CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

February 27, 2025

Nina Maruyama, *Via E-mail*
Chief Officer, Compliance and 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 April 15, 2024 through April 26, 2024. The audit covered the period from March 1, 2023, through March 31, 2024.

The items were evaluated, and DHCS accepted the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

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

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]
Lyubov Poonka, Chief
Audit Monitoring Unit
Process Compliance Section
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Enclosures: Attachment A (CAP Response Form)

cc: Bambi Cisneros, Interim Chief *Via E-mail*
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Grace McGeough, Section Chief *Via E-mail*
Process Compliance Section
Managed Care Monitoring Branch
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Joshua Hunter, Lead Analyst *Via E-mail*
Audit Monitoring Unit
Process Compliance Section
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Jessica Delgado, Unit Chief *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

Kimberly Lamountry, Contract Manager *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

ATTACHMENT A

Corrective Action Plan Response Form

Plan: San Francisco Health Plan

Review Period: 3/1/23 – 3/31/24

Audit: DHCS Medical Audit

On-site Review: 4/15/24 – 4/26/24

MCPs are required to provide a Corrective Action Plan (CAP) and respond to all documented deficiencies included in the medical audit report within 30 calendar days unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in Word format, which will reduce the turnaround time for DHCS to complete its review. According to ADA requirements, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, as well as the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. Finding Number and Summary, 2. Action Taken, 3. Supporting Documentation, and 4. Completion/Expected Completion Date. The MCP must include a project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. If supporting documentation is missing, the MCP submission will not be accepted. For policies and other documentation that have been revised, please highlight the new relevant text and include additional details, such as the title of the document, page number, revision date, etc., in the column "Supporting Documentation" to assist DHCS in identifying any updates that were made by the plan. Implementing deficiencies requiring short-term corrective action should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to remedy or operationalize completely, the MCP is to indicate that it has initiated remedial action and is on the way toward achieving an acceptable level of compliance. In those instances, the MCP must include the date when full compliance will be completed in addition to the above steps. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable, according to existing requirements.

Please note that DHCS expects the plan to take swift action to implement improvement interventions as proposed in the CAP; therefore, DHCS encourages all remediation efforts to be in place no later than month 6 of the CAP unless DHCS grants prior approval for an extended implementation effort.

DHCS will communicate closely with the MCP throughout the CAP process and provide technical assistance to confirm that the MCP offers sufficient documentation to correct deficiencies. Depending on the number and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates.

