DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT DIVISION
SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF SAN FRANCISCO HEALTH PLAN 2024

Contract Number: 04-35400 and 23-30237

Audit Period: March 1, 2023 – March 31, 2024

Dates of Audit: April 15, 2024 – April 26, 2024

Report Issued: July 31, 2024

DHCS

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I. INTRODUCTION

Background

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

As of May 23, 2024, the Plan served 185,819 members through the following programs: Medi-Cal 174,366 and Healthy Workers 11,453.

The scope of this audit includes the review of Seniors and Persons with Disabilities (SPD) population in the areas of Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.

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, 2023, through March 31, 2024. The audit was conducted from April 15, 2024, through April 26, 2024. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was July 12, 2024. 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, 2022, through

February 28, 2023, was issued on July 17, 2023. This audit examined documentation for compliance and to determine to what extent the Plan has implemented their 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

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

The Plan is required to ensure that a member, a provider, or an authorized representatives acting on behalf of a member and with the member's written consent, may file an appeal with the Plan either verbally or in writing. **Finding 1.3.1**: The Plan did not ensure that members' written consent was received when providers filed appeals on the members' behalf. (Repeat)

The Plan must ensure its UM delegate meets standards set forth by the Plan and DHCS. The Plan must approve, modify, or deny a provider's request for health care services for a member as expeditiously as the member's condition requires but within five business

days from the receipt of information reasonably necessary to render a decision but not to exceed 14 calendar days following the Plan's receipt of the request for service. **Finding 1.5.1**: The Plan did not ensure its delegate, All American Medical Group (AAMG), met the contractual requirement of health care service decisions being made within 14 calendar days.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements for Complex Case Management (CCM), Health Risk Assessments (HRA), Initial Health Appointment (IHA), California Children Services, Continuity of Care, Behavioral Health Treatment (BHT), and coordination of mental health services.

The Plan is required to cover and ensure the provision of an IHA to new members within 120 calendar days of enrollment. An IHA consists of a comprehensive history and physical examination. The Plan is required to make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented. **Finding 2.1.1**: The Plan did not ensure new members completed their IHA within the contractual requirement of 120 days. The Plan did not make and document reasonable attempts to contact new members and schedule an IHA.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding member access to care, and the adjudication of claims for emergency services and family planning services, and provisions for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT).

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

Category 4 – Member's Rights

Category 4 includes requirements to establish and maintain a grievance system, the handling of Protected Health Information (PHI), and requirements for the Plan's Cultural and Linguistic Services Program.

The Plan is required to implement and maintain a written description of its Cultural and Linguistic Services (CLS) Program, which is required to include an organization chart showing the key staff persons with overall responsibility for CLS and activities. **Finding 4.2.1:** The Plan's written CLS Program description did not include an up-to-date organization chart. The Plan's written Population Health Management (PHM) Program Charter, which replaced the CLS charter in 2024, did not include an organization chart.

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 monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by providers. **Finding 5.1.1**: The Plan did not adequately evaluate the quality of care delivered by providers and systems in its PQI process.

Category 6 – Administrative and Organizational Capacity

Category 6 includes a review of the Plan's administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse.

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

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the DHCS to ascertain that the medical services provided to Plan members complied with federal and state laws, Medi-Cal regulations and guidelines, and the state Contract.

PROCEDURE

The audit was conducted from April 15, 2024, through April 26, 2024. 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, staff, and delegate All American Medical Group (AAMG).

The following verification studies were conducted:

Category 1 – Utilization Management

Service Requests: A total of 26 medical service requests, including ten for SPD members, were reviewed for timeliness, consistent application of criteria, and appropriate review. Of the 26 cases, nine were retrospective requests, 13 were prior authorization requests, and four were concurrent review requests.

Appeal Requests: A total of 15 prior authorization appeals were reviewed for appropriate and timely adjudication.

