State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
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November 22, 2022

Nina Maruyama, Office of Compliance & Regulatory Affairs
San Francisco Health Plan
50 Beale St., 12th Floor
San Francisco, CA 94105

RE: Department of Health Care Services Medical Audit

Dear Ms. Maruyama,

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of San Francisco Health Plan, a Managed Care Plan (MCP), from February 25, 2019 through March 1, 2019. The audit covered the period of March 1, 2018 through February 28, 2019.

On September 19, 2022, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on September 10, 2019.

All items have been evaluated and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Overall effectiveness of the CAP will continue to be assessed, as well as, to what extent the MCP has operationalized proposed corrective actions on the subsequent audit. The enclosed report will serve as DHCS' final response to the MCP's CAP.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

If you have any questions, feel free to contact me at (916) 345-7942 or Daniel Park at (916) 345-8173.

Sincerely,

[Signature on file]

Oksana Meyer, MPA
Chief, CAP Compliance & FSR Oversight Section
Managed Care Quality & Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
CAP Compliance Unit
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Daniel (Danny) Park, Lead Analyst
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ATTACHMENT A
Corrective Action Plan Response Form

Plan: San Francisco Health Plan **Review Period: 03/01/18 – 02/28/19**

Audit Type: Medical Audit and State Supported Services **Onsite Review: 02/25/19 – 03/01/19**

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP in word format that will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that require long-term corrective action or a period longer than 30 calendar days for implementation, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval in accordance with existing requirements.**

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

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1. Utilization Management				
1.1.1 Delegation Agreements Revise Plan processes to ensure delegation agreements explicitly and comprehensively	SFHP is in the process of updating its Delegations Agreements. An activity that SFHP conducts on an annual basis. During the DHCS audit SFHP	CCHCA Amendment #40	Updates to be completed by 08/30/2019 Internal review and vetting of the document to be	**8/13/19** - The following documentation supports the MCP's efforts to correct this finding: - Contract Amendment 40 between SFHP and CCHCA which includes provisions for implementing and maintaining polices and procedures that are designed to detect and prevent fraud, waste and abuse.

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outline contractual and other regulatory responsibilities.	provided a copy of its Delegation Agreement with CCHCA, which describes in details all delegated activities. During the findings review period granted by DHCS, SFHP provided Contract Amendment # 40 between SFHP and CCHCA, fully executed on January 2, 2019. This amendment includes provisions for implementation of Fraud, Waste, and Abuse policies and procedures. Please note that SFHP does not delegate Compliance activities; therefore, Fraud, Waste, and Abuse requirements are not included in the Delegation Agreement.		completed between 08/30/2019 and 9/30/2019 Revised Delegation Agreements to be sent to Delegates by 10/30/2019	**2/20/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Revised Delegation Agreement amendment contains from three different delegates which details contractual and regulatory responsibilities including UM and fraud waste and abuse. **This finding is closed.**
1.1.2 Delegation Oversight Revise Plan processes to ensure delegate oversight includes comprehensive review and identification of specific items	CCHCA terminated its contract with Excel MSO effective 7/30/2019. CCHCA executed a new MSO contract with NEMS MSO effective 8/1/2019. SFHP Developed a plan for oversight of CCHCA and its	NEMS CCHCA MSO Agreement Fully Executed Redacted Oversight of CCHCA and its MSO Rev	08/01/2019	**08/13/19** - The following documentation supports the MCP's efforts to correct this finding: - NEMS CCHCA MSO Agreement serves as evidence that the delegate terminated it contract with its prior MSO and entered into a contract with a new MSO. The contract states that MCP reserves the right to monitor and oversee the sub-delegates performance of sub-delegated functions by conducting continuous monitoring and an oversight audit as necessary.

