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

2021

Contract Number: 04-35400

Audit Period: March 1, 2020
Through
February 28, 2021

Report Issued: July 27, 2021

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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, 2021, the Plan served 142,526 Medi-Cal members.

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

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of March 1, 2020 through February 28, 2021. The onsite review was conducted from March 8, 2021 through March 19, 2021. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on June 22, 2021. 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, 2019 through February 29, 2020, was issued on July 17, 2020. 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 (UM)

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 its governing body, the public policy body, and a Plan officer or their designee periodically review appeal records and thoroughly document the review. The Plan did not demonstrate a thoroughly documented periodic review of its own, or a delegate's, written record of appeals by its governing body or its public policy body.

If a Plan denies a request to expedite an appeal, it must transfer the appeal to the standard resolution timeframe. The Plan is required to provide written notice of the reason to extend the timeframe of the appeal to the member within two calendar days, and inform the member of their right to file a grievance about the decision. The Plan did not notify members in writing that they could file a grievance if they disagreed with changing an appeal from an expedited to a standard resolution timeframe.

The Plan is required to ensure subcontractors meet standards set forth by the Plan and DHCS. The Plan did not ensure a subcontractor met required standards.

The Plan is required to collect and review its subcontractors' ownership and control disclosure information. The Plan did not review its 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 SPD, and the provision of mental health and substance use disorder services.

The Plan is required to use a risk stratification mechanism or algorithm to analyze member specific data, and to identify newly enrolled SPD members in higher risk groups with more complex health care needs, and lower risk groups, within 44 days of enrollment.

The Plan did not conduct stratification to identify newly enrolled SPD members.

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.

The Plan is required to use a DHCS-approved Physician Certification Statement (PCS) to determine the appropriate level of service for Medi-Cal members. PCS forms must include components such as dates of service needed, mode of transportation needed, and PCS of medical necessity. The Plan did not collect all required information on PCS forms for NEMT requests.

The Plan cannot modify a PCS form once a member's treating physician prescribes the form of transportation. The Plan modified the mode of transportation for NEMT services from that which the treating physician prescribed on the PCS form.

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.

If the Plan does not resolve a standard grievance within 30 calendar days, it shall notify the member in writing of the status of the grievance and the estimated date of resolution. The Plan did not notify members in writing as required.

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

The Plan is required to forward copies of all grievances alleging discrimination to DHCS for review and appropriate action. The Plan did not ensure grievances alleging discrimination were forwarded to DHCS.

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 ensure that the Community Advisory Committee (CAC) is included and involved in policy decisions related to QI, educational, operational, and cultural competency issues affecting groups who speak a primary language other than English. The Plan's CAC was not involved in policy decisions.

The Plan is required to take effective action to address any needed improvements in the quality of care delivered to its members in all settings. The Plan did not take effective action to address the quality of care when it did not implement its stated processes for completing and closing a high-level quality incident.

The Plan is required to conduct training for all new providers (physician and non-physician) within ten working days after the Plan places a newly contracted provider on active status. The Plan did not ensure that delegated entities conducted new provider training within ten working days.

I. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The onsite review was conducted from March 8, 2021 through March 19, 2021. 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 36 cases, that included 13 for SPD members, were reviewed for timeliness, consistent application of criteria, and appropriate review. Of the 36 cases, eight were retrospective requests, 25 were prior authorization requests, and three were concurrent requests.

Appeal procedures: A total of 24 appeals, that included 12 SPD cases, were reviewed for appropriate and timely adjudication.

Delegated prior authorization requests: eight prior authorization cases from a single delegate were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

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

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

Complex Case Management: Five medical records were reviewed for coordination of care.

Behavioral Health Treatment: Five member files were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

Continuity of Care (COC): Five member files were reviewed to confirm COC and fulfillment of 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: 50 standard grievances that included 25 for SPD members and 13 exempt grievances, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. The 50 standard grievance cases included four quality of service and 46 quality of care grievances.

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

Category 5 – Quality Management

Potential Quality Incidents (PQI): Six PQI cases were reviewed for timely 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: Nine fraud and abuse cases were reviewed for appropriate reporting and processing.

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

CATEGORY 1 - UTILIZATION MANAGEMENT

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Appeal Log Reporting

The Plan shall make appeal logs accessible to DHCS, including copies of appeal logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. (*Contract A24, Exhibit A, Attachment 14 (3) (A) and (B))*

The Plan shall maintain a written record for each appeal received. The record of each appeal shall be maintained in a log. *(All Plan Letter (APL) 17-006)*

The written record of appeals shall be reviewed periodically by the governing body, the public policy body, and a Plan officer or their designee. The review shall be thoroughly documented. (*APL 17-006)*

Plan policy *QI-17 Member Appeals (reviewed 12/23/20)* stated the Plan maintains a written record for each appeal received that includes required information. On a monthly basis, the Utilization Management Committee (UMC) reviews appeals resulting in overturn of an authorization decision made by the Plan or one of its delegated medical groups.

Plan policy *DO-08 Oversight of Delegated Member Grievances and Appeals Functions (reviewed 4/17/20)* stated the Plan periodically receives a copy of delegated group Plans' appeals and grievance reports. The Chief Medical Officer, Director of Clinical Operations, or clinician designee shall perform a clinical review of the reports.

The Plan's *2020 QI Program Description* designated the Member Advisory Committee (MAC) as its public policy body.

Finding: The Plan did not demonstrate a thoroughly documented periodic review of its own or a delegate's written record of appeals by its governing body or MAC.

Plan documents demonstrated the Plan's UMC reviewed upheld and overturned appeals on a monthly basis. The Plan provided appeal logs reviewed by the committee, whose membership included the Chief Medical Officer. Quarterly Quality Improvement Committee (QIC) minutes showed inclusion of these logs in the committee's consent Calendar packet. However, governing body and MAC minutes did not document review of the appeal report/log for the Plan or its delegates during the audit period.

The Plan partially delegated appeal review and resolution to a delegate. Governing body and MAC minutes did not document review of the delegate's appeal report/log during the audit period.

Plan policy *QI-17 Member Appeals (reviewed 12/23/20)* stated the Grievance Program Leadership Team reviewed appeal data and the QIC reviewed an appeals report quarterly; however, it did not describe the periodic review and documentation of member appeal report/log review by the governing body and the MAC.

Plan policy *DO-08 Oversight of Delegated Member Grievances and Appeals Functions (reviewed 4/17/20)* stated the Provider Network Oversight Committee and the QIC reviews summaries of delegated groups' appeal audit reports and provided feedback as needed; it did not describe the review of appeal logs by the governing body and the MAC, or thorough documentation of those reviews.

Plan policy *CL-03 Member Advisory Committee (reviewed 4/16/20)* did not include periodic appeal log review among the MAC's responsibilities.

In an interview, the Plan stated that MAC members were also members of the governing body and QIC, but did not indicate that the governing body reviewed and thoroughly documented its review of appeal logs. It stated the MAC set its own agenda and had not expressed including appeal log review as an activity.

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

Recommendation: Revise Plan policies and procedures to ensure the Plan reviews Plan and delegate appeal logs as required by the Contract, and that it thoroughly documents the reviews.

