

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

REPORT ON THE MEDICAL AUDIT OF

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

Contract Number: 04-35400

Audit Period: March 1, 2017  
Through  
February 28, 2018

Report Issued: September 21, 2018

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## I. INTRODUCTION

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

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

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

As of February of 2018, SFHP served 145,013 members through the following programs: Medi-Cal 131,885, Healthy Kids 1,773, and Healthy Workers 11,355.

The scope of this audit includes the review of Seniors and Persons with Disabilities (SPD) population in the areas of Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of March 1, 2017 through February 28, 2018. The onsite review was conducted from March 5, 2018 through March 16, 2018. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit conference was held on August 3, 2018 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the exit conference. The results of our evaluation of the Plan's response are reflected in this report.

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

The prior DHCS medical audit (for the period of March 1, 2016 through February 28, 2017, with onsite review conducted from March 20, 2017 through March 24, 2017) was issued September 22, 2017. The corrective action plan (CAP) closeout letter was sent to the Plan on February 1, 2018. This audit examined documentation for compliance and to determine to what extent the Plan has implemented their CAP.

The summary of the findings by category follows:

### **Category 1 – Utilization Management (UM)**

The Plan is required to develop, implement and continuously update the UM program to ensure appropriate processes are used to review and approve the provision of medically necessary covered services. The Plan's UM policies describe the processes by which the UM program functions. The Plan's written policy for referring members to a transplant evaluation center was outdated and inconsistent with its actual process. The Plan's transplant policy has not been updated since 2015.

The Plan is required to ensure that its pre-authorization, concurrent review and retrospective review procedures meet specific minimum requirements by having a qualified health care professional with appropriate clinical expertise in treating the condition and disease to deny or authorize an amount, duration, or scope that is less than requested. The Plan denied out of network and out of medical group (services rendered outside of the member's assigned medical group) prior authorizations and retrospective reviews without documentation of a review by a qualified physician.

The Plan is required to send written notices to members that include a clear and concise explanation of the reasons for the Plan's decision. The Plan's notice of action (NOA) and appeals resolution letters were not written in clear, concise, consumer-friendly language and contained abbreviations and technical terms.

### **Category 2 – Case Management and Coordination of Care**

The Plan must cover and ensure the provision of an Initial Health Assessment (IHA) to each new member. An IHA consists of a comprehensive history and physical examination, preventive services, and the Individual Health Education Behavioral Assessment (IHEBA). The Plan did not ensure that all providers documented two of the required components of an IHA: IHEBA and USPSTF "A" & "B" recommended services.

### **Category 3 – Access and Availability of Care**

Category 3 covers members' access to services in routine, urgent and emergency care, specialist and specialty care, and pharmaceutical services. The Plan is required to develop, implement, and maintain a procedure to monitor telephone call answer and return times. The Plan did not monitor call return times or whether providers returned members' telephone calls.

The Plan did not maintain an accurate and complete provider directory, both online and printed, as required by Health and Safety Code, Sections 1367.26 and 1367.27.

### **Category 4 – Member's Rights**

Category 4 includes requirements to protect member's rights by proper handling of grievances and reporting of protected health information (PHI). The Plan is required to establish and maintain a grievance system, which processes and resolves all member grievances and complaints. The Plan did not capture all grievances that members communicated to providers or delegated groups. The Plan allowed providers to resolve grievances reported to them but did not require reporting of these grievances back to the Plan. The Plan did not document the medical director's final determination in clinical grievances.

The contract requires specific timeframes and methods for reporting breaches of PHI and suspected security incidents. The Plan did not report the discovery of breaches via e-mail or fax. The Plan did not report all suspected security incidents to DHCS within 24 hours of discovery.

## **Category 5 – Quality Management**

Category 5 covers requirements to deliver adequate quality of care services to members. The Plan is required to monitor, evaluate and take effective action to address any needed improvements in quality of care delivered by providers. The Plan's process for monitoring and evaluating quality issues did not capture all problems when it did not identify Potential Quality Issues (PQI) from clinical grievances, conduct investigations, and resolve quality issues. Several quality of care grievances met the Plan's criteria for a PQI but were not classified as a PQI or investigated.

The Plan did not ensure its delegated entities conducted provider training within 10 working days.

### **III. SCOPE/AUDIT PROCEDURES**

#### **SCOPE**

This audit was conducted by the DHCS Medical Review Branch to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contracts.

#### **PROCEDURE**

The onsite review was conducted from March 5, 2018 through March 16, 2018. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

#### **Category 1 – Utilization Management**

Prior Authorization requests: 28 Medical and 28 pharmacy prior authorization requests, including 4 medical and 11 pharmacy SPD cases, were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 20 Medical appeals, including 11 SPD cases, were reviewed for appropriate and timely adjudication.

#### **Category 2 – Case Management and Coordination of Care**

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

Complex case management (CCM): Five medical records were reviewed for coordination of care.

Initial Health Assessment (IHA): Five medical records were reviewed for fulfillment of IHA requirements.

Behavioral Health Treatment (BHT): Five member files were reviewed for coordination of care.

Non-Emergency Medical Transportation: 25 claims were reviewed for to confirm compliance with the Non-Emergency Medical Transportation requirements.

Non-Medical Transportation: Three claims were reviewed to confirm compliance with the Non-Medical Transportation requirements.

### **Category 3 – Access and Availability of Care**

Appointment availability verification: 27 providers from the Plan's 10 delegated entities and in-network providers of routine, urgent, specialty, and prenatal care were reviewed. The third next available appointment was used to measure access to care.

Claims: 15 emergency services and 15 family planning claims were reviewed for appropriate and timely adjudication.

### **Category 4 – Member's Rights**

Grievance procedures: 45 grievances, including 17 SPD grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality rights: Six Health Insurance Portability and Accountability Act (HIPAA)/protected health information (PHI) breach and security incidents were reviewed for appropriate reporting and processing.

### **Category 5 – Quality Management**

New provider training: 12 new provider training records were reviewed for timely Medi-Cal managed care program training.

### **Category 6 – Administrative and Organizational Capacity**

Fraud and abuse: Two fraud and abuse cases were reviewed for appropriate reporting and processing.