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requiring correction when a delegate does not comply with regulatory and contractual requirements. Report any significant instances of non-compliance, or corrective actions pertaining to their obligations under the contract with DHCS to their contract managers.	new MSO.			- Oversight of CCHCA and its MSO Letter 7/19/19 informs the delegate of the MCP's intention to exercise its right to monitor and oversee the delegate's MSO's performance of sub-delegated functions. **10/01/19** - The following additional documentation supports the MCP's efforts to correct this finding: - Email communication from 10/1/19 the MCP states they leveraged the annual oversight audit of NEMS which occurred in April 2019 as the pre-delegation audit of NEMS as an MSO for CCHCA. **10/30/19 –** NEMS Routine Annual Audit Final Report dated 11/26/18 serves as evidence of monitoring of sub delegated MSO. **This finding is closed.**
1.2.1 Retrospective Authorization Revise Plan 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 retrospective case	The Plan is concerned that this is a "repeat finding" when DHCS has not yet issued guidance on this topic. The Plan looks forward to working with DHCS MCQMD to come up with an appropriate Corrective Action to this finding.			**12/7/20** – MCQMD Policy Clarification: -The MCP has established utilization management protocols for the receipt and review of retrospective authorization review requests. The MCP performs medical necessity reviews if request are submitted with 30 calendar days of service delivery. -MCPs are required to communicate to providers the procedures and services that require prior authorization and ensure all contracting providers are aware of the procedures and timeframe necessary to obtain prior authorization. -The contract allows the MCP to establish reasonable administrative time

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denials receive a medical director's review				limits for the receipt and review of retrospective authorization review requests. The imposition of an administrative time limit is not a contract violation. -MCPs are required to have policies and procedures that cover how the MCP authorizes, modifies, and denies services via prior authorization, concurrent authorization, or retrospective authorization. -MCP protocols involving provider disputes of claims denied for lack of prior authorization are forwarded to the MCP Claims Department for adjudication. -The contract allows the MCP to forego medical necessity reviews if the retrospective authorization review request is received after an established administrative time limit. **This finding is closed.**
1.2.2 Well Publicized Appeal Process Revise Plan processes so that provider information regarding appeal processing is up to date and consistent.	Although the Appeal process is well-publicized in the EOC, in all NOA letters, the Network Operations Manual, and also online at www.sfhp.org, there were two items that led to this deficiency: An outdated fax cover sheet for a specific NOA letter and the Summary of Key Information (SOKI) for Practitioners. The fax cover sheet that contained incorrect	Provider NOA Fax Cover Sheet Current SOKI can be found online at https://www.sfhp.org/files/providers/SOKI_August_2019.pdf	02/27/19 08/01/2019	**08/13/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated Provider NOA Fax Cover Sheet (02/27/19) which has been amended to remove the appeal information. - Updated Summary of Key Information (SOKI) (08/01/19) which has been amended to correct the appeal submission timeframe. The SOKI document now reflects the correct time frame of 60 days from the date of the NOA letter to file an appeal.

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	information has been removed from rotation. This correction was done on 02/27/19. The SOKI was also updated and published on 08/01/2019. Please note, all new providers are required to review and sign the SOKI within 10 days of approval to join the network and changes are communicated via email. The most current SOKI is available online at www.sfhp.org, in the Provider Resources section. A direct link to the specific document is https://www.sfhp.org/files/providers/SOKI_August_2019.pdf.			**This finding is closed.**
1.2.3 Early and Periodic Screening, Diagnosis and Testing (EPSDT) Revise Plan policies and provider communications to ensure providers receive clear information about delivering EPSDT services	The Plan is in the process of updating the Provider Manual, formerly known as the Provider Network Operations Manual. Proposed language is attached. The revisions to the Provider Manual require approval from the Provider Network and the Plan must allow providers 45 working days to review and provide feedback on the proposed changes. The	Proposed language for Provider Network Operations Manual	11/01/2019	10/29/19 – The following documentation supports the MCP's efforts to correct this deficiency: - P&P UM-33 is replaced by, "CO-33: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and EPSDT Supplemental Services" (10/10/19) which has been established to include, "San Francisco Health Plan (SFHP) covers and monitors the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and Supplemental Services, including Supplemental Nursing Services, for Medi-Cal members under the Age of 21". It further outlines how the MCP is responsible to provide all medically necessary EPSDT services, including services which exceed the amount provided by Local Education