1.3.2 Provider Manual Requirements

The Plan is required to issue a Provider Manual to the contracting and subcontracting providers of Medi-Cal health care services that includes information and updates regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access, special requirements, and the member grievance, appeal, and State Fair Hearing (SFH) process. The Provider Manual shall include the member's right to file grievances and appeals, requirements and timeframes for filing, and member's right to request continuation of benefits during an appeal or SFH. (*Contract A24, Exhibit A, Attachment 7 (4) (B) and (E)*)

The Plan's 2020 *Provider Manual*, the provider section of its website, and a delegate's Provider Manual regarding services for the Plan's members described the member appeal process.

Finding: The Plan's 2020 *Provider Manual* and a delegate's Provider Manual did not include contractually required member appeal information.

The Plan's 2020 *Provider Manual* did not describe a member's right to request continuation of benefits during an appeal or SFH. Documentation did not include updates to the *Provider Manual* that supplied the missing information.

The Plan delegated member appeal resolution to a subcontractor; the subcontractor's Provider Manual specifically designated for Plan member services, and dated February 2019, contained inaccurate information about member appeals:

- The manual described a 90-day instead of a 60-day submission timeframe for member appeals and SFH filing.

- It stated members could file a SFH or Independent Medical Review request immediately after receipt of a *Notice of Action* letter, instead of after the completion of a first level appeal by the subcontractor and receipt of a *Notice of Appeal Resolution* letter.

The Plan's *Provider Manual* stated the Plan would update this reference tool regularly to include program, administrative, and regulatory changes as needed. The last listed revision was dated June 2018 and did not include appeals in the list of topics.
The subcontractor's Provider Manual for the Plan's members directed providers to the subcontractor's website for manual updates. The most recent update listed was January 2019 and concerned revised clinical guidelines.

When the Plan's provider informing materials contain inaccurate or incomplete information about member rights, providers may not be aware of how they may assist members in exercising and benefitting from their health-care-service-related rights.

Recommendation: Revise and implement Plan processes to ensure Provider Manuals are contractually compliant.

1.3.3 Written Notice after Appeal Change

The Plan is required to have in place a system in accordance with Code of Federal Regulations (CFR), Title 42, 438.402-424. (*Contract A24, Exhibit A, Attachment 14 (1)*)

If a Plan denies a request to expedite an appeal, it must transfer the appeal to the standard resolution timeframe and follow requirements in 42 CFR 438.408 (c) (2). (*CFR, Title 42, section 438.410 (c*))

If the Plan extends appeal timeframes not at the request of the enrollee, it must:

- Make reasonable efforts to give the enrollee prompt verbal notice of the delay.
- Within two calendar days, give the enrollee written notice of both the reason to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision. *(CFR, Title 42, section 438.408 (c) (2))*

Plan policy *QI-17 Member Appeals (reviewed 12/23/20)* stated the Plan notified the member they could file a grievance if they disagreed with changing the appeal from an expedited to a standard resolution timeframe.

Finding: The Plan did not notify members in writing that they could file a grievance if they disagreed with changing an appeal from an expedited to a standard resolution timeframe.

A verification study of 24 appeals showed the Plan sent acknowledgement letters that did not meet contractual requirements:

- The Plan downgraded two pharmacy appeals to standard from expedited timeframes not at the member's request, and did not notify the member in writing that they could file a grievance if they disagreed with the decision.

- The Plan downgraded six medical appeals to standard from expedited timeframes not at the member's request, and did not notify the member in writing that they could file a grievance if they disagreed with the decision.

- The Plan resolved four of the above eight appeals after July 1, 2020; the Plan stated it revised its acknowledgement letter in July 2020.

Plan policy *QI-17 Member Appeals (reviewed 12/23/20)*, Desk Top Procedure (DTP) *Member UM Appeals Clinical (reviewed 1/4/21),* and DTP *Member Pharmacy Appeals Clinical (reviewed 12/29/20)* stated the Plan would verbally notify the member and offer to file a grievance if the member disagreed with downgrading an appeal from an expedited to a standard processing timeframe. The documents noted the Plan would send a downgraded-appeal acknowledgement letter, but did not state the letter informed the member of their right to file a grievance about the downgrade.

A 2019 DHCS-audit finding resulted in the Plan's creation of a draft *Acknowledgement* letter template, which included the required right-to-file-a-grievance information. A review of the Plan's CAP for the audit showed a letter implementation date of March 2020. A Plan memo stated the Plan "revised the *Member Appeal Denial of Expedited Acknowledgement Letters* in July 2020". However, the verification study did not demonstrate implementation of the letter.

In a written post exit response, the Plan claimed the date of implementation of the acknowledgement letter was July 21, 2020. One of eight appeals cases in the verification study that were downgraded to standard from expedited was received after July 21, 2020. In this one case, the appeal was received approximately three and a half months after the Plan's implementation date, but the acknowledgement letter did not contain the required right-to-file-a-grievance information.

When the Plan does not send written notices that contain contractually required information, it cannot ensure members receive information about their grievance rights.

Recommendation: Implement a process to ensure the Plan sends a contractually compliant written notification informing members of their right to file a grievance when they disagree with the Plan's decision to downgrade an appeal not at the member's request.

1.5	DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Delegated UM Oversight

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

The Plan is required to ensure the UM program includes an established specialty referral system to track and monitor referrals requiring Prior Authorization (PA). The system shall include authorized, denied, deferred, or modified, and the timeliness of the referrals. *(Contract A24, Exhibit A, Attachment 5 (1) (F))*

The Plan may defer a PA when it needs more information to make a decision about a service request and it is in the member's interest. *(Contract A24, Exhibit A, Attachment 5, 3 (G))*

The Plan is required to provide notification to members regarding denied, deferred, or modified referrals as specified in the Contract. There shall be a well-publicized appeals procedure for both providers and patients. (*Contract A24, Exhibit A, Attachment 5 (2) (F)*)

The Plan is required to issue a Provider Manual to contracting and subcontracting providers who provide services to Medi-Cal members. The manual shall include information and updates regarding Medi-Cal services, SFHs, appeal requirements and filing timeframes, and continuation of benefits during appeals. (*Contract A24, Exhibit A, Attachment 7 (4) (A-E)*)

Plan policy *DO-02 Oversight of Delegated Functions (reviewed 9/28/20)* stated the Plan ensures that delegated functions comply with the DHCS contract and applicable regulations through an annual audit process and monthly and quarterly monitoring activities.

Finding: The Plan did not ensure the subcontractor met standards set forth by the Plan and DHCS.

The Plan delegated UM duties to a subcontractor. The agreement between the Plan and the subcontractor described the subcontractor's responsibilities, which included developing and implementing a UM program description, work plan, policies, and procedures; performing annual review of UM criteria; and submitting periodic reports, including specialty referral tracking reports.

- A verification study of eight cases showed the subcontractor denied PA service requests and listed five cases as deferred rather than denied. The services were carved out and covered by a program other than the subcontractor. The Contract required tracking PAs, including denied and deferred requests. The Plan's audits of the subcontractor did not document the deficiency.

