DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

October 18, 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 7, 2022 through March 18, 2022. The audit covered the period of March 1, 2021 through February 28, 2022.

The items were evaluated and 5 of 15 findings were repeat findings on the subsequent 2023 Medical Audit; therefore, DHCS will assess remediation for the 5 repeat findings in the superseding 2023 Corrective Action Plan (CAP). As such, DHCS accepts and will close the 2022 CAP with findings 1.3.2, 1.5.2, 2.1.1, 2.1.4 and 5.1.1 still needing remediation. The open findings are transferred to the subsequent CAP which has the same findings. The enclosed documents will serve as DHCS' final response to the MCP's 2022 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
Managed Care Quality and Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Stacy Nguyen, Chief
Managed Care Monitoring Branch
Managed Care Quality and Monitoring Division
Department of Health Care Services

Joshua Hunter, 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: 3/1/21 – 2/28/22

Audit Type: Medical Audit

On-site Review: 3/7/22 – 3/18/22

MCPs are required to provide a 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 that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, 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, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. Deficiency Number and Finding, 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include 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 detail such as 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. For deficiencies that require short-term corrective action, implementation 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 completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.

Please note, 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 prior approval for an extended implementation effort is granted by DHCS.

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				
1.3.1 Appeal Log Reporting The Plan's governing body and Member Advisory Committee did not periodically review the written appeal log and did not thoroughly document the review.	This finding was first delivered to the Plan in June 2021. Since then, the Plan worked on a process to present the written appeal log to the Member Advisory Committee (MAC) and Governing Board in a comprehensive and informative way, without compromising Protected Health Information (PHI). The MAC and Governing Board are currently meeting virtually. The Plan determined that it will not share a paper or an electronic copy of the written appeal log with committee members in order to reduce risks related to PHI. The Plan will 1) remove PHI and other identifying details from the appeal log, 2) provide committee members with an overview of appeal volume and trends, and 3) showing the appeal log to committee members onscreen during committee meetings. The Plan has revised its Policies and Procedures CLS-03 and QI-17 to clearly state that the MAC and Governing Board will review the written appeal log annually.	1.3.1 P&P CLS-03 Member Advisory Committee 1.3.1 P&P QI-17 Member Appeals 1.3.1_MAC June 10, 2022 Minutes 1.3.1_MAC Presentation 1.3.1_Q1 2022 Appeal Log 1.3.1_Draft Update Compliance Audit Plan	MAC: June 10, 2022 and every June meeting thereafter Governing Board: November 2, 2022 and every November meeting thereafter	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy CLS-03 updated to state that Member G&A log is to be review in the MAC and for that review to be documented in the MAC minutes. • Policy QI-17 updated to state the written record of grievances and appeals to be submitted to the Governing Board and the MAC. **MONITORING AND OVERSIGHT** • MAC minutes, MAC presentation and redacted G&A log demonstrates that G&A log was reviewed and discussed at the meeting. • Joint San Francisco Health Authority/San Francisco Community Health Authority Governing Board November 2, 2022 Meeting Minutes confirm that the MCP is presenting grievance and appeal logs with the governing body. **The corrective action plan for finding 1.3.1 is accepted.**

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	The Plan has already corrected this deficiency as it pertains to the MAC. The Plan presented the appeal log to MAC on June 10, 2022 and will continue to present the appeal log every June meeting thereafter. The Plan will present the appeal log to the Governing Board on November 2, 2022, and every November meeting thereafter. The Plan has added monitoring tasks to its Compliance Audit Work Plan to ensure the appeal log is reviewed by the MAC each June and by the Governing Board each November.			
1.3.2 Written Consent for Appeals The Plan did not ensure that members' written consent was received when providers filed appeals on behalf of members.	The Plan currently sends an "Appeal Signature Form" with every appeal acknowledgement letter to attempt to obtain the member's written appeal following receipt of an oral appeal. The same form is used to obtain the member's written consent when a provider submits an appeal on the member's behalf. If the Plan did not receive the member's signed appeal form, the Plan still proceeded to resolve the appeal. However, the	1.3.2_P&P CS-13: Member Grievances and Appeals: Rights, Intake and Case Creation 1.3.2_P&P QI-17: Member Appeals 1.3.2_Appeal Signature Form	SFHP will submit the Appeal Signature Form, CS-13, QI-17, and the Grievance/Appeal Consent Form to the DHCS Contract Manager for review on or before 9/23/2022. SFHP will implement the revised policies	The Plan took steps to address the deficiency during the 2022 CAP; however, due to the overlap in the open CAP and subsequent audit period, the 2023 Medical audit revealed a lack of complete remediation. Therefore, finding 1.3.2 is a repeat finding in the 2023 Medical audit and will be assessed using the superseding 2023 DHCS CAP. The open finding 1.3.2 is transferred to the subsequent CAP which has the same finding.

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	DHCS auditors found this process to be deficient because the Plan continued to process appeals filed by providers without members' written consent. The Plan determined that obtaining a written appeal following an oral appeal should be treated as a separate requirement from obtaining written consent when an appeal is filed by a provider or other third party. As a result, Policy and Procedure QI-17 was revised to separate the two processes so that they are described in two sections: "D. Written Appeal Following a Member's Oral Appeal" and "E. Member Consent." SFHP will continue to request the Appeal Signature Form from members who file appeals orally. SFHP will also continue to process members' oral appeals, even if the member does not return the Appeal Signature Form. This process is described in QI-17, D. Written Appeal Following a Member's Oral Appeal. The Plan has made minor revisions to the Appeal Signature Form.	1.3.2_Grievance/Appeal Consent Form	and forms within one month of receiving the DHCS Contract Manager's approval. SFHP will revise its appeal audit tool by the next October 2022 CAP update. SFHP will begin using the revised audit tool for the Quarter 3 2022 internal audit.	

