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

REPORT ON THE MEDICAL AUDIT OF

# San Francisco Health Authority
# dba San Francisco Health Plan

Contract Number: 04-35400

Audit Period: March 1, 2019
Through
February 29, 2020

Report Issued: July 17, 2020

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# I. INTRODUCTION

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

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

As of January 2020, the Plan served 134,819 members through the following programs: Medi-Cal 123,116 and Healthy Workers 11,703. The Plan's Healthy Kids Members were moved to Medi-Cal effective October 1, 2019.

# II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of March 1, 2019 through February 29, 2020. The onsite review was conducted from March 2, 2020 through March 12, 2020. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on June 18, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

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

The prior DHCS medical audit for the period of March 1, 2018 through February 28, 2019, was issued on July 10, 2019. This audit examined documentation for compliance and to determine to what extent the Plan has implemented their Corrective Action Plan.

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**

Category 1 includes procedures and requirements for the Plan's UM program, including delegation of UM, prior authorization review, and its appeal process.

The Plan is required to ensure that its retrospective review procedures meet the following minimum requirements: a qualified health care professional with appropriate clinical expertise in treating the condition and disease shall decide to deny or to authorize an amount, duration, or scope of covered services that is less than requested. The Plan placed administrative conditions not specified in the Contract on retrospective requests for covered services; it allowed denials without medical necessity review by a physician.

The Plan is required to collect and review its subcontractors' ownership and control disclosure information. The Plan did not review ownership and control disclosure information for its UM delegates.

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

Category 2 includes requirements to provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) for members.

The Plan is required to use a DHCS-approved Physician Certification Statement (PCS) to determine the appropriate level of service for Medi-Cal members. PCS forms must include, at a minimum, the following components: documentation of specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles, dates of service needed, mode of transportation needed, and PCS of medical necessity. The Plan did not collect all required information on PCS forms for NEMT requests.

The Plan must ensure that all network providers are enrolled in the Medi-Cal program. The Plan contracted with transportation vendors not enrolled in the Medi-Cal program.

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

Category 3 includes procedures and requirements regarding the adjudication of claims for emergency services and family planning services.

The Plan is required to provide family planning services through any provider without prior authorization. The Plan denied non-contracted family planning claims for lack of prior authorization.

The Plan is required to forward all misdirected emergency service claims and any non-contracted claim to the appropriate capitated provider within ten working days of receipt by the Plan. The Plan did not forward misdirected claims to the proper capitated provider for reimbursement of services.

**Category 4 – Member's Rights**

Category 4 includes procedures and requirements to establish and maintain a grievance system.

The Plan is required to implement and maintain a procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance. The Plan did not ensure that the person who resolved a clinical grievance had not participated in any prior decisions related to the case.

The Plan is required to send grievance acknowledgement and resolution letters to complainants, including members and representatives who file grievances on members' behalf. The Plan did not send acknowledgement and resolution letters to member representatives who filed grievances on members' behalf.

**Category 5 – Quality Management**

Category 5 includes procedures and requirements to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by providers.

The Plan is required to list the qualifications of staff responsible for QI studies and activities including education, experience, and training, in the written description of its Quality Improvement Program (QIP). The Plan's QIP Description (QIPD) did not list the qualifications of staff responsible for QI studies and activities, including their education, experience, and training.

**Category 6 – Administrative and Organization Capacity**

The Plan is required to report to DHCS all cases of suspected fraud and/or abuse within ten working days of the date Plan first becomes aware of, or is on notice of, such activity. The Plan did not report all suspected fraud and/or abuse cases to DHCS within ten working days.

# I. SCOPE/AUDIT PROCEDURES

## SCOPE

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

## PROCEDURE

The onsite review was conducted from March 2, 2020 through March 12, 2020. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

### Category 1 – Utilization Management

Delegated UM: 43 prior authorization cases from a delegate were reviewed for appropriate and timely adjudication.