- The subcontractor's member appeal information for members and providers, including that contained in its Provider Manual, was incomplete and showed inaccuracies:

    - The subcontractor's website provided a link to the Plan's *Summary of Key Information* for providers, which described the appeal process but included an inaccurate submission timeframe of 90 rather than 60 days from receipt of a *Notice of Action* letter.

    - The subcontractor's website contained a member section that defined appeals and directed members to call the Plan to submit appeals, but did not describe the appeal procedure.

    - The subcontractor's Provider Manual did not state the Plan resolved its members' appeals, and that members and providers could submit appeals directly to the Plan. It did not describe appeal timeframes, continuation of benefits during pending appeals, and SFH rights.

The subcontractor utilized a third party administrator for UM purposes. Subcontractor documents revealed that it relied on the administrator to develop its UM program and policies, and to resolve PA requests. In an interview, the subcontractor stated the administrator considered decisions to deny services that other programs covered to be deferrals. The subcontractor reported discussions with the Plan revealed these adverse decisions should be considered denials. The subcontractor acknowledged there had been a categorization error.

In a written response to the question of whether the Plan had instructed the subcontractor that deferrals were not denials, the Plan reported it had provided information to subcontractors regarding defining deferrals; however, it could find no written record of these discussions between itself and the subcontractor.

In an interview, the Plan stated its 2020 audit of the subcontractor found the subcontractor's policies did not describe forwarding of appeals to the Plan. The audit report to the Plan's Provider Network Oversight Committee stated the subcontractor's *UM Program* did not describe the process for handling and resolving appeals. However, the Plan's audit did not identify deficiencies related to website or Provider Manual appeal information. The Plan's audit tool did not include UM requirements for a well-publicized appeal procedure.

When the Plan's oversight activities do not capture contractually non-compliant delegate practices, the result may be continued deficiencies.

Recommendation: Revise oversight processes to ensure that subcontractors follow contractual requirements.

1.5.2 Ownership and Control Disclosure Review

The Plan is required to comply with 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 07/27/20)* 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 of ten UM delegates' disclosure forms revealed the following deficiencies:

- Two disclosure forms did not disclose any owners and individuals with control interest and four forms did not list all owners and individuals with control interest.
- Four disclosure forms did not contain social security numbers or tax identification numbers for all owners and individuals with control interest.
- Three disclosure forms did not contain dates of births for all owners and individuals with control interest.
- One disclosure form did not contain addresses for all owners and individuals with control interest.

In interviews, the Plan stated the collection and review of ownership and control disclosure information was completed through the credentialing process. As part of a CAP to the prior year's finding, the Plan reminded delegates of disclosure requirements and requested re-submissions. However, DHCS review shows that the forms continue to be incomplete.

When the Plan does not collect and review ownership and control disclosure information of its 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 1.1.1 – 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 CARE MANAGEMENT AND HEALTH RISK ASSESSMENT CALIFORNIA CHILDREN'S SERVICES EARLY INTERVENTION/DEVELOPMENTAL DISABILITIES/EPSDT

2.1.1 Health Risk Stratification

The Plan is required to apply a DHCS-approved health risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs within 44 days of enrollment. The health risk stratification shall be done in accordance with APL 17-013. (*Contract A24, Exhibit A, Attachment 10 (4)*)

For the duration of the public health emergency, the Plan is still required to conduct risk stratification using health care utilization data for all newly enrolled SPDs. The Plan must also continue to comply with Title 42, CFR, section 438.208(b)(3)5 through the use of the Health Information Form/Member Evaluation Tool, within 90 days of enrollment for all newly enrolled members, as required in APL 17-013 and the Contract. (*APL 20-011)*

The first process is a risk stratification mechanism, or algorithm, which the Plan uses to analyze health care utilization data it receives from DHCS for each of its newly enrolled SPD members. This data represents the SPD member's prior health care utilization under Medi-Cal Fee-for-Service (FFS). The Plan must analyze this data or Health Information Form (HIF) / Member Evaluation Tool (MET) data when it exists to identify newly enrolled SPD members with higher risk and more complex health care needs. *(APL 17-013)*

Plan policy *CARE-02 Health Information Forms (HIFs) and Health Risk Assessments (HRAs) (Reviewed 7/30/20)* stated, based on the information provided in the HIF/MET, the Plan performs risk stratification on all Medi-Cal members; those scored at high-risk are referred to case management. For all newly enrolled SPD members, the Plan evaluates members within 90 days of enrollment for the presence of high-risk factors.

Finding: The Plan did not conduct stratification to identify newly enrolled SPD members as higher or lower risk within 44 days.

A verification study of five SPD members was conducted. In four cases, the Plan did not provide any evidence that it conducted a stratification process or that it classified members as high or low risk. There was no evidence that the Plan analyzed the health care utilization data received from DHCS or if HIF/MET data was used.

When the Plan does not conduct health risk stratifications for SPD members as required, health risk assessments may be delayed with resultant adverse health effects.

Recommendation: Revise and implement policies and procedures to stratify each newly enrolled SPD member's current health care condition within 44 days of their enrollment as required by APL 17-013.

2.1.2 Use of Long-Term Services and Support (LTSS) Referral Questions

The Plan must use the HRA to comprehensively assess each newly enrolled SPD member's current health risk. In addition, the HRA must include specific LTSS referral questions. These questions are intended to assist the Plan in identifying members who may qualify for, and benefit from, LTSS services. These questions are for referral purposes only and are not meant to be used in classifying high and low risk members (*APL 17-013*).

Plan policy *CARE-02 Health Information Forms (HIFs) and Health Risk Assessments (HRAs)(Reviewed 7/30/20)* stated risk factors are identified based on the evaluation of historical Medi-Cal FFS utilization data; if available, member responses to the HIF; and member responses to the HRA survey tool administered by Plan customer service staff.

Finding: The Plan used LTSS referral questions for classifying members as higher risk.

In two separate interviews, the Plan stated LTSS referral questions are included in the HRA form. Members that answer "yes" to three or more questions on the HRA form, including the LTSS referral questions, are classified as higher risk.

When the Plan inaccurately classifies a member as higher or lower risk, the result may be inappropriate access to, and delivery of, healthcare services.

Recommendation: Revise and implement procedures to use LTSS referral questions for referral purposes only, and not for classification of higher and lower risk.

2.1.3 California Children's Services Contractual Requirements

Upon adequate diagnostic evidence that a Medi-Cal member under 21 years of age may have a CCS-eligible condition, the Plan shall refer the member to the local CCS office for determination of eligibility. (*Contract A24, Exhibit A, Attachment 11(9)*)

The Plan shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. *(Contract A24, Exhibit A, Attachment 11 (9) (A))*

Ensure that, once eligibility for the CCS program is established for a member, the Plan shall continue to provide all medically necessary covered services that are not authorized by CCS, and shall ensure the coordination of services and joint case management between its Primary Care Providers (PCP), the CCS specialty providers, and the local CCS program. *(Contract A24, Exhibit A, Attachment 11 (9) (A)(5))*

Plan's policy *CARE-12 California Children's Services (Reviewed 10/28/20) stated:*

- Providers perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise reasonable suspicion that a member has a CCS-eligible medical condition.
- CCS-covered services are delivered by CCS-paneled providers, CCS-approved hospitals and special care centers, and other outpatient clinics.
- Plan staff coordinate with providers to make CCS referrals when indicated.
- Plan continues to authorize and cover all medically necessary services for the member until CCS eligibility is confirmed.
- Providers will initiate referrals to CCS for members with CCS-eligible conditions, and provide CCS with any supporting clinical documentation necessary for CCS to evaluate the referral and determine CCS eligibility.
- Providers continue to deliver all primary care services and all other medically necessary medical services unrelated to the CCS diagnosis or denied by CCS.