1. Utilization Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
1.3.1 Members' Written Consent for Appeals Filed by Provider The Plan did not ensure that members' written consent was received when providers filed appeals on the members' behalf.	During the audit review period, SFHP was unable to implement the new process for obtaining written member consent for appeals filed by a provider on behalf of a member because SFHP policy and procedure GA-03 (formally QI-17) was pending approval from DMHC and DHCS. Please see below for more details. SFHP policy and procedure GA-03 was revised on 1/9/2023 to ensure that members' written consent was received prior to closing cases when providers filed appeals on behalf of members. SFHP received approval from DHCS on this policy and procedure and consent form on 1/23/2023. However, SFHP was unable to implement due to pending approval from DMHC. DMHC approved the policy and procedure and consent form on 01/29/2024. The policy and procedure was then sent	1) SFHP policy and procedure GA-03 5) 4/9/2024 G&A, CS, and QRN Meeting Minutes 6) Translated consent forms 7) Member Consent Process Desktop Procedure 8) Screenshot of consent forms on the SFHP website 9) September Provider Newsletter 10a) CRA Appeal Internal Audit Tool	Completed-Implemented 4/17/2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Policy GA-03 Grievances and Appeals was updated (11/01/24 CAP monthly submission) to require written consent to be obtained prior to resolving provider-initiated appeals. If MCP staff does not receive written consent from the member, staff will ask the member if they would wish to file their own verbal appeal and will process it accordingly. (1.3.1_12_20241011_SFHP_GA-03 Member Appeals_clean_GC) » The MCP's CAP update 11/01/24 confirmed revisions to Member Consent for Grievance and Appeals Desktop Procedure. The DTP was updated to require written consent to be obtained prior to resolving provider-initiated appeals. If MCP staff does not receive written consent from the member, staff will ask the member if they would wish to file their own verbal appeal and will process it accordingly. (1.3.1_11_DTP_Member_Consent_Process_10.28.24) **MONITORING AND OVERSIGHT** » "Clinical Grievance Audit Checklist", 2024 Grievance Tool and Q2 Written consent Universe demonstrates the MCP has a process in place to monitor whether member written consent was obtained.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	back to DHCS for their review and approval. DHCS approved the policy and procedure in the third week of March 2024. It was then presented to SFHP's Policy Compliance Committee (PCC) on 03/28/2024, and PCC approved it. The Grievances and Appeals and Customer Service teams were trained on the process on 04/09/2024. The consent forms were sent to SFHP's Marketing team for translation to SFHP's threshold languages, and these were completed on 04/17/2024. SFHP's Grievances and Appeals team also created a Desktop Procedure that details the steps for this process. The consent forms were also uploaded to the grievance page of the SFHP website, and a reminder was added to the September 2024 Provider Newsletter.	10b) Focused Audit- Written consent for appeals.		(1.3.1_10a._2024_Grievance_Tool, 1.3.1_10b._WrittenConsent Universe Q2 2024) » The Plan committed to publish the updated procedure in the 01/02/25 Provider Newsletter. (January Monthly Deliverable) **The corrective action plan for finding 1.3.1 is accepted.**
1.5.1 Delegated Utilization	1. There is a process in place to audit files quarterly. Unfortunately, at the time of the transition from CCHCA to	1. Current SFHP DMG UM	Completed	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
Management Activities The Plan did not ensure its delegate, All American Medical Group (AAMG), met the contractual requirement of health care service decisions being made within 14 calendar days.	AAMG, many CCHCA staff were let go, and the AAMG staff reported that they could not access records from before the transition. The issue was escalated to SFHP's Compliance and Provider Network Operations teams. Ultimately, these missed turnaround times (TATs) weren't caught by SFHP in real time due to the delay in providing the files. 2. Once the access issue was resolved, SFHP conducted quarterly audits per policy (see Document 1) and identified missed turnaround times for authorization decision. 3. A root cause analysis was conducted on quarterly audit summaries and it was determined that staff shortages and lack of training contributed to the missed turnaround times. AAMG provided SFHP proof of staff training and stated that their staffing issues had been resolved (see Documents 2 and 3).	Quarterly Audit DTP 2. Q3 2023 proof of staff training 3. Q4 2023 proof of staff training 4. Q3 2023 Audit finding summary and response 5. Q4 2023 Audit finding summary and response 6. Q1 2024 audit, file audit tab (Score of 100%, no summary with CAP created)		» Plan developed a DLP (1/1/24) – DMG Quarterly UM Audit which outlines the audit process. Plan will review the UM Activity Report – select approved and denied file for review. Medical necessity authorizations will be prioritized. File review results are shared with the Medical Director and any components that do not meet requirements will be listed in a CAP. Quarterly audit findings are shared with oversight and UM committees. **TRAINING** » Plan conducted a root cause analysis and determined staff shortages and lack of training contributed to missed turnaround time. The Plan transitioned delegates from CCHCA to AAMG. AAMG provided evidence of staff training and reported staffing issues had been resolved (see documents 2 and 3). UM training (1/23/24) involved discussion of oversight monitoring, audit findings, TAT, member and provider notification, and member language preference. **MONITORING AND OVERSIGHT** » Plan completed quarterly UM file reviews Q3 and Q4, including TAT for urgent requests, and member language preference. Training provided to address non-compliance; TAT, notification requirements, and language preference (see document 4 which includes a sample Chinese approval letter). Q1 audit demonstrated delegate fully compliant with TAT for NCQA and DHCS standards. **The corrective action plan for finding 1.5.1 is accepted.**

