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

2022

Contract Number:	04-35400
Audit Period:	March 1, 2021 Through February 28, 2022
Dates of Audit:	March 7, 2022 Through March 18, 2022
Report Issued:	August 4, 2022

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

As of February 1, 2022, the Plan served 168,555 members through the following programs: Medi-Cal 156,817 and Healthy Workers 11,738.

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, 2021 through February 28, 2022. The audit was conducted from March 7, 2022 through March 18, 2022. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on June 28, 2022. 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, 2020 through February 28, 2021, was issued on July 27, 2021. 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, provider or authorized representatives acting on behalf of a member and with the member's written consent, may file an appeal with the Plan either orally or in writing. The Plan did not have a process to ensure written consent was received from members prior to appeal resolution when the provider filed standard appeals on behalf of the member.

The Plan's governing body, public policy body, and a Plan officer are required to review the written record of appeals periodically. The review must be thoroughly documented. The Plan's governing body and public policy body did not periodically review the written appeal log and did not thoroughly document the review.

If the Plan delegates UM functions, the Plan is required to maintain a system in which delegated UM activities, at a minimum, meet standards set forth by the DHCS. The Plan must update their nondiscrimination notices and language assistance taglines to align with the language in templates provided with All Plan Letter (APL) 21-004 within 180 days of publication. The Plan did not ensure a delegate had updated information in nondiscrimination notices and language assistance taglines in accordance with APL 21-004.

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

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to provide Health Risk Assessments (HRA) for Seniors and Persons with Disabilities (SPD), and the provision of mental health and substance use disorder services.

The Plan is required to use data from a Health Information Form/ Member Evaluation Tool (HIF/MET) to help identify newly enrolled SPD members who may need expedited services. The Plan is required to, at a minimum, comply with the following: mail a DHCS approved HIF/MET to all new members as part of the Plan's welcome packet and include a postage paid envelope for response, and make at least two call attempts to remind and/or collect the HIF/MET information from new members. The Plan did not ensure that HIF/METs were mailed to the newly enrolled SPD members or that it made at least two telephone call attempts to remind members to return the HIF/METs.

The Plan is required to use a risk stratification mechanism or algorithm to analyze member-specific Fee-For-Service (FFS) utilization data or HIF/MET data, when it exists, and identify newly enrolled SPD members with higher risk and more complex health care needs. The Plan must complete this stratification within 44 calendar days of enrollment. The Plan did not conduct the initial health risk stratification to identify newly enrolled SPD members as higher or lower risk within 44 calendar days of enrollment.

The Plan must have a process for contacting SPD members within the required HRA timeframes that includes repeated efforts (letter followed by at least two phone calls) to contact each member. The Plan did not make the necessary telephone call attempts to conduct the HRA with the SPD members.

The Plan is required to cover and ensure the provision of an Initial Health Assessment (IHA) to new members within 120 calendar days of enrollment. An IHA consists of a comprehensive history and physical examination, preventive services, and an Individual Health Education Behavioral Assessment (IHEBA). The Plan did not ensure the provision of a complete IHA to each new member.

Category 3 – Access and Availability of Care

Category 3 includes requirements to provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) for members.

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's governing body, public policy body, and official are required to review the written record of grievances periodically. The review shall be thoroughly documented. The Plan's governing body and public policy body did not review the written grievance log periodically and did not document the review thoroughly.

The grievance system must be established in writing and provide for procedures that will receive, review, and resolve grievances. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance. The Plan sent resolution letters for grievances without completely resolving all member complaints.

The Plan is required to resolve a standard grievance within 30 days. The Plan did not provide written resolution to members within 30 calendar days from the date of receipt of the standard grievance.

If the Plan does not resolve a standard grievance within 30 days, the Plan is required to notify the member in writing of the status of the grievance and the estimated date of resolution. The Plan did not notify members of grievance resolution delays and did not provide estimated dates of resolution in writing for cases not resolved within 30 calendar days.

A member, provider, or an authorized representative acting on behalf of a member and with the member's written consent, may file a grievance with the Plan either orally or in writing. The Plan did not ensure that members' written consent for authorized representatives were obtained when the representatives filed standard grievances on behalf of members.

The Plan is required to conduct a thorough background check of members of its workforce before the worker may access DHCS PHI or Personal Information (PI). The Plan did not ensure that contracted consultants completed a thorough background check prior to having access to DHCS PHI or PI.

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 all providers. The Plan did not evaluate Potential Quality Issues (PQI) identified from grievances and did not determine if actions to address quality of care issues were necessary.

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 Medical Review Branch 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 March 7, 2022 through March 18, 2022. 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

Service Requests: A total of 27 medical service requests were reviewed for timeliness, consistent application of criteria, and appropriate review. Of the 27 cases, three were retrospective requests, 21 were prior authorization requests, and three were concurrent review requests.

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

Delegation of UM: A total of 12 Behavioral Health Treatment (BHT) prior authorization requests from a delegate were reviewed for timeliness, consistent application of criteria and appropriate review.

Category 2 – Case Management and Coordination of Care

HRA requirements: 15 files concerning SPD members were reviewed to confirm coordination of care and fulfillment of HRA requirements.

