DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF SAN FRANCISCO HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 23-30237

Audit Period: April 1, 2024 — February 28, 2025

Dates of Audit: March 3, 2025 — March 14, 2025

Report Issued: August 22, 2025

TABLE OF CONTENTS

I. INTRODUCTION

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

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

The Plan contracts with 16 medical entities and 1 transportation broker to provide or arrange comprehensive health care services. The Plan delegates several functions to these entities.

As of January 1, 2025, the Plan served 190,654 members through the following programs: Medi-Cal 178,808 and Healthy Workers 11,846.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of April 1, 2024, through February 28, 2025. The audit was conducted from March 3, 2025, through March 14, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on July 17, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On August 1, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Population Health Management (PHM) and Coordination of Care, Network and Access to Care, Member Rights, Quality Improvement and Health Equity Transformation, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of March 1, 2023, through March 31, 2024, was issued on July 31, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation and effectiveness of the Plan's prior year 2024, Corrective Action Plan (CAP).

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

There were no findings noted for this category during the audit period.

Category 2 – Population Health Management and Coordination of Care

The Plan must ensure that a member's completed Initial Health Appointment (IHA) is documented in their medical record and that appropriate assessments from the IHA are available during subsequent health visits. The Plan must make reasonable attempts to contact a member to schedule an IHA and must document all attempts to contact a member. The IHA must be completed within 120 days of enrollment for new members and can be completed over the course of multiple visits. All IHA requirement attempts should be documented in the member's medical record. Finding 2.1.1: The Plan did not ensure new members completed their IHAs within the required contractual requirement of 120 days. The Plan did not make and document reasonable attempts to contact new members and schedule an IHA.

The Plan must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum: Ensure that each member has an ongoing source of care that is appropriate, ongoing and timely to meet the member's needs; ensure that each member is engaged with their assigned Primary Care Provider (PCP) and that the member's assigned PCP plays a key role in the care; ensure efficient care coordination; provide members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes. Finding 2.1.2: The Plan did not ensure members received Basic PHM services.

The Plan must ensure all members receive all seven Enhanced Care Management (ECM) core service components: Outreach and Engagement; Comprehensive Assessment and Care Management Plan (CMP); Enhanced Coordination of Care; Health Promotion; Comprehensive Transitional Care; Member and Family Supports; and Coordination of and Referral to Community and Social Support Services. Finding 2.6.1: The Plan did not ensure that all members received all seven ECM core service components.

Category 3 – Network and Access to Care

There were no findings noted for this category during the audit period.

Category 4 – Member Rights

The Plan must ensure each issue presented by the member in the grievance is addressed and resolved. Finding 4.1.1: The Plan sent resolution letters without resolving each issue presented in the members' submitted grievances.

Category 5 – Quality Improvement and Health Equity Transformation

There were no findings noted for this category during the audit period.

Category 6 – Administrative and Organizational Capacity

The Plan is required to have written policies and procedures that outline the Plan's process to ensure policies and procedures are reviewed at least annually and how changes are disseminated to impacted operational areas. Finding 6.2.1: The Plan's policies did not ensure all policies and procedures are reviewed at least annually.

Plan policies and procedures are required to include the criteria for selecting a Compliance Officer and a job description, including responsibilities and the authority of the position. Finding 6.2.2: The Plan did not have policies and procedures that included criteria for selecting a Compliance Officer and a job description outlining the responsibilities and authority of the position.

The Plan is required to have a system for board members, officers, senior management, and employees to receive training on policies and procedures related to compliance for specific job functions. Finding 6.2.3: The Plan did not have a system for board members to receive training on policies and procedures related to compliance for specific job functions.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from March 3, 2025, through March 14, 2025, for the audit period of April 1, 2024, through February 28, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Service Requests: Thirty-two medical service request cases were reviewed for timeliness, consistent application of criteria, and appropriate review. Twenty-four were prior authorization requests, three were concurrent review requests, three were retrospective review requests, and two were post-stabilization authorization requests.