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



**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

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**CATEGORY 1 - UTILIZATION MANAGEMENT**

**1.1**

**UTILIZATION MANAGEMENT PROGRAM**

**Utilization Management (UM) Program Requirements:**

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

2-Plan Contract A.5.1

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

2-Plan Contract A.5.2.C

**Review of Utilization Data:**

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

2-Plan Contract A.5.4

**SUMMARY OF FINDING(S):**

**1.1.1 Updating Utilization Management (UM) Processes**

The Plan shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services (*Contract A10, Exhibit A, Attachment 5 (1)*).

Plan policy *UM-03 Organ Transplants* stated, "SFHP or the delegated medical groups's UM department reviews all transplant evaluation authorization requests for medical necessity. The request must meet the following criteria: 1) medically necessary according to national guidelines, InterQual, or other objective criteria. 2) The member has access to ongoing health coverage eligibility."

The Plan's written policy for referring members to a transplant evaluation center was outdated and inconsistent with its actual process.

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In an interview, the Plan stated that it did not require a medical necessity review when a provider submitted a request for a transplant evaluation. The Plan last revised plan policy *UM-03 Organ Transplants* on September 9, 2015. Utilization Management Committee (UMC) meeting minutes from the audit period did not show review and revision of the policy.

Inconsistent information and outdated policies about Plan UM processes may lead to confusion and delay in referring members for needed treatment.

**RECOMMENDATION(S):**

- 1.1.1** Review, revise and implement plan UM policies to ensure consistency with current prior authorization processes for organ transplants.

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**1.2**

**PRIOR AUTHORIZATION REVIEW REQUIREMENTS**

**Prior Authorization and Review Procedures:**

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

2-Plan Contract A.5.2.A, B, D, F, H, and I.

**Exceptions to Prior Authorization:**

Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

2-Plan Contract A.5.2.G

**Timeframes for Medical Authorization**

Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto.

2-Plan Contract A.5.3.F

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

2-Plan Contract A.5.2.H

**Denial, Deferral, or Modification of Prior Authorization Requests:**

Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.

2-Plan Contract A.13.8.A

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### SUMMARY OF FINDING(S):

#### 1.2.1 Retrospective Authorization

The Plan shall ensure that its prior authorization (PA), concurrent review and retrospective review procedures meet the following minimum requirements: a qualified health care professional with appropriate clinical expertise in treating the condition and disease shall decide to deny or to authorize an amount, duration or scope that is less than requested (*Contract A10, Exhibit A, Attachment 5 (2) (A)*).

Plan policy *UM-22 Authorization Requirements* stated the Plan performed medical necessity reviews for retrospective requests submitted within 30 days of service delivery.

Plan policy *CL-07 Provider Dispute Resolution Mechanism* stated that the Plan forwarded provider disputes of claims denied for lack of prior authorization from the Claims Department to the UM Department. The UM Department then resolved the disputes according to the retrospective review process described in Plan policy *UM-22 Authorization Requirements*.

The Plan denied retrospective requests without review by a medical director if the provider submitted the request more than 30 days past service delivery. The contract did not place time restrictions or other limitations on filing retrospective requests for services.

A verification study revealed the Plan denied six of six retrospective medical service cases without physician review for submission past 30 days.

The Plan explained that providers submitted retrospective requests in two ways:

- They submitted requests directly to the Utilization Management (UM) Department as a late authorization request for a service already delivered.
- They submitted a provider dispute contesting denial of a claim for payment of a delivered service to the Claims Department. The Claims Department forwarded it to the UM Department, which then processed it as a retrospective authorization.

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In an interview, the Plan reported out of network (OON) providers submitted most retrospective requests for services requiring PA, and that it made multiple efforts to educate providers about submitting PA requests before service delivery. In UMC meeting minutes, the Plan asserted there was no requirement for processing retrospective PAs. UMC meeting minutes confirmed the Plan considered increasing the timeframe for retrospective request submission to 180 days. However, there was no discussion about eliminating the requirement that retrospective service requests must meet certain exceptions or face automatic denial.

Policies and processes that allow resolution of retrospective reviews in a manner that varies from contractual and regulatory requirements, including denial without a medical necessity review by a medical director, may negatively affect providers' payments and their future willingness to provide services to Plan members.

### 1.2.2 Prior Authorization Determinations

The Plan shall ensure that a qualified health care professional with appropriate clinical expertise in treating the condition and disease shall decide to deny or to modify a service request. A qualified physician will review all denials made because of medical necessity (*Contract A10, Exhibit A, Attachment 5 (2) (A) (B)*).

Plan policy *UM-22 Authorization Requests* stated a nurse could make benefit denials; these included denial of requests for services available within the member's medical group.

The Plan did not require a qualified physician to review PAs that qualified as medical necessity requests. Some PA requests were denied by the Plan as non-covered benefits. The Plan did not document a Medical Director's medical necessity review.

A verification study showed 6 of 28 medical service cases were requests for treatment outside of the member's assigned medical group. In three of the six cases, a Plan Registered Nurse (RN) determined after investigation that an in-network provider could deliver the requested service and denied the request as "not a covered benefit":

- In one case, the requesting provider did not explain why a member required an out of network (OON) neuropsychology referral. A deferral letter stated the Plan needed clinical documentation to review the medical necessity of the request. The denial letter stated the Plan reviewed the case and did not find medical necessity for the referral.

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- In another case, the UM nurse's initial review indicated the request was a Medi-Cal covered benefit and "met medical necessity". The member had multiple heart problems and had seen her OON cardiologist a year earlier. The Plan called the provider for more information and denied for not a covered benefit.
- In a third case, the RN reviewer noted that there were no documented medical reasons that the member needed to have speech therapy OON.
- In a PA case that resulted in an appeal, a Plan RN reviewed clinical documents and made a benefit denial after noting that the recommended treatment for the member was physical therapy (available in network), not OON neurosurgery as requested.
- In a case that resulted in an overturned decision upon appeal, the UM RN denied shoe inserts for a member with a neurological condition that limited his ability to walk; the review stated they were not a covered benefit after reviewing clinical information and finding the provider submitted an incorrect billing code.

