DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

July 13, 2023

Brandy Armenta, Compliance Directory
Health Plan of San Mateo
801 Gateway Blvd, Suite 100
South San Francisco, CA 94080

RE: Department of Health Care Services Cal MediConnect Audit

Dear Ms. Armenta:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Cal MediConnect (CMC) Audit of Health Plan of San Mateo, a Medicare-Medicaid Plan (MMP), from August 30, 2021 through September 10, 2021. The audit covered the period of November 1, 2019 through July 31, 2021.

All items have been evaluated and DHCS accepts the MMP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MMP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MMP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

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

If you have any questions, please reach out to CAP Compliance personnel.

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
Managed Care Quality and Monitoring Division
Department of Health Care Services

Daniel Park, Lead Analyst
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Jeff Kilty, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Health Plan of San Mateo

Review Period: 11/1/19 – 7/31/21

Audit Type: Cal MediConnect

On-site Review: 8/30/21 – 9/10/21

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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 CAP Request letter. MCPs are required to submit the CAP in word format that willreduce turnaround time for DHCS to complete its review. According to ADA requirement, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken tocorrect the deficiency, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken.
For policies and other documentation that have been revised, please highlight the new relevant text. For deficiencies thatrequire short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to includethe date when full compliance will be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.**

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance toensure 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.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.2.1 - Integrated Denial Notices for Prior Authorization The Plan did not include the correct timeframes of 60 calendar days to file an appeal and 120 days to request a State Fair Hearing in its integrated denial notices to members.	Grievance and Appeals (G&A) Policy and Procedure Manual GA-05 has been updated to include an annual process to monitor and review all written material related to Grievance and Appeals, including HPSM's website and Provider Manual, to ensure they include the appropriate G&A processes and timeframes.	• GA-05 Part C AppealsProcess CA • HPSM Provider Manual • HPSM Website-Appeal Timeframes • Integrated Denial Notice	Complete	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** • GA-05 Part C Appeals Process CA o The P&P has been revised to include an annual review & monitoring process of all written material relating to Grievance & Appeals. (Page 22, section 11.6) **TRAINING & IMPLEMENTATION** • HPSM Provider Manual o The provider manual has been revised to ensure the correct timeframes of 60 calendar days to file an appeal & 120 days to request a State Fair Hearing is included in its integrated denial notices to members. (Page 34 & 37) • HPSM Website – Appeal Timeframes o The Plan provided a screenshot of its website reflecting the correct timeframes of 60 calendar days to file an appeal & 120 days to request a State Fair Hearing. • Integrated Denial Notice o The redacted denial notice is evidence that the Plan has revised to include the correct timeframes of 60 calendar days to file an appeal & 120 days to request a State Fair Hearing in its integrated denial notices to members. **MONITORING & OVERSIGHT**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• GA-05 Part C Appeals Process CA ○ The P&P has been revised to include an annual review & monitoring process of all written material relating to Grievance & Appeals. (Page 22, section 11.6). **The Corrective Action Plan for Finding 1.2.1 is accepted.**
1.3.1 - Notice of Resolution Letters The Plan did not ensure that notice of resolution letters included easily understood language when explaining the reason for denial.	Grievance and Appeals Policy and Procedure Manual GA-05 has been updated to include a daily process to review member appeals written notifications to ensure they include all applicable NCQA requirements.	• 1.3.1 GA-05 Part C Appeals Process CA (*page 22 section 11.7*)	Complete	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - Procedure GA-05 was updated to include a daily review of appeal notifications of all NCQA requirements. - The Plan updated its policy GA-05 to include a daily review of appeal resolution letters by the G&A team to ensure all applicable NCQA requirements are applied to member appeal written notification letters. The Plan provided examples from these reviews which show the Plan is indeed review appeal notification letters for understandability. The criteria examined in the reviews include: • Is the flow of the letter logical and coherent? • Are sentences and paragraphs short and to the point? • Is vocabulary simple and include common words? • Has jargon been avoided or explained? • Are /acronyms spelled out the first time they are used? **MONITORING & OVERSIGHT** - Examples of daily reviews of appeals letters demonstrate the

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				MCP is actively monitoring the understandability of the language in member appeal resolution letters. - The Plan has demonstrated they have a process in place to ensure that appeal notification letters are written clearly and understandable. **The Corrective Action Plan for Finding 1.3.1 is accepted.**
3. Access and Availability of Care				
3.8.1 - Mode of Transportation for Non-Emergency Medical Transportation (NEMT) Services The Plan did not subject non-COVID related NEMT services to prior authorization and did not require providers to use the PCS forms.	The Plan lifted authorization requirements as allowed under the Public Health Emergency (PHE) which was during the audit review period. The Plan has updated policy and procedure UM-013 Non-Emergency Medi-Cal	• 3.8.1 UM.013 Non-Emergency Medical Transportation (*page 2 section 2.0; page 3 section 3.5; page 3 section 4.0*)	The PHE is still in effect; however, the Plans goal is to reinstate the prior authorization requirement by April 1, 2022.	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - Updated P&P, "UM.013: Non-Emergency Medical Transportation" (01/28/22) in which the MCP requires prior authorization for non-emergency transport services. PCS forms must be completed before NEMT will be provided to determine the appropriate level of service (UM.013 Non-Emergency Medical Transportation, Section 2.0, Page 2, Section 3.5, Page 3). **MONITORING & OVERSIGHT** - An email stating that the MCP plans on reinstating prior authorization and will do so by September 1, 2022. This allows the MCP to ensure appropriate system configuration, proper notification to their network, and convey the processes appropriately (6-28-22 MCP Response). **The Corrective Action Plan for Finding 3.8.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.8.2 - Non-Emergency Medical Transportation Provider Enrollment The Plan did not ensure that NEMT providers complied with Medi-Cal screening and enrollment requirements.	The Plan complies with Policy and procedure CR-07 Health Delivery Organization Credentialing and utilizes the provider intake form and new provider vetting and onboarding desktop procedure.	• 3.8.2 CR-04 Health Delivery Organization (HDO) • Credentialing	Completed by adhering to policy and procedures, new provider intake form and new provider vetting and onboarding procedure. Long-term: Pending (2) contractors' response, estimated time: Q2 2022 for completion.	**The following finding is being addressed through the County Organized Health Systems contract #08-85213 (Main) and the 2022 Corrective Action Plan**.
4. Member Rights				
4.1.1 - Grievance Filing Timeframe The Plan did not include the correct timeframe of any timeto file a grievance in its provider and member informing materials during the audit period.	Grievance and Appeals Policy and Procedure Manual GA-05 has been updated to include an annual process to monitor and review all written material related to Grievance and Appeals, including HPSM's website and Provider Manual, to ensure they include the appropriate G&A processes and timeframes.	• 4.1.1 GA-05 Part C Appeals Process CA (*Page 22* • *section 11.6*)	Completed	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - Updated P&P, "GA-05: Medicare Part C Appeals" (02/19/21) which has been updated to include an annual process to monitor and review all written material related to Grievance and Appeals, including the Plan's website and Provider Manual, to ensure they include the appropriate G&A process and timeframes. - Manual, "Provider Manual" (09/02/21) (Page 27) revised to

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				include, “there is no time limit to file a grievance.” - Member Handbook, “CMC Member Handbook” (03/22/22) (Page 210) revised to include, “You can make the complaint at any time.” - Website, “Problems and Complaints” (10/01/21) revised to include, “You can file a complaint at any time.” **The Corrective Action Plan for Finding 4.1.1 is accepted.**

Submitted by:_____ **Date: February 7, 2022**

Title: Interim Chief Executive Officer