CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

May 31, 2023

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

RE: Department of Health Care Services Medical Audit

Dear Ms. Maruyama,

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of San Francisco Health Plan, a Managed Care Plan (MCP), from March 2, 2020 through March 12, 2020. The audit covered the period of March 1, 2019 through February 29, 2020.

All items have been evaluated and DHCS accepts 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]

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

Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Daniel Park, Lead Analyst
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Tia Elliott, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: San Francisco Health Plan

Review Period: 03/01/2019-02/29/2020

Audit Type: Medical Audit and State Supported Services

On-site Review: 03/02/2020-03/12/2020

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

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that require long-term corrective action or a period longer than 30 calendar days for implementation, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval in accordance with existing requirements.**

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

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.1.1 - Ownership and Control Disclosure Review The Plan must require each disclosing entity to disclose certain information, including the name, address, date of birth, and social security number of each person or other tax identification number of each corporation with an ownership or control interest in the disclosing entity. (*CFR, Title 42, section 455.104*)	For new contracts, SFHP has a process in place to obtain this form as part of the contracting process. For established contracts, including delegated groups, SFHP has reached out to all delegates to explain the importance of completing Ownership and Control Disclosure forms. The Plan has requested the form from all delegates. Three delegates, Kaiser, Brown and Toland, and Hill Physicians, have not yet submitted the form, but we will continue to follow up with them to obtain the completed form.	1.1.1 Updated Ownership and Control Documents	12/31/20	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - DTP – Screening or Subcontractors and UM Delegates This desktop procedure describes the information collection and screening process for the individuals listed in the ownership and disclosure forms submitted by sub-contractors and UM delegates, as required by DHCS APL 17-004. **Plan Attestation** - (5/16/23) Plan submitted a signed attestation indicating full compliance with APL 17-004 requirements to collect and review delegate's ownership and disclosure information. **The Corrective Action Plan for Finding 1.1.1 is accepted.**
1.2.1 Retrospective Authorization The Plan shall ensure that its prior authorization, concurrent review, and retrospective	The Plan disagrees with this finding. The Plan has prior authorization, concurrent review and retrospective review procedures that include a qualified healthcare professional with appropriate clinical expertise in treating the condition and disease to decide to deny or modify service	1.2.1 Policy CO-22 Authorization Requests.	Approx. 3 months from approval date	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - MCPs are required to communicate to providers the procedures and services that require prior authorization and ensure all contracting providers are aware of the procedures and timeframe

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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 modify a service request. A qualified physician will review all denials based on medical necessity. *(Contract Exhibit A, Attachment 5 (2) (A) and (B)).*	requests appropriately. The Plan contends that authorization requests that are received after the requested service has been performed and after the well-publicized time frame for submission are not eligible for medical necessity review. However, the Plan understands that the Plan and the Department have different interpretations of this contractual requirement and would like to resolve this finding. The Plan suggests that the difference in interpretation is related to the review that occurs to determine if a retrospective authorization that has been submitted 30 or more days after the service has been performed would be eligible for medical necessity review, as described in SFHP policy CO-22 on page 12, section E (1). If this is the focus of the finding, the plan proposes that a physician review is inserted into the process at this stage to review late retrospective authorization requests. This would allow SFHP to maintain submission guidelines while still meeting the contractual requirement.			necessary to obtain prior authorization. - The MCP has established utilization management protocols for the receipt and review of retrospective authorization review requests. The MCP performs medical necessity reviews if request is submitted with 30 calendar days of service delivery. - The contract allows the MCP to establish reasonable administrative time limits for the receipt and review of retrospective authorization review requests. While not specified in the contract, the imposition of an administrative time limit is not a contract violation. - MCPs are required to have policies and procedures that cover how the MCP authorizes, modifies, and denies services via prior authorization, concurrent authorization, or retrospective authorization. - MCP protocols involving provider disputes of claims denied for lack of prior authorization are forwarded to the MCP Claims Department for adjudication. - The contract allows the MCP to forego medical necessity reviews if the retrospective authorization review request is received after an established administrative time limit. - Written notification to members is still required if the retrospective authorization review request is not submitted timely or whether there is a medical necessity review or not. Denial of payment is considered an adverse benefit determination per federal