Appeal Requests: Nineteen prior authorization appeals were reviewed for appropriate and timely adjudication.

Delegated Authorization Requests: Twenty-five medical service requests from North East Medical Services were reviewed for timeliness, consistent application of criteria, and appropriate adjudication. Of the 25 cases, 5 were urgent requests, and 20 were standard prior authorization requests.

Category 2 – Population Health Management and Coordination of Care

IHA: Twenty medical records were reviewed for evidence of coordination of care and fulfillment of IHA requirements.

Basic PHM/Population Risk Stratification and Segmentation, and Risk Tiering: Fifteen medical records were reviewed to confirm coordination of care and fulfillment of requirements.

ECM: Ten files were reviewed to confirm coordination of care and compliance with requirements.

Category 3 – Network and Access to Care

Emergency Services and Family Planning: Twenty emergency services and 20 family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation: Twenty claims were reviewed for timeliness and appropriate adjudication.

Non-Medical Transportation: Twenty claims were reviewed for timeliness and appropriate adjudication.

Category 4 – Member Rights

Grievances: Forty-five standard grievances and four exempt grievances were reviewed for timely resolution, appropriate classification, response to complainant, and submission to the appropriate level for review. The 45 standard grievance cases included 15 quality of service and 30 Quality of Care (QOC) grievances.

Category 5 – Quality Improvement and Health Equity Transformation

Potential Quality Issues (PQI): Fifteen PQI cases were reviewed for timely evaluation and effective action taken to address needed improvements.

Category 6 – Administrative and Organizational Capacity

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

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.1 Initial Health Appointment

2.1.1 Requirement for Initial Health Appointment

The Plan must ensure provision of an IHA in accordance with California Code of Regulations (CCR), Title 22, sections 53851(b)(1), 53910.5(a)(1), and *All Plan Letter (APL) 22-030, Initial Health Appointment*. An IHA at a minimum must include: a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases. The Plan must ensure that a member's completed IHA is documented in their medical record and that appropriate assessments from the IHA are available during subsequent health visits. The Plan must make reasonable attempts to contact a member to schedule an IHA and must document all attempts to contact a member. Documented attempts that demonstrate the Plan's efforts to unsuccessfully contact a member and schedule an IHA will be considered evidence in meeting this requirement. The Plan may delegate these activities, but the Plan remains ultimately responsible for all delegated functions. *(Contract 23-30237, Exhibit A, Attachment III, 5.3.3(B)(C))*

The Plan must cover and ensure the provision of all medically necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA, or during visits for routine, urgent, or emergent health care situations. The Plan must ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow-up. *(Contract 23-30237, Exhibit A, Attachment III, 5.3.5(B)(2))*

The IHA occurs during a member's encounter with a provider within the primary care medical setting. During the IHA, the provider assesses and manages the acute, chronic, and preventative health needs of the member. Guidance on the IHA requirements can be found in the PHM Policy Guide and the Managed Care Plan Contract. *(APL 22-030, Initial Health Appointment)*

The Plan is required to ensure that their network providers who perform periodic health assessments on child members between the ages of six months to six years (72 months) comply with current federal and state laws, and industry guidelines for health care providers issued by the Childhood Lead Poisoning Prevention Branch, including any future updates or amendments to these laws and guidelines. The Plan must ensure that the network provider documents the reason for not performing the blood lead screening test in the child member's medical record. *(APL 20-016, Blood Lead Screening of Young Children)*

The IHA must be completed within 120 days of enrollment for new members. The IHA requirement can be completed over the course of multiple visits. All IHA requirement attempts should be documented in the member's medical record. Plans should continue to hold network providers accountable for providing all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce. DHCS will leverage existing Managed Care Accountability Sets (MCAS) measures focused on preventive services, such as Child and Adolescent Well-Care Visits and Adults' Access to Preventive/Ambulatory Health Services, as proxies for monitoring the IHAs. A sample list of MCAS measures that will be used as proxies includes lead screening in children. *(CalAIM: Population Health Management (PHM) Policy Guide, January 2024, (2)(C)(2))*