The above PA cases demonstrated medical necessity reviews but did not include documentation of a qualified physician's final decision.

In an interview, the Plan reported that it investigated PA requests; if there was any indication of the need for a medical necessity review, the UM nurse forwarded the case to the medical director for completion. The Plan stated that it is a close network, and the diligence and professionalism of its UM nursing staff allowed UM RNs to decide whether a case required a medical director's review or could be denied as not a covered benefit.

The Plan reported that an accrediting agency representative advised that the Plan could forego medical necessity reviews, "If there is no indication from a member or practitioner that there is a clinical need for an OON request that cannot be met in-network."

Case review by a qualified physician helps to ensure the appropriate determination of service requests and prevents delays in service delivery for members.

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### 1.2.3 Member Notice of Action (NOA) Letters

The Plan shall notify Members of a decision to deny, defer, or modify requests for prior authorization. Notifications shall be as specified in Health and Safety Code, Section 1367.01 (*Contract A10, Exhibit A, Attachment 13 (8) (A)*).

The Plan's written notices to members shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity (*Health and Safety Code, Section 1367.01 (h) (4)*).

The Plan shall send NOA letters to members that are clear and concise in explaining reasons for adverse benefit determinations (*All Plan Letter 17-006*).

Plan policy *UM-01 UM Notice of Action Letters* stated that the Plan's letters were written at the 6th grade level in clear, concise, consumer-friendly language and do not contain abbreviations or technical terms.

The Plan's member NOA letters were not clear and concise.

A verification study of 28 medical and 28 pharmacy prior authorization cases revealed deficiencies in 5 medical and 16 pharmacy NOA letters:

Letters contained excessive and technical information.

- One example is, "The SFHP "OFF-LABEL USES" prior authorization criteria requires that you try the following preferred medicines before TACROLIMUS 0.1% OINTMENT can be approved: Mometasone 0.1% Cream/Ointment, Triamcinolone 0.1% Cream, Triamcinolone 0.5% Ointment, Desoximetasone 0.25% Cream, Fluocinonide 0.05% Ointment, Betamethasone Dipropionate 0.05% Ointment, Halobetasol 0.05% Cream/Ointment, Clobetasol 0.05% Cream/Ointment/Gel/Solution, and Betamethasone Dipropionate Augmented 0.05% Cream/Ointment/Lotion/Gel. Based on the clinical information submitted by your provider and your prescription history, you have not yet tried preferred medicines."

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- Another example is, “A board certified physician of Genetics reviewed the case using American College of Medical Genetics Practice Guidelines: Array based technology and recommendations for utilization in medical genetics practice for the detection of chromosomal abnormalities. Manning M. and Hudgins L Genetics in Man Vol9, No9 650-653, 2007. Manning M, Hudgins L; for the Professional Practice and Guidelines Committee. American College of Medical Genetics Practice Guidelines: Array-based technology and recommendations for utilization in medical genetics practice for detection of chromosomal abnormalities. Genet Med. 2010;12(11);742-5 This reviewer and our SFHP Medical Director both decided that your condition doesn’t meet criteria for the specific tests requested are not appropriate methods for diagnostic purposes in this case, because they are not considered the standard of care.”

Letters contained compositional errors, high-level language and unnecessary phrases that led to unclear or incorrect information. An example is, “Modafinil 100 mg Tablet for Chronic Fatigue is not approved by the FDA and has not been shown to be beneficial in the treatment of this diagnosis...” This statement may mislead the member. The statement could lead to three different interpretations:

1. FDA has not approved the medication, which is not beneficial for chronic fatigue.
2. The FDA has approved the medication, but not for chronic fatigue for which it is not beneficial.
3. The FDA has not approved a dose of 100 mg of Modafinil for chronic fatigue because it is not helpful.

In an interview, the Plan reported that reviewing RNs followed a checklist to write NOA letters; the Senior Manager of PAs finalized the letters. The Plan’s UM Nurse Supervisor reported that UM RNs received individual training to improve NOA letter writing. The Plan reported that it had improved its NOA letters after trainings and recommendations from an accrediting agency. Although documentation showed letter writing training, several examples were not written at the 6th grade level in clear, concise, consumer-friendly language and contained abbreviations or technical terms.

In an interview, the Plan reported it did not have a formal review process for pharmacy letters. The pharmacy team reported it worked with an accrediting agency consultant to achieve a more readable letter and acknowledged the letters were lengthy.



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Deficient NOA letters may lead to member misunderstandings about the Plan's adverse benefit determinations and subsequent impaired health-care decision-making.

### 1.2.4 Information about Appeal Submission Timeframe

There shall be a well-publicized appeals procedure for both providers and patients (*Contract A10, Exhibit A, Attachment 5 (2) (E)*).

The member or provider appealing on the member's behalf may request an internal Appeal with the Plan within 60 calendar days from the date on the NOA (*All Plan Letter 17 - 006*).

Plan policy *UM-01 Notice of Action Letters* stated that the Plan would send NOA letters with attached appeal rights to members and/or their authorized representatives.

The Plan gave providers incorrect and conflicting information about the UM appeal submission timeframe.

A verification study revealed that the Plan's cover faxes notifying providers of medical PA determinations stated providers had 90 days from the NOA letter to file an appeal. As of July 1, 2017, the time limit was 60 days to file an appeal about an adverse benefit determination. The Plan's website and the Network Operations Manual also contained the misinformation. A provider newsletter updated the timeframe for filing UM appeals to 60 days. The *Your Rights Under Medi-Cal Managed Care* document attached to the notices contained correct appeal filing time limits. The Plan's practice was to accept appeals requested within 60 days of the NOA letter.

In an interview, the Plan reported that it updated its website as needed. It acknowledged that it was updating a currently outdated provider manual.

Faxes containing outdated appeal information that conflicts with accompanying letter attachments containing the correct date for filing UM appeals may lead to confusion, late appeals and resultant denied member health services.