Finding: The Plan did not demonstrate compliance with contractual requirements for referring children to the local CCS program and coordinating care for children with CCS-eligible conditions. The Plan did not provide documentation that it delivered medically necessary services for non-CCS conditions.

A verification study of seven member records revealed the following:

- Four of seven records requested were not submitted.
- For the three records submitted, the following was not documented:
    - Referral of members with CCS-eligible conditions to the local CCS program.
    - Coordination of care between CCS and the Plan or PCP.
    - Provision of medically necessary services for non-CCS conditions or when CCS eligibility is denied.

In an interview, the Plan stated providers directly referred the seven members in the verification study to the CCS program; the Plan did not have documentation of these referrals. After providing medical records for three of seven members, the Plan did not respond to requests for the remaining four files.

When the Plan does not provide evidence of contract compliance, the Plan cannot ensure members receive medically necessary CCS program services.

Recommendation: Implement policies and procedures for referring children to the local CCS program and coordinating care for children with CCS-eligible conditions with the local CCS program. Provide medically necessary services for non-CCS-eligible conditions.

2.5 MENTAL HEALTH AND SUBSTANCE ABUSE

2.5.1 Mental Health Plan (MHP) Memorandum of Understanding (MOU) Attachment 1 Requirements

The Plan shall negotiate in good faith and execute MOU with the MHP in accordance with Welfare and Institutions Code section 14715. The MOU shall specify the respective responsibilities of the Plan and the MHP in delivering medically necessary covered services and specialty mental health services to members. *(Contract A24, Exhibit A, Attachment 12, (3) (A))*

For those members with a tentative psychiatric diagnosis which meets eligibility criteria for referral, the member shall be referred to the MHP in accordance with the MOU between the Plan and the MHP, and APL 13-018. *(Contract A24, Exhibit A, Attachment 11 (6) (A))*

California Code of Regulation (CCR), Title 9, Chapter 11 MOU requirements include:

- How the MHP will provide a referral to the Plan when the MHP determines that the member's mental illness would be responsive to physical-health-care-based treatment.

- The MHP's obligation to designate a process or entity to receive notices of actions, denials, or deferrals from the Plan and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination by the Plan, and the MHP's obligation to respond by the close of business day following the day the deferral notice is received by the MHP as outlined in section 1810.370.

- Numerous requirements for referrals by the MHP when the member's diagnosis is not included in specialty mental health or would be responsive to physical-health-care-based-treatment (e.g. a provider with an existing patient-provider relationship, the Plan in which the member is enrolled, health care options program, local Child Health and Disability Prevention program, other community resources available in the county) as outlined in section 1810.415.

- Numerous requirements for dispute resolution process, process for dispute resolution by DHCS, and provision of medically necessary services pending resolution of dispute as outlined in sections 1850.505, 1850.515, and 1850.525. *(APL 18-015, Attachment 1)*

The Plan's MOU with the county MHP (signed 11/5/18) states the MHP "will provide information and referral to appropriate agencies, e.g. social services, entitlements, housing, physical health, and substance abuse." The MHP "will respond to all Plan and/or provider referrals by fax or phone to acknowledge referral and document action plan (accepted, modified, denied)." The MOU states "current regulations specify that if the local dispute resolution process is not able to resolve the dispute, that either the Plan or MHP may request dispute resolution by a state-level process staffed by DHCS." Both the Plan and MHP "agree to provide services to the member during the dispute resolution process in accordance with current regulations."

Finding: The Plan's MOU with the county MHP did not meet the requirements of APL 18-015, Attachment 1. The MOU did not describe:

- How the MHP provides a referral to the Plan when a member's mental illness would be responsive to physical health care based treatment.
- The MHP's process to receive and respond to notice of actions, denials, and deferrals.
- The MHP's requirements to refer members to appropriate entities.
- The dispute resolution process.
- The provision of services pending resolution of a dispute.

The MOU stated the MHP would provide a referral for physical health but did not describe how the member would be referred when a member's mental illness was responsive to physical-health-care-based treatment.

The MOU stated the MHP would respond to all Plan referrals and action plans but did not describe the MHP's obligation to designate a process or entity to receive notices of actions, denials, or deferrals from the Plan, and to provide additional information requested in the deferral notice for medical necessity determinations. The MOU did not describe the MHP's obligation to respond to the deferral notice within timeframes required by CCR, Title 9, section 1810.370.

The MOU stated the MHP would provide information and referral to appropriate agencies. However, the MOU did not include all required entities to which the MHP must refer the member as stipulated in *CCR, Title 9, section 1810.415.*

The MOU stated that a dispute resolution process staffed by DHCS may be requested; the MOU did not describe the process and how to request dispute resolution by DHCS as required by *CCR, Title 9, sections 1850.505 and 1850.515*.

The MOU stated the Plan and MHP agreed to provide services during the dispute resolution process according to current regulations, but the MOU did not describe the details of which entity would provide medically necessary services pending resolution of dispute as outlined in CCR, Title 9, section 1850.525.

The Plan did not describe or submit written policies or procedures that met the detailed requirements in APL 18-015, Attachment 1. During the interview, the Plan stated its MOU with the MHP renews automatically every year. The Plan did not have a process to update the MOU due to lack of management staff.

Without detailed processes in the MOU, the Plan and MHP may not consistently provide necessary care or resolve disputes involving the delivery of medical and mental health services for members.

Recommendation: Revise the MOU to include and describe all required elements in APL 18-015, Attachment 1.

2.5.2 Mental Health Plan Memorandum of Understanding Attachment 2 Requirements

The Plan shall execute a MOU with the county MHP as stipulated in the Contract. *(Contract A24, Exhibit A, Attachment 11(6) (B))*

The MOU must include elements such as reporting and QI requirements, which are described in the MOU Template *(APL 18-015, Attachment 2).*

APL 18-015, Attachment 2 stated the MOU shall specify policies, procedures, and reports to address QI requirements for mental health services including, but not limited to:

- Regular meetings, as agreed upon by the Plan and MHP, to review the referral and care coordination process and to monitor member engagement and utilization.

- No less than a semi-annual calendar year review of referral and care coordination processes and at least semi-annual reports summarizing quality findings. Reports summarizing findings of the review must address the systemic strengths and barriers to effective collaboration between the Plan and MHP.

- Reports that track cross-system referrals, beneficiary engagement, and service utilization, including, but not limited to, the number of disputes between the Plan and MHP, the dispositions/outcomes of those disputes, the number of grievances related to referrals and network access, and the dispositions/outcomes of those grievances. Reports shall also address utilization of mental health services by members receiving such services from the Plan and the MHP, as well as quality strategies to address duplication of services.