Plan policy, *PHM-02 Initial Health Appointment (IHA)* (revised 1/2/25), stated that the Plan ensures providers complete an IHA for each member within specific timeframes following enrollment. The IHA must be completed within 120 days of enrollment of new members and must continue to include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. The Plan or delegates conduct reasonable attempts to contact members that have not completed an IHA within 120 days of enrollment. When outreach is delegated, the provider is responsible for outreach and documentation of outreach. A complete IHA consists of the following components, including but not limited to, a plan of care including interventions, referrals, health education, and high-risk behavior counseling and follow-up care.

Plan policy, *HE-03 Preventive Health Care Guidelines* (revised 11/26/24), stated that the Plan's PCPs conduct IHAs of Medi-Cal members within 120 days of member enrollment into the Plan. In accordance with DHCS APL 20-016 the Plan covers routine Blood Lead Level testing of members at 12 and 24 months of age.

Finding: The Plan did not ensure new members completed their IHAs within the required contractual requirement of 120 days. The Plan did not make and document reasonable attempts to contact new members and schedule an IHA.

In a verification study, 14 of 20 new members did not have an IHA completed within 120 days. Examples included:

- Six members were seen by a provider during the audit period, but the IHA was not completed. For one member, the provider did not order a blood lead screening test or reach out to a three-year-old pediatric member to complete all IHA components. Another member was treated for a knee injury but did not receive an IHA. In a written response, the Plan acknowledged that the other four members had no recorded IHA or outreach attempts.
- Four members did not complete an IHA within 120 days. Instead, the IHA completion timeframes were between 165 days to 228 days. There was no record of outreach attempts documented for these members.

In an interview, the Plan does not delineate responsibilities for IHA performance or outreach attempts between itself and its providers. The Plan's policy did not specify whether the Plan or the providers were responsible for conducting the member outreach when a member is assigned to a delegated entity. However, the Plan is ultimately responsible for all member outreaches.

This is a repeat finding of the prior year's finding 2024-2.1.1 Requirement of Initial Health Appointment. The Plan did not ensure new members completed their IHA within the contractual requirements of 120 days. The Plan did not make and document reasonable attempts to contact new members and schedule an IHA.

As a CAP to the prior audit deficiency, the Plan created an IHA workgroup, added an IHA annual audit and updated their IHA policy and outreach letter.

The Plan's IHA workgroup meeting minutes noted that the Plan was tracking outreach processes. However, the Plan stated that it did not have the staff capacity to conduct outreach attempts to members.

In a written response, the Plan stated that as part of its CAP, an IHA audit was added to the annual delegation audit process. However, no results from the IHA audits were submitted for review. Although the Plan's CAP was in progress, non-compliance with IHA requirements was identified throughout the audit period.

When the Plan does not make attempts to contact members and schedule an IHA, members may not receive necessary behavioral and medical health screenings that can help identify and prevent illnesses.

Recommendations: Implement policies and procedures to ensure that an IHA is completed within the contractual requirement of 120 days or reasonable attempts to contact members are documented.

2.1 Basic Population Health Management

2.1.2 Basic Population Health Management Services for Members

The Plan must provide Basic PHM to all members, in accordance with Code of Federal Regulations, Title 42, section 438.208. The Plan must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum: Ensure that each member has an ongoing source of care that is appropriate, ongoing and timely to meet the member's needs; ensure that each member is engaged with their assigned PCP and that the member's assigned PCP plays a key role in the care; ensure efficient care coordination; provide members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes. *(Contract 23-30237, Exhibit A, Attachment III, 4.3.8 (A)(1)(2)(3)(5)(13))*

Basic PHM is an approach to care that ensures needed programs and services are made available to each member, regardless of the member's risk tier, at the right time and in the right setting. In contrast to care management, which is focused on populations with significant or emerging needs, all Plan members receive Basic PHM, regardless of their level of need. Basic PHM replaces DHCS' previous "Basic Case Management" requirements. Basic PHM is ultimately the responsibility of the Plan. *(CalAIM: Population Health Management (PHM) Policy Guide, January 2024, (II)(E)(1))*