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	In addition, SFHP is developing a process to include a physician review at the stage described above. The adjustments to this process require configuration of the UM Authorization Tracking system. If the Department agrees with this Plan, the configuration and implementation can be completed within a 3-month timeline and interim processes can be developed in the interim.			regulations. To avert potential member confusion, notices should clarify to the member that the provider may not seek to recover payment from the member for services rendered. **The Corrective Action Plan for Finding 1.2.1 is accepted.**
2. Case Management and Coordination of Care				
2.4.1 Physician Certification Statement The Contract included NEMT as part of "Medically Necessary Covered Services for the member." (*Contract Exhibit A, Attachment 10 (2) (e)*	The Plan disagrees with this finding. The Plan publicizes and requires a Department-approved Physician Certification Statement (PCS) Form, as described in policy CO-28 and online at https://www.sfhp.org/providers/authorizations/pre-authorizations/. If PCS forms are submitted for authorization and are missing information, the Plan makes every attempt to obtain the information necessary to conduct a clinical review of the request. The current process allows for approval of transportation services when enough information is	2.4.1 CO-28 Transportation March Provider Newsletter	Approx. 1 month from approval date March 2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - The Plan Policy CO-28 Transportation Services and Authorization Requests state that the PCS would include diagnosis and function limitations, justification, dates of service needed, mode of transportation needed, and a certification statement that the attending provider used medical necessity to determine the type of transportation needed. Each field much be completed. **MONITORING & OVERSIGHT** - MCP's written response indicated the plan is putting a reminder in the March Provider newsletter around NEMT. It is up to the

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	submitted to conduct a clinical review for medical necessity. In all of the cases reviewed during this audit, SFHP contends that the Plan was in possession of enough information to approve the request to avoid delays in providing members with medically necessary transportation services. The Plan would like clarification from the Department whether the Department would prefer the Plan develop a process to only process PCS forms, which would likely delay approval for medically necessary services. If this is the intent, the Plan will provide education to the Clinical Operations staff involved in the review of Transportation requests to delay approval of Transportation services until a completed PCS form is received. The Plan believes, however that such as process would not be in the best interest of the member.			referring physician to complete a Physician Certification Statement (PCS) Form and complete every field of the form, as required to authorize the NEMT benefit, per the Department of Health Care Services (DHCS) All Plan Letter, APL 17-010. The MCP will send a copy of the newsletter once published. - Plans are required to use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Per APL 17-010 all components must be captured on the forms. **The Corrective Action Plan for Finding 2.4.1 is accepted.**
2.4.2 Medi-Cal Enrolled Transportation Vendors The Plan must ensure	The Plan has been working with the two transportation vendors that have not yet enrolled in Medi-Cal. The Plan has made multiple attempts to persuade these vendors to enroll in Medi-Cal and we have not terminated	2.4.2 First Aid Transportation Medi-Cal Application	12/31/20	The following documentation supports the MCP's efforts to correct this finding: **MONITORING & OVERSIGHT** - Medi-Cal Enrollment for First Aid Transportation has been

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that all network providers are enrolled in the Medi-Cal program. (*CFR, Title 42, section 438.608 (b)*)	the contract yet because the San Francisco Bay area is very limited in transportation options. One of the two vendors, First Aid Transportation, has attempted to enroll directly with DHCS since last year but has experienced delays from DHCS. Please see attached application. If the vendor is not enrolled with DHCS by December 31, 2020, the Plan will remove the vendor from the network. The second vendor, 24-7 Transport, is in the process of completing their application to use to enroll in Medi-Cal through the Plan's in-house option. If the process is not completed by the Physician Advisory Committee meeting on 12/10/20, the Plan will terminate the contract.			confirmed & the provider is active in the Medi-Cal program (5/31/23). - The provider, 24-7 MedTransport, has been in-house enrolled directly through the Plan & the enrollment package has been verified. The provider is active. **The Corrective Action Plan for Finding 2.4.2 is accepted.**

