grievance Forms provided by SFHP to assist members in filing grievances. All expressions of dissatisfaction should be forwarded to SFHP for processing." This makes the capturing process of all grievances clear.

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				This finding is closed.
4.1.2 Revise Plan processes to include documentation that a health care professional qualified to treat a condition or disease determines the outcome of a clinical grievance.	Documentation previously submitted to A & I included documentation that the CMO and/or Medical Director were involved in the decision making of clinical grievances via the Grievance Review Committee (GRC0by documented initials of attendees. The Plan proposes that acceptable documentation of involvement of physicians is a statement input into the case management system by a grievance coordinator that states “Dr. <Insert name of decision-making physician> made final decision of <insert decision> on <insert date>. If proposal not accepted, a configuration to the case management system to develop a Medical Director Queue to route cases to the MDs for documentation will be created in July 2019. In the meantime, the documentation in Essette has been expanded to fully document all attendees of the GRC and who made final decision.	Essette GRC Notes	Upon approval of CAP, process will be implemented within 2 weeks. If proposal not accepted, configuration to Essette will be added to July 2019 configuration.	**12/20/18** – The following documentation supports the MCP’s efforts to correct this finding: - The MCP’s written documentation (12/20/18) explains current process and commits the MCP to a thorough documentation recording. All cases are routed to the physician through the case management system, which requires a physician to log on to the case management system to document that they reviewed the case and document the decision. - A screen shot of the case management system that documents the current process (12/20/18). Entrée (10/01/18) shows physician notes on a clinical review of the case followed by Grievance Review Committee notes (10/02/18). **This finding is closed.**

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4.3.1 Implement Plan policy and notify DHCS immediately upon discovery of a breach by telephone call plus email or fax.	Policy CRA-06 updated to include call AND email or fax.	Draft Policy CRA-06	Policy to be presented to PCC on 11/21/2018.	**01/16/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "C&RA-06: "PHI Breach Investigation and Reporting" (01-16-19) which has been amended to include breach reporting to all required DHCS entities (at each of the reporting junctures (24hrs, 72hrs, 10 working days). -Updated P&P, "C&RA – 07: "Breach Notification" (CG Draft 011619) which has been amended to include breach reporting to all required DHCS entities and reporting timeframes. **12/28/18** Screen shot of Compliance calendar. Lyu asked for detailed explanation of the calendar (01-23-19) **01/16/19** MCP's written confirmation that the revised HIPAA log will be incorporated ASAP. - The MCP is also implementing additional measures to ensure compliance exceed requirement (correspondence 12-28-18). The plan is to get System management tool to track security incidents. **02/11/19** - MCP submitted a template "Breach Incident Monitoring Report as evidence of implementation of monitoring procedure to ensure and document breach reporting to all required DHCS entities at each of the reporting junctures (24hrs, 72hrs, 10 working days). **This finding is closed.**

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4.3.2 Revise policy to include requirements for suspected security incidents reporting and report all suspected security incidents to DHCS within 24 hours.	Policy CRA-06 updated to include reporting of suspected breaches within 24 hours.	Draft Policy CRA-06	Policy to be presented to PCC on 11/21/2018.	**01/16/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "C&RA-06: "PHI Breach Investigation and Reporting" (01-16-19) which has been amended to include breach reporting to all required DHCS entities (at each of the reporting junctures (24hrs, 72hrs, 10 working days). -Updated P&P, "C&RA – 07: "Breach Notification" (CG Draft 011619) which has been amended to include breach reporting to all required DHCS entities and reporting timeframes. **12/28/18** Screen shot of Compliance calendar. Lyu asked for detailed explanation of the calendar (01-23-19) **01/16/19** MCP's written confirmation that the revised HIPAA log will be incorporated ASAP. - The MCP is also implementing additional measures to ensure compliance exceed requirement (correspondence 12-28-18). The plan is to get System management tool to track security incidents. **02/11/19** - MCP submitted a template "Breach Incident Monitoring Report as evidence of implementation of monitoring procedure to ensure and document breach reporting to all required DHCS entities at each of the reporting junctures (24hrs, 72hrs, 10 working days). **This finding is closed.**

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5. Quality Management				
5.1.1 Implement policy and establish mechanisms to communicate and monitor processes for identifying and resolving PQI cases.	During the lookback period, the Quality Nurse position that oversees the PQI process was vacant, resulting in delays in review and documentation. This position is now fully staffed and able to follow the process and procedures outlined in the policy UM-56 Potential Quality Issues. In addition, the PQIs moved from an external tracking process to be included in the case management tracking system, Essette for better tracking of timelines and more accountability for follow up.		April 2018	**11/16/18** – The following documentation supports the MCP's efforts to correct this finding: -MCP's 2018 Quality Improvement Program as evidence that explains plan's quality improvement methods which is based on regulatory requirements, NCQA standards, data review, provider and member identified opportunities in the key domains of Clinical Quality & Patient Safety, Quality of Service & Access to Care, Utilization Management, and Care Coordination & Services for Members with Complex Health Needs. In addition, Plan monitors and tracks complaints and grievances and provides a quarterly analysis to the Quality Improvement Committee, identifying trends and addressing patterns when evident. -Policy and Procedure "PNO-PR-20: Enact Corrective Action Plan" which describes MCP's Corrective Action Plan process for correcting, minimizing and monitoring future occurrence or deficiencies identified through any monitoring activities including QI Plan and PQIs. -Policy "QI-10 Governing Board's Role in SFHP Quality Improvement Program" which describes the Governing Board is responsible for the overall direction of SFHP including approving the annual QI Program and evaluation. -Policy "QI-15: Quality Improvement Program" which the purpose of this program is to establish comprehensive methods for systematically monitoring, evaluating, and improving the quality of the care and services provided to plan's members. The QI