- Performance measures and QI.

Plan policy *CARE-10, Behavioral Health Services (reviewed 6/08/20)* stated, "The Plan maintains an MOU with the MHP to provide such specialty care. The Behavioral Health Governance Committee holds responsibility for monitoring the performance of behavioral health vendors and the MHP through quarterly meetings, reports from vendors, and review of data submitted to the Plan in accordance with the MOU."

Finding: The Plan's MOU with the MHP did not specify policies, procedures, and reports to address QI requirements for specialty mental health services.

In an interview, the Plan stated it met regularly with the MHP and discussed health service programs but did not conduct oversight of the MHP because specialty mental services were carved out. The Plan stated it was National Committee for Quality Assurance (NCQA) accredited and followed standards for coordination of medical and behavioral health care. However, the MOU did not describe the policies, processes, and reports addressing QI for specialty mental health services.

Without specifying processes in the MOU, the Plan and MHP may not consistently improve the quality of specialty mental health services for members.

Recommendation: Revise the Plan's MOU with the MHP to include reporting and QI requirements described in APL 18-015, Attachment 2.

2.5.3 Alcohol Misuse Screening and Behavioral Counseling Intervention

The Plan is required to provide Alcohol Misuse Screening and Counseling (AMSC) services by a member's PCP. (*Contract A24, Exhibit A, Attachment 20 (5)*)

The Plan is required to develop and implement policies and procedures to define and describe mental health services provided by a PCP, including those for alcohol use disorders and referrals for treatment. *(Contract A24, Exhibit A, Attachment 20 (4) (E)*

In accordance with *APL 18-014*, the Plan must maintain policies and procedures regarding alcohol misuse as follows:

- Policies and procedures shall ensure that providers in primary care settings offer and document alcohol misuse screening services.

- The Plan must offer members who screen positive for hazardous drinking brief behavioral counseling sessions to reduce alcohol misuse.

- The Plan must ensure it refers appropriate members for further evaluation and treatment.

Plan policy *HE-06 Alcohol Misuse Screening and Behavioral Counseling Interventions (reviewed 5/8/20)* stated providers in primary care offered and documented AMSC adult members. It stated the Plan offered providers information about alcohol misuse screening trainings on its website and in provider communications.

Finding: The Plan did not develop procedures that defined and described AMSC services that PCPs provided. Provider-informing materials did not include information regarding AMSC services, policies, and procedures.

Although Plan policy *HE-06* stated the Plan offered providers information about alcohol misuse screening services and trainings on its website and in provider communications, investigation revealed deficiencies in the Plan's *2020 Provider Manual* and its website materials:

- Neither the manual nor the website included screening, counseling, and referral for alcohol misuse in the list of mental health services PCPs could provide.

- The behavioral health services section of the manual and the providers' section of the Plan's website only instructed providers to call the county MHP to refer members for alcohol abuse services.

- Neither the manual nor the provider's section of the website included information about alcohol misuse screening frequency, accepted screening tools, and types of counseling interventions that providers could implement.

- The above resources did not inform providers they could train for additional expertise in alcohol misuse disorder screening and counseling, or contain training materials.

In an interview, the Plan stated it did not have policies restricting what mental health services PCPs could provide, and that the *Provider Manual* stated PCPs could provide non-specialty mental health services within the scope of their license. However, the Contract required the Plan have procedures that defined and described AMSC services PCPs provided.

When the Plan does not define, describe, and communicate procedures for AMSC services, providers may not know how to deliver this benefit to members, who may experience adverse effects as a result.

Recommendation: Develop and implement procedures that describe and detail AMSC services PCPs deliver.

2.5.4 Initial Mental-Health-Assessment-Informing Materials

The Plan shall be responsible for the delivery of non-specialty mental health for children, and outpatient mental health services for adult members with mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder:

- The Plan shall not require a referral from a PCP or PA for an initial mental health assessment performed by a network mental health provider.

- The Plan's informing materials must clearly state that referral and PA are not required for a member to seek an initial mental health assessment from a network mental health provider. *(APL 17- 018)*

Plan policy *CARE -10 Behavioral Health Services (reviewed 6/30/20)* stated no referral or PA is required for an initial mental health assessment performed by a network mental health provider.

Finding: The Plan's informing materials did not clearly state that a referral and PA are not required for a member to seek an initial mental health assessment from an in-network mental health provider.

The Plan delegated responsibility for mental health healthcare services to a subcontractor, which provided UM services and contracted with mental health providers to deliver care. Members who required outpatient mental health services were first assessed for the need for mental health care and appropriate level of service using a screening tool.

Neither the Plan's 2020 *Provider Manual,* the *2020 Member Guidebook,* nor the Plan's website stated the Plan did not require a referral or PA for an initial mental health assessment:

- The behavioral health section of the *Provider Manual* stated members needed referral and screening to qualify for mental health services and that PCPs or the subcontractor could screen the member; it did not state no PA for services was required, or that the member could self-refer to a mental health provider for an initial assessment.

- The Plan's *Member Guidebook* described outpatient services available to members, but did not describe the provision of a mental health assessment that did not require a referral or PA. It instructed members to call the Plan's mental health subcontractor to access services.

- The *Our Programs* section of the Plan's website contained a *Benefits and Coverage* link that directed users to a menu listing *Behavioral Health Services*. This section included covered mental health services and directed users to the subcontractor's website or phone number for more information. The information did not state the Plan did not require a referral or PA for an initial mental health screening.

- The subcontractor's website did not state that neither a referral nor PA was required for an initial mental health screening.

In an interview, the Plan stated it did not require a PA for an initial mental health screening. However, documentation did not clearly state this.

When the Plan's informing materials do not clearly state services do not require a referral or PA, members and providers may lack information and be confused about precisely what their benefits are. Members may not access medically necessary services without this information.

Recommendation: Amend informing materials to include information that no referral or PA is required for an initial mental health assessment from an in-network mental health provider.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-MEDICAL TRANSPORTATION AND NON-EMERGENCY MEDICAL TRANSPORTATION

3.8.1 Physician Certification Statement Form – Required Information

The Contract included NEMT as part of medically necessary covered services for the member. *(Contract A24, Exhibit A, Attachment 10 (1) (A))*

The Plan is required to use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. All NEMT PCS forms must include, at a minimum, the following components: documentation of specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles, dates of service needed, mode of transportation needed, and PCS of medical necessity. The Plan must have a mechanism to capture and submit data from the PCS form to DHCS. Once the member's treating physician prescribes the form of transportation, the Plan cannot modify the authorization. *(APL 17-010)*

Plan policy *CO-28 Transportation Services and Authorization Requirements (reviewed 8/31/20),* stated the PCS form would include the diagnosis and functional limitations justification, dates of service needed, mode of transportation needed, and a certification statement that the attending provider used medical necessity to determine the type of transportation needed.

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

A verification study revealed 18 of 25 NEMT service requests did not include all required information on the PCS form.