Prior Authorization Requests: 74 prior authorization files, including 40 medical and 34 pharmacy, were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: Ten appeals of denied prior authorization were reviewed for appropriate and timely adjudication.

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

NEMT and NMT: 50 claims, including 25 NEMT and 25 NMT, were reviewed for timeliness and appropriate adjudication.

### Category 3 – Access and Availability of Care

Claims: Ten emergency services claims, 15 family planning claims and ten State Supported Services claims were reviewed for proper adjudication.

**Category 4 – Member's Rights**

Grievance Procedures: 49 grievances, including 30 standard and 19 quality of care grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: Six Health Insurance Portability and Accountability Act/Protected Health Information breach and security incidents were reviewed for processing and timeliness requirements.

**Category 5 – Quality Management**

Provider Training: 33 new provider training records were reviewed for the timeliness of Medi-Cal Managed Care program training.

**Category 6 - Administrative and Organizational Capacity**

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

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

## CATEGORY 1 - UTILIZATION MANAGEMENT

| 1.1 | UTILIZATION MANAGEMENT PROGRAM<br>REFERRAL TRACKING SYSTEM / DELEGATION OF UM<br>MEDICAL DIRECTOR AND MEDICAL DECISIONS |
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### 1.1.1 Ownership and Control Disclosure Review

The Plan is required to comply with Code of Federal Regulations (CFR), Title 42, section 455.104. (*Contract Exhibit A, Attachment 1(2) (B)*)

The Plan must require each disclosing entity to disclose certain information, including the name, address, date of birth, and social security number of each person or other tax identification number of each corporation with an ownership or control interest in the disclosing entity. (*CFR, Title 42, section 455.104*)

The Plan is required to collect and review their subcontractors' ownership and control disclosure information as set forth in CFR, Title 42, section 455.104. The Plan must make the subcontractors' ownership and control disclosure information available, and upon request, this information is subject to audit by DHCS. (*All Plan Letter (APL) 17-004*)

Plan policy *CR-02 Credentialing, Re-Credentialing, Screening, and Enrollment of Organizational Providers (revised 2/13/19),* stated "Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information."

**Finding:** The Plan did not review ownership and control disclosure information for their UM delegates.

Review of six of nine delegates' disclosure forms revealed the following deficiencies:

- Four delegates' disclosure forms did not contain all owners and individuals with control interest
- Four delegates' disclosure forms did not contain social security numbers or tax identification numbers for all owners and individuals with control interest
- Four delegates' disclosure forms did not contain dates of birth for all owners and individuals with control interest

- Four delegates' disclosure forms did not contain addresses for all owners and individuals with control interest
- One delegate's disclosure form did not disclose any owners and individuals with control interest
- One delegate's disclosure form was not provided

In an interview, the Plan stated the collection and review of ownership and control disclosure information was completed through the credentialing process, however, the Plan was unable to explain the omissions and incomplete information on the disclosure form.

When the Plan does not collect and review delegates' ownership and control interest information, it cannot ensure that the delegates' owners and individuals with controlling interest are eligible for program participation.

**Recommendation:** Implement procedures to ensure review and collection of delegates' ownership and control disclosure information.

## 1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

### 1.2.1 Retrospective Authorization

The Plan shall ensure that its prior authorization, concurrent review, and retrospective review procedures meet the following minimum requirements: a qualified health care professional with appropriate clinical expertise in treating the condition and disease shall decide to deny or modify a service request. A qualified physician will review all denials based on medical necessity. *(Contract Exhibit A, Attachment 5 (2) (A) and (B)).*

Plan policy *CO-22 Authorization Requests (revised 12/12/19),* stated the Plan performed medical necessity reviews for retrospective requests if they met certain requirements, including submission within 30 days of service delivery.

**Finding:** The Plan did not ensure that a qualified physician reviewed or decided all denials based on medical necessity. The Plan placed administrative conditions not specified in the Contract on retrospective requests for covered services; it allowed denials without medical necessity review by a physician.