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	updates are due to be distributed by 09/01/2019.			Agencies, Regional Centers, or local governmental health programs. SFHP is required to, coordinate the provision of services with the other entities to ensure SFHP and other entities are not providing duplicative services, and that the child is receiving all medically necessary EPSDT services in a timely manner. In addition, SFHP regularly educates and communicates EPSDT benefits and coverage expectations to its members, delegated groups and network providers. Communication occur at least annually through the Provider Manual, Member Handbook, Provider Newsletters, Member Newsletter and SFHP member and Provider websites. - Revised Provider Manual language, (October 2019) which includes EPSDT services that the MCP ensures and monitors the provision of all services available to Medi-Cal eligible children and youth under the EPSDT program. **This finding is closed.**
1.3.1 Appeal Resolution Letters Develop and implement policies to ensure that the Plan provides clear and concise appeal resolution letters without	The Plan will conduct a quarterly audit of Grievance and Appeal letters to reduce misstatements and ensure that communication to members is clear and concise. DHCS approved SFHP's revised Appeal letter templates.	Audit Tool Audit Workplan MC NAR Overturn Letter MC NAR Uphold Letter	Quarterly audits for Grievance letters were implemented in 2018, Appeal letters will be added into the schedule and will be audited on a	08/29/19 – The following documentation supports the MCP's efforts to correct this deficiency: - "Compliance Audit Risk Assessment and Work Plan" (FY 2019-2020) as evidence that the MCP is conducting internal audits and monitoring of Clinical Grievances and Appeals-resolution letters. - Sample Audit Report, "Clinical Grievance – Internal Audit" (08/29/19) as evidence that the MCP is monitoring appeal resolution letters. The report includes feed back on the quality of the resolution letter.

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misstatements; implement the DHCS NAR template without revision unless approved by DHCS.	These templates follow the DHCS NAR template and include an Appeal Acknowledgement Letter. SFHP is working to implement the letters with our Case Management Software.	MC Appeal Acknowledgement Downgrade Letter	quarterly basis, beginning with Q3 2019 audit. Audit plan will be presented to the Policy and Compliance Committee for approval on 08/25/2019. Letters have been approved and translated and are the schedule to be updated in the Case Management System, Essette, by October 1, 2019	**This finding is closed**.
1.3.2 Member Notification of Plan-Downgraded Appeals Revise and implement Plan policies to ensure appropriate notification when the Plan downgrades	The Corrective Action for this finding is broken into two parts: Revise Appeal Acknowledgement letter: SFHP's Appeal Acknowledgment letter that notifies members of appeal downgrade will be revised to	Revised Appeal Downgrade Acknowledgement Letter	Revised Appeal Acknowledgement Letter: 03/01/2020 Updated Policy to be presented to Policy and Compliance	**08/13/19** – To address this deficiency, the MCP took the steps described in the Action Taken column and provided the following documentation to support its efforts to correct this deficiency: The template "Appeal Acknowledgement" letter was revised to inform the member of their rights. **02/11/20** – The following additional documentation supports the MCP's efforts to correct this finding:

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appeals.	clearly state members can file a grievance if they are unhappy with the decision to downgrade the Appeal from expedited to standard timeframe for investigation. This will require SFHP to send revised letter to DHCS for approval before being able to implement the letters internally. Revised letter attached. DHCS has 60 days to approve letter once submitted. If letter satisfies requirement, the Plan will submit to DHCS Contract Manager for review. <u>Revise member appeal policy:</u> SFHP will revise member appeal policy (QI-17) to include 42 CFR 438.402 (c) (2), Requirements following extension of timeframes. Policy revisions will include: 1. If an Expedited Review is requested and the issue(s) do not meet criteria for Expedited Review, the HOI QR RN		Committee 09/19/19.	- Updated Member Appeal Policy and Procedure "QI-17" (revised 12/04/19) includes notification requirements (including notification timeframes for oral and written notification and the member's right to file a grievance if member does not agree with the decision) when the MCP downgrades expedited appeals to standard. (Section II, (f)(6)) - Revised "Appeal Acknowledgment letter" notifies members of appeal downgrade from expedited to a standard timeframe. The letter states that members can file a grievance if they are unhappy with the decision. **07/09/20** – The MCP's written response (07/09/20), confirmed results of an audit. "An audit was conducted of all requests for expedited appeals from March 2019-May 2020. There were only 7 requests for expedited appeals in that time period, and all of them were processed correctly as expedited, and processed within the correct time frame." Subsequent onsite review conducted for the 2020 Medical Audit, did not identify a deficiency in this area. **This finding is closed.**

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	or HOI Grievance Coordinator/Specialist make reasonable attempts to provide prompt oral notice to the member that the Appeal will be processed within the standard timeframe of 30 calendar days from receipt. This is done within two (2) calendar days of receipt of the Appeal. a. The member is informed of their right to file a Grievance if they are unhappy with the decision to downgrade the Appeal from expedited to standard timeframe for investigation. 2. Within two (2) calendar days of receipt of the Appeal, the HOI Grievance			