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3. Access and Availability of Care				
3.3.1 Family Planning Claims Members have the right to access family planning services through any family planning provider without prior authorization. (*Contract Exhibit A, Attachment 8 (9)*)	The Plan has conducted a root cause analysis of this issue and determined that code 81025 was not added to the code directory to allow the service to pay to non-contracted providers without an authorization. The claims system has been updated to allow claims with this code to process without an authorization. The claims system was updated while the auditors were onsite in March 2020.	3.3.1 81025 File Report	Completed 03/12/20	The following documentation supports the MCP's efforts to correct this finding: **MONITORING & OVERSIGHT** - Report, "81025 File Report" (03/2020) as evidence that the MCP has completed a system reconfiguration to reflect service code 81025 for family planning claims to be paid to non-contracted providers without a~~n~~ prior authorization. - An email (01/14/21) which the MCP states, "The 99214 (office visit) was denied because it did not have a "special arrangements" diagnosis code, so it would not fall under the family planning benefit". **The Corrective Action Plan for Finding 3.3.1 is accepted.**
3.3.2 Misdirected Claims The Plan is required to forward all misdirected emergency service claims and any non-contracted claim to the appropriate capitated provider within ten working	The Plan has a split Division of Financial Responsibility (DOFR) with two delegates in which SFHP is responsible for a specific set of services~~,~~ and the delegate is responsible for a different specific set of services. During the root cause analysis of this finding, it was determined that all of the claims that were identified during this audit were representative of those delegates that have such a split DOFR. This makes	3.3.2 Misdirect SARA		The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - Timely Processing of Misdirected Claims in QNXT (09/30/20) which describes the short term plan the MCP is taking. **MONITORING & OVERSIGHT** - Corrective Action Analysis, Solutions Analysis and Risk Assessment (SARA) (08/20) as evidence that the Plan has

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days of receipt by the Plan. (California Code of Regulations (*CCR), Title 28, section 1300.71(b)(2)*) Plan policy *CL-04 Misdirected Claims (revised 2/28/18),* stated all misdirected claims are re-directed within ten working days from the date the claim is received to the member's group that is delegated to process the claim. The original submitter of the claim is notified that the claim was misdirected and that the claim has been re-directed to the appropriate party for processing.	the misdirection of claims incredibly difficult as the claims need to be entered into the system for processing and determination of responsibility. The Plan is working on reconfiguration of the claim's preprocessor, which identifies claims that need to be forwarded immediately upon receipt. Currently, the Plan is reviewing three potential options to accomplish this, as defined in the attached document titled Misdirect Solutions Analysis and Risk Assessment (SARA.) The first option would forward all claims that even have a partial responsibility to the delegate immediately, however, the coordination of payment of split claims is difficult because the delegate is likely to return the claim to the Plan for processing of the services the Plan is responsible for, which causes additional claims processing and may be confusing to providers who are informed of the misdirect. Option 2 would reconfigure the entire preprocessor to forward only the lines that are split from SFHP responsibility. This option will take up to a year to configure the preprocessor, based on available resources and complexity of			reviewed three potential options to correct this deficiency. - After the MCP assessed the current operations, the following actions shall be taken for claims in QNXT wherein Brown & Toland (BTP) or Hills Physicians (HIL) have some financial responsibility. 1. Create a mechanism to identify claims in QNXT that should be forwarded within 10 days. (Dec 2020) 2. Create report to monitor timely claims forwarding and update processes as needed. (Dec 2020) 3. Implement a manual process to forward paper claims by mail to responsible party. Note that this is the only for paper claims that have made it into QNXT and have other responsibility. (Dec 2020) 4. Implement short-term process to forward EDI claims to responsible party (Dec 2020) - An email (01/06/21) which includes another email attachment as evidence that the MCP has a process to forward misdirected claims seated in QNXT and has been deployed to production on 12/21/20. **The Corrective Action Plan for Finding 3.3.2 is accepted.**