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	However, for appeals filed by a provider or other third party, SFHP either 1) confirm that there is a form on file demonstrating that the third party is the member's authorized representative, or 2) if the third party does not have an authorized representative form on file, SFHP will require at least the member's verbal consent to begin processing the appeal and attempt to obtain written consent afterwards. The Plan cannot even begin to investigate the appeal without the member's consent, so the receipt date of the appeal must be the date the member verbally consents, at the earliest. The Plan will then request the member's written consent before the Plan will disclose any information about the appeal to the provider/third party. If the member verbally consents but never sends the Plan the written consent, all communications (e.g., acknowledgement letter, resolution letter) will be sent to the member only.			

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	The Plan has revised Policies and Procedures CS-13 and QI-17 to clarify the process for obtaining members' consent when appeals are submitted by providers or other third parties. The process for obtaining consent when the member is present at the time of intake is described in the revised Policy and Procedure CS-13, C. Member Consent. The process for obtaining consent when the member is not present at the time of appeal submission is described in the revised Policy and Procedure QI-17, E. Member Consent. The Plan believes this is the most member-centric solution and allows investigation and resolution of an appeal if the member at least verbally consents to the appeal. The Plan will require a Personal Representative Form, Standard Release and Authorization Form, or the Grievance/Appeal written consent form before sharing or disclosing any information about the appeal to the provider/third party. This solution allows an appeal to move forward if			

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	the member's verbal consent is obtained and protects the member's PHI in case a written consent is not obtained. The Plan will update its appeal audit tool to confirm that written member consent was received for each applicable case. The Plan will begin using the updated audit tool for the Quarter 3 2022 audit. The revised appeal audit tool will be provided at the next October 2022 CAP update.			
1.5.1 Oversight of Nondiscrimination Notice and Language Assistance Taglines The Plan did not ensure a delegate met standards for Utilization Management (UM) activities set forth by DHCS. The delegate did not update information in nondiscrimination	SFHP has a process in place to implement new All Plan Letters (APLs) and other mandates/guidance (collectively referred to below as "requirements"). The process for triggering the implementation of new requirements is explained in "1.5.1_Mandate DTP," which was in effect beginning December 2018. Following the project/task initiation outlined in this DTP, a work plan is developed to complete all required tasks for implementation. One standing task for all new requirements is to notify SFHP's delegates of any new and/or updated	1.5.1_Mandate DTP 1.5.1_Attestation DTP 1.5.1_Delegate Evidence 1.5.1_Sample Audit Tool 1.5.1_UM Audit DTP	Attestation Process – September 9, 2022 Delegate Template Implementation – December 16, 2021 Delegate Audit Start – August 25, 2022 Audit Tool DTP Implementation – October 15, 2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Mandate Implementation DTP is used to direct staff to notify SFHP's delegates of any new and/or updated requirements that pertain to their responsibilities as a subcontractor of SFHP. • Attestation DTP defines the MCP's conditions for requesting Delegate attestations. Attestations are requested to confirm the entity's completeness of implementation for applicable regulations. Attestations are due back to the MCP within 15 calendar days of MCP's initial notification to the delegates. If

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notices and language assistance taglines in accordance with APL 21-004.	requirements that pertain to their responsibilities as a subcontractor of SFHP. As a result of this finding, SFHP has implemented a new process for ensuring its delegates also comply with new requirements. The new process requires delegates to attest to receiving information from SFHP and to respond with an implementation plan for the new requirement(s) (including a timeline). Attestations are due back to SFHP within 15 calendar days of SFHP's initial notification to the delegates. If processes are required to be updated, SFHP gives its delegates 30 calendar days to provide updated policies and procedures supporting their compliance with the new requirement(s). This new process will aid SFHP in its delegation oversight practices ensuring its delegates are complying with new requirements in a timely manner. SFHP's delegate confirmed, on December 16, 2021, that it had updated its language assistance			processes are required to be updated, the MCP gives its delegates 30 calendar days to provide updated policies and procedures supporting their compliance with the new requirement(s). **MONITORING AND OVERSIGHT** • Audit Tool DTP created for updating audit tool to reflect new and updated requirements. • Audit Tool Template is currently being used in the current delegation oversight audit. The audit tool has a field for language assistance information. • Email between MCP and delegate from 12/16/21 confirmed delegate updated its language assistance taglines and non-discrimination notice attachments to comply with updated requirements. **The corrective action plan for finding 1.5.1 is accepted.**

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	taglines and non-discrimination notice attachments to comply with updated requirements. SFHP's delegate is currently undergoing its annual delegation oversight audit. SFHP is conducting a file review for the audit, which began on August 25, 2022. To demonstrate SFHP's audit process for reviewing member notices that require these attachments, attached is SFHP's DTP for conducting audits of its delegates' appeals and grievances and the template audit tool. SFHP did not previously have a DTP in place for updating its audit tool to reflect new and/or updated requirements. This was another process that was included as a standing action item as part of the mandate implementation process. As a result of this finding, SFHP has attached a new DTP it created to meet this need.			

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1.5.2 Ownership and Control Disclosure Review The Plan did not review ownership and control disclosure information for their Utilization Management (UM) delegates	Upon receipt of this finding, SFHP reviewed its current version of its DHCS-approved Provider Disclosure Form and discovered that the form is misleading. This is causing confusion for SFHP's UM delegates. As such, SFHP has revised its Provider Disclosure Form (1.5.2_Draft Form Update). SFHP seeks the review of the form attached to this response and will then send the form to its UM delegates for completion. SFHP intends to have completed forms from all of its UM delegates by January 31, 2023. SFHP has created a Credentialing DTP to outline its process for continuing its monitoring and oversight of this process. This process is already in effect, even as SFHP continues to work with its existing UM delegates to become compliant with these requirements.	1.5.2_Draft Form Update 1.5.2_Cred DTP	SFHP will implement the new form after receiving DHCS feedback – December 2022 SFHP intends to collect all completed delegate forms by January 31, 2023	The Plan took steps to address the deficiency during the 2022 CAP; however, due to the overlap in the open CAP and subsequent audit period, the 2023 Medical audit revealed a lack of complete remediation. Therefore, finding 1.5.2 is a repeat finding in the 2023 Medical audit and will be assessed using the superseding 2023 DHCS CAP. The open finding 1.5.2 is transferred to the subsequent CAP which has the same finding.
2. Case Management and Coordination of Care				