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	4. Correction has been demonstrated in UM files since this finding in the following ways: a) AAMG was the delegated medical group audited by our most NCQA survey and their files passed, including turnaround times. (Document 4) b) Improvements in AAMG's Quarterly Audits—audits showed correction, staffing tracking, and their most recent audit, which scored 100%. (See Documents 5, 6, and 7) 5. AAMG will continue to be subject to quarterly UM audits to ensure continued compliance. CAP Remediation Status: Completed			

2. Case Management and Coordination of Care

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
2.1.1 Requirement of Initial Health Appointment The Plan did not ensure new members completed their IHA within the contractual requirement of 120 days. The Plan did not make and document reasonable attempts to contact new members and schedule an IHA.	1. Updated the IHA policy- draft attached 2. Developing new outreach letter for members with no IHA on record 60 days after enrollment. Letter will remind them to schedule the appointment, how to contact SFHP with questions, and the importance of the IHA 3. In response to previous CAPs, SFHP has developed several communications for both members and providers to ensure that both are adequately educated on the importance of the IHA as well as when it should be completed. We have included those materials as well so that DHCS may see the entire package of IHA messaging that SFHP has committed to. Additionally, SFHP continues to convene the internal IHA workgroup on regular basis	1. PP_PHM_(PHM-02)_IHA_2024 3A. IHA_Banner 3B. IHA_PopUp 3C. IHA_SocialPost1 3D. IHA_SocialPost2 3E. IHA_SocialPost3 3F. IHA_SocialPost4 3G. IHA_SocialPost5 3H. IHA_MemberIncentive 3I. IHA_TipSheet 3J. ACC_IHA_2023; Presented 2023 IHA completion rates to Access Compliance Committee 3K. 2. 6.10.24_IHA_Workgroup_Agenda 3L. 7.8.24_IHA_Workgroup_Agenda 3M. 8.20.24_IHA_Workgroup_Agenda	1. **Short-term**- Updated policy PHM-02 8/28/24. Will go before Policy and Compliance Committee on 9/26/24 for approval. 2. **Short-term**- Letter on track to be developed by 10/1/24 for DHCS review/approval. 3. **Completed**- Provided for historical context on this CAP finding.	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Updated P&P, "PHM-02: Initial Health Appointment (IHA)" (10/24/24) which states that the MCP or delegates conduct reasonable attempts to contact members that have not completed an IHA within 120 days of enrollment. Members receive written correspondence from the MCP reminding them to complete an IHA if records show there has been no IHA completed within 60 days of their enrollment. The MCP maintains a record of which members have been sent this IHA reminder. When outreach is delegated, the clinic/provider is responsible for outreach and documentation of outreach. Outreach mechanisms may include mailed reminders, text messaging, and/or phone calls. The MCP regularly audits delegates to demonstrate reasonable attempts are made to contact new members. (PP PHM (PHM-02) IHA, Page 2). » Various examples of messaging for both members and providers, including banners, pop ups, social media posts in English, Spanish, and Chinese to demonstrate that the MCP has conducted outreach to members about the importance

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	(currently monthly) to monitor compliance and address barriers			of wellness checks with their PCP, including a member incentive program. (IHA Banner, IHA Pop Up, IHA Social Post, IHA Member Incentive). » "Outreach Letter" (12/01/24) to demonstrate that the MCP has developed a new outreach letter for members with no IHA on record 60 days after enrollment. The Outreach Letter will remind members to schedule the appointment, how to contact the MCP with questions, and the importance of the IHA. (IHA Ongoing Mailing FY 24-25 Letter). **MONITORING AND OVERSIGHT** » Excel Spreadsheet, "IHA Audit Tool" (January 2025) to demonstrate that the MCP has implemented a monitoring process to track documented attempts to contact the member and schedule an IHA. The MCP will audit delegates annually to demonstrate outreach attempts are being made and documented in the member's chart. (IHA Audit Tool Jan 2025). » Excel Spreadsheet, "Monthly 60 Day IHA Letter" to demonstrate that the MCP has implemented a monitoring process to track which members are receiving the IHA outreach letter. The report will be run on the 15th of every month, and letters will be sent out each month to any new member who has been enrolled with the MCP for 60 days