IHA: 19 medical records were reviewed for evidence of coordination of care and fulfillment of IHA requirements.

Category 3 – Access and Availability of Care

Claims: 20 emergency services and 20 family planning claims were reviewed for appropriate and timely adjudication.

NMT: 20 claims were reviewed for timeliness and appropriate adjudication.

NEMT: 25 claims were reviewed for timeliness and appropriate adjudication. Contracted NEMT providers were reviewed for Medi-Cal enrollment.

Category 4 – Member's Rights

Grievances: 49 standard grievances, five expedited grievances and 12 exempt grievances, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. The 49 standard grievance cases included 25 quality of service and 24 quality of care grievances.

Confidentiality Rights: Four samples were reviewed to determine if appropriate background check procedures were performed.

Category 5 – Quality Management

PQI: 9 PQI cases were reviewed for appropriate evaluation and effective action taken to address needed improvements.

Provider Training: 40 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: Ten 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 (CAF) ❖
PLAN: San Francisco Health Authority dba San Francisco Health Plan
AUDIT PERIOD: March 1, 2021 through February 28, 2022 **DATES OF AUDIT:** March 7, 2022 through March 18, 2022

CATEGORY 1 - UTILIZATION MANAGEMENT

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Appeal Log Reporting

The Plan is required to have in place a system in accordance with Code of Regulations (CCR), Title 28, section 1300.68. The Plan must follow grievance and appeal requirements and use all notices included in APL 17-006 (*Contract A24, Exhibit A, Attachment 14(1)*).

The written record of appeals must be reviewed periodically by the governing body, the public policy body, and a Plan officer or their designee. The review must be thoroughly documented. (*CCR, Title 28, section 1300.68(b)(5), APL 17-006, and APL 21-011 which superseded APL 17-006*)

The Plan's *2021 Quality Improvement Program Description* designated the Member Advisory Committee (MAC) as its public policy body.

Finding: The Plan's governing body and MAC did not periodically review the written appeal log and did not thoroughly document the review.

During the interview, the Plan stated its written appeal log was contained in its case management system and was routinely reviewed by the Plan's designee, the Grievance and Appeal Manager. Meeting minutes from the audit period revealed the governing body and MAC did not review the written appeal log.

Plan Policy *CLS-03: MAC (reviewed 4/16/2020)* did not include periodic review of member appeals as part of the MAC's responsibilities.

Plan Policy *QI-17 Member Appeals (reviewed 12/2/2021)* did not include periodic documented review of the written appeal log or appeal reports by the governing body and MAC. The Plan did not submit any policies or charters that describe the governing body's responsibilities.

This is a repeat finding of prior year's finding 1.3.1 - Appeal Log Reporting.

As part of the CAP to the prior year's finding, the Plan stated it would find a safe way to share the appeal log with the MAC by January 2022. However, the Plan acknowledged it did not implement the CAP during the audit period.

When the Plan does not follow requirements regarding appeal log review, important details about appeals may be missed by key Plan entities.

Recommendation: Revise and implement Plan policies and procedures to ensure the governing body and MAC periodically review the written appeal log and thoroughly document their review.

1.3.2 Written Consent for Appeals

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 orally or in writing. (*Contract A24, Exhibit A, Attachment 14(1)(A)*)

In accordance with federal and state law, appeals may be filed either orally 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 17-006 and APL 21-011*)

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. (*CFR, Title 42, section 438.402(c)(1)(ii)*)

Plan Policy *QI-17 Member Appeals (reviewed on 12/17/2021)* stated that appeals may be filed by a member, a provider acting on behalf of the member, or an authorized representative either verbally or in writing. Appeals filed by the provider on behalf of a member require written consent from the member. With the exception of expedited appeals, when an appeal is submitted without a member's written consent, the Plan sends the Member Appeal Signature Form to obtain the member's written consent in accordance with the DHCS contract and federal regulations. The Plan does not dismiss or delay the appeal if a written consent form is not received from the member.

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

A verification study of 15 prior authorization member appeals showed that in four of four standard appeals where a provider filed an appeal on the member's behalf, the Plan did not receive written member consent prior to appeal resolution. In all four cases, the Plan mailed the written consent form along with the appeal acknowledgement letter to the member. There was no evidence the Plan called or reminded the members to return the consent forms prior to appeal resolution. All four cases were processed and resolved without signed member consent on file.

During the interview, the Plan explained it mailed a consent form to the member along with the appeal acknowledgement letter when a provider filed a pre-service appeal on behalf of a member. The Plan still processed the appeal if the member did not return the signed form.

When the Plan does not ensure written member consent is received for standard appeals filed by providers on members' behalf, the Plan is out of compliance with federal and DHCS contractual obligations for member appeals.

Recommendation: Revise and implement policies and procedures to ensure the Plan receives written member consent for standard appeals when a provider files on behalf of a member.