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### 1.2.5 Provider Contact Information in Pharmacy NOAs

The Plan is shall comply with *Health and Safety Code, Section 1367.01 (h) (4)* which states, “any written communication to a physician or other healthcare provider of a denial, delay, or modification of a request shall include the name and telephone number of the healthcare professional responsible for the decision. The telephone number provided shall be a direct number or an extension to allow the physician or healthcare provider to easily contact the professional responsible for the denial” (*Contract, Exhibit A, Attachment 13 (8) (A)*).

The Plan’s written communications to providers about adverse benefit determinations shall include the name of the decision-maker and their direct phone number, or a method of easily contacting them (*All Plan Letter 17-006*).

The Plan’s pharmacy letters did not consistently list the decision maker’s phone number. The contact information listed on the letters did not allow easy connection with the decision-maker.

A verification study showed that in 10 of 28 pharmacy PA denials, the Plan did not provide a direct phone number or a method of easily contacting the decision maker. Callers were directed through the following steps:

- Call the main Plan number.
- Enter the provided extension.
- Select option three; (selection led to a general Pharmacy Department voicemail after a live representative did not respond to the call).

Further investigation revealed additional information:

- Calling the main phone number revealed that the caller could access the Plan’s directory, enter part of the pharmacist’s name, and connect to their direct line.
- Calling the Plan’s main number, entering the pharmacy’s extension and selecting option one (“If you are a physician, select option one.”) connected the caller to the Pharmacy Benefit Manager (PBM). The representative would record the information about the denial in question and forward the caller to the correct pharmacist.

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Inconsistently providing an easy way to contact Plan pharmacists about denied medication requests may delay the communication of information needed for the delivery of pharmaceutical services.

### 1.2.6 Pharmacy Deferrals

The Plan shall notify members and providers when it delays a service request beyond 14 days for more information needed to make a PA decision (*Contract A10, Exhibit A, Attachment 5 (3) (G)*).

The Plan shall use DHCS' approved NOA letter with accompanying member rights (*All Plan Letter 17-006*).

Plan Policy *Pharm-02 Pharmacy Prior Authorization* stated that the Plan would call or send providers a fax requesting additional information needed to resolve a medication PA request.

The Plan did not notify members of deferred requests for medications or of their appeal and grievance rights.

A verification study showed that in 3 of 28 pharmacy cases, the Pharmacy Department requested more information to resolve pharmacy PAs. While the Plan sent providers requests for missing information, in 2 of 3 pharmacy cases, it deferred the final decision beyond 14 days without notifying members.

Plan policy *Pharm-02* did not describe the DHCS' approved NOA letter or specify time limits for deferral notification.

Notifying members and providers appropriately of delays in approving PAs avoids delays and confusion about requested and needed services.

### 1.2.7 Pre-Authorizations and Review Procedures

The Plan shall consistently apply its written criteria or guidelines for utilization review (*Contract A10, Exhibit A, Attachment 5 (2) (C)*).

Plan policy *UM-57 UM Clinical Criteria* stated the Plan used annually updated Medi-Cal, Plan-developed, InterQual and Hayes criteria and that it would consider the member's individual situation in prior authorization cases.

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Plan policy *Pharm-02 Pharmacy Prior Authorization* stated clinical pharmacists reviewed PA requests using Pharmacy and Therapeutics (P&T) committee approved criteria and consulted medical directors in complicated cases.

The Plan did not follow processes outlined in its prior authorization policies and criteria.

A verification study of 28 pharmacy and 28 medical service PA denials revealed deficiencies in the Plan's PA process:

- In a pharmacy denial resulting in an appeal, the Plan used criteria dated April 2016 to deny medication for a hospitalized member on October 27, 2017. It stated that its criteria did not allow the medicine for his condition and that an external reviewer found that the medication had not been studied or shown to be safe and effective for the problem. Expert opinion at the time (published August 2015) revealed that the medication could be used for this member if he was deemed inoperable by experts. The Plan did not follow current medical recommendations, and used outdated criteria.
- The Plan denied requests that met its own criteria in one pharmacy case. A provider documented a new Plan member's cow milk allergy and difficulty gaining weight in a request for a nutritional product. Criteria stated that the Plan would approve continuation of therapy with the item for a new member upon documentation of medical necessity.
- The Plan denied treatment after applying incorrect criteria in one medical and three pharmacy cases.
- The Plan denied requests for medications when providers asked for medications over the allowable amount without consulting the providers about the patient's condition.

The Plan reported that pharmacists consulted Plan medical directors on an informal basis regarding complicated pharmacy requests. None of the pharmacy PAs cited above documented a medical director review upon initial submission, including those for off-label use. The pharmacy reported that it required two peer-reviewed clinical studies supporting off label use of medications based on CMS and state regulations not cited in the Contract.

Prior Authorization processes that do not follow Plan criteria for PA, and do not follow Plan policy (i.e., consideration for unique patient circumstances, consultations with medical directors) may lead to denials of appropriate treatments and adverse member health outcomes.

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**RECOMMENDATION(S):**

- 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.
- 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 physician.
- 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.
- 1.2.4 Ensure that provider resources and written notifications contain current and consistent information about UM appeals.
- 1.2.5 Revise and implement pharmacy policies to ensure that NOA letters consistently provide an easy method to contact the decision maker.
- 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.
- 1.2.7 Consistently implement policy and criteria regarding prior authorization.

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1.4

### PRIOR AUTHORIZATION APPEAL PROCESS

**Appeal Procedures:**

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

### SUMMARY OF FINDINGS:

#### 1.4.1 Member Appeal Resolution Letters

The Plan's appeal resolution process shall follow guidelines in CCR, Title 28, Section 1300.68. The Plan's resolution letters shall contain a clear and concise explanation of the Plan's decision (*Contract A10, Exhibit A, Attachment 14 (1), CCR, Title 28, Section 1300.68 (d) (3)*).

The Plan shall utilize DHCS template packets for appeal resolutions (*All Plan Letter 17-006*).

Plan policy *QI-06 Member Grievances and Appeals* stated that the Plan wrote resolution letters in easy to understand language and did not include unexplained terminology.

The Plan's member appeal resolution letters were unclear and lengthy, and contained misstatements. The Plan did not follow the DHCS Notice of Appeal Resolution (NAR) template.