Delegated Authorization Requests: A total of 15 medical service requests from AAMG were reviewed for timeliness, consistent application of criteria, and appropriate adjudication. Of the 15 cases, one was a retrospective request, and 14 were prior authorization requests.

Category 2 – Case Management and Coordination of Care

Health Risk Assessment (HRA) requirements: ten files involving SPD members were reviewed to confirm coordination of care and fulfillment of HRA requirements.

Initial Health Appointment (IHA): ten medical records were reviewed for evidence of coordination of care and fulfillment of IHA requirements.

Complex Case Management (CCM): Three medical records were reviewed to confirm coordination of care.

California Children Services (CCS): Three medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Behavioral Health Treatment (BHT): Three member files were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

Continuity of Care (COC): Three medical records were reviewed to confirm COC and fulfillment of requirements.

Category 3 – Access and Availability of Care

Claims: Ten emergency services and ten family planning claims were reviewed for appropriate and timely adjudication.

Non-Medical Transportation (NMT): 15 claims were reviewed for timeliness and appropriate adjudication. Contracted NMT providers were reviewed for Medi-Cal enrollment requirements.

Non-Emergency Medical Transportation (NEMT): 20 claims were reviewed for timeliness and appropriate adjudication. Contracted NEMT providers were reviewed for Medi-Cal enrollment requirements.

Category 4 – Member's Rights

Grievances: 26 standard grievances, including eight for SPD, four expedited grievances and five exempt grievances, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. The 26 standard grievance cases included 15 quality of service and 11 quality of care grievances.

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

Category 5 – Quality Management

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

Provider Training: 25 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.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.3 PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Member's Written Consent for Appeals Filed by Provider

The Plan must ensure that the following requirement is met through the grievance and appeal system: a member or a provider or authorized representative acting on behalf of a member and with the member's written consent, may file an appeal with the Plan either verbally or in writing. (*Contract A24, Exhibit A, Attachment 14(1)(A)*)

If state law permits and with the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. (*Code of Federal Regulations (CFR), Title 42, section 438.402(c)(1)(ii)*)

In accordance with federal and state law, appeals may be filed either verbally or in writing by a member, a provider acting on behalf of the member, or an authorized representative. Appeals filed by the provider on behalf of the member require written consent from the member. Plans must comply with this requirement in accordance with DHCS Contract and federal regulations. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Plan Policy, *QI-17 Member Appeals (approved 7/29/22)*, stated that appeals filed by the provider on behalf of a member require written consent from the member.

Finding: The Plan did not ensure that members' written consent was received when providers filed appeals on the members' behalf.

In a verification study of 15 appeals, two were filed by a provider. The Plan did not obtain written member consent in two of two of these provider-generated appeals cases.

During the interview, the Plan confirmed that it had no procedure in place during the audit period to obtain member written consent, which included the two cases found non-compliant in the verification study.

In the CAP to the prior audit finding 1.3.2, the Plan developed a new process, created a new member consent form specific to provider filings, and revised Policy QI-17. During

interviews, the Plan acknowledged it did not implement the new process and did not finalize the new consent form and draft policy during the audit period.

Without a member's written consent to a provider generated appeal on a member's behalf, a member is not able to provide input into their own healthcare decisions.

This is a repeat of the prior years' finding 1.3.2 – Written Consent for Appeals.

Recommendation: Implement policies and procedures to ensure the Plan obtains written member consent for appeals filed by a provider on behalf of a member.