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2.1.1 - Health Information Form (HIF)/Member Evaluation Tool (MET) Documentation The Plan did not provide evidence that HIF/METs were mailed to the newly enrolled SPD members or that it made at least two telephone call attempts to remind members to return the HIF/METs.	The Plan discovered that it was not sending the HIF/MET to all newly enrolled SPD members. The Plan's definition of a newly enrolled member did not include members who re-enrolled in SFHP after a break in eligibility. The Plan is working on updating this definition to ensure that all newly enrolled SPD members receive the HIF/MET. The Plan will have more information about its progress at the November 2022 CAP update. Currently, SFHP sends the HIF/MET in a separate mailing from the Welcome Kit. SFHP sends these documents separately because the Welcome Kit is sent to each household while the HIF/MET is sent to each individual member. The HIF/MET is prepopulated with the member's SFHP ID number and name to reduce the amount of information that the member must fill out on the HIF/MET. A postage prepaid envelope is included. Due to the complexity of the mailing processes and the time needed to develop processes with the mail	2.1.1_2.1.3_HRA HIF Form DTP San Francisco Health Plan 2022-2023 CARE-02 HIF and HRA Q4_2022_HIFMet HRA	1. 9/12/2022 – SFHP Customer Service implemented the HRA desktop procedure 2. 12/27/2022 3. An update regarding the inclusion of the HIF/MET in welcome kits will be provided at the November 2022 CAP update.	The Plan took steps to address the deficiency during the 2022 CAP; however, due to the overlap in the open CAP and subsequent audit period, the 2023 Medical audit revealed a lack of complete remediation. Therefore, finding 2.1.1 is a repeat finding in the 2023 Medical audit and will be assessed using the superseding 2023 DHCS CAP. The open finding 2.1.1 is transferred to the subsequent CAP which has the same finding.

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	vendor, SFHP is still determining whether it can begin including the HIF/MET in Welcome Kits. The Plan will have more information about progress in this area by the November 2022 CAP update. SFHP has developed a new desktop procedure to ensure that the required number of phone call attempts are made if the member does not complete and mail back the HIF/MET. The desktop procedure includes specific instruction to Customer Service representatives (starting on page 8) on what to do when members refuse to answer questions or get disconnected.			
2.1.2 Health Risk Stratification The Plan did not conduct an initial health risk stratification to identify newly enrolled SPD members as higher or lower risk within 44 calendar days of	During the audit, the Plan identified that risk stratification logic in its care management system was incorrect. The Plan is in the final stages of an RFP for a new care management system. The Plan will implement this new care management system within six months of awarding the contract to the new vendor. The Plan will ensure that is new care management system is set up with the correct risk	N/A	Update Policy and Procedure CARE-02 by the next October 2022 CAP update	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "CARE-02: Health Information Forms (HIFs) and Health Risk Assessments (HRAs)" which demonstrates that members who answer yes to one of the LTSS questions are considered "high risk" and referred to Care Management for outreach. (2.1.2 CARE-02 HIF and HRA_RL, Page 3).

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enrollment.	stratification logic. In the meantime, the Plan will continue to use its current system and open care management case members identified as high risk. The Plan's HRA workgroup (which is a cross-functional team of care coordination subject matter expects from Customer Service, Data Management, Business Solutions and Care Management) will review its HRA workflow and update Policy and Procedure CARE-02 by the November 2022 CAP update.			• "2022-2023 Compliance Audit Risk Assessment and Work Plan" to demonstrate that the MCP will schedule on an annual basis the HIF-Met and HRA Audit, which will be implemented in January 2023 (San Francisco Health Plan 2022-2023, Page 3). **MONITORING AND OVERSIGHT** • Audit Results, "HRA HIF-MET Audit" (Quarter 4, 2022) which demonstrates that the MCP has implemented a monitoring process to confirm that an initial health risk stratification was conducted to identify newly enrolled SPD members as higher or lower risk within 44 calendar days of enrollment. The Audit Results tracks the following categories: Assessment completed or at least 2 contact attempts made within 44 calendar days, Did member answer "yes" to trigger questions, Was member referred to Case Management (CM), Was a CM case opened for high risk members. (Q4_2022_HIFMet HRA). **The corrective action plan for finding 2.1.2 is accepted.**

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2.1.3 Health Risk Assessment (HRA) Survey The Plan did not make the necessary telephone call attempts to conduct the HRA with the SPD members.	The SFHP Customer Service department developed a training and a new desktop procedure to ensure that the required number of phone call attempts are made if the member does not complete and mail back the HIF/MET. The desktop procedure includes specific instruction to Customer Service representatives on what is considered a complete and successful outreach attempt.	2.1.3_Customer Service Desk Level Procedure Processing a HRA & HIF Form	SFHP Customer Service held an updated training during the week of 9/5/2022 and implemented a new HRA desktop procedure on 9/12/2022.	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated Desktop Procedure, "Processing a HRA & HIF Form" (09/08/22) in which the MCP staff must make at least 2 attempts at reaching the member to follow up, for any instance below: • MCP contacts Member to follow up on HRA or HIF Form and Member states they would like to have the form mailed out again. • MCP contacts Member and the member requests a call back. • MCP contacts Member and member states they have already sent the form in. • MCP will wait 7 calendar days before calling again if the form has not been received. (HRA HIF Form DTP, Page 6). • Updated P&P, "CARE-02: Health Information Forms (HIFs) and Health Risk Assessments (HRAs)" which demonstrates that Customer Service contacts the member at least once by mail and at least two times by phone within 44 calendar days of receipt of the member file prior to closing the case as "incomplete". (2.1.2 CARE-02 HIF and HRA_RL, Page 3). **MONITORING AND OVERSIGHT**