A 40-case verification study revealed the Plan processed nine retrospective cases as administrative reviews (submission past 30 days), and denied all nine without a physician's medical review.

Plan policy *CO- 22 Authorization Requests (revised 12/12/19)* defined retrospective review as a request for authorization after the first and last date of service have occurred (post-service). It stated the Plan would not consider these requests if they did not meet certain administrative criteria, including a 30-day post-service submission timeframe. The Plan could deny retrospective requests for covered services as benefit exclusions without a qualified physician's review and make a decision about the medical necessity of the service.

This was a finding in the prior two DHCS audits. The Plan did not implement corrective actions, stating DHCS had offered no guidance on the topic. A February 24, 2020 DHCS email stated that DHCS informed the Plan in late January 2020, the Contract did not allow placing submission time limits on retrospective prior authorizations. Further, it recommended communicating "the need to review all retrospective review requests for medical necessity within the required timeframe."

Resolution of retrospective reviews in a contractually non-compliant manner may negatively affect providers' payments and their future willingness to provide services to Plan members.

This is a repeat of the prior year's finding 1.2.1 Retrospective Authorization

**Recommendation:** Revise Plan's policy and processes to ensure the Plan places no conditions other than those that apply to prior authorizations on the submission of retrospective authorizations, and a physician reviews retrospective request denials for covered services.

## CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

| 2.4 | NON-EMERGENCY MEDICAL TRANSPORTATION<br>NON-MEDICALTRANSPORTATION |
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### 2.4.1 Physician Certification Statement

The Contract included NEMT as part of "Medically Necessary Covered Services for the member." (*Contract Exhibit A, Attachment 10 (2) (e))*

Plans are required to use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. All NEMT PCS forms must include, at a minimum, the following components: documentation of specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles, dates of service needed, mode of transportation needed, and PCS of medical necessity. Each Plan must have a mechanism to capture and submit data from the PCS form to DHCS. *(APL 17-010)*

Plan policy *CO-28 Transportation Services and Authorization Requests (revised 4/5/19)*, stated the PCS would include the diagnosis and function limitations justification, dates of service needed, mode of transportation needed, and a certification statement that the attending provider used medical necessity to determine the type of transportation needed.

**Finding:** The Plan did not collect all required information on PCS forms for NEMT requests.

A verification study revealed 12 of 25 NEMT service requests did not include all required information on the PCS form:

- Six of 12 did not include specific physical and/or medical limitations (function limitations)
- Five of 12 did not have ending dates of service
- Three of 12 did not have any dates of services
- Three of 12 did not state the mode of transportation
- One of 12 did not have a PCS form

In an interview, the Plan reported that necessary information for prior authorization could be inferred through case notes and follow-up calls. PCS forms that did not provide

ending dates but checked yes for ongoing services could be authorized up to a maximum of 12 months. This process did not comply with DHCS requirements.

When the Plan does not include DHCS required components in its PCS forms, the Plan cannot consistently confirm that it complies with DHCS requirements to provide justification for medically necessary services.

**Recommendation:** Implement policies and procedures to ensure collection of all required information on a DHCS-approved PCS form for NEMT requests.

### 2.4.2 Medi-Cal Enrolled Transportation Vendors

The Plan must ensure that all network providers are enrolled in the Medi-Cal program. (*CFR, Title 42, section 438.608 (b)*)

All Managed Care Plan network providers must enroll in the Medi-Cal program. Managed Care Plans have the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through DHCS. (*APL 19-004*)

Plan policy *CR-02 Credentialing, Re-Credentialing, Screening, and Enrollment of Organizational Providers (revised 2/13/19),* stated providers that participate in Medi-Cal must enroll in the Medi-Cal program. Plan verifies prospective providers' enrollment with DHCS prior to enrollment.

**Finding:** The Plan contracted with transportation vendors not enrolled in the Medi-Cal program.

A verification study revealed two of eight contracted transportation providers were not enrolled in the Medi-Cal program.