- Two of 18 did not have a PCS or any other form with the required information.
- Five of 18 did not include any dates of service.
- Ten of 18 did not have ending dates of service.
- Five of 18 did not have specific physical and/or medical limitation justifications.

In an interview, the Plan stated it will contact providers and vendors if required information is needed. The Plan will not delay authorization of services if an updated PCS form has been requested, but not received. PCS forms that did not provide ending dates of service, but noted ongoing services, could be authorized up to a maximum of 12 months. This process did not comply with DHCS requirements to collect all required information on PCS forms for NEMT requests as specified in APL 17-010.

In a written post-exit response, the Plan provided additional statements identifying why the Plan did not have all required information on the PCS forms. These statements did not comply with APL 17-010 requirements.

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

This is a repeat finding of the prior year's finding 2.4.1 – Physician Certification Statement.

Recommendation: Implement policies and procedures to ensure collection of all required information on the Plan's PCS form for NEMT requests.

3.8.2 Physician Certification Statement Form - Modifications

The Contract included NEMT as part of medically necessary covered services for the member. *(Contract A24, Exhibit A, Attachment 10 (1) (A))*

Plans are required to use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. All NEMT PCS forms must include the mode of transportation needed. Once the member's treating physician prescribes the form of transportation, the Plan cannot modify the authorization. Each Plan must have a mechanism to capture and submit data from the PCS form to DHCS. *(APL 17-010)*

Plan policy *CO-28 Transportation Services and Authorization Requirements (reviewed 8/31/20)*, stated the PCS form would include the mode of transportation needed. The Plan will review the PCS form for appropriate level of transport and medical necessity and may deny the request but does not modify it.

Finding: The Plan modified the mode of transportation for NEMT services from that which the treating physician prescribed on the PCS form.

A verification study revealed that in three of 25 NEMT service requests, the Plan modified the mode of transportation from that prescribed on the PCS form.

- In one of three cases, the provider prescribed ambulance transportation. The transportation vendor requested wheelchair van transportation. The Plan requested clarification from the prescribing provider, but was unable to obtain clarification. The Plan authorized wheelchair van transportation.

- In another case, the provider prescribed ambulance transportation, but the PCS form included billing codes for wheelchair van transportation. The Plan requested an updated PCS form prescribing wheelchair van transportation, but did not receive it. The Plan authorized wheelchair van transportation.

- In a third case, the PCS form included billing codes for both wheelchair and gurney van transportation; however, the provider prescribed gurney transportation only. The Plan requested an updated PCS form prescribing both modes, but did not receive it. The Plan authorized wheelchair van transportation in addition to gurney van transportation.

In an interview, the Plan stated it would contact providers and vendors if clarification were needed. The Plan would not delay authorization of services even if it did not receive an updated PCS form. This process did not comply with DHCS requirements that once the member's treating physician prescribes the form of transportation, the Plan cannot modify the authorization.

In a written post-exit response, the Plan provided additional statements identifying the reasoning for modifying the prescribed modes of transportation. These statements did not comply with APL 17-010 requirements.

When the Plan modifies a prescribed mode of transportation, it cannot ensure compliance with a treating physician's decision regarding medically necessary transportation for a member. Members may experience adverse effects when they do not receive the prescribed mode of transportation.

Recommendation: Implement policies and procedures to ensure the Plan does not modify the mode of transportation that the treating physician prescribed on the PCS form.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: San Francisco Health Authority dba San Francisco Health Plan
AUDIT PERIOD: March 1, 2020 through February 28, 2021 **DATE OF AUDIT:** March 8, 2021 through March 19, 2021

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Written Notification of Delay Letters

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

"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." (*APL17-006)*

Plan policy *QI-06 Clinical Member-Grievances (Reviewed 12/23/20)* stated if resolution cannot be provided within the required timeframe, the Grievance Coordinator makes reasonable efforts to contact the member by the grievance due date to notify them of their right to contact the Department of Managed Health Care and pending status of the grievance investigation and resolution.

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

A verification study revealed 14 of 50 cases where members did not receive written notification letters regarding delays in the resolution of their grievances.

For all cases, the Plan attempted to verbally notify the member of delays in their resolution through phone calls and voicemail. In one case, the Plan was unable to leave a voicemail due to a full mailbox.

In interviews, the Plan confirmed its process of verbally notifying the member and not sending written notification letters.

As part of the post-exit response, the Plan provided a DHCS e-mail dated 09/17/2018, stating Plans will not be cited for certain requirements regarding a 14-day extension period. However, this exemption only applies to appeals and does not apply to written notifications for delays of grievances. By DHCS contract, Plans are not allowed delays or extensions in resolving grievances.

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

Recommendation: Develop and 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.

4.1.2 Review of Written Grievance Log

The Plan shall have in place a system in accordance with CCR Title 28, section 1300.68. The Plan shall 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 shall be reviewed periodically by the governing body of the Plan, the public policy body created pursuant to section 1300.69, and by an officer of the Plan or their designee. This review shall be thoroughly documented. *(CCR, Title 28, section 1300.68 (b) (5))*

The written record of grievances and appeals shall be reviewed periodically by the governing body of the Plan, the public policy body, and by an officer of the Plan or their designee. The review shall be thoroughly documented. *(APL 17-006)*

Plan policy *QI-06 Clinical Member Grievances (reviewed 12/23/20)* stated that the Associate Program Manager for appeals and grievances reviews the grievance log and analyzes all grievances on a monthly basis.

Finding: The Plan's Governing Board, public policy body, and a Plan official did not review the written grievance log periodically and did not thoroughly document the review.

In an interview, the Plan acknowledged its Governing Board, MAC (the Plan's public policy body), and Chief Medical Officer, who oversees the grievance program, did not review a written log of all grievances. The Plan stated each grievance in the case management system is captured in the grievance log. The Plan stated that trends and aggregated grievance data, not grievance logs, were presented in quarterly grievance reports and reviewed by the Plan's QIC and Chief Medical Officer on a quarterly basis. The Governing Board did not review grievance reports or logs during the audit period. The Plan stated its MAC created its own agenda and did not review grievance reports or logs during the audit period.

If key Plan entities do not periodically review the written grievance log, they may miss significant issues not captured by aggregated data in grievance reports.

Recommendation: Develop and implement procedures to ensure the Plan's Governing Board, public policy body (MAC), and an officer of the Plan or their designee review the written grievance log periodically, and thoroughly document the review.

4.1.3 Clear and Concise Grievance Resolution Letter

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

The written response shall contain a clear and concise explanation of the Plan's decision. *(CCR, Title 28, section 1300.68 and APL 17-006)*

Plan policy *QI-06 Clinical Member Grievances (Reviewed 12/23/20)* stated the Grievance Coordinator drafts the resolution letter, which includes a clear and concise explanation of the findings and the Plan's decision. The Access and Care Experience (ACE) Manager, or their designee, reviews and approves the grievance resolution letter to ensure it is clear and concise.

Plan *Desktop Procedure: Access and Care Experience Manager or Designee Readability Assessment (approved 3/18/19)* stated the ACE Manager or their designee, runs a readability assessment, and makes edits to simplify, replace, or shorten complex words and sentences including medical jargon until the proposed language shows a readability of 85 percent.