1.5	DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Oversight of Nondiscrimination Notice and Language Assistance Taglines

The Plan is required to maintain a system to ensure accountability for delegated UM activities that at a minimum ensures a delegate meets standards set forth by the Plan and DHCS. (*Contract A24, Exhibit A, Attachment 4(6)(B)(2)*)

Nondiscrimination notices and language assistance taglines must be included in all informational notices targeted to members. Plans must update their nondiscrimination notices and language assistance taglines to align with the language in templates provided with this APL within 180 days of publication. Templates for nondiscrimination notice were updated by DHCS to conform to state laws and include new information on additional protected discrimination categories and how to file a discrimination grievance directly with DHCS. Templates for language assistance taglines were updated by DHCS to conform to changes in federal laws and include additional languages such as Laotian, Ukrainian and Mien. The APL was initially published on 4/8/2021, and the implementation date for full-sized nondiscrimination notice and language assistance taglines was 10/5/2021. (*APL 21-004 and associated templates*)

Plan Policy *DO-02 Oversight of Delegated Functions (reviewed 9/29/2021)* stated that the Plan ensures that delegated functions comply with DHCS contract and applicable regulations through an annual audit and monthly and quarterly monitoring activities. For the annual oversight audit of the delegate, the Plan uses an audit tool that incorporates DHCS requirements.

The Delegation Agreement between a delegate and the Plan (dated 9/9/2020) stated that delegated UM functions will be performed in compliance with DHCS Managed Care requirements and all state and federals laws and regulations.

Finding: The Plan did not ensure a delegate met standards for UM activities set forth by DHCS. The delegate did not update information in full-sized nondiscrimination notices and language assistance taglines in accordance with APL 21-004.

The Plan delegated UM responsibilities for BHT services to a delegate. A verification study of the delegate's prior authorization decisions revealed that in four of four cases resolved after October 5, 2021, full-sized notifications mailed to the members (including Notice of Action letters and authorization approval letters) did not contain updated DHCS templates for nondiscrimination notice and language assistance taglines. The templates used by the delegate did not contain updated information on new protected categories for discrimination, how to file a discrimination grievance directly with DHCS, and additional languages required by APL 21-004.

The delegate stated in interviews and written statements that it monitored DHCS websites for updates and received emails with relevant new DHCS requirements from Plan staff. The delegate confirmed the Plan informed it of APL 21-004 in September 2021 via email prior to the implementation date; however, the email did not contain the new templates for nondiscrimination and language assistance taglines, and the Plan did not provide guidance on implementation of the new templates. The delegate acknowledged there was a delay in achieving full compliance with APL 21-004.

Plan Policy *DO-02* did not describe how the Plan shares new DHCS requirements, such as new APLs, with the delegate or how the audit tool is updated with new DHCS requirements.

When the delegate does not follow new requirements set forth by DHCS, such as member notification templates, members may not receive information necessary to exercise their rights.

Recommendation: Develop and implement UM oversight processes to ensure that delegates follow and implement new requirements set forth by DHCS.

1.5.2 Ownership and Control Disclosure Review

The Plan is required to comply with Code of Federal Regulations (CFR), Title 42, section 455.104. (*Contract A24, 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. (*APL 17-004*)

Plan Policy *CR-02 Credentialing, Re-Credentialing, Screening, and Enrollment of Organizational Providers (reviewed 7/27/20),* 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 delegates' disclosure forms revealed the following deficiencies:

- Three forms did not list all owners and individuals with control interest.
- Three forms did not contain dates of births for all owners and individuals with control interest.
- Two forms did not contain social security numbers or tax identification numbers for all disclosed owners and individuals with control interest.

As part of a corrective action from the prior audit, the Plan requested updated disclosure forms from their UM delegates. However, DHCS' review of the updated forms continued to show missing information.

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

This is a repeat finding of the prior year's finding 1.5.2 – Ownership and Control Disclosure Review

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

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	BASIC CASE MANAGEMENT AND HEALTH RISK ASSESSMENT INITIAL HEALTH ASSESSMENT

2.1.1 Health Information Form (HIF)/Member Evaluation Tool (MET) Documentation

The Plan is required to use data from a HIF/MET to help identify newly enrolled members who may need expedited services. The Plan shall, at a minimum, comply with the following:

- Mail a DHCS approved HIF/MET to each newly enrolled member as part of the Plan's welcome packet and include a postage paid envelope for response.

- Make at least two call attempts to remind and/or collect the HIF/MET information from new members. *(Contract A24, Exhibit A, Attachment 10(8)(B))*

To implement the risk stratification, Plans are required to have a HIF/MET process that will be used for each new SPD member including at least two telephone call attempts to remind new SPD members to return the HIF/MET and/or to collect the HIF/MET information from new SPD members. (*APL 17-013)*

Plan Policy *CARE-02 HIF & HRAs (revised 10/21/2021)* stated Plan mails a DHCS approved HIF/MET to all new members, who are three years old or older, as a part of the Plan's welcome packet and includes a postage paid envelope for response.

Finding: The Plan did not ensure that HIF/METs were mailed to the newly enrolled SPD members or that it made at least two telephone call attempts to remind members to return the HIF/METs.

A verification study revealed that for 11 of 15 newly enrolled SPD members, the Plan did not mail HIF/METs to the members and did not make at least two telephone call attempts as a reminder to return the forms.