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				• "2022-2023 Compliance Audit Risk Assessment and Work Plan" to demonstrate that the MCP will schedule on an annual basis the HIF-Met and HRA Audit. (San Francisco Health Plan 2022-2023, Page 3). • Audit Tool Results, "HRA HIF-MET Audit" (Quarter 4, 2022) which demonstrates that the MCP has conducted an internal audit. The Audit Tool Results tracks the attempted outreach to the member at least 2 times by phone and 1 time by mail. (Q4_2022_HIFMet HRA). **The corrective action plan for finding 2.1.3 is accepted.**
2.1.4 Provision of Initial Health Assessment (IHA) The Plan did not ensure the provision of a complete IHA to each new member.	San Francisco Health Plan (SFHP) will conduct the following interventions in response to the Department of Health Care Services in response to the 2022 audit findings on the IHA. Specifically, SFHP will: 1. Hire Specialist, Access and Care Experience-posted August 2022 2. Develop an analytical framework to identify members by assigned provider who have not complied with the IHA timeframe – by September 30, 2022	2.1.4_DHCS Audit Response Form - IHA	9/30/2022; 12/31/2022; 2/28/2023; 3/31/2023 (see narrative for detail)	The Plan took steps to address the deficiency during the 2022 CAP; however, due to the overlap in the open CAP and subsequent audit period, the 2023 Medical audit revealed a lack of complete remediation. Therefore, finding 2.1.4 is a repeat finding in the 2023 Medical audit and will be assessed using the superseding 2023 DHCS CAP. The open finding 2.1.4 is transferred to the subsequent CAP which has the same finding.

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	3. Contact newly enrolled seniors and persons with disability during Health Risk Assessment and Health Information Form outreach calls and remind members to schedule an IHA appointment with their assigned PCP – by December 31, 2022 4. Remind all new members to include that call SFHP's Customer Services to make an IHA appointment when they call SFHP and help support the member with making an appointment with their PCP – by December 31, 2022 5. Develop targeted outreach letter to providers about IHA, as well as post IHA information on its website for members and providers – December 31, 2022 6. Provide PCPs with common billing codes for pediatric and adult new patients and preventive care screening by age group category – by December 31, 2022 7. Provide PCPs with a list of new members who are newly enrolled to support PCP provider office outreach to assigned members – by February 28, 2023 8. Review the new member welcome			

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	packet and make appropriate revisions that clearly outline what IHA is and the importance of the IHA and provider engagement for within 120 days of enrollment – by March 31, 2023 9. Target new members that are eligible for Enhanced Care Management (ECM) will be informed to make an appointment with their PCP for an IHA. SFHP and its ECM provider network will make necessary efforts to support member with making appointments with their PCP – by March 31, 2023 10. Provide PCPs with training/education on appropriate IHA documentation and Initial Health Education and Behavioral Assessment and applicable U.S. Preventive Services Taskforce (USPSTF) category A and B recommendations offered to and completed by members 11. Incorporate the review of IHA and USPSTF trend analysis in SFHP established data workgroups as part of the Plan's overall Population Health Management framework 12. Integrate requirements related to			

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	assessments to include IHA in SFHP's PHM strategy and roadmap in accordance with the DHCS Population Health Management Strategy and Roadmap – by Quarter 2 2023 13. Update medical groups about IHA and USPSTF during joint operations meetings and leverage meetings as training opportunities with delegated entities – by Quarter 4 and ongoing 14. Update SFHP Policy HE-02 Initial Health Assessment and Initial Health Education Behavioral Assessment and implement to ensure the provision of a complete IHA to each new member SFHP will make reasonable attempts to contact members and schedule an IHA through the aforementioned interventions. These activities will be documented to demonstrate both passive and active attempts to support member's IHA is conducted within the 120-day timeframe. SFHP will document provider compliance using Medi-Cal codes that identify initial and preventive care visits.			

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4. Member Rights				
4.1.1 - Resolution of Grievances The Plan sent resolution letters for grievances without completely resolving all member complaints.	The Plan has added language to policy and procedure QI-06 to include details about the Grievance Review Committee (GRC) detailing the process and members involved. GRC reviews grievances and proposed resolution letters to ensure that all components are investigated and resolved. GRC membership includes representatives from Customer Service, Provider Network Operations, Health Services Operations, and Compliance and Regulatory Affairs. Designees from Pharmacy, Utilization Management, and Claims departments attend as needed. The Plan also added language to refer to the desktop procedure for escalation issues if needed. The new additions to QI-06 will be implemented within one month of approval by the DHCS Contract Manager. The desktop procedure was created to address issues with provider delay or non-responsiveness and will be implemented by October 2022. The Plan believes this escalation	4.1.1_DTP Escalation Draft 4.1.1_QI-06 Draft 4.1.1_Staff training 4.1.4_Compliance Audit Work Plan 4.1.1_Audit results *(please note that this document contains actual audit results and PHI)*	Revisions to QI-06 will be implemented within one month of approval by the DHCS Contract Manager. The Plan is submitting QI-06 to the DHCS Contract Manager on or before 9/23/2022. The desktop procedure regarding escalation due to late provider responses will be implemented in October 2022. By September 30, 2022: develop plan for education and training, identify responsible parties By December 31, 2022: identify opportunities for cross-training. Complete outline of training materials for	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "QI-06: Grievance and Appeals" (07/21/22) which has been updated to include details about the Grievance Review Committee (GRC) detailing the process and members involved. GRC reviews grievances and proposed resolution letters to confirm that all components are investigated and resolved. GRC membership includes representatives from Customer Service, Provider Network Operations, Health Services Operations, and Compliance and Regulatory Affairs. The Plan added language to refer to the desktop procedure for escalation issues if needed. • Desktop Procedure, "Grievance and Appeal Investigation Escalation" (10/22) which was created to address issues with provider delay or non-responsiveness. This escalation procedure will contribute to providers responding to all of the Plan's grievance questions in timely manner. **MONITORING AND OVERSIGHT** • Audit Results, "Clinical Grievance Internal Audit Scores and Number of Findings by Area of Review" (Q1 – 2022) as evidence the Plan is conducting a quarterly review of 10 grievances. The audit addresses various components