Plan policy, *PHM-01 Population Health Management* (revised 1/2/25), stated that if the PCP contacts and engages the individual, the Plan may choose to delegate responsibility to the PCP for Basic PHM care coordination and health education functions whenever feasible. If an individual does not engage with a PCP, the Plan is fully responsible for the provision of Basic PHM. The Plan ensures that individuals have access to needed services that address all their health and health-related needs. The Plan is required to partner with primary care and other delivery systems to guarantee that individuals' needs are addressed. This includes ensuring that everyone's assigned PCP plays a key role in coordination of care, ensuring everyone has sufficient care coordination and continuity

of care with out-of-network providers, and communicating with all relevant parties on the care coordination provided. The Plan must also assist individuals in navigation, provider referrals, and coordination of health and services across other Plans, settings, and delivery systems.

Plan policy, *CARE-01 Care Management Programs Time-Limited Care Coordination and Child, Adolescent and Transition Age Youth Programs* (revised 2/23/24), stated that basic case management services provided by the Plan include coordination with PCPs in the provision of basic case management services, including educating members how to access needed care, and by providing care coordination and case management services when indicated. This includes care management services for all medically necessary Early and Periodic Screening, Diagnostic, and Treatment services. All members receive basic case management services as a component of the practice of primary care medicine within the member's medical home.

Finding: The Plan did not ensure members received Basic PHM services.

A verification study of 4 of 15 member records showed that members did not receive Basic PHM services.

- For one member with multiple medical conditions including lung disease, glaucoma, schizophrenia, and intellectual disabilities, the Plan's Care Coordinator initiated contact with the member and PCP, but did not conduct care coordination, referrals or follow-ups for two months before closing the case. The member's PCP reported that the member had cancelled all their follow-up appointments. The member's assessment noted that they had a case manager at the Regional Center and lived in a facility. However, there was no documentation that the Plan's care coordinator reached out to the member's case manager at the Regional Center. The member's assessment also stated that they would like a mental health referral, but this was not completed.
    - The Plan's self-audit case closure tool for this member did not contain information on care coordination but was signed off by the Plan's staff. A review of the Plan's tool revealed that it did not contain a section for care coordination evaluation such as referrals and coordination with other programs. The Plan acknowledged there had been a gap in care for the member due to an oversight.

- Three member records did not contain documentation of PCP engagement, follow-up services, care coordination, or referrals. All three members' assessments reported they needed assistance with obtaining medical equipment such as a wheelchair, adaptive stroller and a cane. The Plan could not provide any information for the three members.

The Plan's processes did not ensure all Basic PHM requirements, including care coordination and oversight of delegated Basic PHM were conducted.

When the Plan does not ensure that members are provided with Basic PHM services, members may not receive needed medical services to manage their physical and emotional health conditions.

Recommendation: Revise and implement policies and procedures to ensure that all members receive Basic PHM services.

2.6 Enhanced Care Management

2.6.1 Enhanced Care Management Core Service Components

The Plan must ensure members receive all of the following seven ECM core service components, as further defined in APLs: Outreach and Engagement; Comprehensive Assessment and CMP; Enhanced Coordination of Care; Health Promotion; Comprehensive Transitional Care; Member and Family Supports; and Coordination of and Referral to Community and Social Support Services. *(Contract 23-30237, Exhibit A, Attachment III, Subsection 4.4.11)*

The Plan must administer ECM and provide the seven core ECM services to eligible members in applicable ECM populations of focus. The requirements under the following core service components must include, but is not limited to:

- Component 2, Comprehensive Assessment and CMP, which must include, but is not limited to:
    - Requirement b: Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess member health status and gaps in care and may be needed to inform the development of an individualized CMP.