A verification study of 20 appeal cases revealed deficiencies in 12 member letters explaining the Plan's appeal resolutions:

- Letters were unnecessarily lengthy.
- Letters contained technical language (i.e., listed multiple medications, technical procedures and medical resources used to determine cases), that made them unclear.

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- Letters contained misstatements; for example, the provider wrote, “There is no evidence to support the efficacy of long acting over short acting pain medication. I have specifically chosen NOT to provide Oxycontin to simplify her regimen and reduce her overall morphine milligram equivalent use.” The Plan wrote, “There is no evidence of long acting over short acting pain medications. (Your doctor) explained that she has not specifically prescribed Oxycontin to simplify your medication regime and reduce your overall morphine dose.” The Plan did not accurately convey the provider’s statement in this resolution letter.

The Plan’s grievance and appeal policy included templates of the NAR letters required by DHCS as of July 1, 2017. When interviewed about why its letters did not follow the templates but were longer and therefore not concise, the Plan reported that it instead followed an accrediting agency’s appeal letter guidelines.

Lengthy appeal resolution letters with complicated language and misstatements may result in confusion about a health plan’s decisions and the reasons why they were made; members may then make poor health plan decisions based on misinformation or misunderstanding.

### **RECOMMENDATION(S):**

- 1.4.1** Develop and implement policies to ensure that the Plan provides clear and concise appeal resolution letters using the DHCS NAR template.

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**CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE**

**2.4**

**INITIAL HEALTH ASSESSMENT**

**Provision of Initial Health Assessment:**

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.  
2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21

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

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

2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

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



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2-Plan Contract A.10.6 Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

2-Plan Contract A.10.3.D

**SUMMARY OF FINDING(S):**

**2.4.1 Required Components of the Initial Health Assessment**

The Plan must cover and ensure the provision of an Initial Health Assessment (IHA) to each new member within timelines stipulated in the Contract. An IHA consists of a comprehensive history and physical examination, preventive services, and the Individual Health Education Behavioral Assessment (IHEBA) (*Contract A10, Exhibit A, Attachment 10 (3) (6) and MMCD Policy Letter 08-003*).

An IHEBA enables a provider of primary care services to comprehensively assess the member's current acute, chronic and preventive health needs. The Plan is required to follow the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) to provide preventive services to asymptomatic, healthy adult members. All preventive services identified as USPSTF "A" and "B" recommendations must be provided and the status must be documented. The Plan must have written procedures requiring providers to include and document all components of the IHA (*Contract A10, Exhibit A, Attachment 10 (6) (B) (1), and MMCD Policy Letter 08-003*).

The Plan's policies, *HE-01 Staying Healthy Assessment/ Individual Health Education and Behavioral Assessment* and *HE-03 Preventive Health Care Guidelines*, required providers to conduct an IHEBA and to provide preventive services according to USPSTF "A" and "B" recommendations.

The Plan did not ensure that all providers documented two of the required components of an IHA: IHEBA and USPSTF "A" & "B" recommended services.

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The Plan's 2017 annual IHA rate measurement showed that the completion rate was 26.2% for 2017, which met the Plan's established goal of 25%. Although the Plan monitored for IHA completion by completing the IHA measurement and medical record reviews during facility site reviews, it did not identify and incorporate any improvements to include in its work plan, and did not monitor for compliance with required IHA components such as IHEBA or preventive services requirements.

A verification study on five sampled members' medical records showed that documentation did not contain the required components of the IHA related to the specific members' health care needs. None of the five medical records had evidence that an IHEBA was conducted. Preventive services identified as USPSTF "A" and "B" recommendations were missing screenings for colorectal cancer in two records, hepatitis C in two records, HIV in three records, and lung cancer in four records. The status of these recommended services was not documented. For example, the four records for lung cancer screening had the following deficiencies:

- In one record, the member's smoking history was not documented.
- In two records, the provider documented the number of cigarettes the member smoked per day but there was no information on when the member started smoking. This information is required to determine whether the member meets the screening criteria of 30 pack-year history.
- In one record, the provider documented that the member smokes on a daily basis but did not specify the quantity used and the length of the member's smoking history.

The Plan requires that IHAs include an identification of risks, an assessment of need for preventive screens, and a member's comprehensive history. The medical record verification study focused on high priority preventive services and validated each of the reviewed patients was a candidate for screening and the member had not declined.

The Plan's post-exit response did not address the lack of documentation in the records, and did not provide supporting medical justification for not providing the recommended screenings for patients that met the screening criteria.

When the Plan does not ensure providers conduct all components of the IHA, members may not receive important behavioral and medical health screenings that can help identify and prevent illnesses.

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**RECOMMENDATION(S):**

**2.4.1** Implement policies and procedures to ensure documentation of all components of an IHA.

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**CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE**

**3.1**

**APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES**

**Appointment Procedures:**

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children’s preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

2-Plan Contract A.9.3.A

Members must be offered appointments within the following timeframes:

- 3) Non-urgent primary care appointments – within ten (10) business days of request;
- 4) Appointment with a specialist – within 15 business days of request;

2-Plan Contract A.9.4.B

**Prenatal Care:**

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

2-Plan Contract A.9.3.B

**Monitoring of Waiting Times:**

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers’ offices, telephone calls (to answer and return), and time to obtain various types of appointments...

2-Plan Contract A.9.3.C

**SUMMARY OF FINDING(S):**

**3.1.1 Monitoring of Return Calls**

The Plan is required to develop, implement, and maintain a procedure to monitor telephone call answer and return times (*Contract A10, Exhibit A, Attachment 9 (3) (C)*).

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The Plan did not monitor whether providers returned members' telephone calls in its 2017 Daytime Survey (previously called the Time to Answer Survey). The Plan's survey tracked the wait time on the line before a call was picked-up but not whether a telephone call was returned. The Plan did not have a procedure to monitor the time to return members' non-urgent telephone calls.

DHCS' prior audit found that the Plan did not monitor waiting times for providers to return members' calls in the 2015 and 2016 Time to Answer Surveys. As part of the corrective action to address the prior audit finding, the Plan intends to add a question to the survey to capture the length of time it takes to return non-urgent calls. However, the Plan did not include this measurement in its 2017 Daytime Survey because they wanted feedback from their medical groups to determine an appropriate timeframe. Once established, the Plan intends to communicate the expected timeframe to providers before measuring it in the next Daytime survey that will begin in October 2018.