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	procedure will contribute to providers responding to all of the Plan's grievance questions in a timely manner. In addition, the Plan has created a training process for staff which includes review of the non-complaint cases. The training will be for all current and new employees who participate in processing grievances. The Plan will develop training materials for each role in the grievance process, including Grievance Review Committee members. The Plan will then provide process training as needed to ensure consistent processing of grievances.		each role. By March 31, 2023: Present completed training materials to leadership and GRC for review and approval. By June 30, 203: Complete training for all GRC members. Complete cross-training for all identified staff. Incorporate training materials into orientation for new hires going forward.	including that member's grievance complaints are all fully addressed in the resolution letter. Audit results reveal 91% compliance in documentation of resolution letters. • Checklist, "Clinical Grievance Audit Checklist" (Q1 – 2022) as evidence the Plan identified, developed, and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance. **TRAINING** • Process, "Staff Training and Education" (09/22) as evidence the Plan has created a process for staff which includes review of the non-compliant cases. The trainings will be for all current and new employees who participate in the processing of grievances. The Plan will develop training materials for each role in the grievance process, including GRC members. The Plan will then provide process training as needed to confirm consistent processing of grievances. • The scheduled process begins by 09/30/22 which the Plan will develop a plan for education and training and to identify responsible parties. • By 12/31/22, the Plan will identify opportunities for cross-training and complete outline of training materials for each role. • By 03/31/23, the Plan will present completed training

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				materials to leadership and GRC for review and approval. • By 06/30/23, the Plan will complete training for all GRC members. Complete cross-training for all identified staff and incorporate training materials into orientation for new hires going forward. **The corrective action plan for finding 4.1.1 is accepted.**
4.1.2 Review of Written Grievance Log The Plan's governing body and Member Advisory Committee did not periodically review the written grievance log and did not thoroughly document the review.	This finding was first delivered to the Plan in June 2021. Since then, the Plan worked on a plan to present the grievance log to the Member Advisory Committee (MAC) and Governing Board in a comprehensive and informative way, without compromising Protected Health Information (PHI). The MAC and Governing Board continue to meet virtually. The Plan determined that it will not share an electronic copy of the grievance log with committee members in order to reduce risks related to PHI. The Plan will 1) remove PHI and other identifying details from the grievance log, 2) provide committee members with an overview of grievance volume and trends, and 3) showing the grievance log to committee members onscreen	4.1.2 P&P QI-06 Clinical Member Grievances 4.1.2 P&P CS-14 Non-Clinical Member Grievances 4.1.2 P&P CLS-03 Member Advisory Committee 4.1.2_MAC June 10, 2022 Minutes 4.1.2_MAC Presentation 4.1.2_Q1 2022 Grievance Log	MAC: June 10, 2022 and every June meeting thereafter Governing Board: November 2, 2022 and every November meeting thereafter	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy CLS-03 updated to state that Member G&A log is to be review in the MAC and for that review to be documented in the MAC minutes. **MONITORING AND OVERSIGHT** • 6/10/22 MAC minutes, MAC presentation and redacted G&A log demonstrates that G&A log was reviewed and discussed at the meeting. • 11/2/22 Joint San Francisco Health Authority/San Francisco Community Health Authority Governing Board November 2, 2022 Meeting Minutes confirm that the MCP is presenting grievance and appeal logs with the governing body.

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	during committee meetings. The Plan has already corrected this deficiency as it pertains to the MAC. The Plan presented the grievance log to MAC on June 10, 2022, and will continue to present the grievance log every June meeting thereafter. The Plan will present the grievance log to the Governing Board on November 2, 2022, and every November meeting thereafter. The Plan has added monitoring tasks to its Compliance Audit Work Plan to ensure the grievance log is reviewed by the MAC each June and by the Governing Board each November.	4.1.2_Draft Update Compliance Audit Work Plan		**The corrective action plan for finding 4.1.2 is accepted.**
4.1.3 Timely Standard Grievance Resolution The Plan did not provide written resolution to members within 30 calendar days from the date of receipt of the standard grievance.	To address staffing shortage, since the audit, the Plan has hired new full-time staff and the quality review nurses who have been carrying out the with the grievance process. The Grievances and Appeals Department moved from Health Services and now report to the Customer Service Senior Manager, who in turn reports to the Chief Operations Officer. The Customer Service Senior Manager	4.1.3_DTP Escalation Draft 4.1.3_QI-06 DRAFT 4.1.3_Compliance Audit Work Plan 4.1.3_Audit results *(please note that*	Revisions to QI-06 will be implemented within one month of approval by the DHCS Contract Manager. The Plan is submitting QI-06 to the DHCS Contract Manager on or before 9/23/2022. The desktop	The following documentation supports the MCP's efforts to correct this finding: **POLICY AND PROCEDURES** • Updated P&P, "QI-06: Grievance and Appeals" (07/21/22) which has been updated to include details about the Grievance Review Committee (GRC) detailing the process and members involved. GRC reviews grievances and proposed resolution letters to confirm that all components are investigated and resolved. GRC membership includes