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				with no IHA claim/encounter. The first round of IHA letters were mailed out on 1/27/25. (Monthly 60 Day IHA Mailer). **The corrective action plan for finding 2.1.1 is accepted.**

4. Member's Rights

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
4.2.1 Cultural and Linguistic Written Program Description The Plan's written CLS Program description did not include an up-to-date organization chart. The Plan's written Population Health Management (PHM) Program Charter, which replaced the CLS charter in 2024, did not include an organization chart.	1. The Plan's written Population Health Management (PHM) Program Charter, which replaced the CLS charter in 2024, has now included an organization chart.	1. San Francisco Health Plan 2024 Quality Improvement Health Equity Transformation Program Description & Work Plan	**Completed-** 9/2/2024	The following documentation supports the MCP's efforts to correct this finding: Org Chart, "2024 Quality Improvement Health Equity Transformation Program Description & Workplan" (Implemented 09/02/24) demonstrates the MCP has included a current organization chart to their 2024 Quality Improvement Health Equity Transformation Program Description and Workplan. **The corrective action plan for finding 4.2.1 is accepted.**

5. Quality Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
5.1.1 Evaluation of potential quality issues (PQIs) The Plan did not adequately evaluate the quality of care delivered by providers and systems in its PQI process.	Additions have been made to the QI_18 PQI policy. Although currently in draft form awaiting final approval, these changes will be implemented immediately to the PQI process.	1A. QI_18 PQI policy draft 1B. Compliance statement for 5.1.1	**Short term-** QI-18 will be finalized by October 31, 2024, after presentation at the Plan's September 26, 2024 Policy & Compliance Committee meeting	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** Revised Policy "QI-18: Potential Quality Issues" (10/24/24) » If the provider submits additional information after a case rating has been determined, QRN will review additional information and route to the Medical Director who made the initial determination. If the Medical Director makes a new determination based on the additional information provided, the rating will be adjusted in the care management system and a new resolution letter will be sent to the provider by the QRN. (5.1.1_1D_PP_CQ_(QI-18) PQI_2024.10.17, D(i), page 4) » Medical Directors will conduct an audit of a random selection of 10 cases at a frequency of every 6 months to monitor appropriateness of PQI scoring. Review will be conducted by a Medical Director other than original reviewer. In cases where Medical Directors disagree, case will be presented to PQI workgroup for discussion and final determination. Results of these reviews will be included in reporting to the Physician Advisory Council (PAC). (5.1.1_1D_PP_CQ_(QI-18) PQI_2024.10.17, page 10)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				The Plan established a CAP Process for cases rated S3/P3 that may include continuing education, training/re-training and/or certification and trend analysis. (5.1.1_1A._QI_18_PQI_DRAFT, page 6) **MONITORING AND OVERSIGHT** » Developed DTP, "PQI IRR" (10/4/24) which outlines the audit process of Inter-rater reliability review. Twice a year in December and June, a random selection of 10 cases will be selected by the QR Nurse. The cases will be blinded, and all Medical Directors and Senior Medical Director will review the cases and assign a P rating (Provider Issue) and an S rating (Systems Issue). If results show less than 85% agreement in rating, Medical Directors to meet and discuss and determine whether additional training needed. (5.1.1_1F_PQI IRR DTP 10 10 2024) » Plan completed first IRR review of 10 random cases to monitor appropriateness of PQI scoring. Three of the cases reviewed were those that had been ranked P0/S0 by a QR RN. There was 100% concurrence with the No PQI decision by the nurse. (5.1.1_PQI IRR 12 2024, 5.1.1_Physician IRR December 2024) **The corrective action plan for finding 5.1.1 is accepted.**

*Attachment A must be signed by the MCP's compliance officer and the executive officer(s) responsible for the area(s) subject to the CAP.

Submitted by: John Bhambra

Title: Director, Regulatory Affairs (SFHP)

Signed by: John Bhambra

Date: 9/3/20204