- Requirement c: Developing a comprehensive, individualized, person-centered CMP with input from the member and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate, to assess strengths, risks, needs, goals and preferences and make recommendations for service needs.

- Component 3, Enhanced Coordination of Care, which must include, but is not limited to:
  - Requirement b: Maintaining regular contact with all providers that are identified as being a part of the member's multi-disciplinary care team since their input is necessary for successful implementation of the member's goals and needs.
  - Requirement d: Providing support to engage the member in their treatment, including coordination for medication review and reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to member engagement in treatment.
  - Requirement f: Ensuring regular contact with the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as appropriate, consistent with the CMP.
- Component 4, Health Promotion, which must include, but is not limited to:
  - Requirement a: Working with the member to identify and build on successes and potential family and/or support networks.
  - Requirement b: Providing services to encourage and support the member to make lifestyle choices based on healthy behavior, with the goal of supporting the member's ability to successfully monitor and manage their health.
- Component 6, Member and Family Supports, which must include, but are not limited to:
  - Requirement c: Activities to ensure the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, are knowledgeable about the member's conditions, with the overall goal of improving the member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.

- Requirement f: Providing appropriate education for the member and their family members, legal guardians, authorized representatives, caregivers, and/or authorized support persons, as applicable, about care instructions for the member.
- Requirement g: Ensuring that the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, have a copy of the member's CMP and information about how to request updates.

(APL 23-032, Enhanced Care Management Requirements)

Plan policy, *CARE-13 ECM* (revised 1/2024), describes ECM core service components such as 1) Outreach and Engagement; 2) Comprehensive Assessment and CMP; 3) Enhanced Coordination of Care; 4) Health Promotion; 5) Comprehensive Transitional Care; 6) Member and Family Supports; and 7) Coordination of and Referral to Community and Social Support Services. The ECM program has an oversight and monitoring committee that oversees various components of the program and determines if actions or adjustments are needed.

Finding: The Plan did not ensure that all members received all seven ECM core service components.

A verification study of ten of ten member records showed that members did not receive all seven ECM core service components:

- Component 2, Comprehensive Assessment and CMP: Two members received an assessment and CMP that was not comprehensive.
  - Requirement c: For two members, the Care Manager did not obtain input from the family members or caregivers to assess strengths, risks, needs, goals and preferences and make recommendations for the member's service needs when developing a CMP.
- Component 3, Enhanced Coordination of Care: Six members did not receive all the required services under component 3.
  - Requirement b: For three members, the case manager did not engage with the member's primary care provider for input in the implementation of member goals and needs.

- Requirement d: For four members, they did not receive coordination and reconciliation of their medication.
- Requirement f: For three members, they did not receive regular contact from the ECM provider. For example, one member had a three-month delay in initiating the ECM outreach and another three-month gap in member engagement.

- Component 4, Health Promotion: Two members did not receive health promotion support.
  - Requirement b: For both members, there was no documentation that the member and/or family members were provided the tools and support that would help the member and/or family member better monitor and manage their current health status.
- Component 6, Member and Family Supports: Nine members did not receive adequate member and family supports services.
  - Requirement c: For three members, there were no activities to ensure the member and family members, or caregivers, are knowledgeable about the member's conditions with the overall goal of improving the member's care planning and follow-up.
  - Requirement f: For three members, there was no documentation that the ECM provider engaged or educated the member and their family or caregiver on the member's current health issues to assist in the management and improvement of the member's health conditions.
  - Requirement g: For nine members, the member and family member, or caregiver did not receive a copy of the member's CMP and information about how to request updates.

Plan policy CARE-13 did not include all requirements under each ECM core service component as described below:

- Component 2 did not include requirement c: developing a comprehensive, individualized, person-centered CMP with input from the member and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate, to assess strengths, risks, needs, goals and preferences and make recommendations for service needs.

- Component 3 did not include requirement f: ensuring regular contact with the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as appropriate, consistent with the CMP.
- Component 6 did not include requirement g: ensuring that the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, have a copy of the member's CMP and information about how to request updates.