Monitoring providers' return of member calls provides the Plan with information regarding possible barriers for members' access to care. The Plan's lack of monitoring of this component may lead to missed opportunities for improvement in members' access to care. **This is a repeat finding.**

### 3.1.2 Provider Directory Accuracy and Completeness

The Plan is required to distribute a provider directory that includes the following information: name, provider number, and telephone number of each Service Location. In the case of a medical group/foundation or independent practice association, the medical group name, provider number and telephone number shall appear for each physician provider (*Contract A10, Exhibit A, Attachment 13 (D) (4)*).

The Plan is required to provide, upon request, a list of contracting providers and update this information at least quarterly. The Plan is required to ensure the accuracy of the provider directory information by updating the online directory at least weekly or more frequently and when informed of and upon confirmation by the Plan of any information that affects the content or accuracy of the provider directory. Health plans shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the Plan's provider directory in accordance with this section, and shall, at least annually, review and update the entire provider directory for each product offered (*Health & Safety Code, Section 1367.26 and Section 1367.27*).

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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:

- (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.

The Plan did not maintain an accurate and complete provider directory. During the Plan's 2017 access surveys, the Plan identified 419 providers with inaccurate information in the provider directory. DHCS selected and called a sample of 12 providers with inaccurate information from the Plan's 2017 access survey for review. 10 of 12 providers called still had incorrect information on the online directory. The Plan did not take appropriate steps to ensure the accuracy of the information and did not document its investigation or changes as described in their policy.

In addition, DHCS conducted an appointment availability verification study that included the participation of 9 Primary Care Providers, 10 specialists, and 8 OBGYNs. This study measured the Plan's average member wait times to obtain an appointment and verified the accuracy of the Plan's provider directory information. The following deficiencies related to the Plan's provider directory information were identified:

- 3 of 10 specialists had incorrect phone numbers listed and 2 of 8 OBGYNs did not have a phone number listed.
- 2 of 10 specialists and 1 of 8 OBGYN were not part of the clinic they were listed under.
- 1 of 8 OBGYNs had his specialty incorrectly identified.

Inaccurate and incomplete information on the provider directory may increase barriers for members' access to care.

### **RECOMMENDATION(S):**

- 3.1.1** Develop and implement policies and procedures to monitor return calls by providers.

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**3.1.2** Develop and implement policies and procedures to update provider directory to reflect accurate and complete information.

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**CATEGORY 4 – MEMBER’S RIGHTS**

**4.1**

**GRIEVANCE SYSTEM**

**Member Grievance System and Oversight:**

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).  
2-Plan Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member’s grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858....(as required by Contract)  
2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).  
2-Plan Contract A.14.3.A

**SUMMARY OF FINDING(S):**

**4.1.1 Capturing Grievances**

Each Plan in a designated region shall establish and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints. The Plan shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall be maintained as set forth in Title 22. A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. A complaint is the same as a Grievance (*Contract A10, Exhibit A, Attachment 14 (3) (A), CCR, Title 22, Section 53858 and All Plan Letter 17-006*).



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A beneficiary need not use the term “Grievance” for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a beneficiary expressly declines to file a Grievance, the complaint shall still be categorized as a Grievance and not an inquiry. While the MCP may protect the identity of the beneficiary, the complaint shall still be aggregated for tracking and trending purposes as with other Grievances (*All Plan Letter 17-006*).

The Plan’s policy *QI-06 Member Grievances and Appeals* stated the member has the right to file a grievance directly to their Medical Group.

The Plan did not capture all grievances that members communicated to providers or delegated groups. The Plan allowed providers to resolve grievances reported to them, but did not require reporting of these grievances back to the Plan.

During interviews with staff, the Plan stated that it did not delegate the grievance process to its providers or delegates. It further clarified, “If a member encounters an issue with the provider’s office and decides to inform and work with the provider’s office to address the member’s concerns without filing a grievance with SFHP, then SFHP’s position is that this is part of the relationship between the member and their provider... Members may not wish SFHP to be aware of their concerns, or feel it necessary to involve SFHP, and SFHP must therefore respect the member’s privacy and autonomy in these situations.”

Not capturing and reviewing all expressions of dissatisfaction could result in overlooked and unresolved grievances and potential quality issues.

### 4.1.2 Clinical Grievance Determinations

The Plan shall ensure that the person making the final decision for the proposed resolution of a grievance shall be a health care professional with clinical expertise in treating a beneficiary’s condition or disease for any grievance involving clinical issues. Grievances related to medical quality of care issues shall be referred to the Plan’s medical director (*Contract A10, Exhibit A, Attachment 14 (2) (E) and (G) (3)*).

Plan policy *QI-06 Member Grievances and Appeals* stated that a health care professional with clinical expertise in treating a beneficiary’s condition or disease was the decision maker in the case of any clinical grievance. The policy described the grievance process stating, after investigation, “The investigation responses will be presented to the grievance review committee (GRC) to ensure that the grievance is fully investigated. The participants of the GRC will be recorded in SFHP’s Care Management System with at least one SFHP Medical Director present.”

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The Plan did not document the medical director/CMO's final determination in clinical grievances and therefore could not ensure that the medical director/CMO made the final decision for the clinical grievance resolutions.

A verification study of 13 quality of care grievances showed the Plan's process for completing clinical grievances.

- All cases contained a dated and marked checkbox labeled "Medical Director's Review Completed," which did not name the physician and did not have accompanying notes.
- In all cases, notes indicated the GRC determined the outcome of cases. Notations did not indicate the physician's final decision.
- In all cases, grievance staff documented the "Final Determination Language," which comprised the body of the grievance resolution letter. The CMO signed all grievance resolution letters.
- A medical director reviewed four cases for expedited status but did not participate in a final decision about the case.
- The Plan provided emails for three cases documenting specific medical director concerns about the cases but not resolutions.

The Plan's clinical grievance process denoted that the CMO/GRC reviewed investigated grievances.