In an interview, the Plan stated that all Medi-Cal members receive HIF/METs and outreach is done via phone call; however, in a written statement, the Plan stated that it could not provide evidence that the HIF/MET was included in the welcome packet mailing.

The Plan's policy and procedure did not describe a process to call the SPD members at least twice to remind them to return the forms.

When the Plan does not mail or make attempts to remind SPD members to return the HIF/MET, delivery of necessary services may be delayed.

Recommendation: Revise and implement policies and procedures to mail HIF/MET and make at least two telephone call attempts to all newly enrolled SPD members.

2.1.2 Health Risk Stratification

The health risk stratification and assessment shall be done in accordance with Welfare and Institution Code (WIC), Sections 14182 (c)(11) to (13) and APL 17-013. *(Contract A24, Exhibit A, Attachment 10(4))*

The Plan is required to use a risk stratification mechanism or algorithm to analyze member-specific FFS utilization data or HIF/MET data (when it exists) and identify newly enrolled SPD members with higher risk and more complex health care needs. The Plan must complete this stratification within 44 calendar days of enrollment. If FFS utilization data and/or HIF/MET data is not available, the Plan must determine by other means if SPD members are higher or lower risk. The HRA is then used to re-classify all newly enrolled SPD members as higher or lower risk. (For some members, this re-classification based on the HRA may be different from their earlier classification based on the stratification tool.) *(APL 17-013)*

Plan Policy *CARE-02 HIF & HRAs (revised 10/21/2021)* stated Plan reviews HIFs for non-SPD Medi-Cal members, identifies "high-risk" members, and refers them for care coordination. For all newly enrolled SPD members, Plan evaluates members within 44 days of enrollment for the presence of "high-risk" factors. These risk factors are identified based on the evaluation of historical Medi-Cal FFS utilization data provided by the State, if available, member responses to the HIF, and member responses to the HRA survey tool administered by the Plan's Customer Service staff. In addition, the Plan assesses the risk of all new and existing SPDs based on utilization of inpatient and Emergency Department (ED) services on a quarterly or monthly basis.

Finding: The Plan did not conduct an initial health risk stratification to identify newly enrolled SPD members as higher or lower risk within 44 calendar days of enrollment.

A verification study of 15 newly enrolled SPD members' records showed that none of the members' data was analyzed for health risk stratification.

In a written statement, the Plan acknowledged that it did not have an initial health risk stratification process separate from the HRA survey.

This is a repeat finding of the prior year's finding 2.1.1 - Health Risk Stratification.

As part of the corrective action for the prior year's finding, the Plan stated it would update Plan Policy *CARE-02*. However, the verification study revealed that the Plan did not conduct initial health risk stratification.

When the Plan does not conduct health risk stratifications for newly enrolled SPD members as required, delivery of necessary services may be delayed.

Recommendation: Revise and implement policies and procedures to utilize a health risk stratification mechanism or algorithm to identify newly enrolled SPD members with higher risk and more complex health care needs within 44 calendar days of enrollment.

2.1.3 Health Risk Assessment (HRA) Survey

The health risk stratification and assessment shall be done in accordance with WIC, Sections 14182 (c)(11) to (13) and APL 17-013. *(Contract A24, Exhibit A, Attachment 10 (4))*

The Plan must have a process for contacting SPD members within the required HRA timeframes that includes repeated efforts (letter followed by at least two phone calls) to contact each member. (*APL 17-013)*

Plan Policy *CARE-02, HIF & HRAs (revised 10/21/2021)* stated the following: First, a letter containing the HRA survey is sent to all members. If there is no response within one week, customer service attempts to reach the member by phone. Customer service contacts the member at least once by mail and four times by phone within 44 calendar days (for "high-risk" members) or 105 calendar days (for "low-risk" members) of receipt of the member file prior to closing the case as "incomplete".

Finding: The Plan did not make the necessary telephone call attempts to conduct the HRA with the SPD members.

A verification study of 15 member records revealed that five members did not receive at least two phone calls as a reminder to complete and mail the HRA form.

In an interview, the Plan stated that it would not conduct further telephone follow up attempts if members acknowledge that they would return the HRA form to the Plan.

When the Plan does not perform repeated efforts to contact each new SPD member as required, delivery of necessary services may be delayed.

Recommendation: Implement policies and procedures to make the necessary telephone call attempts to obtain HRA forms as required in APL 17-013.

2.1.4 Provision of Initial Health Assessment (IHA)

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

An IHA consists of a comprehensive history and physical examination, preventive services and an IHEBA using an age appropriate DHCS approved tool that enables a provider of primary care services to comprehensively assess the member's current acute, chronic and preventive health needs and identify those members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this Contract. The Plan is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.

The Plan is required to ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members [age 21 or older]. All preventive services identified as USPSTF "A" and "B" recommendations must be provided.

The Plan is required to make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Plans 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) and (6); MMCD Policy Letter 08-003).*

Plan Policy *HE-02 Initial Health Assessment (IHA) and Initial Health Education Behavioral Assessment (IHEBA)(revised 02/18/2021)* stated that the Plan ensured providers complete an IHA for each member within 120 days after the effective date of enrollment. An IHA consists of a history and physical exam and an IHEBA. An IHEBA may be conducted using the Staying Healthy Assessment, or other DHCS-approved assessment tool.