The Plan reported it verifies Medi-Cal enrollment through the California Health and Human Services' open data portal as part of the enrollment verification process for all providers. However, DHCS' review did not find the transportation providers through the portal. The Plan was unable to provide supporting documentation.

If the Plan cannot verify that providers are enrolled in the Medi-Cal program, it cannot ensure that providers meet Medi-Cal requirements.

**Recommendation:** Revise and implement policies and processes to ensure all network providers are enrolled in the Medi-Cal program.

## CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

| 3.3 | EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS |
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### 3.3.1 Family Planning Claims

Members have the right to access family planning services through any family planning provider without prior authorization. (*Contract Exhibit A, Attachment 8 (9)*)

Plan policy *CL-03 Payment for Out-of-Network Family Planning Services (revised 2/28/18)* stated, the Plan pays claims for out-of-network family planning services in compliance with the requirements of its DHCS Contract.

Plan policy *CO-22 Authorization Request (revised 12/12/19)* stated prior authorization is not required for family planning regardless of where services are received.

**Finding:** The Plan denied non-contracted family planning claims for lack of prior authorization.

A verification study of 15 family planning claims found five claims were denied for lack of prior authorization. The Plan denied four family planning claims with service code 81025, urine pregnancy test, and one family planning claim with service code 99214, outpatient established office visit.

In an interview, the Plan acknowledged that the claims were denied incorrectly for lack of prior authorization.

Inappropriate denials of family planning claims may limit members' access to care and discourage providers from participating with the Plan if not properly reimbursed.

**Recommendation:** Develop and implement procedures to ensure appropriate adjudication of non-contracted family planning claims.

### 3.3.2 Misdirected Claims

The Plan is required to forward all misdirected emergency service claims and any non-contracted claim to the appropriate capitated provider within ten working days of receipt by the Plan. (California Code of Regulations (*CCR), Title 28, section 1300.71(b)(2)*)

Plan policy *CL-04 Misdirected Claims (revised 2/28/18),* stated all misdirected claims are re-directed within ten working days from the date the claim is received to the member's group that is delegated to process the claim. The original submitter of the claim is notified that the claim was misdirected and that the claim has been re-directed to the appropriate party for processing.

**Finding:** The Plan did not forward misdirected claims within ten working days of receipt.

A verification study of 15 family planning claims and ten emergency services claims found four family planning claims and five emergency services claims were denied as misdirected. All nine claims were submitted by non-contracted providers. These claims were the responsibility of two delegated entities contracted to provide capitated services. The Plan notified providers on the remittance advices that claims should be directed to the responsible delegated entities, but did not forward the claims to the delegated entities for processing.

In an interview, the Plan stated that its process did not include forwarding any misdirected claims to responsible delegated entities, and only informed providers of the misdirection on remittance advices.

When the Plan does not forward misdirected claims, providers may not be reimbursed for services rendered.

**Recommendation:** Implement policies and procedures to ensure forwarding of misdirected claims within ten working days.

## CATEGORY 4 – MEMBER'S RIGHTS

| 4.1 | GRIEVANCE SYSTEM |
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### 4.1.1 Clinical Grievance Decision Maker

The Plan is required to implement and maintain a procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance for any grievance or appeal involving clinical issues. (*Contract Exhibit A, Attachment 14, 2 (G)*)

The Plan shall ensure that the person making the final decision for the proposed resolution of any grievance has not participated in any prior decisions related to the grievance. *(APL 17-006 Grievance and Appeals Requirements, VII (M))*

Plan policy *CS 14 Non-Clinical Grievances and Non-Clinical Decline to File (revised 11/5/19)*, stated the Plan ensured that the person making the final decision for the proposed resolution of a non-clinical grievance had not participated in any prior decisions related to the non-clinical grievance.

**Finding**: The Plan did not ensure that the person who resolved a clinical grievance had not participated in any prior decisions related to the case.