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	coding for each possible service. The third option would require that the Claims Department run a report every week to look for claims were a split responsibility exists and manually forward those claims. The project team has made a recommendation to SFHP management and will implement the approved process. This decision is expected by September 11, 2020.			
4. Member Rights				
4.1.1 Clinical Grievance Decision Maker The Plan is required to implement and maintain a procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance for any grievance or appeal involving	The Plan has informed all employees involved in the grievance process that the clinical decision maker may not have participated in the original decision or any subsequent appeals or grievances. The case cited in the Audit Report was a grievance about the way that the Plan resolved a grievance, and there was not another Medical Director on staff that had not been involved in the original decision or subsequent grievances. To ensure that this does not occur again, the Plan is developing a process to send the grievance to an independent		12/31/20	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - Updated P & P, Policy Number QI-06, Clinical Member Grievances, which has been amended to include, "The HOI Grievance Coordinator ensures that the person making the final decision for the proposed resolution of a Clinical Grievance has not participated in any prior decisions related to the Clinical Grievance. (Page 6-Subsection G) - Desktop Procedure, "Internal Audit" (11/25/2020) as evidence that the MCP has outlined a quarterly audit on clinical grievances and the results will be shared with the Grievance Oversight Committee.

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clinical issues. (*Contract Exhibit A, Attachment 14, 2 (G)*)	medical review organization if necessary. The process will be submitted to the Quality Improvement Committee for approval at the October 8, 2020 meeting.			**MONITORING & OVERSIGHT** - SFHP Meeting Minutes, "Appeals and Grievance Team Biweekly Meeting" (06/17/2020) which provides evidence of the documented review and training of grievances, categorization, and proper follow up to ensure proper monitoring and oversight. **The Corrective Action Plan for Finding 4.1.1 is accepted.**
4.1.2 Grievance Acknowledgement and Resolution Notification The Plan is required to implement and maintain a Member Grievance System in accordance with CCR, Title 28, section 1300.68. This shall include a procedure to ensure notification of grievance acknowledgement and resolution to the complainant. *(Contract Exhibit A, Attachment 14 (1) and (2) (A))*	The Plan has reminded all employees involved in the grievance process that policies QI-06, QI-17, CS-13 and CS-14 all state that the Complainant is defined as the member or member's authorized representative and acknowledgement and resolution letters must be addressed to the authorized representative that filed the complaint if such an individual filed the grievance or appeal on behalf of a member. The Plan will configure the Essette Case Management system to allow for alternative addresses/recipients on the "member" letters. The request has been submitted to configure the Essette Case Management System and is awaiting prioritization.		12/31/20	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - Updated P & P, Policy Number QI-06, Clinical Member Grievances, which has been amended to include The Acknowledgement Letter is sent to the designated representative if the member's designated representative filed a grievance on the member's behalf. (page 5-E) - Updated P & P, Policy Number QI-06, Clinical Member Grievances, which has been amended to include the Resolution Letter is sent to the designated representative if the member's designated representative filed a grievance on the member's behalf. (Page 6-G) - Desktop Procedure, "Internal Audit" (11/25/2020) as evidence that the MCP has outlined a quarterly audit on clinical grievances and the results will be shared with the Grievance Oversight Committee.