Plan Policy *HE-03 Preventive Health Guidelines)(revised 06/17/2021),* stated that the Plan Primary Care Providers(PCP) use the Guide to Clinical Preventive Services published by the US Preventive Services Task Force (USPSTF) to determine the provision of clinical preventive services. All preventive services identified as USPSTF "A" and "B" recommendations are provided. PCPs record preventive health activities in the member's medical record.

Finding: The Plan did not ensure the provision of a complete IHA to each new member.

A verification study on 19 sampled members' medical records showed the following:

- Nine of 19 samples had no evidence of IHA. Requested medical records were not submitted.

- For ten of 19 samples in which records were submitted, the following deficiencies were identified:

    - Ten records showed that the IHA was not provided within 120 calendar days of enrollment.

    - Ten records had no evidence that an IHEBA was conducted.

    - Ten records did not contain documentation that all applicable preventive services identified as USPSTF "A" and "B" recommendations were offered to members who qualified based on condition and age, or that the status of services was recorded.

        - For example, in one record for a 55 year old male member, the provider did not document that colorectal cancer, hepatitis C virus infection, and depression screenings were offered to the member or that the member had declined them. The USPSTF A and B recommendations include screening for: depression in the general adult population, colorectal cancer in all adults aged 50 to 75 years, and hepatitis C virus infection in adults aged 18 to 79 years.

        - In another record, a 63 year old male member, the provider did not document that tobacco smoking cessation screening was offered to the member or that the member had declined it. The USPSTF A and B recommendation states that clinicians should ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions.

In an interview and a written response, the Plan stated the IHA re-implementation was affected by staff shortages and coverage.

When the Plan does not ensure the provision of a complete IHA, members may not receive important behavioral and medical health screenings that can help identify and prevent illnesses.

This is a repeat finding of the 2019 audit finding 2.1.1 – Required Components of the Initial Health Assessment. IHA requirements were not reviewed in the 2020 or 2021 audits.

Recommendation: Develop and implement policies and procedures to ensure the provision of a complete IHA to each new member.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Resolution of Grievances

The Plan is required to have in place a grievance system in accordance with CCR, Title 28, section 1300.68. (*Contract A24, Exhibit A, Attachment 14(1))*

The grievance system must be established in writing and provide for procedures that will receive, review, and resolve grievances. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance. (*CCR, Title 28, section 1300.68*)

Plan Policy *QI-06 Clinical Member Grievances (reviewed 12/7/2021)* stated the following: The Plan sends investigation questions to the provider and/or medical group involved in the grievance to ensure all member concerns were addressed. Medical group staff and providers are required to assist in the review and resolution of member grievances, which includes retrieving medical records and providing any other information necessary to resolve the grievance. Then, the Grievance Coordinator presents the grievance to the Plan's Grievance Review Committee to ensure all components of the grievance have been fully investigated and to determine if the grievance can be closed or if additional follow up is needed. The clinical grievance is resolved when the grievance has reached a conclusion with respect to the member's submitted grievance. The Supervisor for Grievances and Appeals, or designee, reviews and approves the grievance resolution letter to ensure it reflects decisions made by the Plan's physician decision-maker and is responsive to the member's desired resolution.

Finding: The Plan sent resolution letters for grievances without completely resolving all member complaints.

A verification study of 49 standard grievances showed that in five clinical grievances, the Plan's physician decision-makers did not completely resolve all complaints within grievances prior to finalizing resolution letters.

- In one quality of service grievance with clinical issues, the Plan closed the grievance without receiving any responses from the medical group or provider. The member submitted multiple complaints to the Plan including the following; A provider and staff

- Did not accept the member's Medi-Cal insurance
- Requested the member to pay out-of-pocket for services due to reimbursement issues with the Plan
- Yelled at the member
- Caused delays in receiving a referral to a pulmonologist
- Informed the member they no longer provided laboratory services.
- May retaliate against the member.

The Plan submitted an inquiry, comprised entirely of questions related to perceived discrimination, to the medical group. The Plan's Quality Review Nurse did not document a review of clinical records and did not submit inquiry questions related to the member's clinical care and access to services. The Plan did not receive a response to the discrimination questions despite multiple outreach and escalation attempts.

- In one quality of care grievance, the Plan closed the grievance without resolution of a perceived discrimination issue and did not escalate the incomplete medical group response to the Plan's provider network operations staff. The member sought care from a provider and expressed dissatisfaction about a back surgery performed by a different provider. Because the second provider refused to perform further surgery, the member felt punished and alleged the two providers were friends. After a significant delay, the medical group did not respond to the Plan's questions of whether the two providers were friends and if there may have been perceived discrimination based on the interactions the member had with the two providers.

- In another quality of care grievance, the Plan closed the grievance without resolving all complaints. The member complained of the following:
  - A provider's poor technique during an eye procedure due to lack of appropriate equipment.
  - Due to worsening vision, the member requested a specialist referral with a different medical group.