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	manages the overall Grievance and Appeals process. The Grievance and Appeals Supervisor oversees two staff members an Associate Program Manager and a Specialist. SFHP currently has a vacant position for another Specialist position. The Chief Interim Medical Officer, Medical Directors, and Quality Review Nurses provide the clinical review and clinical oversight of grievances and appeals. The Plan has drafted additions to QI-06 Clinical Member Grievances Policy and Procedure to include language and details of the Grievance Review Committee. New QI-06 additions also direct staff to use the desktop procedure for Grievances and Appeals Escalation when responses to provider investigation questions are not answered. The new additions to QI-06 will be implemented within one month of approval by the DHCS Contract Manager. The desktop procedure was created to address issues with provider delayed non-responsiveness and will	*this document contains actual audit results and PHI)*	procedure regarding escalation due to late provider responses will be implemented in October 2022.	representatives from Customer Service, Provider Network Operations, Health Services Operations, and Compliance and Regulatory Affairs. The Plan added language to refer to the desktop procedure for escalation issues if needed. • Desktop Procedure, "Grievance and Appeal Investigation Escalation" (10/22) which was created to address issues with provider delay or non-responsiveness. This escalation procedure will contribute to providers responding to all of the Plan's grievance questions in timely manner. **MONITORING AND OVERSIGHT** • Audit Results, "Clinical Grievance Internal Audit Scores and Number of Findings by Area of Review" (Audit Period Q1, Q2 and Q3 – 2022) as evidence the Plan is conducting a quarterly review of 10 grievances. The audit addresses various components including written resolution to members is sent within 30 calendar days from the date of receipt of the standard grievance. Audit results reveal 80% compliance in documentation of resolution letters. • MCP states that the internal audit was moved to quarterly therefore sample size of audit represents approximately 10% of the total number of grievances received by the Plan each year. • In addition, 6 cases were audited in regard to investigation responses received from providers and all 6 were received

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	be implemented by October 2022. The Plan believes this escalation procedure will contribute to providers responding to the Plan's grievance questions in a timely manner.			timely. • Checklist, "Clinical Grievance Audit Checklist" (Q1 – 2022) as evidence the Plan identified, developed, and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance. • Internal Audit, "Correction Action Plan (CAP) Form" (Audit Period Q2 4/1/22 – 06/30/22) as evidence the G&A Department is provided a copy of the preliminary audit results and if non-compliance is found then a CAP form is provided. The G&A Department has 30 days to review the findings and return the CAP form with a corrective action to the lead auditor. The lead auditor and Sr. Manager of Compliance and Oversight will confirm the proposed corrective action will meet the needs of the requirement. • Memo, "Clinical and Non-Clinical Grievance Internal Audit" (Internal Audit Q2 – 2022) as evidence the audit team is sharing audit scores and number of findings by area of review with Senior Manager of Members Services. • Audit Results, "Clinical Grievance Internal Audit Scores" (Audit Period Q3 07/01/22 – 09/30/22) Out of 29 standard grievances reviewed for written resolution to members within 30 calendar days, 28 standard grievances were compliant, giving the Plan a 97% passing score. **The corrective action plan for finding 4.1.3 is accepted.**

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4.1.4 Written Notification of Delay Letters The Plan did not notify members of grievance resolution delays and did not provide estimated dates of resolution in writing for cases not resolved within 30 calendar days.	The Plan was waiting for DMHC and DHCS to approve the delay templates. SFHP drafted the delay letter templates (since no template was provided by DHCS) and submitted them to DHCS and DMHC in December 2021. During the March 2022 audit, the grievance delay letter templates were still pending with DMHC. DMHC ultimately issued an approval of the grievance delay letter templates on 5/23/2022. After approval, the Plan translated the delay templated to the Medi-Cal threshold languages. Since then, the Plan has corrected this deficiency and has implemented the notification of delay letters to members as of 7/13/2022. As of 7/13/2022 to 9/15/2022 there have not been any delayed grievances. This is indicated in the	4.1.4_Grievance Delay Letter 4.1.4_QI-06 DRAFT 4.1.4_Delay Letters Report 4.1.4_Report as of 7.13.22 4.1.4_Audit Plan	Delay letters were implemented on 7/13/2022 The Plan will begin auditing for delay letters in Quarter 3 2022.	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "QI-06: Grievance and Appeals" (07/21/22) which has been updated to address the requirement of sending a written letter to notify the member of a grievance resolution delay and the maximum delay time is 14 calendar days. • Template Letter, "Grievance Resolution Delay" (07/13/22) as evidence that the Plan has implemented this delay letter to notify members of their grievance resolution delay. This delay letter was approved by DMHC on 05/23/22 and with DHCS on 07/13/22. **MONITORING AND OVERSIGHT** • Checklist, "Clinical Grievance Audit Checklist" (Q1 – 2022) as evidence the Plan identified, developed, and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance.

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	attached report of grievances as of 7/13/22 to 9/15/2022 and delay letters report which describes the grievance report. The Plan's draft of QI-06- Clinical Member Grievances policy and procedure include an added sentence to direct the Grievances and Appeals Coordinator/ Specialist to send a written delay letter to member and that the maximum delay time is 14 calendar days. The Plan has already implemented this practice. The Plan will update the audit tool by the October 2022 update to include review of delayed grievances. The Plan will start auditing for delayed grievances starting with the Quarter 3 2022 audit in November/December.			• Report, "Essette Grievance Report" (Audit Period Q2 07/13/22 – 09/15/22) as evidence the Plan conducted a quarterly review of grievances to confirm that grievances were resolved within 30 calendar days and that no delays were present. The Plan has stated that during this review period there have not been any delayed grievances to report. • Internal Audit, "Correction Action Plan (CAP) Form" (Audit Period Q2 4/1/22 – 06/30/22) as evidence when the Plan is found non-compliant a CAP is issued on the finding and a citation is provided along with a recommendation to correct the finding. • Memo, "Clinical and Non-Clinical Grievance Internal Audit" (Internal Audit Q2 – 2022) as evidence the audit team is sharing audit scores and number of findings by area of review with Senior Manager of Members Services. • Audit Results, "Clinical Grievance Internal Audit Scores" (Audit Period Q3 07/01/22 – 09/30/22) as evidence the Plan conducted a quarterly review of grievances to confirm that grievances were resolved within 30 calendar days and that no delays were present. The report reflects that during this review period there have not been any delayed grievances to report. • Quarterly Report, The Plan conducts a quarterly QIC report which includes information on how many grievances were