In an interview, the Plan acknowledged the need to revise their current policy.

Plan policy CARE-13 stated the ECM program has an oversight and monitoring committee that oversees various components of the program and determines if actions or adjustments are needed. However, the policy did not specify how and when the Plan conducts the oversight activities.

The Plan's ECM file review process did not include all the required components of the ECM core services such as: component 2, requirement c, component 3, requirement d, and component 6, requirement c, e, f and g.

When the Plan does not ensure all ECM core service components are completed, members may not receive proper coordination of services and comprehensive care management, resulting in adverse health outcomes.

Recommendation: Revise and implement policies and procedures to ensure members receive all seven ECM core service components.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member Rights

4.1 Member Grievance System

4.1.1 Resolution of Quality of Care Grievances

The Plan must have in place a grievance system that complies with CCR, Title 28, section 1300.68. *(Contract 23-30237, Exhibit A, Attachment III, 4.6.1)*

The Plan must comply with all DHCS guidance, including APLs. APLs existing on the effective date of this Contract will be considered part of the Contract. *(Contract 23-30237, Exhibit E, 1.1.2(A)(1))*

The Plan's written response to the resolution shall contain a clear and concise explanation of the Plan's decision. *(CCR, Title 28, section 1300.68(d)(3))*

The Plan must ensure each issue is addressed and resolved. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance. The Plan must operate in accordance with its written grievance procedures. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan Policy, *GA-01 Clinical Member Grievances* (approved 4/4/24), stated that grievances are presented to the Grievance Review Committee (GRC) to ensure all components were fully investigated, including clinical care, and to determine if the grievance can be closed. A grievance is resolved when it has reached a conclusion with respect to the member's submitted grievance. The resolution will address all issues presented by the member.

Finding: The Plan sent resolution letters without resolving each issue presented in the members' submitted grievances.

The verification study revealed 5 of 30 QOC grievances were closed without providing a clear and concise explanation of the Plan's decision for all issues presented by the members, prior to sending resolution letters to the members. Examples of deficient grievances include:

- A member filed a grievance against multiple providers because they would not order testing of a lump on the member's chest. The member also alleged discrimination and requested a referral. The Plan closed the grievance and sent

the resolution letter without receiving and reviewing the providers' responses and fully investigating the grievance. The resolution letter did not resolve the issues presented by the member. The resolution letter stated the Plan is still working on the member's complaints with the providers.

- A member filed a grievance alleging their provider was rude, did not listen, and offered an unacceptable solution. The member also requested to change providers. The Plan closed the grievance and sent the resolution letter without receiving and reviewing the provider's response and fully investigating the grievance. Other than changing the provider, the resolution letter did not address and resolve each issue presented by the member.
- A member filed a grievance alleging inappropriate care and denial of care by the provider. The resolution letter stated that the Plan is still working on the member's complaints with the provider.
- A member filed a grievance with multiple complaints because they disagreed with the treatment they were provided and denied their medication. The resolution letter did not address each issue presented by the member, as the letter stated that additional questions needed to be answered by the provider and the Plan will continue to look into it.
- A member with a broken foot filed a grievance against the provider due to the delay and cancellation of their urgent specialist appointment. Despite multiple attempts from the Plan to obtain a response, the provider declined to forward the request to the specialist department. The provider stated that they considered the grievance closed because the member subsequently received an appointment; therefore, the provider would not require a response from the specialist department. However, the resolution letter did not address and resolve the member's complaints about the reasons for the delay and cancellation of their urgent specialist appointment.

In a written statement, the Plan stated that if the provider's response is not received in a timely manner, but the member's grievance was addressed the grievance is closed. However, this process only ensures that the grievances were addressed but not resolved with a final conclusion as contractually required.

In an interview, the Plan outlined its procedure for closing grievances, indicating the resolution letter is drafted, the case is reviewed by the GRC, and the final decision whether to close the grievance is made by the Medical Director. However, the Plan's resolution letters showed the Plan had not resolved all issues presented by the member prior to closing the grievance.