The Plan's physician decision-maker determined the care provided was appropriate; however, the resolution letter did not explain how the provider's treatment plan addressed the member's abnormal vision and if a referral to a different medical group was indicated.

- In another quality of care grievance, the Plan closed the grievance without resolving the complaint. A member with pain and inflammation throughout the body was scheduled for an appointment to receive crutches at one medical group's outpatient clinic. The member complained the clinic did not have available staff to push the member in the loaner wheelchair within the facility; therefore, the member could not attend the appointment and felt discriminated against. In response to the Plan's inquiry, the medical group stated it only provides manual transport wheelchairs, and members are required to push themselves to outpatient appointments or should bring someone to help them. The Plan did not conduct further follow-up on whether the medical group's transport policy complied with federal and state regulations against physical disability discrimination, and whether the member qualified for any Medi-Cal benefits that could have helped with the disability.

- In another quality of care grievance, the Plan closed the grievance without resolving one of the member's complaints. A member with knee arthritis and pain, who used a cane to walk and could not stand for long periods of time, voiced multiple complaints including not being able to receive a wheelchair from a clinic. In response to the Plan's inquiry, the clinic did not directly respond to the wheelchair complaint and stated that the member was scheduled for a home safety and equipment evaluation, which was never completed due to staff deployments for the public health emergency. The Plan did not follow up on whether the member was evaluated for a wheelchair or other appropriate durable medical equipment.

During the interview, the Plan stated that on a case-by-case basis, the Plan's grievance staff could escalate missing or incomplete medical group responses to the Plan's provider network operations staff, and physician decision-makers could contact medical groups directly for follow-up. The Plan acknowledged that it did not maintain clearly written escalation procedures for each medical group.

When the Plan does not ensure grievances are completely resolved, members' health may be negatively impacted.

Recommendation: Implement policies and procedures to ensure that the Plan completely resolves all member complaints within grievances prior to sending resolution letters.

4.1.2 Review of Written Grievance Log

The Plan is required to have in place a grievance system in accordance with CCR, Title 28, section 1300.68. The Plan must follow grievance and appeal requirements and use all notices included in APL 17-006 *(Contract A24, Exhibit A, Attachment 14(1))*.

The written record of grievances must be reviewed periodically by the governing body, the public policy body, and a Plan officer or their designee. The review must be thoroughly documented. *(CCR, Title 28, section 1300.68 (b)(5), APL 17-006, and APL 21-011 which superseded APL 17-006)*

The Plan's *2021 Quality Improvement Program Description* designated the MAC as its public policy body.

Plan Policy *CLS-03 MAC (reviewed 4/16/2020)* stated that the MAC was responsible for reviewing member grievance trends at least annually.

Finding: The Plan's governing body and MAC did not periodically review the written grievance log and did not thoroughly document the review.

During the interview, the Plan stated its written grievance log was contained in its case management system and was routinely reviewed by the Plan's designee, the Grievance and Appeal Manager. Meeting minutes from the audit period revealed the governing body and MAC did not review the written grievance log.

Plan Policy *CLS-03 MAC* did not include periodic review of the written grievance log as part of the MAC's responsibilities. Plan Policies *QI-06 Clinical Member Grievances (reviewed 12/7/2021)* and *CS-14 Non-Clinical Grievances and Non-Clinical Decline to File (reviewed 12/7/2021)* did not include periodic documented review of the written grievance log or grievance reports as part of the responsibilities for the governing body and MAC. The Plan did not submit any policies or charters that describe the governing body's responsibilities.

This is a repeat finding of prior year's finding 4.1.2 – Review of Written Grievance Log.

As a part of the CAP to address the prior year's finding, the Plan stated it would find a safe way to share the grievance log with the MAC by January 2022. However, the Plan acknowledged it did not implement the CAP during the audit period.

When the Plan does not follow requirements regarding grievance log review, important details about member grievances may be missed by key Plan entities.

Recommendation: Revise and implement policies and procedures to ensure the governing body and MAC periodically review the written grievance log and thoroughly document their review.

4.1.3 Timely Standard Grievance Resolution

The Plan is required to provide a written notice of resolution to the member within 30 calendar days from the receipt date of the standard grievance. (*Contract A24, Exhibit A, Attachment 14(1)(B)*)

The Plan is required to provide written resolution to the member that is dated within 30 days of receipt of the grievance. Federal regulations allow for a 14-calendar day extension for standard and expedited appeals. This allowance does not apply to grievances. (*APL 17-006 and APL 21-011*)

Plan Policy *QI-06 Clinical Member-Grievances (reviewed 12/07/2021)* stated that, for standard grievances, the Grievance Coordinator mails the Grievance Resolution Letter to the member within 30 calendar days of receipt of the grievance.

Finding: The Plan did not provide written resolution to members within 30 calendar days from the date of receipt of the standard grievance.

A verification study revealed that in ten of 49 standard grievances, the Plan sent resolution letters to members between 34 to 71 calendar days after the date of receipt.