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				delayed and this information is then presented to the Grievance PLT meeting every quarter. • Countdown Tracker, "Case Management System" (12/22) which tracks the potential overdue date of a resolution letter. **The corrective action plan for finding 4.1.4 is accepted.**
4.1.5 Written Consent for Standard Grievances The Plan did not ensure that members' written consent for authorized representatives were obtained when the representatives filed standard grievances on behalf of members	Previously, the Plan accepted the member's oral consent when third parties submitted grievances on behalf of members. A written form demonstrating that the third party was an authorized representative, or other written consent, was not obtained in some cases. For grievances filed by an individual who is not the member (third party), SFHP either 1) confirm that there is a form on file demonstrating that the third party is the member's authorized representative, or 2) if the third party does not have an authorized representative form on file, SFHP will require at least the member's verbal consent to begin processing the grievance and attempt to obtain written consent afterwards. The Plan cannot even begin to	4.1.5_P&P CS-13: Member Grievances and Appeals: Rights, Intake and Case Creation 4.1.5_P&P QI-06: Clinical Member Grievances 4.1.5_P&P CS-14: Non-Clinical Member Grievances 4.1.5_Grievance/Appeal Consent Form	SFHP will submit the CS-13, CS-14, QI-06, and the Grievance/Appeal Consent Form to the DHCS Contract Manager for review on or before 9/23/2022. SFHP will implement the policies and forms within one month of receiving the DHCS Contract Manager's approval. SFHP will revise its grievance audit tool by the next October 2022 CAP update. SFHP will begin using the revised audit tool	The following documentation supports the MCP's efforts to correct this finding: **POLICY AND PROCEDURES:** • Updated P&P, "CS-13: Member Grievances and Appeals: Rights, Intake and Case Creation" (07/21/22) this process was updated to include grievances or appeals filed by the provider or other third party on behalf of a member requires the member's consent to begin processing. In addition, the Plan requires the member's written consent to share any information about the grievance and appeal with the provider or third party. • Updated P&P, "QI-06: Grievance and Appeals" (07/21/22) which has been updated to confirm that members' written consent for authorized representatives were obtained when the representative filed a standard grievance on behalf of the member. • Updated P&P, "CS-14: Non-Clinical Member Grievances",

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	investigate the grievance without the member's consent, so the receipt date of the grievance must be the date the member verbally consents, at the earliest. The Plan will then request the member's written consent before the Plan will disclose any information about the grievance to the third party submitting the grievance. If the member verbally consents but never sends the Plan the written consent, all communications (e.g., acknowledgement letter, resolution letter) will be sent to the member only. The process for obtaining consent when the member is present at the time of intake is described in the revised Policy and Procedure CS-13, C. Member Consent. The process for obtaining consent when the member is not present at the time of grievance submission is described in the revised Policy and Procedure QI-06 (I.C. Member Consent), and CS-14 Non-Clinical Member Grievances (I.C. Member Consent).		for the Quarter 3 2022 internal audit.	(01/20/22) this process was updated to include the steps necessary to confirm that member's written consent is obtained when a representative files a standard grievance on behalf of the member. • Form, "Grievance and Appeal Consent Form" as evidence the Plan has a DHCS approved written member consent form to provide to member's who wish to authorize representation in regard to filing a standard grievance on behalf of the member. **MONITORING AND OVERSIGHT** • Audit Tool, "Clinical Grievance Audit Checklist" (Q3 2022) which demonstrates the Plan confirms if written consent is obtained from the member when the representatives file standard grievances on behalf of member. • Audit Results, "Clinical Grievance Audit Checklist" (Q3 2022) as evidence the plan conducted an audit review of 30 case files and 29 cases that were 97% compliant with the requirement of obtaining written consent from the member when representatives filed standard grievances on behalf of the member. **The corrective action plan for finding 4.1.5 is accepted.**

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	The Plan believes this is the most member-centric solution and allows investigation and resolution of a grievance if the member at least verbally consents to the grievance. The Plan will require a Personal Representative Form, Standard Release and Authorization Form, or the Grievance/Appeal written consent form before sharing or disclosing any information about the grievance to the third party. This solution allows a grievance to move forward if the member's verbal consent is obtained and protects the member's PHI in case a written consent is not obtained. The Plan will update its grievance audit tool to confirm that written member consent was received for each applicable case. The Plan will begin using the updated audit tool for the Quarter 3 2022 audit. The revised grievance audit tool will be provided at the next October 2022 CAP update.			

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4.3.1 - Background Check
 	
The Plan did not ensure that contracted consultants completed a thorough background check prior to having access to DHCS PHI or PI.
	It is SFHP's practice to perform a background check on all SFHP employees. When SFHP requires a consultant for positions that have access to PHI, SFHP works with a vendor to fill that consultant role. The vendor conducts a background check on the consultant. The two consultants that DHCS identified as not receiving a background check prior to accessing PHI were part of an isolated incident with one of SFHP's vendors.
	
	SFHP contracted with a specific vendor solely for the purpose of general consulting, and not to support staffing arrangements. As such, this vendor did not sign the proper contract amendment template, SFHP's Staffing Services Agreement (see attached), which includes the background screening requirements and process. The need for staffing arose after initial contracting with this vendor and SFHP's Human Resources department was not informed that the two consultants had been contracted with until after they were already conducting plan duties.
		4.3.1_MTM Agenda 03.2022
		
		4.3.1_MTM Slides 03.2022
		
		4.3.1_SSA Amendment
			Management Team was trained on new process – March 30, 2022
			
			New DTP Drafted – November 15, 2022
			
			Expected Audit Completion – December 31, 2022
				The following additional documentation supports the MCP's efforts to correct this finding:
				
				POLICIES AND PROCEDURES
				
				• ADM-01: Execution of Administrative Contract
				  ○ The Plan submitted a revised P&P committing the Plan to monitor and review for background checks for those with access to PHI/PI as a part of the contracting process (pages 4-6).
				  ○ Secondarily, the revised P&P designates additional liaisons between interested departments and the Contracts department to increase oversight on the vendor selection process (page 3).
				