Finding: The Plan did not ensure grievance resolution letters contained a clear and concise explanation of the Plan's decision.

A verification study showed that eight of 50 grievances did not contain a clear and concise explanation in the resolution letters. Examples of resolution letter language that was complex, difficult to understand, or lengthy include:

- In one case, the resolution letter stated, “Computed Tomography (CT) of your chest showed multiple pulmonary nodules, suggesting the possibility of metastatic breast cancer. Most patients with metastatic breast cancer are under surveillance imaging every 3-6 months. The lung lesions were small and not amenable to biopsy...She recommended neoadjuvant treatment.”

- In another case, the resolution letter stated, “You had vitreous hemorrhage…due to proliferative diabetic retinopathy. This is a late, advanced stage of diabetic retinopathy that can cause permanent vision loss. [The provider] advised you continue anti-VEGF injections to prevent re-bleed or retinal detachment which can cause permanent vision loss. You returned to see [the provider] due to severe vitreous hemorrhage and hand motions vision.”

- In another case, the resolution letter stated, “You were reminded you did not pass subsequent drug screens and have been forthright in acknowledging your drug use. You were given a regimen of antibiotics, IV hydration, and oral steroids and the provider noted your pneumonia dramatically improved.”

- In another case, the resolution letter stated, “They ordered an electrocardiogram (ECG), transthoracic echocardiogram (TTE), and a Ziopatch to further examine your symptoms.”

- In another case, the resolution letter stated “he used a prescription guide book to convey adverse reactions that occur with anti-hyperlipidemic medication.”

- In another case, the resolution letter stated “Both medications are sedating and can suppress the respiratory system.”

In an interview, the Plan confirmed that all grievance letter language is drafted by coordinators, reviewed by the Grievance Review Committee, and then forwarded to a Manager or their designee to check for readability using reading level tools. The Plan explained resolution letters are drafted using the exact language from the provider’s response. The Plan stated for medico-legal reasons, it did not substitute medical terminology or multi-syllable words.

If the Plan does not provide grievance resolution letters with a clear and concise explanation, members may not understand the investigation and resolution of their complaints, which may adversely impact their health care.

Recommendation: Implement policies and procedures to ensure that grievance resolution letters contain clear and concise explanations of the Plan's decisions.

4.1.4 Grievances Alleging Discrimination

The Plan agrees that copies of all grievances alleging discrimination against members or eligible beneficiaries because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, will be forwarded to DHCS for review and appropriate action. *(Contract A24, Exhibit E, Attachment 2 (28) (C))*

Plan policy *QI-06 Clinical Member Grievances (reviewed 12/23/20)* stated the Plan forwards grievances alleging discrimination against Medi-Cal members because of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability to DHCS for review and appropriate action. The Grievance Coordinator sends the case to the Regulatory Affairs Counsel, or their designee, for forwarding to DHCS.

The Plan's DTP *Cultural, Linguistic and Health Education Clinical Grievance Process (approved 3/12/18)* stated, for cases involving any form of discrimination, the Grievance Coordinator sends the case to the Regulatory Affairs Department, which forwards the documents to DHCS and copies the Grievance Coordinator on the email. The email notifying DHCS is attached to the case and a confirmation note is recorded in the case management system.

The Plans DTP *DHCS Discrimination Case Monitoring and Reporting (approved 3/31/20) stated,* on a monthly basis, the Plan will monitor all grievance cases closed in the prior month to ensure all grievances involving discrimination are submitted to DHCS in a timely manner by identifying missing cases that were not sent to DHCS.

Finding: The Plan did not ensure grievances alleging discrimination were forwarded to DHCS. The Plan's monthly monitoring process did not detect cases that were not sent to DHCS.

A verification study revealed that in four of ten grievances with allegations of discrimination, the Plan did not forward the cases to DHCS. During the audit, the Plan was asked to submit evidence of notification to DHCS for all ten cases in the verification study. The Plan conducted an additional review of grievances alleging discrimination and discovered four cases in the verification study that were not forwarded to DHCS. After the audit period, the Plan forwarded the four cases to DHCS by email. Then, the Plan provided the evidence of notification for the four cases to the auditors.

- In one case, the member alleged discrimination based on race. After the audit period, the Plan forwarded the case to DHCS by email approximately eight months after the resolution date.

- In another case, the member alleged discrimination based on race. After the audit period, the Plan forwarded the case to DHCS by email approximately seven and a half months after the resolution date.

- In another case, the member alleged discrimination based on age and race. After the audit period, the Plan forwarded the case to DHCS by email approximately seven months after the resolution date.

- In another case, the member alleged discrimination based on national origin. After the audit period, the Plan forwarded the case to DHCS by email approximately five months after the resolution date.

In a written response, the Plan confirmed the appeals and grievance team completes a monthly check of all closed grievances where the member alleged discrimination to ensure these grievances are sent to DHCS. The Plan did not explain why its monthly monitoring process failed to identify cases alleging discrimination that should have been sent to DHCS.

Plan policy *QI-06 Clinical Member Grievances (reviewed 12/23/20)*, did not incorporate all required categories for the basis of discrimination listed in the Contract including sex, gender identity, physical or mental disability, and identification with any other persons or groups defined in Penal Code 422.56.

When the Plan does not ensure grievances alleging discrimination are forwarded to DHCS, further investigation and corrective actions for discrimination may not occur, which may lead to poor health outcomes.

Recommendation: Implement policies and procedures to ensure all grievances alleging discrimination described in contractual requirements are forwarded to DHCS.

4.2 CULTURAL AND LINGUISTICS SERVICES

4.2.1 Cultural and Linguistic Written Program Description

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

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

Finding: The Plan's written CLS Program description did not include an organization chart.

The Plan acknowledged that they did not have an organization chart for the CLS program.

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

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: San Francisco Health Authority dba San Francisco Health Plan
AUDIT PERIOD: March 1, 2020 through February 28, 2021 **DATE OF AUDIT:** March 8, 2021 through March 19, 2021

CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM

5.1.1 Community Advisory Committee

The Plan is required to establish a CAC in compliance with *CCR Title 22, section 53876 (c).* The Plan shall ensure that the CAC is included and involved in policy decisions related to QI, educational, operational, and cultural competency issues affecting groups who speak a primary language other than English. *(Contract A24, Attachment 9 (15))* The Plan shall ensure that Medi-Cal members are included and participate in establishing public policy within its advisory committee or other similar committee. (*Contract A24, Attachment 1 (9))*

Public policy means acts performed by a Plan to assure the comfort, dignity, and convenience of its patients. (Knox-Keene Act, CA HSC 1369)

The Plan is encouraged to provide the following support for CACs: (1) hold regular meetings, (2) address barriers to participation, and (3) provide sufficient resources to support CAC activities. (*MMCD Policy Letter 99-01*)

Plan policy *CL-03 Member Advisory Committee* (reviewed 4/16/20) stated the Plan implemented and maintained a CAC that met monthly through its MAC. The MAC's responsibilities included providing information, advice, and the Committee's perspective and recommendations to the Plan on its health education and CLS programs.