In an interview, the Plan stated that the main reason for the late resolution letters was due to non-responsiveness or late provider responses. In some cases, the providers requested for extension due to the impact of COVID-19 pandemic or staff shortage. In other cases, the providers did not give the reason for the delayed responses. The Plan also attributed the deficiencies to their staffing shortages.

Delayed member notifications of grievance resolutions may result in missed opportunities for improved health care delivery and in poor health outcomes for members.

Recommendation: Implement policies and procedures to ensure the Plan provides written resolutions to members within 30 calendar days from the date of receipt of standard grievances.

4.1.4 Written Notification of Delay Letters

The Plan is required to follow grievance and appeal requirements and use all notices included in APL 17-006. (*Contract A24, Exhibit A, Attachment 14(1))*

In the event a grievance resolution is not reached within thirty days, the member shall be notified in writing by the Plan of the status of the grievance and shall be provided with an estimated completion date of resolution. Such notice shall include a statement notifying the member they may exercise their right to request a fair hearing. (*CCR, Title 22, section 53858*)

"In the event that resolution of a standard grievance is not reached within 30 calendar days as required, the managed care plan shall notify the beneficiary in writing of the status of the grievance and the estimated date of resolution, which shall not exceed 14 calendar days." (*APLs 17-006 and 21-011*)

Plan Policy *QI-06 Clinical Member-Grievances (Reviewed 12/07/2021)* stated that if a resolution to the standard grievance is not reached within 30 calendar days, the Plan notifies the member in writing of the status of the grievance and the estimated date of resolution. The estimated date will not exceed 14 calendar days.

Finding: The Plan did not notify members of grievance resolution delays and did not provide estimated dates of resolution in writing for cases not resolved within 30 calendar days.

A verification study revealed deficiencies in ten of 49 standard grievances. Members did not receive written notifications regarding delays in the resolution of their grievances.

This is a repeat finding of the prior year's finding 4.1.1 – Written Notification of Delay Letters.

As part of the CAP to address the prior year's finding, the Plan stated that it had developed the delay notification letter template and the procedure to provide written notification of delayed resolution. The Plan confirmed that it had not implemented the CAP.

When the Plan does not send written notification of delay letters, it cannot ensure members are notified within reasonable time to exercise their rights regarding their grievances.

Recommendation: Implement procedures to ensure that members are notified in writing of grievance resolution delays, and are provided an estimated date of resolution for cases not resolved within 30 calendar days.

4.1.5 Written Consent for Standard Grievances

A member, or a provider or an authorized representative acting on behalf of a member and with the member's written consent, may file a grievance with the Plan either orally or in writing. (*Contract A24, Exhibit A, Attachment 14(A)*)

If state law permits and with the written consent of the member, an authorized representative may file a grievance on behalf of a member. *(CFR, Title 42, section 438.402(c)(1)(ii))*

Complainant is the same as grievant, and means the person who filed the grievance including the member, a representative designated by the member, or other individual with authority to act on behalf of the member. *(CCR, Title 28, section 1300.68(a)(3))*

Plan's procedure *CS-13: Member Grievances and Appeals Rights Intake (reviewed 12/07/2021)* stated that members, a provider acting on behalf of the member, or an authorized representative may file a grievance for any reason, either orally or in writing.

Plan's procedure *CRA-16 Personal Representatives* (*Reviewed 09/01/2021*) stated that the personal representative may access the member's PHI. Upon verbal notification by a member of his/her intent to designate a personal representative, a Customer Services Representative provides to the member a "Designation of Personal Representative (DPR) Form". Upon receiving the completed form from a member, the Compliance Manager will review and approve the form to ensure appropriate personal representative designation.

Finding: The Plan did not ensure that members' written consent for authorized representatives were obtained when the representatives filed standard grievances on behalf of members.

A verification study revealed that in three of 49 standard grievances filed by representatives on behalf of members, the Plan did not acquire written member consent prior to grievance resolution. For all three cases, the Plan received members' verbal consent for the representatives to file grievances on behalf of members during the grievance intake process. However, the Plan did not provide DPR forms to the members, and did not have a follow-up process for the grievance system to obtain the completed DPR forms for review and approval.

In a written response, the Plan stated that the three members did not request DPR forms during the grievance intake process; therefore, the Plan did not send DPR forms to them.

When the Plan does not ensure that written member consent is obtained for standard grievances filed by representatives on members' behalf, the Plan is out of compliance with DHCS requirements for member grievances.

Recommendation: Revise and Implement policies and procedures to ensure the Plan acquires member's written consent prior to resolution of standard grievances when an authorized representative files a complaint on behalf of a member.

4.3	CONFIDENTIALITY RIGHTS

4.3.1 Background Check

The Plan is required to conduct a thorough background check of a member of the workforce before the worker may access DHCS PHI or PI, and evaluate the results to assure there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Plan is required to retain each workforce member's background check documentation for a period of three years following DHCS contract termination. *(Contract A24, Exhibit G, Attachment A(I)(D))*

DHCS requires that a background check must be conducted for all employees who will have access to DHCS PHI. *(CFR, Title 45, section 164.530 and APL 09-014)*

Plan Policy *HR-06 Employee Background Checks (revised 8/20/20)* stated that the Plan will perform a background check on Plan's employees before access is allowed to member PHI. The Plan conducts thorough background checks of prospective employees including checking for criminal background and verification of social security number and evaluates the results to assure that there are no indications that employees may present a risk for theft of confidential data. If the background check of the individual indicates a presence of a risk for theft of confidential data, or is found to be included on either federal sanction list (List of Excluded Individuals and Entities of the Office of the Inspector General (U.S. Department of Health and Human Services), and the General Services Administration's Excluded Parties Listing System), the individual will be denied employment with the Plan.