				• ADM-03: Vendor Contract Maintenance Policy
				  ○ The P&P delegates the Department Lead over monitoring performance, service rates, reviewing deliverables, approving invoices, and monitoring contract termination/renewal dates.
				  ○ The Compliance and Regulatory Affairs Department works with Department Leads to monitor vendor contracts to confirm compliance with regulatory reporting requirements during Business Associate Agreement (BAA) reviews.
				
				MONITORING AND OVERSIGHT
				
				• ADM-01: Execution of Administrative Contract

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	As a result of this finding, SFHP has updated its process for vendor contracting with consultants. Any time a SFHP department wishes to fill a role with a consultant, that request to contract now begins with SFHP's Human Resources Department. SFHP Human Resources staff reviews the manager's request for a consultant and initiates the process to reach out to SFHP's existing staffing services vendors to request a bid for filling that role. SFHP Human Resources is the only department that can make this type of request. This process update was discussed with all SFHP managers at its March Management Team Meeting (MTM). SFHP is currently drafting a DTP to document process and expects the DTP. Additionally, SFHP is no longer contracted with this vendor and the staff members involved in this isolated incident are no longer employed by SFHP. The manager that contracted with the vendor and both consultants are no longer with			○ The Administrative Contracts Manager (ACM) provides department leads with monthly reports of all active contracts and communicates the requirement for background checks. ○ The Compliance Officer reviews contracts for completion of background checks on a quarterly basis (page 6). ○ A Department Lead works with the ACM to create vendor contracts and requires proposals be reviewed by Chief Office of Compliance, Regulatory Affairs, and/or the Regulatory Affairs Counsel. ○ The Department Lead uses a Business Associate (BA) Decision Tree to determine if the Vendor has access to a PHI/PI (page 9); if the BA has access, then the Department Lead moves forward with completing the Administrative Contract (page 3). • ADM-03: Vendor Contract Maintenance Policy (page 3-4) ○ The Administrative Contracts Manager (ACM) maintains compliance through monthly reports of all active administrative contracts which are sent to department executives/directors. ○ This section also outlines that, on top of agreed upon service levels, performance guarantees, and reports, that there must be: (1) a governance structure (2) a scorecard (3) formal and recurring review meetings to include review of score card and reports for gaps or outlying trends, development and follow-up of Corrective Action Plans for the Plan and the Vendor to resolve any operational or contractual issues, develop new strategies and tactics that continuously

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	SFHP. SFHP is conducting an audit of all current consultants to confirm they have all undergone background checks.			improve the value and performance of the SFHP-Vendor relationship • Audit Contractors December 2022 – Audit Results o The Plan conducted an audit of consultants to confirm they have undergone background checks and submitted an Excel tracker. o Some vendors were highlighted and flagged due to their background check status listed as “in progress” and it was “to be determined” whether checks were completed before active status. o Several vendors had specific notes mentioning that they lacked access to PI/PHI. **The corrective action plan for finding 4.3.1 is accepted.**
5. Quality Management				
5.1.1 Evaluation of Potential Quality Issues (PQIs) The Plan did not evaluate Potential Quality Issues (PQIs) identified from grievances and did not determine if actions to address quality of care issues	SFHP’s Quality Review Nurses, Medical Directors, and Chief Medical Officer are actively working to update SFHP’s PQI process to address these findings. SFHP’s process revision includes the following items: • Already developed a tracking mechanism for PQI case progress. • Researched other Medi-Cal Managed Care Plans’ PQI processes and learned best	5.1.1_PQI Plan	1. 9/29/2022 August 2022 – Research Other Plan’s PQI Process August 4, 2022 – Monthly Process Improvement Meetings December 31, 2022 –	The Plan took steps to address the deficiency during the 2022 CAP; however, due to the overlap in the open CAP and subsequent audit period, the 2023 Medical audit revealed a lack of complete remediation. Therefore, finding 5.1.1 is a repeat finding in the 2023 Medical audit and will be assessed using the superseding 2023 DHCS CAP. The open finding 5.1.1 is transferred to the subsequent CAP which has the same finding.

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were necessary.	practices from the joint Kaiser audit. This research was completed in August 2022. • Beginning August 4, 2022, implemented monthly meetings to discuss the process revision progress. • Updating SFHP's PQI P&P, creating an accompanying DTP, and finalizing the case leveling grid by December 31, 2023. • Continue to conduct the annual Inter-Rater Reliability process for oversight and monitoring of clinical decision-making in the PQI process. • Create a training plan for ongoing staff training by January 31, 2023. • Complete PQI process revisions entirely by June 30, 2023. SFHP underwent staffing issues last year in the team that identifies and investigates PQIs. There were several vacancies, including the manager overseeing the team. SFHP		Update P&Ps, DTPs, and Leveling Grid January 31, 2023 – Training Plan Creation June 30, 2023 – PQI Process Revisions Complete, including Trainings Conducted	

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	has filled the vacant roles and the interim manager is no longer with SFHP. Following receipt of this finding, SFHP reviewed its PQI cases from that time and re-opened any cases that required further investigation. The volume of PQI cases has tripled this year compared to last year. The two deficient cases that DHCS identified during the audit continue to be under investigation with SFHP. SFHP will make sure to investigate all concerns included in these cases, and will issues corrective action plans, as needed.			

Submitted by: **Yolanda R. Richardson** (Signature on file) **Date: 9/20/2022**
Title: **CEO**