A verification study revealed a grievance processing deficiency in one case. In the grievance, the member complained about the appeal process. The Plan deemed the case a clinical grievance according to Plan policy. The same clinician who previously upheld the member's appeal resolved the grievance.

In an interview, the Plan acknowledged that it did not have a procedure to ensure the decision maker had not participated in related clinical grievance cases.

When the same decision maker resolves a clinical grievance related to a previous case, members may not receive an objective decision about their complaint.

**Recommendation:** Develop and implement a procedure to ensure that the final decision maker of a resolution of a clinical grievance has not participated in any prior decisions related to the clinical grievance.

### 4.1.2 Grievance Acknowledgement and Resolution Notification

The Plan is required to implement and maintain a Member Grievance System in accordance with CCR, Title 28, section 1300.68. This shall include a procedure to ensure notification of grievance acknowledgement and resolution to the complainant. *(Contract Exhibit A, Attachment 14 (1) and (2) (A))*

"Complainant" is the same as "grievant," and means the person who filed the grievance including the member, their designated representative, or person with authority to act for the member. The Plan shall send written acknowledgement and resolution letters to the complainant. *(CCR, Title 28, section 1300.68)*

Plan policy *CS-13: Member Grievances and Appeals Rights Intake and Case Creation (revised 11/5/19)* stated the member or their representative could file a grievance. The policy defined complainant as a person who files a complaint including a member, their designated representative, or individual authorized to act on their behalf.

**Finding:** The Plan did not send acknowledgement and resolution letters to member representatives who filed grievances on members' behalf.

A verification study of 49 grievances showed the Plan did not send acknowledgement or resolution letters to complainants who filed grievances for members in nine cases.

Plan policy *CS-13: Member Grievances and Appeals Rights Intake and Case Creation (revised 11/5/19)*, stated only members receive acknowledgement and resolution letters.

The Plan's desktop procedure, *Member Grievances Clinical* did not include sending acknowledgement and resolution letters to member representatives who filed grievances on their behalf.

In an interview, the Plan stated it did not send acknowledgement and resolution letters to complainants who filed grievances on members' behalf, explaining that its system did not have capacity to capture representatives' contact information. It sent notifications only to members.

When the Plan does not send grievance notices to member representatives, grievance information may be miscommunicated, as members may rely on representatives to understand the Plan's processes and decisions.

**Recommendation:** Revise and implement policies and procedures to include sending grievance acknowledgement and resolution notifications to members' representatives who complain on their behalf.

| ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖ |
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| **PLAN:** San Francisco Health Authority dba San Francisco Health Plan |
| **AUDIT PERIOD:** March 1, 2019 through February 29, 2020<br>**DATE OF AUDIT:** March 2, 2020 through March 12, 2020 |

## CATEGORY 5 – QUALITY MANAGEMENT

| 5.1 | QUALITY IMPROVEMENT SYSTEM |
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### 5.1.1 Written Description of the Quality Program

The written description of the Plan's QIP shall list the qualifications of staff responsible for QI studies and activities, including their education, experience, and training. *(Contract Exhibit A, Attachment 4 (7) (C))*

The Plan's *2020 Quality Improvement Program Description* stated the Quality Improvement Committee, chaired by the Chief Medical Officer and composed of physicians, behavioral health professionals, pharmacists, and two members of the Member Advisory Committee, were responsible for providing oversight of the Plan's QI activities. The QIPD described the Health Outcomes Improvement staffing structure, and individual members' responsibilities.

**Finding:** The written description of the Plan's quality program did not list the qualifications of staff responsible for QI studies and activities, including their education, experience, and training.

According to the QIPD, QI staff had primary accountability for implementing the QIP. The QIPD named key QI staff positions, staffers' duties, and supervision, but did not describe staffers' education, experience, and training, including those of Quality Directors, Managers, and Specialists.

A Plan document titled, *Committee Reporting Structure,* named members of committees that contributed to the quality program, listing their professional and job titles (e.g., MD, Associate Medical Director; MPA, Director of Health Outcomes Improvement). The document did not otherwise describe QI staff's education, experience, and training.