Plan policy GA-01 stated that grievances are presented to the GRC to ensure all components were fully investigated, including clinical care, and to determine if the grievance can be closed. However, the policy did not provide sufficient guidance to ensure grievances were fully investigated, resolved, and that a final conclusion was reached prior to closing grievances and sending resolution letters to members.

When QOC grievances are not adequately considered and resolved prior to closing the grievances and sending resolution letters, members may be deprived of information necessary to make informed healthcare decisions, which could adversely affect QOC.

Recommendation: Revise and implement policies and procedures to ensure each issue in QOC grievances is resolved before closing the grievances and sending resolution letters to members.

COMPLIANCE AUDIT FINDINGS

Category 6 – Administrative and Organizational Capacity

6.2 Fraud and Abuse

6.2.1 Written Policies and Procedures Reviews

The Plan is required to have written policies and procedures that outline the Plan's process to ensure policies and procedures are reviewed at least annually and how changes are disseminated to impacted operational areas. *(Contract 23-30237, Exhibit A, Attachment III, 1.3.1(C))*

Plan policy, *CRA-11 Developing New and Revising Existing SFHP Policies and Procedures* (reviewed 8/15/23), stated that the Plan reviews policies and procedures at least once every two years from the date of their last review. All of the Plan's policies and procedures must undergo annual or biennial review in accordance with the review and approval procedures detailed in the policy even when revisions are not necessary.

Plan policy, *CRA-28 Policy and Compliance Committee* (reviewed 11/26/24), stated that the Regulatory Affairs Analyst reminds the Policy and Compliance Committee to review policies and procedures that are due for annual or biennial review.

The Plan's *Program Integrity Program FY 2024-2025,* stated that the Plan's staff reviews and updates policies and procedures at least bi-annually (every two years).

Finding: The Plan's policies did not ensure all policies and procedures are reviewed at least annually.

Review of the Plan's policies and *Program Integrity Program FY 2024-2025,* revealed non-compliant and inconsistent timeframes for Plan policies and procedures reviews (biennial vs bi-annually). "Biennial" means occurring every two years, while "Bi-annual" means occurring twice a year. However, neither document stated that policies and procedures should be reviewed annually.

A sample of six plan policies revealed that plan policies were reviewed every two years. For example:

- CRA-*11 Developing New and Revising Existing SFHP Policies and Procedures* (Biennial reviewed 8/15/23 and 3/4/25)
- *CRA-25 Minor Consent* (Biennial reviewed 6/23/22 and 8/1/24)

- *CRA-28 Policy and Compliance Committee* (Biennial reviewed 11/17/22 and 11/26/24)
- *CL-04 Misdirected Claims* (Biennial reviewed 4/22/21 and 6/26/23)
- *CL-15 Claims Remittance Advice* (Biennial reviewed 5/19/22 and 6/25/24)
- *CR-13 Credentialing or Vetting ECM & Community Supports Providers* (Biennial reviewed 2/24/22 and 6/25/24)

In a written response and interview, the Plan acknowledged the policy review timeframe deficiency and the need to update its process.

When the Plan does not review policies and procedures annually, the Plan cannot effectively incorporate changes to the impacted operational areas and comply with updated laws, regulations, and requirements.

Recommendation: Revise and implement policies and procedures to ensure policies and procedures are reviewed at least annually.

6.2.2 Compliance Officer Criteria

Plan policies and procedures are required to include the criteria for selecting a Compliance Officer and a job description, including responsibilities and the authority of the position. *(Contract 23-30237, Exhibit A, Attachment III, 1.3.1(E))*

The Plan's *Program Integrity Program FY 2024-2025,* stated the Compliance Officer reports to the Plan's Chief Executive Officer and has an indirect reporting relationship to the Governing Board. The document also listed the Compliance Officer's duties and responsibilities including, but not limited to the following:

- Submits annual reports regarding the Plan's anti-fraud and abuse activities and findings to the Department of Managed Health Care and the Plan's Finance Committee, Board of Governors and Executive Team (ET).
- Informs the Board and ET of suspected and investigated fraud and abuse activities on an on-going basis.
- Updates or develops new policies and procedures.
- Plans and oversees audits and monitoring of the Plan's operations in order to identify and rectify any possible barriers to the efficacy of this Program.