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				Program is designed to ensure that members have access to quality health care services that are safe, accessible, equitable, and meet their unique needs and expectations. -Under a document titled “DHCS CAP response_ACE Response” MCP has provided evidence of follow up conducted for the 4 quality of care grievances cases indicated in the report. -A document titled “Essette.Case Summary” which provides summaries of few cases as samples. -Under a document titled “DHCS CAP response_ACE Response” MCP has provided a screen shot of Essette system which plan’ s Quality Review Nurse use it to create PQI cases and tracks these cases to ensure timeliness of case reviews and follow up of the cases. MCP has established a 45 day turnaround time for PQI case completion, and a 60 day turnaround time for PQI cases involving a Corrective Action Plan (CAP). -Quality Improvement Committee meeting minutes from the meeting on June 8, 2017 as evidence that shows the committee has discussed the Potential Quality Issues. -PQI Issue Report for Q2 of 2017 (09/27/2017) as evidence that shows MCP has reviewed 136 PQI cases. All of these cases were reviewed within 45 day timeframe as outlined in UM56. Sources of these cases were from reviewing: Grievances (clinical/ non-clinical), UM referrals, Provider Preventable condition reporting, and appeals.

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				-"Quality Review Nurse Workflow Map" as evidence that shows the Quality Review Nurse performs an initial review on all grievances including decline to file grievances, and PQI referrals. These cases are not closed without review by either the CMO or Medical Director. **This finding is closed.**
5.1.2 Include the UMC in the QIS organization chart and demonstrate its reporting relationship to the QIC.	The 2018 QI Plan states UMC reports to QIC. The 2019 QI Plan will include an organizational chart that includes a visual representation of that relationship.		2019 QI Plan to be presented to Board by February 2019.	**02/05/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated Quality Improvement Committee Structure Organizational Chart (February 2019) which has been amended to include the Utilization Management Committee (UMC) on its quality organizational chart. **This finding is closed.**
5.2.1 Implement policies and procedures to ensure providers receive new provider training within 10 working days after being placed on active status.	SFHP developed policy DO-11 Oversight of New Provider Training, revised audit methodology, and developed a new audit tool. Policy DO-11 was implemented in April of 2018. Audit results will be available at the end of 2018.	P&P DO-11 2018 New Provider Training Audit Tool	April 2, 2018 April 17, 2018	**10/26/18** – The following documentation supports the MCP's efforts to correct this finding: -Revised P&P "DO-11 Compliance and Regulatory Affairs" (04/02/2018) which demonstrates MCP's oversight system of contracted delegated group responsible for new provider training to ensure compliance. -Audit tool which is designed and will be used for 2018 New Provider Trainings. **12/03/18** – The following additional documentation submitted

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				supports the MCP's efforts to correct this finding: -P&P "PR-03: Provider Relations" as evidence that shows MCP's policy to ensure that all new providers are trained and oriented within 10 business days after being placed in active status. In addition, this P&P indicates MCP's methods of sharing information between the plan, providers and members is through regularly scheduled joint administrative meetings, providers newsletters, health plan's website and electronic messages. In a written statement received via an email (12-03-18) MCP has emphasized that "Our primary method of communication is via the Network Operations Manual, available online at https://www.sfhp.org/providers/provider-resources/network-operational-manual/. We also communicate policy changes via newsletters, a library of which is available online at https://www.sfhp.org/providers/provider-update/." -In a written statement sent via an email (12-03-18) MCP has indicated that "evidence of training is tracked in the individual credentialing files, which are tracked until training is complete" -Two samples of "Practitioner Orientation Attestation Form" received from recently hired providers. **02/06/19** – The following additional documentation submitted supports the MCP's efforts to correct this finding: - In a written statement via an email (02/06/19) the MCP communicates ongoing provider training when necessary. The Network Operations Manual

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				https://www.sfhp.org/files/providers/NetworkOperationsManual.pdf states that, “In addition, SFHP regularly communicates with and updates the medical groups with policy changes, new program implementations, provider/member survey results and other quality improvement outcome information through mechanisms such as special mailings, Provider Newsletters, Plan Collaborating with Provider Meetings (PCP M) at the sites, and/or Joint Administrative Meetings (JAM) attended by representatives of each medical group.” (Page 76). - An email (02/06/19) which includes a link to Provider Newsletters, https://www.sfhp.org/providers/provider-update/ as evidence that the MCP is performing ongoing provider training. - Eight sample Provider Training Delegate Audit Reports, “2018 Annual Oversight Audit” (2018) as evidence that the MCP is performing audits to ensure that the providers are receiving new provider training within 10 working days after being placed on active status. **This finding is closed.**
State Supported Services				
SSS.1 Ensure all informing materials clearly state that minors of any age may consent to obtain abortion services without parental	Provider Network Operations Manual corrected to reflect that minors of any age may consent to abortion services without consent. See page 41.	Link to Provider Manual online: https://www.sfhp.org/files/providers/NetworkOperationsManual.pdf	August 2018	**10/26/18** – The following documentation supports the MCP’s efforts to correct this finding: -Revised Provider Network Operations Manual to demonstrate that MCP has indicated the correct language of “minors of any age do have the authority to consent to abortion” (page 41).

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
consent.				**This finding is closed.**

Submitted by: Crystal Garcia **Date: 10/26/18**
Title: Supervisor, Compliance Program

[Signature on File]