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	Coordinator/Specialist also sends the member an Acknowledgement Letter informing the member their Appeal was received, that the Appeal was downgraded to a standard Appeal, and will be resolved within 30 calendar days. ("Downgrade Acknowledgement Letter").			
2. Case Management and Coordination of Care				
2.1.1 Required Components of the Initial Health Assessment Implement policies and procedures to ensure documentation of all components of an IHA.	This Corrective Action is still in the formative stage. The Plan has added a Bi-Annual (twice yearly) audit of IHAs to the annual Audit Work Plan. The Work Plan will be submitted to Policy and Compliance Committee 09/19/19.		09/19/19 (Audit Work Plan Approval) 12/31/19 (First Medical Record Review Audit)	**11/21/**22 - The Plan lacked documented evidence that required components of a comprehensive IHA or preventive services were consistently provided or their current status documented. The Plan has proposed various corrective actions and been impacted by COVID, DHCS Guidance - Public Health Emergency, staff shortages, etc. In response to the COVID-19 pandemic, DHCS issued APL 20-004 which allowed plans to defer IHA completion until the emergency declaration was rescinded. IHA reinstatement occurred on 10/1/21. All of these issues have served as contributing factors for where the Plan stands today. In response to the Emergency Guidance (APL 20-004) that resulted from

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				the COVID-19 pandemic, the Plan was reminded of their responsibility to not only address newer member IHA requirements, but to be sure to address the backlog of members that did not receive or complete a comprehensive IHA during the emergency order. In addition to current new members, medical groups will receive lists of members who were not provided IHAs during their original onboarding. The backlog of members will be addressed through a phased in approach. The Plan is creating a dashboard to track adult preventive care and is creating a workgroup to identify opportunities to improve access to adult preventive care services. The Plan is currently in the process of soliciting members for the workgroup. Plan has identified members who have not received an IHA during the Public Health Emergency to current. Plan has identified members who have not received USPSTF A and B recommended preventive care. Dashboard will be used to identify providers who are not providing preventive care and identify which services are not being regularly provided. Planned outreach includes: Monthly reminders in the Provider Newsletter Letter campaign to adult members about the importance of completing an IHA Possible provider incentive program Catch-up Campaign for members that still need IHAs Additional quarterly audits of providers based on dashboard

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				The Plan has developed processes and protocols to address IHA requirements, while also addressing the backlog of members that did not receive an IHA while the emergency order was in effect. However, while the Plan has processes in place, increased emphasis will be placed on overall IHA implementation and compliance on the 2022 audit/CAP; including the following: • Timely completion of an initial comprehensive IHA within 120 calendar days of enrollment. • Ensure medical records demonstrate evidence/documentation age-appropriate preventive screenings were offered and/or declined OR consistently provided and/or status documented. • Evidence of implementation of previously proposed bi-annual audits surrounding documentation; including meeting the 120 day requirement, documenting all required components of an IHA, documenting the offer, provision, or current status of all age-appropriate preventive services. • Evidence the Plan is addressing the backlog after reinstatement of IHAs. **This finding is closed.**
3. Access and Availability of Care				
3.1.1 Provider Directory Accuracy Follow Plan policy and implement a procedure to ensure the provider directory	The Plan disagrees with this finding. San Francisco Health Plan does have an employee dedicated to and a process to investigate inaccuracies to the Provider Directory. The Plan	PR-21 Provider Directory Accuracy Log	05/30/2017	**08/13/19** – The following documentation supports the MCP's efforts to correct this deficiency: - Policy and Procedure "PR-21: Provider Network Operations" (04/26/17) commits the MCP to enter confirmed changes regarding accepting new patients status, address changes, telephone changes, provider

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is accurate and up-to-date.	objects to the comment that, “the Plan did not provide the log nor other evidence of any investigations.” The investigation process was described to the auditors during the interview, is described in SFHP Policy PR-21, was clarified, with regard to inaccuracies discovered in the PAAS survey, in an email to auditors on 03/11/19, and the log was provided, as requested, to the auditors on 03/19/19. SFHP investigates inaccuracies in a timely manner, as described in PR-21. The Plan actively works to maintain an accurate provider directory as documented in both policy and actual process. If A & I’s intent is to maintain that SFHP does not maintain an accurate provider directory based on a review of a very small sample of 70 providers, the Plan would like A & I to consider that as an unreasonable expectation.			terminations within five (5) business days of receipt. Once updated information about primary care providers and specialists is entered into the QNXT system, the updated information is available for viewing in the online Provider Search Tool the next business day.(Section 8 (b), (c)) Provider data is extracted form QNXT on at least a quarterly basis to create printed provider directories and on at least a weekly basis to support online provider directories. (Sections 9 &10) In response to the prior year’s DHCS audit, the Plan submitted (10/16/18) a provider inaccuracy log to MCQMD. This tool demonstrated tracking and monitoring provider directory inaccuracies. This log captures resolution date, investigation outcome and tracks the changes made. The MCP has policies and procedures in place to ensure the Provider Directory is accurate and up-to-date. **This finding is closed.**