In an interview, the Plan reported it met the Contract's requirement. However, documentation did not support this assertion.

When the Plan details the qualifications of accountable quality program staff in its written quality program description, it demonstrates its commitment to quality assurance and compliance with the Contract.

**Recommendation:** Develop and implement processes to ensure the QIPD lists the qualifications of staff responsible for QI studies and activities, including their education, experience, and training.

## CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

| 6.2 | FRAUD AND ABUSE |
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### 6.2.1 Fraud and Abuse Reporting

The Plan is required to report to DHCS all cases of suspected fraud and/or abuse within ten working days from the date the Plan first becomes aware of, or is on notice of, such activity. The report shall be submitted on a Confidential Medi-Cal Complaint Report (MC 609) *(Contract Exhibit E, Attachment 2 (25) (B) (4)).*

Plan policy *CRA-08 Fraud and Abuse Prevention and Investigation (revised 4/3/17),* stated that the Plan reports all cases of suspected fraud and abuse to DHCS within ten working days of becoming aware of such activities.

**Finding:** The Plan did not report all suspected fraud and/or abuse cases to DHCS.

A verification study revealed the Plan did not report two of five suspected fraud and abuse cases to DHCS.

- In one case, the California Department of Justice notified the Plan of a suspected fraud and/or abuse case. The Plan did not notify DHCS under the assumption DHCS was aware of the case.
- In another case, the Plan did not report to DHCS after its investigation determined there was no fraud and/or abuse.

In an interview, the Plan acknowledged the deficiencies.

By not reporting all suspected cases of fraud and/or abuse, the Plan is out of compliance with the Contract.

**Recommendation:** Implement policies and procedures to ensure the Plan reports all cases of suspected fraud and/or abuse to DHCS within ten working days.

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

REPORT ON THE MEDICAL AUDIT OF

# San Francisco Health Authority
# dba San Francisco Health Plan

| | |
|---|---|
| Contract Number: | 03-75800<br>State Supported Services |
| Audit Period: | March 1, 2019<br>Through<br>February 29, 2020 |
| Report Issued: | July 17, 2020 |

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# I. INTRODUCTION

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

The onsite review was conducted from March 2, 2020 through March 12, 2020. The audit period was March 1, 2019 through February 29, 2020 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

An Exit Conference with the Plan was held on June 18, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

**AUDIT PERIOD:** March 1, 2019 through February 29, 2020
**DATE OF AUDIT:** March 2, 2020 through March 12, 2020

### STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

**Abortion**
Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes*: 59840 through 59857
HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*
State Supported Services Contract Exhibit A.1

**SSS 1. Misdirected Claims**

The Plan is required to forward all misdirected emergency service claims and any non-contracted claim to the appropriate capitated provider within ten working days of receipt by the Plan. (*California Code of Regulations, Title 28, section 1300.71(b)(2)*)

Plan policy *CL-04 Misdirected Claims (Revised 2/28/18)* stated all misdirected claims are re-directed within ten working days from the date the claim is received to the member's group that is delegated to process the claim. The original submitter of the claim is notified that the claim was misdirected and that the claim has been re-directed to the appropriate party for processing.

**Finding:** The Plan did not forward misdirected claims within ten working days of receipt.

A verification study of ten State Supported Services claims found four claims were denied as misdirected. All claims were submitted by non-contracted providers. These claims were the responsibility of two delegated entities contracted to provide capitated services. The Plan notified providers on the remittance advices that claims should be directed to the responsible delegated entities, but did not forward the claims to the delegated entities for processing.

In an interview, the Plan stated that its process did not include forwarding any misdirected claims to responsible delegated entities and only informed providers of the misdirection on remittance advices.

When the Plan does not forward misdirected claims, providers may not be reimbursed for services rendered.

**Recommendation:** Implement policies and procedures to ensure forwarding of misdirected claims within ten working days.