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				MONITORING & OVERSIGHT - An email (11/23/20) which includes a description of the MCP's quarterly grievance review process that will take place by the Compliance Department, this will include review of all letters prior to them being sent out. - Sample Report "Clinical Grievances Audit Checklist and Monitoring "(11/23/20) is evidence that the MCP is monitoring grievances on a quarterly timeframe and reviewing letters prior to them being sent. The tool will be used starting Q4 2020 audit. **-**SFHP Meeting Minutes, "Appeals and Grievance Team Biweekly Meeting" (06/17/2020) which provides evidence of the documented review and training of grievances, categorization, and proper follow up to ensure proper monitoring and oversight. In addition, to proper documentation and categorization in Essette. **The Corrective Action Plan for Finding 4.1.2 is accepted.**
5. Quality Management				
5.1.1 Written Description of the Quality Program The written description of the Plan's QIP shall list the qualifications of staff responsible for	The Plan is in the process of developing the 2021 QI Program. The Plan will add a section to the QI Program that details each participants education, experience, and training to the 2021 Quality Improvement Program.		12/31/2020	The following documentation supports the MCP's efforts to correct this finding: **MONITORING & OVERSIGHT** - Updated Program Description and Work Plan, "San Francisco Health Plan – 2021 Quality Improvement Program Description & Work Plan" as evidence that the MCP is listing the qualifications of staff responsible for QI studies and activities, including their

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QI studies and activities, including their education, experience, and training. *(Contract Exhibit A, Attachment 4 (7) (C))*				education, experience, and training. Beginning on page 10 of the Quality Improvement Program Description & Work Plan, the MCP describes the education, experience, and training for the Quality Directors, Managers, and Specialists. **The Corrective Action Plan for Finding 5.1.1 is accepted.**
6. Administrative and Organizational Capacity				
6.2.1 Fraud and Abuse Reporting The Plan is required to report to DHCS all cases of suspected fraud and/or abuse within ten working days from the date the Plan first becomes aware of, or is on notice of, such activity. The report shall be submitted on a Confidential Medi-Cal Complaint Report (MC 609) *(Contract Exhibit E, Attachment 2 (25) (B) (4)).*	In October 2019, the Plan implemented an electronic Case Tracker System for fraud, waste, and abuse cases. Built into the system is a reminder that informs the investigator that the case needs to be submitted to DHCS by the 10-day mark. In addition, please refer to attached Fraud Investigation Process Map; each member of the Compliance and Oversight team has been trained to submit all potential cases of Medi-Cal fraud, waste, and abuse to DHCS within 10 days.	6.2.1 CaseTracker Screenshot 6.2.1 Fraud Investigation Process Map 6.2.1 CRA-08	Fully Implemented January 2020. CRA-08 updated 05/21/20	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** "Fraud Investigation Process Map" (08/21/20): A flow chart provided by the Plan displays the workflow for reporting cases of suspected fraud, waste, and abuse. The flow chart shows that cases must be reported to DHCS within ten days of notice and displays internal personnel responsible for their designated areas of expertise. - "CRA-08 Fraud, Waste, and Abuse Prevention and Investigation" (08/21/20): Internal policy and procedures provides direction on how to report potential fraud, waste, and abuse to the Plan's Compliance Officer and/or the Compliance and Oversight Manager. The document explains that all cases of suspected fraud, waste, and/or abuse are to be reported to DHCS within "10 State working days." Policies outline two different ways SFHP may contact DHCS to report suspected cases of fraud, waste, and abuse. The first way of contact is through the "Stop Medi-Cal Fraud Complaint Form",

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				the second is by emailing a completed MC 609, via secure email, to the DHCS Program Integrity Unit. **MONITORING & OVERSIGHT** - "Case Tracker Screenshot" (10/19/20): An image capture of an internal monitoring tool developed for monitoring potential cases of fraud, waste, and abuse. The user interface (UI) for the software displays multiple tabs that allow for an analyst to report potential fraud and abuse cases. The UI tabs include, but are not limited to, "Case Profiles, Attachments, Forms, Time Tracking, History, Safety Indicators, User Guide, Reports". The UI incorporates a reporting reminder date within the software to advise an analyst to contact DHCS on the specified date per case, within the "Investigation Details" section. - "DTP_Case Tracker, Case Management Process" (10/27/20): The Plan's Case Management Process provides an overview and instructions on using internal software to analyze potential cases of fraud, waste, and abuse **The Corrective Action Plan for Finding 6.2.1 is accepted.**

Submitted by: Crystal Garcia **Date: 08/20/20**
Title: Manager, Compliance and Oversight