1.5 DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Delegated Utilization Management Activities

Utilization Management (UM) activities may be delegated. If the Plan delegates these activities, the Plan shall comply with contract requirements for Delegation of UM Activities. The Plan shall maintain policies and procedures, approved by DHCS, to ensure subcontractors fully comply with all terms and conditions of this contract. The Plan shall evaluate the prospective subcontractor's ability to perform the subcontracted services, shall oversee and remain responsible and accountable for any functions and responsibilities delegated. *(Contract A24, Exhibit A, Attachment 5(5) and 6(14))*

The Plan must approve, modify, or deny a provider's request for health care services for a member as expeditiously as the member's condition requires but within five business days from the receipt of information reasonably necessary to render a decision but not to exceed 14 calendar days following the Plan's receipt of the request for service. (*Contract A24, Exhibit A, Attachment 5(3)(G) and APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan is responsible for ensuring that their delegated entities comply with all applicable state and federal laws and regulations; contract requirements; reporting requirements; and other DHCS guidance including, but not limited to, APLs. The Plan must have in place policies and procedures to communicate these requirements to all delegated entities. The Plan must also have in place policies and procedures for imposing corrective action and financial sanctions on delegated entities upon discovery of noncompliance with the subcontract or other Medi-Cal requirements. *(APL 17-004, Subcontractual Relationships and Delegation and APL 23-006, Delegation and Subcontractor Network Certification)*

Plan Policy, *DO-02 Oversight of Delegates (approved 2/28/24)* stated that the Plan ensures delegated functions comply with DHCS contract and applicable regulations through an annual audit and monthly and quarterly monitoring activities. For the annual audit of the delegate, the Plan uses an audit tool that incorporates DHCS requirements.

Finding: The Plan did not ensure its delegate, All American Medical Group (AAMG), met the contractual requirement of health care service decisions being made within 14 calendar days.

This delegate's implementation of its obligations under the Plan's contract and related APLs was not compliant as to timeliness in its denial/modification decision process.

In a verification study of AAMG's UM processes, three of 15 samples had late notice of action (NOA) modification/denial decision letters sent to members. These three verification samples were denials/modifications of standard prior authorization requests for out-of-network services. The NOA denial letters were late between one and six days past the 14 calendar days deadline required by the DHCS Contract and APL 21-011.

During the delegate interview, AAMG was asked for an explanation as to why these three verifications samples had late prior authorization decisions. This delegate explained the untimely decisions were due to staff shortage issues that impacted the turnaround time for prior authorization decisions.

The Plan required AAMG to submit monthly UM activity reports. DHCS' review of the reports revealed the Plan's monitoring oversight did not fully address the timeliness issue. The UM activity reports during four months of the audit period did not have documentation of the date of receipt of the authorization requests. In these months, the Plan did not have the necessary information to assess timeliness as to this delegate's UM decision making, including the required timely written notification to members.

If medical authorization decisions are not made in a timely manner, this may lead to a delay in providing necessary care for members and result in poor health outcomes.

Recommendation: Implement policies and procedures to ensure that correct timeframes for processing all health care service authorizations are followed by all UM delegates.

COMPLIANCE AUDIT FINDINGS

Category 2 – Case Management and Coordination of Care

2.1 BASIC CASE MANAGEMENT AND INITIAL HEALTH APPOINTMENT

2.1.1 Requirement of Initial Health Appointment

The Plan is required to cover and ensure the provision of an IHA (complete history and physical examination) in conformance with California Code of Regulations (CCR), Title 22, section 53851(b)(1) to each new member within 120 calendar days of enrollment.

The Plan shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate the Plan's unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement. (Contract A24, Exhibit A, Attachment 10(3).

Plan Policy PHM-02 IHA (revised 10/18/2023) stated that the Plan sends a New Member Packet to all new members within seven business days of joining the Plan. The welcome letter encourages the member to make an appointment for the IHA and described the importance of the IHA.

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

A verification study revealed that four of ten member medical records did not have any documentation of an IHA. The Plan did not make, and document attempts to contact the member and schedule an IHA.

In a written response, the Plan acknowledged that they did not make outreach attempts to schedule the IHA on four of ten member samples used in the verification study.

In an interview, the Plan stated that welcome packets are mailed to all new members. Plan's customer service calls members twice to remind them to make an appointment with their primary care provider. The Plan also stated that all outreach to members are documented in their system. However, review of the sample records did not show that the Plan followed its outreach process.