The Plan's *2020 Quality Improvement Program* stated the MAC consisted of Plan members who voiced concerns and advised regarding health services the Plan offered. It stated the MAC reported to the Governing Board and served as the Plan's public policy body as required by the Knox Keene Act.

Finding: The Plan's MAC was not involved in policy decisions related to QI, educational, operational and cultural competency issues affecting groups who speak a primary language other than English. The CAC did not participate in establishing the Plan's public policy or hold regular meetings during the audit period.

Plan documents showed the MAC met in September and November of 2020, and in January and February of 2021:

- Committee activities did not include public policy decisions or voting on quality initiatives, educational, operational, or cultural competency issues.
- The Committee received updates and information on Plan activities and programs.
- The Committee postponed its 2020 goals until 2021.
- A list of the Committee's goals for 2021 listed monthly topics as transition to State pharmacy benefits, new vaccine laws and requirements, how to overcome post traumatic stress disorder and trauma recovery, wellness check, and medications and resources for attention deficit hyperactivity disorder.

Governing Board minutes showed two of its members were enrollees who were also MAC members. The Board received a MAC report at each meeting when available, but reports did not demonstrate policy decisions or recommendations.

In an interview, the Plan reported the MAC set its own agenda. However, the agenda did not demonstrate the Committee's involvement in policy decisions related to QI, educational, operational, and cultural competency issues affecting groups who speak a primary language other than English.

When the Plan does not ensure the MAC operates as required by the Contract, opportunities for members to affect the Plan's policy may be missed.

Recommendation: Revise Plan policy to ensure it includes and involves the MAC in establishing public policy, and in policy decisions related to QI, educational, operational and cultural competency issues affecting groups who speak a primary language other than English. Revise Plan processes to ensure the MAC meets regularly.

5.1.2 PQI Resolution

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 rendering services on its behalf in any setting. The Plan shall be accountable for the quality of all covered services regardless of the number of contracting and subcontracting layers between the Plan and the provider. (*Contract A24, Exhibit A, Attachment 4 (1)*)

Plan policy QI- 18 *Potential Quality Issues (reviewed 10/2019)* stated the Plan ensured members received quality health care services in environments that were safe, appropriate, and compliant with regulations. A PQI was "an identified adverse variation from expected clinical standard of care requiring further investigation." PQI case investigation might include review of medical records, external physician review, or peer review. A P3 label, the highest level of severity, indicated "significant opportunity for improvement and /or care deemed inappropriate. Potential/actual significant adverse outcome to member." Referral to the Peer Review Committee for a P3 case was not required.

Finding: The Plan did not take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf in any setting.

A verification study of PQIs showed one case where the Plan did not act after finding a significant opportunity for improvement:

- A medical group's hospital staff overmedicated a Plan member who then required ICU care for resultant altered mental status and respiratory depression.

- The Plan requested the medical group conduct a quality investigation of the incident and share its findings and conclusions, including a description of any corrective actions.

- The medical group sent the Plan medical records but replied that it could not report the details of its extensive quality investigation, claiming peer review laws and the Patient Safety Work Product privilege protected the review. The group did not provide conclusions regarding the investigative outcome or corrective actions.

- The Plan's final letter to the group dated August 2020 stated it found a significant quality that it would refer the case to the Peer Review Committee, which might make further recommendations, and closed the case. Peer Review Committee minutes for the audit period did not reveal a discussion of the case. Documentation did not reveal further corrective action on the Plan's part.

An agreement between the Plan and the medical group in the above case stated that the Plan may collect data necessary to assess member experience and clinical performance. It also stated the Plan retained the right to approve, suspend, and terminate individual practitioners' providers in situations where it delegated decision-making.

In an interview, the Plan stated its process included conducting its own PQI investigation based on information received from a provider. If the outcome was a P3 level incident, the Plan would follow its policy and refer the case to its Peer Review Committee, which would conduct a review and make recommendations. However, documentation did not show the Plan followed its stated process. The Plan reported that the contracted provider had a robust QI process and structure, that the Plan knew what likely happened, and that the Plan had the ability to follow up after confirming a quality issue. Documentation did not show that the Plan took further actions.

When the Plan finds a significant opportunity for improvement in the quality of care delivered to its members by contracted providers, incomplete implementation of its stated processes may lead to further incidents with adverse outcomes.

Recommendation: Implement Plan policies and procedures to ensure appropriate action after quality investigations involving its members.

5.3	PROVIDER QUALIFICATIONS

5.3.1 New Provider Training Requirements

The Plan is required to conduct training for all new providers (physician & non-physician) within ten working days after the Plan places a newly contracted provider on active status. *(Contract A24, Exhibit A, Attachment 7 (5)(A))*

The Plan is accountable for all QI functions and responsibilities (e.g. provider training) that are delegated to subcontractors. If the Plan delegates QI functions, the Plan and the delegated entity (subcontractor) shall include in their subcontract a provision to maintain a system to ensure the subcontractor meets standards set forth by the Contract *(Contract A24, Exhibit A, Attachment 4, (6)(A)).*

Plan policy *PR-03: New Provider Training (Approved 7/31/19)* stated that credentialed providers are required to complete new provider training, and have signed attestation of provider training within ten business days of their start date. Providers contracted with medical groups who do not service Medi-Cal members at the time of the initial credentialing process, and who later become Medi-Cal providers, are required to sign the *Summary of Key Information* attestation within ten business days after the date they became active Medi-Cal providers.

Plan policy *DO-11 Oversight of Delegated New Provider Training (Approved 2/7/19)* stated, that an audit lead will conduct the annual file review for compliance. A new provider training audit tool is used to determine any deficiencies. A CAP is required from a delegate when the total score is missing one critical element and the total score falls below 95 percent.

Finding: The Plan did not ensure that delegated entities conducted provider training within ten working days.

A verification study of 40 new provider training records from six delegated entities revealed the following deficiencies:

- Ten of 40 records did not have documentation that new providers received new provider training.

- Of the remaining 30 records:
    - One record did not document provider training within ten working days after the provider obtained active status with the Plan.
    - Three records did not have a dated attestation form confirming training occurred within ten working days of active status.
    - Three attestations did not have the correct new provider name.

Review of the Plan's delegation oversight reports revealed that several delegates were not compliant with completing new provider training within the required timeframe. For one delegate, the Plan indicated that it will review its new provider training process in the next audit.

Post exit documents from the Plan did not include the names of the new providers who received new provider training.

Without documentation of new provider training, the Plan cannot ensure providers operate in full compliance with the Contract and all applicable federal, state, and local regulations.

Recommendation: Implement policies and procedures to ensure providers receive new provider training within ten working days after being placed on active status.

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

2021

Contract Number: 03-75800
State Supported Services

Audit Period: March 1, 2020
Through
February 28, 2021

Report Issued: July 27, 2021

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 onsite review was conducted from March 8, 2021 through March 19, 2021. The audit period was March 1, 2020 through February 28, 2021 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 22, 2021. 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, 2020 through February 28, 2021
DATE OF AUDIT: March 8, 2021 through March 19, 2021

STATE SUPPORTED SERVICES

SUMMARY OF FINDING(S):

No deficiencies were identified in this audit.

RECOMMENDATION(S):

N/A