Finding: The Plan did not have policies and procedures that included criteria for selecting a Compliance Officer and a job description outlining the responsibilities and authority of the position.

The Plan's compliance plan included the Compliance Officer's duties and responsibilities. However, it did not describe the criteria for selecting a Compliance Officer and the authority of the position nor reference policies and procedures that included this information.

In a compliance statement, the Plan confirmed that it did not have any policies and procedures for selecting a Compliance Officer. However, the statement did not address the lack of policies and procedures with a job description related to the role.

Without the required policies and procedures, the Plan cannot fully demonstrate that the Compliance Officer has adequate qualifications to fulfill all the necessary responsibilities.

Recommendation: Develop and implement policies and procedures to include criteria for selecting a Compliance Officer and a job description, including responsibilities and the authority of the position.

6.2.3 Training on Policies and Procedures for Board Members

The Plan is required to have a system for board members, officers, senior management, and employees to receive training on policies and procedures related to compliance for specific job functions. *(Contract 23-30237, Exhibit A, Attachment III, 1.3.1(H))*

The Plan's *Program Integrity Program FY 2024-2025,* stated that all employees are required to attend the mandatory annual educational and training program to ensure that all employees are familiar with all areas of laws, regulations and policies that apply to and are impacted upon the conduct of their respective duties. Contracted providers are required per their contract to provide compliance training to their staff. In addition to annual and other periodic training, all employees have access to a copy of the Program Integrity Program on the organization's internal network. All updates to the Program Integrity Program are provided to all Plan employees in a timely manner.

Finding: The Plan did not have a system for board members to receive training on policies and procedures related to compliance for specific job functions.

The Plan provided evidence of compliance training completion for officers, senior management and employees. However, the Plan confirmed in a written statement that board members were not required to take any compliance training.

The Plan's compliance plan did not describe a process for board members to receive training on policies and procedures related to compliance for specific job functions.

When the Plan does not have a system for board members to receive training on policies and procedures related to compliance for specific job functions, it cannot ensure that board members have sufficient knowledge to perform their duties.

Recommendation: Develop and implement policies and procedures to ensure board members receive training on policies and procedures related to compliance for specific job functions.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF SAN FRANCISCO HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 23-30269

Contract Type: State Supported Services

Audit Period: April 1, 2024 — February 28, 2025

Dates of Audit: March 3, 2025 — March 14, 2025

Report Issued: August 22, 2025

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the results of the audit of San Francisco Health Authority dba San Francisco Health Plan (Plan) compliance and implementation of the State Supported Services contract 23-30269 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of April 1, 2024, through February 28, 2025. The audit was conducted from March 3, 2025, through March 14, 2025, which consisted of a document review and verification study with the Plan administration and staff.

Twenty claims were reviewed for appropriate and timely adjudication.

An Exit Conference with the Plan was held July 17, 2025. No deficiencies were noted during the review of the State Supported Services Contracts.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members enrolled under this Contract or the Primary Contract, the following private services:

1) Current Procedure Terminology codes: 59840 through 59857
2) Centers for Medicare and Medicaid Services Common Procedure Coding System codes: X1516, X1518, X7724, X7726, and Z0336

These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code set provisions. *(Contract, Exhibit A, (1.2.1) (1.2.2))*

The Plan is required to cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements in the Medi-Cal Provider Manual. The Plan, network providers and subcontractors are prohibited from requiring medical justification, imposing any utilization management or utilization review requirements, including prior authorization, for the coverage of outpatient abortion services. *(All Plan Letter 24-003, Abortion Services)*

Finding: No deficiencies were identified in the audit.

Recommendation: None.