Finding: The Plan did not ensure that contracted consultants completed a thorough background check prior to having access to DHCS PHI or PI.

A review of four contracted consultant background checks revealed the following:

- One of four external consultants' background check report was completed 17 days after the person was placed in service.

- One of four external consultants' background check report was completed 45 days after the person was placed in service.

During the interview, the Plan stated that it relied on the consultants' staffing agency to conduct the background checks. In a written response, the Plan stated that it did not have policies and procedures regarding hiring temporary workers or consultants.

Failure to complete background checks of all individuals who will have PHI or PI access increases the risk of theft or unauthorized use of members' PHI or PI.

Recommendation: Revise and implement policies and procedures to ensure background checks are completed for all non-employees prior to providing them with access to PHI or PI.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: San Francisco Health Authority dba San Francisco Health Plan
AUDIT PERIOD: March 1, 2021 through February 28, 2022 **DATES OF AUDIT:** March 7, 2022 through March 18, 2022

CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

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 (reviewed 10/28/20)* stated a PQI, an identified adverse variation from expected clinical standard of care requiring further investigation, can be identified from a variety of sources including grievances and referrals. The Quality Review Nurse or designee receives the referral and performs initial review of the case. If the referral meets the PQI definition, the Quality Review Nurse creates a PQI case in the case management system. The Quality Review Nurse and Medical Director (or designee) jointly review case information to decide if additional information is needed. When a PQI requires follow-up from a provider, the Quality Review Nurse and Medical Director assess the appropriateness of the completed follow-up. Cases where the individual provider or facility refuse to comply with requests are escalated to the Chief Medical Officer for next steps. PQI investigation outcomes are documented as either a “confirmed quality issue” with severity level or as “no confirmed quality issue”.

Finding: The Plan did not evaluate PQIs identified from grievances and did not determine if actions to address quality of care issues were necessary.

A verification study of 49 standard grievances revealed that in three grievance samples, a physician decision-maker requested to open a PQI case. In two of three of these grievance samples, the PQI cases were not thoroughly investigated, and the quality issues were not scored and evaluated by Plan physicians. The Plan did not determine whether corrective actions were needed to address the quality issues.

- In one quality of care grievance, a member was unable to refill a medication used for chronic pain because the provider did not submit clinical information for the prior authorization. The provider could not be reached to submit the missing information because the clinic was closed for the holidays. The Plan appropriately filled the member's prescription and closed the grievance. The physician decision-maker determined a PQI case should be opened to investigate the clinic's processes for provider coverage during holidays and triage of issues by the answering service. A PQI case was never opened, and the quality issue was never evaluated.

- In one quality of service grievance with clinical issues, a member was not informed of imaging results by the ordering provider. After an investigation, the Plan informed the member of the imaging results and closed the grievance, and the physician decision-maker determined a PQI case should be opened to determine the cause of why imaging results were not shared with the member. A Quality Review Nurse opened a PQI case and attempted to obtain requested records from the medical group. The Plan closed the PQI case because it never received the requested information from the medical group. There was no evidence of escalation to obtain the records, and the Plan did not evaluate the quality issue.

During the interview, the Plan explained that on a case-by-case basis, Plan staff and physician decision-makers escalated missing or incomplete medical group responses to the Plan's provider network operations staff. The Plan acknowledged it did not maintain clearly written escalation procedures for each medical group.

In a written response to the first grievance sample, the Plan stated that due to staffing shortages in the Grievance Department in December 2021 which required cross-coverage by staff who were not fully trained in opening PQI cases, a PQI case was not opened because it was inadvertently missed. Both samples in the verification study occurred during the staffing shortage.

When the Plan does not investigate and evaluate quality issues identified in grievances, the Plan does not ensure that effective action has been taken to address quality issues, which may result in further incidents with potential adverse outcomes.

Recommendation: Revise and implement policies and procedures to ensure the Plan investigates and evaluates all PQIs identified from grievances in order to determine if actions are needed to address quality of care issues.

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

2022

Contract Number:	03-75800 State Supported Services
Audit Period:	March 1, 2021 Through February 28, 2022
Dates of Audit:	March 7, 2022 Through March 18, 2022
Report Issued:	August 4, 2022

TABLE OF CONTENTS

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 audit was conducted from March 7, 2022 through March 18, 2022. The audit period was March 1, 2021 through February 28, 2022 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 28, 2022. 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, 2021 through February 28, 2022
DATES OF AUDIT: March 7, 2022 through March 18, 2022

STATE SUPPORTED SERVICES

SUMMARY OF FINDING(S):

No deficiencies were identified in this audit.

RECOMMENDATION(S):

N/A