In an interview, the Plan reported there were no notes for GRC meetings. The final determination language captured the minutes' discussion and decisions about grievances. The Plan reported that GRC members including the medical director/CMO reviewed grievance case investigations prior to GRC case discussions. The Plan asserted that the GRC physicians played key roles in determining the grievance outcomes. Plan GRC staff asserted that clinical grievances were closed only with the assent of the medical director/CMO. The Plan did not provide an explanation for the lack of documentation of the Medical Director's final determination in clinical grievances.

Without a clear statement from the medical director/CMO involved in the determination of a clinical grievance, the Plan cannot demonstrate compliance with physician determination requirements.

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**RECOMMENDATION(S):**

**4.1.1** Develop and implement policy and procedures to capture all grievances.

**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.

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**4.3**

**CONFIDENTIALITY RIGHTS**

**Members' Right to Confidentiality**

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

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

2-Plan Contract A.13.1.B

**Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:**

Business Associate agrees:

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

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

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

1. **Notice to DHCS.** (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided

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to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

2. **Investigation and Investigation Report.** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
3. **Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

2-Plan Contract G.III.J

### **SUMMARY OF FINDING(S):**

#### **4.3.1 Breach Notification Procedures**

The Plan is required to notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of Protected Health Information (PHI) in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person (*Contract A10, Exhibit G, (3) (H) (1)*).

Plan policy *CRA-06 PHI Breach Investigation and Reporting*, stated for breaches involving Medi-Cal members, the Compliance Officer calls and emails or faxes a report to the Department of Health Care Services Privacy Officer, Information Security Office and Contract Manager within 24 hours of a work day after the discovery of the breach.

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The Plan did not properly report the discovery of a breach of PHI to DHCS. When a Plan staff member reported a breach involving a stolen backpack containing members' PHI, the Compliance Officer called the Information Security Office but did not email or fax the report to the DHCS Privacy Officer, Information Security Officer or Contract Manager immediately. Although the Plan policy is consistent with the contract requirements, Plan staff did not follow the process outlined in the policy.

If the Plan does not report potential breaches timely, member confidential information may be jeopardized.

### 4.3.2 Initial Notification of Suspected Security Incidents

The Plan is required to notify DHCS within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI, or potential loss of confidential data (*Contract A10, Exhibit G (3) (H) (1)*).

The Contract defines a subcontract as a written agreement entered into by the Contractor with any of the following... Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHCS under the terms of this contract (*Contract A10, Exhibit E, Attachment 1, 117*).

Plan policy *CRA-06 PHI Breach Investigation and Reporting*, stated the Compliance Officer calls and e-mails or faxes a report to the Department of Health Care Services Privacy Officer, Information Security Office and Contract Manager within 24 hours of a work day after discovery of the breach.

The Plan did not report all suspected security incidents to DHCS within 24 hours of discovery. A verification study showed the following deficiencies in two of five cases:

In one incident, a member received two Notice of Action letters that included PHI for another Plan member. The member contacted the Plan to notify it about the incident and returned the letters. Since the member returned the letters, the Plan determined this incident did not need to be reported.

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In another incident, an entity identified a security incident and notified DHCS directly. The Plan did not have any records of the entity's submission to DHCS. The Plan was still responsible for reporting the security incident to DHCS and taking the appropriate follow up actions. The Plan relied on the entity to notify DHCS and take appropriate action to mitigate the risk of unauthorized use of PHI.

The Plan's policy CRA-06 did not address reporting requirement for suspected security incidents.

By ensuring that the Plan consistently reports all suspected security incidents, the Plan will meet both its contractual and regulatory requirements in safeguarding the privacy of members' protected health information.

**RECOMMENDATION(S):**

- 4.3.1** Implement Plan policy and notify DHCS immediately upon discovery of a breach by telephone call plus email or fax.
- 4.3.2** Revise policy to include requirements for suspected security incidents reporting and report all suspected security incidents to DHCS within 24 hours.

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**CATEGORY 5 – QUALITY MANAGEMENT**

5.1

**QUALITY IMPROVEMENT SYSTEM**

**General Requirements:**

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

2-Plan Contract A.4.1

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

2-Plan Contract A.4.7.A-I

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

2-Plan Contract A.4.2

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

2-Plan Contract A.4.3.A-D

**Provider Participation:** Contractor shall ensure that contracting physicians and other providers from the community shall be involved as an integral part of the QIS.

Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.

2-Plan Contract A.4.5



## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** San Francisco Health Authority dba San Francisco Health Plan

**AUDIT PERIOD:** March 1, 2017 through February 28, 2018

**DATE OF AUDIT:** March 5, 2018 through March 16, 2018

### SUMMARY OF FINDING(S):

#### 5.1.1 Potential Quality Issues (PQIs)

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting (*Contract A10, Exhibit A, Attachment 4 (1)*).

Plan policy *UM-56 Potential Quality Issues (PQIs)* described the Plan's PQI process as addressing providers' clinical decisions and behavior that may present potential or actual harm to members. Quality of care issues might result from an individual provider's actions or from facility practices and procedures. The Plan listed criteria that might lead to PQI investigations:

- Failure to follow standard of care or follow up on treatment plan
- Complications due to delay/denial of service by a provider
- Delay in ordering tests
- Inadequate referral of a suicidal patient
- Lack of coordination of care
- Staff rudeness
- Allegations of sexual misconduct or discrimination

The Plan reviewed quality of care grievances, but did not identify PQIs that met its listed criteria, and did not conduct investigations outside of the grievance process to resolve potential quality issues. The Plan did not demonstrate taking effective actions to address needed improvements in quality of care.