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	SFHP requires that providers notify the Plan if there are any changes to their information. This requirement is in the Provider Manual and also in the provider contracts. We validate any information as provided, actively audit records, and investigate any discrepancies as discovered. It is unreasonable that a provider directory of thousands of providers is 100% accurate, as it is simply a reflection of the information at a specific moment in time. The Plan requests that MCQMD provides guidance on how to correct this deficiency.			
4. Member Rights				
4.1.1 Delegated Grievance Processing Revise Plan processes and implement procedures to ensure the prompt forwarding of delegated grievances and timely grievance	This Corrective Action is still in planning stages. SFHP will revise procedure documents to include: • SFHP will forward delegates' grievances within 24 hours of receipt of the grievance. • The grievance		12/31/2019	**12/19/19** – The following documentation supports the MCP's efforts to correct this finding: - Desktop procedure, "Delegated Grievance and Appeals" (09/03/19) which has updated to include forwarding timeframes of re-directing grievances to appropriate delegate within 24 hours, grievance notification to delegates will include date of receipt by the MCP, and Grievance Coordinator will notify the member that their grievance has been forwarded to the delegate for resolution and contact information of the appropriate delegate provider.

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resolution.	notification to delegates will include date of receipt by the plan to ensure the delegate resolves the grievance within 30 calendar days of receipt by the Plan. This notification will be documented in the grievance in SFHP's Care Management System, Essette. • SFHP will make reasonable efforts to contact the member to notify them that their grievance has been forwarded to the delegate and provide the delegates contact information should the member want to follow up on their grievance. This information will be documented in the grievance in SFHP's Care Management System, Essette. To ensure SFHP's delegated			**01/22/20** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Two samples grievance notification emails as evidence that MCP is forwarding grievances to the appropriate delegates within 24 hours of receipt. - Two samples of grievance notifications to the member as evidence that MCP is making reasonable efforts to contact the member to notify them that their grievance has been forwarded to the delegate. The letter includes the delegate's contact information in case the member wants to follow up on grievance. - Two samples of grievance resolution letters from the delegate to the member as evidence that the grievance has been resolved within 30 days. - JAM meeting minutes (09/12/19) between the MCP and delegate which provide evidence of documented review and discussion of DHCS audit finding. Minutes also include MCP's revised process to correct the finding in which MCP will forward grievances to delegate within 24 hours of receipt (page 2-3). **This finding is closed.**

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	providers are aware of the CAP and plan we will inform Delegates of the following at an upcoming JAM/ JOC or via delegate grievance contacts: DHCS finding For grievances that are forwarded to delegates the date of receipt should be the date of receipt by the plan, which will be included in the grievance notification to delegated providers.			
5. Quality Management				
5.1.1 Preventive care Implement Plan policy and revise Plan processes to require the provision of applicable preventive services identified as USPSTF "A" and "B" recommendations as written and when age and individual appropriate.	This Corrective Action is still in the formative stage. The Pla has added a Bi-Annual (twice yearly) audit of IHAs to the annual Audit Work Plan. Pa of the scope of the audit is to check the medical record to verify that preventative serv will be offered according to the USPTF A & B recommendations. The Wo Plan will be submitted to Poli and Compliance Committee		09/19/19 (Audit Work Plan Approval) 12/31/19 (First Medical Record Review Audit) 11/01/2019 (Distribution of Updated Provider Manual)	The Plan did not require the provision of all applicable preventive services identified as USPSTF "A" and "B" recommendations. Provider informing materials did not require that providers offer USPSTF preventive services labeled "A" or "B" to members as applicable. The Plan's *Network Operations Manual* for providers stated "SFHP refers providers to the following primary sources for preventive health guidelines: the U.S. Preventive Health Services Task Force (USPSTF)." However, the manual did not inform providers that they were required to provide, or offer, the services. The Plan updated its Provider Manual to reflect the need to offer USPSTF recommended preventive services and follow USPSTF