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

Recommendation: Revise and 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.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.2 CULTURAL AND LINGUISTICS SERVICES

4.2.1 Cultural and Linguistic Written Program Description

The Plan is required to implement and maintain a written description of its Cultural and Linguistic Services (CLS) Program, which shall include an organization chart showing the key staff persons with overall responsibility for CLS and activities. *(Contract A24, Exhibit A, Attachment 9(13)(A))*

The Plan's *CLS Program Charter's (last revised 11/11/22)* program scope includes DHCS Contract requirements for Exhibit A, Attachment 9, section 13. The Charter described measures to implement new CLS program processes and policies as needed to minimally ensure that all CLS programs meet DHCS requirements. The Program Manager is responsible for maintaining program documentation.

Finding: The Plan's written CLS Program description did not include an up-to-date organization chart. The Plan's written Population Health Management (PHM) Program Charter, which replaced the CLS charter in 2024, did not include an organization chart.

The Plan's change in staff for Program Sponsor, Business Lead, and Program Manager was not updated in the CLS Program Charter's organization chart due to the transition to the PHM Program.

Without including an organization chart in the written program description, the Plan cannot meet Contract requirements.

Recommendation: Develop and include an up-to-date organization chart in the Plan's CLS written program description.

COMPLIANCE AUDIT FINDINGS

Category 5 – Quality Management

5.1 QUALITY IMPROVEMENT SYSTEM

5.1.1 Evaluation of Potential Quality Issues (PQIs)

The Plan is required to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers. *(Contract A24, Exhibit A, Attachment 4(1))*

Plan Policy, *QI-18 Potential Quality Issues (revised 2/13/23)*, stated a PQI was an identified adverse variation from expected clinical standard of care requiring further investigation. The Plan documents investigation outcomes and the severity level. Provider issues are scored from P0, care is appropriate to P3, significant opportunity for improvement and/or care deemed inappropriate and potential for significant adverse outcome to member. System issues are similarly scored from S0, no system issue to S3, significant opportunity for improvement and/or care deemed inappropriate and potential for significant adverse outcome to member. Each PQI receives both a provider and system leveling grid score.

Finding: The Plan did not adequately evaluate the quality of care delivered by providers and systems in its PQI process.

In one PQI verification sample that involved an adverse outcome from a cardiology medical device, the medical director made a final P3/S3 grid level determination, indicating that there was a significant opportunity for both provider and system improvement and/or care deemed inappropriate. The Plan assigned the most severe scoring level to this provider and system despite an outside specialist's opinion that there was no deviation from the standard of care. The Plan stated there was a lack of provider training on the medical device. However, case records including the Physician Advisory Committee packets showed no evidence that would support the Plan's claim. This was confirmed with a post interview document request.

When the Plan does not appropriately score potential quality issues, providers and health systems will not receive the proper oversight, which may adversely impact members' health outcomes.

Recommendation: Implement policies and procedures to ensure all PQI reviews receive proper PQI evaluation.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION
SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF SAN FRANCISCO HEALTH AUTHORITY DBS SAN FRANCISCO HEALTH PLAN 2024

Contract Number: 22-20464 and 23-30269 State Supported Services

Audit Period: March 1, 2023 – March 31, 2024

Dates of Audit: April 15, 2024 – April 26, 2024

Report Issued: July 31, 2024

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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. 22-20464 and No.23-30269. The State Supported Services Contract covers contracted abortion services with the Plan.

The audit was conducted from April 15, 2024 through April 26, 2024. The audit period was March 1, 2023 through March 31, 2024 and consisted of document review of materials supplied by the Plan and interviews with Plan staff.

Ten State Supported Services claims were reviewed for appropriate and timely adjudication.

COMPLIANCE AUDIT FINDINGS

State Supported Services

FINDINGS: No deficiencies were identified in this audit.

RECOMMENDATION: None