A verification study revealed 4 of 14 quality of care grievances met the Plan's criteria for a PQI but were not identified as PQIs and did not receive PQI investigations:

- One case involved a member's allegation of unwanted transportation to an emergency room (ER) and subsequent sexual assault in the ER. The Plan investigated and closed the grievance, deferring further enquiry to the hospital and law enforcement. Lack of follow up by the Plan left questions about the hospital's policies and processes in hiring and in resolving alleged assault cases.
- A needed chemical was unavailable for two separate surgical appointments, resulting in eye surgery postponements for a member with a complicated history and ongoing eye pain. Additional investigation may have resulted in improved supply processes leading to avoidance of prolonged symptomatic conditions due to delayed treatment.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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- An agitated, though non-threatening, member's removal by security resulted in non-treatment of the member's problems and his subsequent suicidal thoughts. Further investigation may have revealed alternate ways of handling such cases and ensuring delivery of care to challenging members at this brain trauma center.
- When a member complained about receiving less than the amount of requested therapy visits and about delayed behavioral health services, the Plan did not process the complaint as both an appeal of an adverse benefit determination and a grievance. The member had checked both the appeal and grievance boxes on the written complaint form. Further review after grievance resolution might have led to improved identification of appeals embedded in grievances, and improved quality of care through delivery of medically necessary services.

Although quality of care grievances met Plan Policy criteria that might lead to a PQI investigation, the Plan asserted that it appropriately investigated potential quality issues within the grievance resolution process. The Plan did not provide an explanation for not identifying PQIs to investigate and resolve.

Not identifying potential quality issues arising from either direct provider treatment or provider/facility practices may result in missed opportunities to prevent member harm.

### 5.1.2 UM Organizational Chart

The Plan shall implement and maintain a written description of its QIS that shall include an organizational chart showing the key staff and committees and bodies responsible for Quality Improvement (QI) activities including reporting relationships of QIS committees (*Contract A10, Exhibit A10, Attachment 4 (7) (B)*).

The Plan did not include the UM Committee (UMC) on its quality organizational chart.

The 2017 QI Program Description named the UM Committee as a QI committee with internal members only. The UMC reported to the QIC and the Plan utilized UM data in its quality projects, but it did not formally encode this key reporting relationship in organizational charts.

Including the UMC in the Plan's QIS organizational chart ensures appropriate UM oversight and communication of UM information to the required entity.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

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**RECOMMENDATION(S):**

- 5.1.1 Implement policy and establish mechanisms to communicate and monitor processes for identifying and resolving PQI cases.
- 5.1.2 Include the UMC in the QIS organization chart and demonstrate its reporting relationship to the QIC.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

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**5.2**

**PROVIDER QUALIFICATIONS**

**Credentialing and Re-credentialing:**

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

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

2-Plan Contract A.4.12

**Standards:**

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

2-Plan Contract A.4.12.A

**Medi-Cal Managed Care Provider Training:**

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

2-Plan Contract A.7.5

**Delegated Credentialing:**

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

2-Plan Contract A.4.12.B

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** San Francisco Health Authority dba San Francisco Health Plan

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### **Disciplinary Actions:**

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.  
2-Plan Contract A.4.12.D

## **SUMMARY OF FINDING(S):**

### **5.2.1 New Provider Training Requirements**

The Plan is required to conduct training for all new providers (physician & non-physician) within 10 working days after the Plan places a newly contracted provider on active status (*Contract A10, Exhibit A, Attachment 7 (5) (A)*).

The Plan is accountable for all quality improvement functions and responsibilities (e.g. Provider Training) that are delegated to subcontractors. If Plan delegates quality improvement functions, Plan and delegated entity (subcontractor) shall include in their Subcontract...maintain a system to ensure subcontractor meets standards set forth by the contract (*Contract A10, Exhibit A, Attachment 4, (6)(A)*).

Plan policy *PR-03 New Provider Training* stated that credentialed providers are required to have new provider training (signed Attestation of Provider Training) within 10 business days of their SFHP start date. Providers contracted with medical groups who do not service Medi-Cal members at the time of the Initial credentialing process, and who later become Medi-Cal providers, are required to sign the Summary of Key Information attestation within 10 business days after the date they became active Medi-Cal providers.

The Plan did not ensure that delegated entities conducted provider training within 10 working days. The Plan delegated provider training to 10 delegated entities. The Plan audited the quality and content of medical group trainings in the annual audit process. The Plan required delegated entities to have proof of new provider training through a signed attestation.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

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The verification study of 12 provider training samples found the following deficiencies:

- Three new providers did not have a signed attestation form to confirm completion of provider training.
- Two new providers received training after the 10 working days after obtaining active status with the Plan.
- Two new providers received provider training 18 months before they became active Medi-Cal providers instead of receiving training 10 working days after they became active Medi-Cal providers. The two new providers did not have a signed summary of key information attestation on file as required by the Plan's policy.

The Plan was not aware of the deficiencies until this audit.

Without new provider training, the Plan cannot ensure providers operate in full compliance with the Contract and all applicable Federal, State, and local regulations to meet program requirements.

**RECOMMENDATION(S):**

- 5.2.1** Implement policies and procedures to ensure providers receive new provider training within 10 working days after being placed on active status.

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

REPORT ON THE MEDICAL AUDIT OF

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

Contract Number: 03-75800  
State Supported Services

Audit Period: March 1, 2017  
Through  
February 28, 2018

Report Issued: September 21, 2018

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## **I. INTRODUCTION**

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

The on-site review was conducted from March 5, 2018 through March 16, 2018. The audit period is March 1, 2017 through February 28, 2018 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

❖ **COMPLIANCE AUDIT FINDINGS (CAF)** ❖

**PLAN:** San Francisco Health Authority dba San Francisco Health Plan

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**STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS**

**Abortion**

Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:

Current Procedural Coding System Codes\*: 59840 through 59857

HCFA Common Procedure Coding System Codes\*: X1516, X1518, X7724, X7726, Z0336

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

State Supported Services Contract Exhibit A.1

**SUMMARY OF FINDING(S):**

**SSS.1 Minor Consent Requirements**

A minor may consent to an abortion at any age without parental consent (*American Academy of Pediatrics v. Lungren, 16 Cal.4th 307 (1997)*).

The Plan's Network Operations Manual inaccurately stated that minors age 12 or older may consent to abortion services without parental consent. As a result of *American Academy of Pediatrics v. Lungren*, minors of any age may consent to abortion services without parental consent.

Providers with incorrect information may result in a barrier accessing abortion services.

**RECOMMENDATION(S):**

**SSS.1** Ensure all informing materials clearly state that minors of any age may consent to obtain abortion services without parental consent.