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	09/19/19. In addition, the Plan is in the process of updating the Provider Manual, formerly known as the Provider Network Operations Manual. Proposed language is attached.			guidelines for preventive services. A review of the Plan's online Provider Manual informs providers that Medi-Cal members are entitled to the entirety of preventive services identified as A and B recommendations and that these preventive services should be provided to eligible patients in the schedule recommended by the USPSTF. The manual also provides documentation instructions relating to preventive services. The Plan included verification of preventive services in their IHA audit scope. A sample audit report, "Preventive Care and Initial Health Assessment Audit" (12/21/20) provided evidence the MCP is conducting audits on IHA compliance. The audit demonstrated a lack of documented evidence that IHAs were completed within 120 calendar days and that all preventive services were offered or provided. While the Plan did not have an audit finding related to IHA compliance in 2020 or 2021, overall IHA compliance continues to be an issue. As a result of the 2022 audit and CAP, the Plan is taking a holistic approach to overall IHA compliance. The Plan is developing processes and protocols to address IHA requirements, while also addressing the backlog of members that did not receive an IHA while the emergency order was in effect. Emphasis will be placed implementation and the following: • Timely completion of an initial comprehensive IHA within 120 calendar days of enrollment. • Ensuring medical records demonstrate evidence/documentation that age-appropriate preventive screenings were offered and/or declined OR consistently provided and/or status documented.

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				• Evidence of implementation of previously proposed bi-annual audits surrounding documentation; including meeting the 120 day requirement, documenting all required components of an IHA, documenting the offer, provision, or current status of all age-appropriate preventive services. • Evidence the Plan is addressing the backlog after reinstatement of IHAs. In response to the Emergency Guidance (APL 20-004) that resulted from the COVID-19 pandemic, DHCS has reminded the Plan of their responsibility to not only address new member IHA requirements, but to be sure to address the backlog of members that did not receive or complete a comprehensive IHA during the emergency order. Medical groups will receive lists of members who were not provided IHAs during their original onboarding. The backlog of members will be addressed through a phased in approach. The Plan is creating a dashboard to track adult preventive care and is creating a workgroup to identify opportunities to improve access to adult preventive care services. The Plan is currently in the process of soliciting members for the workgroup. The Plan has identified members who have not received an IHA during the Public Health Emergency to current, including members who have not received USPSTF A and B recommended preventive care. The dashboard will be used to identify providers who are not providing preventive care and identify which services are not being regularly provided.

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				Planned outreach includes: Monthly reminders in the Provider Newsletter Letter campaign to adult members about the importance of completing an IHA Possible provider incentive program Catch-up Campaign for members that still need IHAs Additional quarterly audits of providers based on dashboard Proposed corrective actions will focus on informing materials, member and provider outreach and the development and implementation of a self-monitoring process that ensures the provision of the IHA and required preventive screenings/immunizations. **This finding is closed.**
5.1.2 Organizational chart Include the UMC in the QIS organization chart and demonstrate its reporting relationship to the QIC.	The QI Work Plan is currently in development. Part of the proposed updates is to update the Governing Board Organizational Chart to include the Utilization Management Committee. This update will be presented in the January 2020 Board Meeting for approval.		01/31/2020	**08/13/19** – The following documentation supports the MCP's efforts to correct this finding: Governing Board Organizational Chart in process of approval by the Board Meeting scheduled January 2020. **2/11/20**- The following documentation supports the MCP's efforts to correct this finding: 2020 QI Program Description and Work Plan which includes a description of the Utilization Management Committee, including reporting relationships and key staff. Appendix B - Quality Improvement Committee Structure depicts that the

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				UMC reports to the QIC which reports to the SFHP Governing Board (page 39). **This finding is closed.**
5.2.1 New Provider Training Requirements Implement policies and procedures to ensure providers receive new provider training within 10 working days after being placed on active status.	The Plan has existing policies and procedures to ensure that providers receive new provider training within 10 working days after being placed on active status. In order to ensure that provider groups are following our policy and providing documentation to satisfy the requirement, the Plan has met with the medical group that does not consistently follow our policy, even after corrective action plans have been placed. Please see the attached minutes from the last Joint Administrative meeting with UCSF. In addition, the Plan recently updated our Summary of Key Information and distributed it to provider groups. Please see	UCSF JAM Minutes SOKI Memo 08/09/19	04/09/2019 08/09/2019	

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	the attached memo to one of the medical groups concerning the SOKI and timeliness of training.			

Submitted by: **Date:**
Title: