DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF SAN MATEO HEALTH COMMISSION DBA HEALTH PLAN OF SAN MATEO FISCAL YEAR 2024-25

Contract Numbers: 08-85213 and 23-30238

Audit Period: September 1, 2023 — August 31, 2024

Dates of Audit: September 23, 2024 — October 3, 2024

Report Issued: April 17, 2025

TABLE OF CONTENTS

I. INTRODUCTION

The California Legislature authorized the Board of Supervisors of San Mateo County to establish a county commission for negotiating an exclusive contract for the provision of Medi-Cal services in San Mateo County in 1983. San Mateo County Board of Supervisors created the San Mateo Health Commission (SMHC) in June 1986, as a local, independent public entity.

In 1987, the SMHC founded the San Mateo Health Commission dba Health Plan of San Mateo (Plan) to provide county residents with access to a network of providers and a benefits program that promotes preventive care.

The SMHC is the governing board for the Plan. Board members are appointed by the San Mateo County Board of Supervisors. The Plan received its Knox-Keene license as a full-service plan on July 31, 1998.

Senate Bill 849 (Chapter 47, Statutes of 2018) authorized the Department of Health Care Services (DHCS) to establish a dental integration program in San Mateo County to include Medi-Cal dental services as a covered benefit under the Plan. The integration of the dental benefit took effect on January 1, 2022. All Medi-Cal members enrolled in San Mateo County now receive dental care through the Plan in addition to medical services.

The Plan's provider network includes independent providers practicing as individuals, small and large group practices, community clinics, and the San Mateo Medical Center, which operates multiple clinic sites.

As of August 31, 2024, the Plan had 147,103 members of which 135,224 (91.92 percent) were Medi-Cal, 8,194 (5.57 percent) were Dual Eligible Special Needs Plan, 1,294 (0.88 percent) were Access and Care for Everyone Program, 1,271 (0.86 percent) were HealthWorx, and 1,120 (0.76 percent) were Whole Child Model (WCM) Program. Out of the Plan's 147,103 members, 8,543 (5.81 percent) were Seniors and Persons with Disabilities (SPD).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of September 1, 2023, through August 31, 2024. The audit was conducted from September 23, 2024, through October 3, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on March 20, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the audit findings. On April 3, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Population Health Management and Coordination of Care, Network and Access to Care, Member Rights, Quality Improvement & Health Equity Transformation, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of July 1, 2022, through June 30, 2023, was issued on January 22, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year's 2023 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

The Plan is required to ensure that its UM program has a specialty referral system to track and monitor referrals requiring prior authorization. Finding 1.1.1: The Plan did not have a system to track and monitor specialty referrals requiring prior authorization.

The Plan is required to provide linguistic services at no cost to members including full and immediate translation of all written materials and correspondence. Finding 1.5.1: The Plan's delegate, Magellan, did not ensure that all Notice of Action (NOA) letters were correctly translated into members' threshold language.

Category 2 – Population Health Management and Coordination of Care

The Plan is required to develop and complete the risk assessment process for WCM members, newly California Children's Services (CCS) eligible members, or new CCS members enrolling in the Plan. Plans must establish an Individual Care Plan (ICP) for all members determined to be high-risk based on the results of the risk assessment process. Finding 2.1.1: The Plan did not develop and implement an ICP for high-risk CCS members in accordance with *All Plan Letter (APL) 23-034*, *All Medi-Cal Managed Care Plans Participating in the Whole child Model Program*.

The Plan is also required to have a Memorandum of Understanding (MOU) with each CCS program within its service area. Finding 2.1.2: The Plan did not have a MOU with the CCS program.

The Plan is required to ensure provision of an Initial Health Appointment (IHA) and document attempts that demonstrate the Plan's efforts to contact a member and schedule an IHA. Finding 2.1.3: The Plan did not ensure that reasonable member outreach attempts for IHAs were conducted and documented for newly enrolled members.

The Plan is required to cover and ensure the provision of blood lead screening tests to members under six years of age. The Plan is required to ensure that the network providers document outreach attempts and reasons for not performing the blood lead screening test. Finding 2.1.4: The Plan did not ensure the provision of blood lead screening tests, nor did it ensure the documentation of attempts to provide this test to members under six years of age.

The Plan's Complex Case Management (CCM) program is required to include a comprehensive assessment of the member's condition, development, and implementation of a Care Management Plan (CMP) with performance goals, monitoring, follow-up, and complete a CMP for all members receiving CCM. Finding 2.2.1: The Plan did not develop and implement CMPs that addressed the CCM members' health needs or reviewed the CMP when there were changes in members' conditions.

The Plan is required to provide Behavioral Health Treatment (BHT) services based on a person-centered behavioral treatment plan that includes a crisis plan and measurable goals with estimated dates of mastery. Finding 2.3.1: The Plan did not include all required criteria for BHT plans, including a crisis plan and estimated dates for goal mastery.

The Plan is required to provide medically necessary BHT services as stated in the member's treatment plan and continuation of BHT services under Continuity of Care (COC) with the member's BHT provider. Finding 2.3.2: The Plan did not ensure the provision of BHT services for members under 21 years of age in accordance with their BHT plans.

The Plan is required to process COC requests; the process begins when the Plan receives the COC requests. Each COC request must be completed within the following timelines from the date the Plan received the request: 30 calendar days for non-urgent requests; 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or as soon as possible, but no longer than 3 calendar days for urgent requests. Finding 2.4.1: The Plan did not ensure that COC requests from members were completed within the required timeframes.

Category 3 – Network and Access to Care

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

Category 4 – Member Rights

The Plan is required to ensure the provision of high-quality interpreter and linguistic services for Limited English Proficiency (LEP) members at all points of contact. Finding 4.2.1: The Plan did not provide and monitor interpreter services for members during BHT service delivery.

Category 5 – Quality Improvement and Health Equity Transformation

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

Category 6 – Administrative and Organizational Capacity

The Plan is required to submit a quarterly report to the DHCS Program Integrity Unit (PIU) on all Fraud, Waste, And Abuse (FWA) investigative activities within ten working days after the close of every calendar quarter. Finding 6.2.1: The Plan did not submit quarterly reports to DHCS PIU on all FWA investigative activities.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from September 23, 2024, through October 3, 2024, for the audit period of September 1, 2023, through August 31, 2024. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, 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

Prior Authorization Requests: Twenty prior authorization requests, including eight SPD members and two dental service samples, were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeals Procedures: Twenty-two prior authorization appeals, including ten SPD members and two dental service samples, were reviewed for appropriate and timely adjudication.

Delegated Authorization Requests: Five medical service requests from Magellan (the Plan's BHT delegate) were reviewed for timeliness, consistent application of criteria, and appropriate adjudication.

Category 2 – Population Health Management and Coordination of Care

CCS: Fifteen sample CCS members were reviewed to confirm care coordination for members with CCS conditions and developmental disabilities.

IHA: Twenty IHA sample files, including four SPD members, were reviewed to confirm the performance and completeness of the assessment.

CCM: Ten sample CCM members were reviewed to confirm the provision of CCM for eligible members.

BHT: Fifteen sample BHT members were reviewed to confirm the performance of services and completion of case file elements.

COC: Fifteen sample COC requests were reviewed for timely processing of members' COC requests.

Category 3 – Network and Access to Care

Claims: Fifteen emergency services and 15 family planning sample claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation (NEMT): Twenty sample records were reviewed to verify compliance with NEMT requirements.

Non-Medical Transportation (NMT): Fifteen sample records were reviewed to verify compliance with NMT requirements.

Category 4 – Member Rights

Grievances: Sixty standard grievances and ten exempt grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. The 60 standard grievance cases included 45 Quality of Service and 15 Quality of Care grievances.

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

Category 5 – Quality Improvement and Health Equity Transformation

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

New Provider Training: Ten new provider training sample records were reviewed for the timeliness of Medi-Cal Managed Care Program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Eleven fraud and abuse sample cases were reviewed for appropriate reporting and processing.

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

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.1 REFERRAL TRACKING SYSTEM

1.1.1 Referral Tracking

The Plan is required to develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. The Plan is responsible to ensure that the UM program includes an established system to track and monitor services requiring prior authorization through the Plan. The system shall include authorized, denied, deferred, or modified prior authorizations, and the timeliness of the determination. The Plan shall ensure that all contracted health care practitioners and non-contracting specialty providers are informed of the prior authorization and referral process. *(2023 Contract 08-85213, Exhibit A, Attachment 5, (1)(F))*

The Plan is required to ensure that its UM program has a specialty referral system to track and monitor referrals requiring prior authorization by the Plan. The Plan's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. The Plan's specialty referral systems must include information on requested Out-Of-Network (OON) services. The Plan must ensure that all network providers are aware of the specialty referral processes and tracking procedures. *(2024 Contract 23-30238, Exhibit A, Attachment III, 2.3 (H))*

The Plan is responsible to ensure the integration of UM activities into the Quality Improvement System QIS, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. *(2024 Contract 23-30238, Exhibit A, Attachment III, 2.3 (I))*

The Plan is required to integrate UM activities into the QIS as specified in 2024 Contract, Exhibit A, Attachment III, Section 2.2 (Quality Improvement and Health Equity Transformation Program), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, appeals, and grievances to the medical director or their designee. *(2024 Contract 23-30238, Exhibit A, Attachment III, 2.3 (I))*

Plan policy, *UM.004 Prospective Prior Authorization Reviews* (revised 7/3/23), describes the Plan's procedures for prospective authorization review requests. Plan policy, *UM.009 Retrospective Prior Authorization Reviews* (revised 7/3/23), describes the Plan's procedure for retrospective authorization review requests.

Finding: The Plan did not have a system to track and monitor specialty referrals requiring prior authorization.

The Plan provided conflicting statements regarding the monitoring of specialty referrals requiring prior authorization.

- In one interview, the Plan stated specialty referrals requiring prior authorization are monitored through various access-related metrics.
- However, in a separate interview, the Plan's staff members were not aware of the use of these metrics to specifically monitor and trend specialty referrals. The Plan also did not provide evidence that these metrics were reviewed by UM staff.

The Plan requires prior authorizations for OON specialty referrals only.

- In response to DHCS document requests for Plan policy documents discussing the review of policies and procedures governing the system to track and monitor referral services requiring prior authorization, the Plan provided UM.004 Prospective Prior Authorization Reviews and UM.009 Retrospective Prior Authorization Reviews. Neither of these documents included information regarding specialty referrals or a system to track, trend, and monitor OON specialty referrals.
- In addition, the Plan UM and Quality Improvement committee minutes did not document any specific specialty referral tracking or monitoring of OON specialty referrals.

If the Plan does not monitor specialty referrals requiring prior authorizations, it may result in delay of medically necessary services and may lead to member harm.

Recommendation: Develop and implement policies and procedures to ensure the Plan's system tracks and monitors specialty referrals that require prior authorization.

1.5 DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Notice of Action Letters in Threshold Languages

Threshold languages/threshold or concentration standard languages means the non-English threshold and concentration standard languages in which the Plan is required to provide written translations of member information, as determined by DHCS. *(2024 Contract 23-30238, Exhibit A, Attachment I, 1.0)*

The Plan is required to comply with Code of Federal Regulations (CFR), Title 42, section 438.10(d)(4), and provide, at a minimum, fully translated member information, including but not limited to NOA letters. *(2023 Contract 08-85213 Exhibit A, Attachment 9 (13)(C)(2))*

The Plan is required to comply with Title VI of the Civil Rights Act of 1964 and CFR, Title 42, section 438.10(d) and have the capacity to provide, at minimum, linguistic services at no cost to members: Full and immediate translation of all written materials and correspondence. *(2024 Contract 23-30238, Exhibit A, Attachment III, 5.2.10 (B)(3)(b))*

The written NOA must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in APL 21-004, *Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*, federal and state law, and all requirements in the DHCS Contract. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, *CP.030 Oversight Responsibilities for Medi-Cal Delegates* (revised 11/14/23), states delegates must agree to comply with all applicable Medicaid laws and regulations, as well as applicable state and federal laws. The Plan maintains the responsibility of ensuring that subcontractors are, and continue to be, in compliance with all applicable Medi-Cal, state and federal laws, and contractual requirements.

Finding: The Plan's delegate, Magellan, did not ensure that all NOA letters were correctly translated into members' threshold language.

A verification study of five prior authorizations included two for Spanish speaking members. However, the Plan's delegate did not send NOA letters translated into the members' threshold language (Spanish).

In a written response the Plan's delegate stated that they identify all members who speak a threshold language and provide written materials in that language, but did not provide an explanation as to why these members did not receive the letters in Spanish.

Review of the Plan monitoring reports related to delegated UM activities revealed that the Plan monitored the total number of different types of referrals, turnaround times of the decisions on authorization requests, and timely access to appointments. However, there was no information monitoring the delegate's compliance with the requirement that NOA letters must be translated in threshold languages. In addition, as of October 1, 2024, a month after the end of the audit period, the Plan finalized de-delegation of Magellan.

When the Plan does not correctly translate member information and notices in the members' threshold language, members may not be fully informed of available health care services.

Recommendation: Revise and implement policies and procedures to ensure that member information disseminated by the Plan's delegate is translated into members' threshold language.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.1 CALIFORNIA CHILDREN'S SERVICES, INITIAL HEALTH ASSESSMENT

2.1.1 Provision of Individual Care Plan for High-Risk California Children's Services Members

The Plan is required to 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 unrelated to the CCS-eligible condition and shall monitor and ensure the coordination of services and joint case management between its Primary Care Provider (PCP), the CCS specialty providers, and the local CCS program. *(2023 Contract 08-85213, Exhibit A, Attachment 11 (10)(A)(1)(5))*

Once eligibility for the CCS program is established for a member, the Plan is required to continue to provide all covered services that are not authorized by the CCS program and must ensure the coordination of services and joint case management between the member's PCP, CCS providers, and the local CCS program. The Plan is required to continue to provide case management services to ensure all covered services authorized through the CCS program are provided timely. *(2024 Contract 23-30238, 4.3.14 (A)(6))*

The Plan is required to develop and complete the risk assessment process for WCM members, newly CCS-eligible members, or new CCS members enrolling in the Plan. The Plan is required to establish an ICP for all members determined to be high-risk based on results of the risk assessment process, with particular focus on coordinated specialty care within 12 months, including new CCS members enrolling in the Plan and newly CCS-eligible members. The ICP must, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables including but not limited to the needs for: medical (primary care and CCS specialty) services; mild to moderate or county specialty mental health services; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The ICP must indicate the level of care the member requires (e.g., case management and care coordination, complex case management). *(APL 23-034, All Medi-Cal Managed Care Plans Participating in The Whole Child Model Program)*.

Plan policy, *CCS-01 Whole Child Model Case Management* (revised 5/9/24), stated that family-centered ICPs are developed with input from the member/parent during the Health Risk Assessment (HRA). The Case Manager (CM) is responsible for developing an appropriate ICP that addresses the specific care coordination needs of the member. The CM is responsible for developing specific timelines to monitor, evaluate and reevaluate the appropriateness of the ICP and obtainment of goals and modifications of the ICP if appropriate. Essential elements of this process include prioritized member goals and preferences, and ability to self-direct care. ICPs are updated annually, at a minimum, or more frequently at the discretion of the CM or member/parent.

The service agreement between the Plan and the County's Family Health Services (FHS) Division (San Mateo County CCS program) stated that the ICP will at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables including but not limited to the needs for medical (primary care and CCS specialty) services; mild to moderate or county specialty mental health services, and EPSDT.

Finding: The Plan did not develop and implement an ICP for high-risk CCS members in accordance with APL 23-034.

A verification study of 15 sample members receiving CCS services included 2 members designated as high-risk members. In both samples, the Plan did not ensure that an ICP was developed and implemented for the high-risk members.

- In one sample, the CCS member was an adolescent whose medical conditions included post-lung transplant status, cystic fibrosis (genetic lung disorder), cystic fibrosis-related diabetes (metabolic disorder), learning disability, and a gastrostomy (tube placed in the stomach for nutrition and hydration). The member's HRA, annual medical review notes, and ICP were done on the same day in October 2023. The member's annual medical review for eligibility included information about the member's ongoing medical needs and specialty medical services, and noted that the member had a limited understanding of their health conditions. However, in contrast the ICP stated that the member had no identified issues or needs. Additionally, the member was hospitalized in April 2024 with a need for follow-up with a pulmonologist, and yet the ICP did not show any revisions or modifications to reflect the member's medical needs or specialty care coordination after hospitalization for a respiratory illness.

- In the second sample, the CCS member was under three years old and enrolled in the High-Risk Infant Follow-Up program whose medical conditions included retinopathy of prematurity (eye disease affecting some premature infants) and unspecified developmental delays. The member's HRA, annual medical review for eligibility, and ICP were done in December 2023. The member's annual medical review for eligibility stated that the member had no signs of significant delay however, development should continue to be monitored, given the member's high-risk factors. In contrast, the ICP stated the member had no issues or needs that have been identified at this time and contained no information regarding care coordination and monitoring for developmental delays.

In an interview, the Plan stated that ICPs are designed to have member input and the ICPs are individualized and member-focused based on information received from the member or family. In a written narrative, the Plan stated that both samples had ICPs based on the member's response to the HRA. Review of the two samples showed both ICPs contained very similar verbiage that were not individualized to reflect the unique needs of each member.

The Plan's CCS Coordination of Care Monitoring Report monitored the timeliness of ICP completion. However, this report did not include monitoring for the ICP components such as individualization (personalized to reflect the member's unique care needs), care coordination, and measurable goals and timetables to meet the member's needs for medical and specialty services.

Review of Plan policy *CCS-01* showed the policy did not have a monitoring section to describe the process for monitoring members' ICPs and ensuring ICPs are individualized to the members' needs.

During the audit period, the Plan implemented a CCS case file review process with a care plan review tool. The review tool included a checklist for HRA completion and if an ICP addressed needs indicated from HRA responses and discussion with the member. The review tool did not include evaluation for ICP components such as measurable objectives and timetables, and the level of care that the member requires, such as case management or complex case management.

Subsequent to the Exit Conference, the Plan submitted a written narrative detailing the various case management and care coordination provided to the members. The Plan provided information that the members were receiving case management through other programs. However, the Plan still has a responsibility to ensure ICPs are developed and implemented for high-risk members. Additionally, these interventions were not reflected

in the members' ICPs. Measurable objectives and timetables were not included in the ICPs. The members ICPs did not indicate the level of care that the member requires (e.g., case management and care coordination, complex case management) as specified in APL 23-034.

When the Plan does not ensure that ICPs are developed and implemented for high-risk CCS members in accordance with APL 23-034, members may not receive care coordination to improve or maintain their health conditions.

Recommendation: Revise and implement policies and procedures to ensure that high-risk CCS members receive ICPs, including monitoring mechanisms and care plan review for ICP components in accordance with APL 23-034.

2.1.2 Memorandum of Understanding with California Children's Services Program

The Plan is required to execute a MOU with the local CCS program as stipulated in 2023 Contract, Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to members. *(2023 Contract 08-85213, Exhibit A, Attachment 11 (10)(B))*

The Plan is required to have MOUs with each CCS program within its service area that are in accordance with the MOU requirements in 2024 Contract, Exhibit A, Attachment III, Section 5.6 (MOUs with local government agencies, county programs, and third parties). The MOU must delineate the roles and responsibilities of the Plan and the CCS program for coordinating care and ensuring the non-duplication of services. *(2024 Contract 23-30238, Exhibit A, Attachment III, 4.3.14 (D))*

Participating WCM Plans and WCM County CCS Programs must execute an MOU that outlines their respective responsibilities and obligations under the WCM Program. The purpose of the WCM MOU is to explain how the Plan and County CCS Program coordinate care, conduct program management activities, and engage in information exchange activities required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the Plan must ensure collaboration between the Plan and County CCS Program. Each MOU must include, at a minimum, all the provisions required in the MOU template posted on the CCS WCM page of the DHCS website. *(APL 23-034, All Medi-Cal Managed Care Plans Participating in The Whole Child Model Program; California Welfare and Institutions (W&I) Code section 14094.9(a))*.

Plans are required to make a good faith effort to execute MOUs with CCS programs by January 1, 2024. The MOU between the Plan and the other party is intended to serve as the primary vehicle for documenting and developing processes and procedures to ensure the Plan and the other party coordinate services, including health related social service needs, when members are accessing services from both systems. *(APL 23-029, Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities)*

Plan policy, *CCS-01 Whole Child Case Management* (revised 5/9/24), stated that the Plan is responsible for reviewing offered coverages to CCS eligible members to prevent duplication of services. Pursuant to APL 23-034, the Plan will conduct an annual review of its MOU with CCS to determine if any modifications, amendments, updates, or renewals of responsibilities and obligations are needed, including incorporating any applicable contractual requirements and policy guidance in its MOU. In the event of a dispute between the Plan and the CCS program, all parties to the MOU are responsible for carrying out their responsibilities under the MOU without delay, including providing members with access to services under the MOU.

Finding: The Plan did not execute a MOU with CCS.

A review of the Plan's submitted documents showed a service agreement with the FHS CCS program, but no MOU was submitted by the Plan. In an interview, the Plan stated that it did not have a MOU with CCS.

In a written response and interviews, the Plan stated that FHS is awaiting DHCS' response to the county's inquiry whether the service agreement with the Plan could be used in lieu of a MOU. However, the Contract clearly states that participating WCM Plans and WCM County CCS Programs must execute a MOU that outlines their respective responsibilities and obligations under the WCM Program.

Subsequent to the Exit Conference, the Plan submitted correspondences between the Plan, the county, and DHCS regarding the use of the service agreement in lieu of a MOU. In October 2024, DHCS confirmed that a WCM MOU is required between the Plan and the county. Pursuant to W&I Code section 14094.9(a), the Plan and the county would need to execute a WCM MOU utilizing DHCS' WCM MOU template as specified in APL 23-034 dated December 27, 2023.

When the Plan does not execute a MOU with CCS, members may not receive care coordination and collaboration between the Plan and CCS to ensure continuous delivery of services.

Recommendation: Revise and implement policies and procedures to execute a MOU with the WCM County CCS Program.

2.1.3 Initial Health Appointment Scheduling Attempts

The Plan is required to cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with California Code of Regulations (CCR), Title 22, sections 53851(b)(1) and 53910.5(a)(1) to each new member within 120 days of enrollment. The Plan shall make at least three documented attempts that demonstrate the Plan's unsuccessful efforts to contact a member and schedule an IHA. Contact methods must include at least one telephone and one mail notification. The Plan must document all attempts to perform an IHA at subsequent office visits until all components of the IHA are completed. *(2023 Contract 08-85213, Exhibit A, Attachment 10 (3)(A)(E)(1)(2))*

The Plan is required to ensure the provision of an IHA in accordance with CCR, Title 22, sections 53851(b)(1), 53910.5(a)(1) and *APL 22-030, Initial Health Appointment*. Documented attempts that demonstrate the Plan's efforts to unsuccessfully contact a member and schedule an IHA will be considered evidence in meeting this requirement. The Plan may delegate these activities, but the Plan remains ultimately responsible for all delegated functions. *(2024 Contract 23-30238, Exhibit A, Attachment III (5.3.3) (C))*

The IHA occurs during a member's encounter with a provider within the primary care medical setting. During the IHA, the provider assesses and manages the acute, chronic, and preventative health needs of the member. *(APL 22-030, Initial Health Appointment)*

Plan policy, *QI-107 Initial Health Appointment* (revised 2/17/24) stated that a PCP is required to perform an IHA with a new Medi-Cal member within 120 days of enrollment. There are specific instances when a member's IHA can be waived. These include but are not limited to when the member's PCP has made three diligent attempts to contact the member to schedule the IHA, including a phone call and a written attempt, and has documented all attempts in the member's medical record, or client management system, or other outreach log or system. Providers are assisted by the Plan with the identification of members needing IHAs on their monthly patient engagement reports. The Plan will review IHA timeliness performance overall and by PCP on a quarterly basis utilizing claims and encounter data for primary care visits to capture the IHA performance within 120 days of enrollment.

Finding: The Plan did not ensure that reasonable member outreach attempts for IHAs were conducted and documented for newly enrolled members.

In a verification study, 2 of 20 samples demonstrated that the Plan did not ensure PCPs made reasonable outreach attempts to schedule an IHA with its adult members enrolled during the audit period. The Plan submitted customer service logs that detailed various letters sent to each member but did not submit any phone call logs or documentation of PCP outreach attempts to schedule an IHA.

In an interview, the Plan stated that it requested documentation of outreach attempts and medical records for the two verification study samples; however, there were no claims on file for review.

The Plan stated that it monitors IHA completion rates by claims utilization on a quarterly basis. Additionally, the Plan stated that limitations with using claims data to verify IHA completion include only capturing certain visits and claims. Claims data would have indicated if the member had an IHA visit with a PCP. The Plan also stated that IHA monitoring involves the Facility Site Review (FSR) and Medical Record Review (MRR) process to review for documentation and timeliness.

As a CAP to the prior audit deficiency (2.1.3 Initial Health Appointment Scheduling Attempts) of the Plan's failure to conduct and document reasonable and/or sufficient attempts to schedule an IHA for members, the Plan updated its provider manual and training guide. Additionally, it revised policy *QI-107*, to include other provider documentation systems in recording IHA-scheduling outreach attempts. The Plan also educated providers on IHA requirements during FSRs. The Plan's CAP was based on the following:

- The Plan identified that some network providers lacked awareness of the IHA requirements.
- Additionally, the Plan determined that some providers did not create a medical record until a new member was presented for care and thus did not have a medical record to document IHA outreach attempts.
- The providers often used other systems to track and document IHA outreach attempts that was not included in the Plan's policy.

In spite of the Plan's CAP for the outreach requirement to schedule an IHA, non-compliance was identified during the initial six-month portion of the audit period.

When the Plan does not ensure that outreach attempts to schedule IHAs are conducted, members may not receive assessment and management for acute, chronic or preventative health needs.

This is a repeat finding of the prior year's finding 2023 - 2.1.3 Initial Health Appointment Scheduling Attempts.

Recommendation: Revise and implement policies and procedures to ensure PCPs make and document reasonable outreach attempts to members to schedule an IHA.

2.1.4 Blood Lead Screening Member Outreach Attempts for Pediatric Members

The Plan is required to cover and ensure the provision of a blood lead screening test to members at ages one and two in accordance with CCR, Title 17, section 37000. The Plan is required to document and appropriately follow-up on blood lead screening test results. The Plan is required to make reasonable attempts to ensure the blood lead screen test is provided and document attempts to provide the test in the member's medical record. Documentation shall be entered into the member's medical record to indicate the receipt of blood lead screen testing and test results, or of voluntary refusal of these services. *(2023 Contract 08-85213, Exhibit A, Attachment 10, (D)(1)(2))*

The Plan is required to cover and ensure the provision of blood lead screening tests to members at the ages and intervals specified in CCR, Title 17, sections 37000 - 37100, and in accordance with *APL 20-016, Blood Lead Screening of Young Children*. The Plan is required to ensure its network providers follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local public health department. If the member, or the member's parent, legal guardian, or Authorized Representatives (AR), refuses the blood lead screening test, the Plan must ensure a signed statement of voluntary refusal is documented in the member's medical record. DHCS will consider unsuccessful attempts to provide the required blood lead screening tests documented in the member's medical record as evidence of the Plan's compliance with blood lead screening test requirements. *(2024 Contract 23-302238, Exhibit A, Attachment III (D)(1)(3)(5))*

The Plan is required to ensure that a complete, legible medical record is maintained for each member in accordance with CCR, Title 22, section 53861, which reflects all aspects of patient care, including, but not limited to, ancillary services, and at a minimum includes, but not limited to, documentation of blood lead screening. Member refusal to receive blood lead screening, immunizations, or other preventive services must also be documented in the member's medical record. *(2024 Contract 23-30238, Exhibit A, Attachment III, 5.2.14 (G)(4)(k))*

The Plan is required to ensure that their network providers (physicians, nurse practitioners, and physician's assistants) who perform periodic health assessments on child members between the ages of six months to six years comply with current federal and state laws, and industry guidelines for health care providers issued by the CLPPB, including any future updates or amendments to these laws and guidelines. The Plan must ensure that the network providers document the reasons for not performing the blood lead screening test in the child member's medical record. *(APL 20-016, Blood Lead Screening of Young Children)*

Plan policy, *QI-122, Blood Lead Screening of Young Children* (revised 2/14/24), stated that the Plan will ensure its contracted network adheres to federal and state requirements regarding performance of assessments on children between the ages of six months to six years, including guidelines issued by the CLPPB. The provider documents all unsuccessful attempts to provide the required blood lead screening tests in the member's medical record.

Finding: The Plan did not ensure the provision of blood lead screening tests, nor ensure the documentation of attempts to provide this test to members under six years of age.

A verification study from a sample of members under six years of age showed that for three of four members, medical records did not contain documentation of blood lead screening test results, a signed refusal, or subsequent provider attempts for blood lead testing. The Plan submitted blood lead screening reports from the audit period that showed blood lead screening was due for the three samples; however, there is no evidence of the provision of blood lead screen tests for these members. In an interview, the Plan stated that it defers to the provider to conduct the follow-up with either a phone call or other outreach attempt when a member does not complete a blood lead test.

A review of the Plan policy QI-122 stated that on at least a quarterly basis, the Plan identifies all child members under the age of six years who have no record of receiving blood lead screening tests, and the Plan notifies the identified child member's assigned PCP of the need to provide blood lead screening tests and the required written or oral anticipatory guidance to the parent/guardian of the child member.

The Plan submitted undated blood lead monitoring reports that indicated the deficient sample members were due for a blood lead test. However, the reports did not include any follow-up actions by the Plan or providers to obtain the needed blood lead level tests for these members. The Plan monitors provider adherence to contractual requirements, including Blood Lead Levels (BLL) through the FSR and MRR process. However, Plan policy *QI-122* did not detail the Plan's follow-up process to ensure non-compliant providers adhere to BLL testing requirements.

As a CAP to the prior audit deficiency (2.1.4 Blood Lead Screening Member Outreach Attempts for Pediatric Members), the Plan implemented the following changes: policy *QI-122* revisions, provider incentive payments for staff resources needed in performing outreach to schedule and follow-up on blood lead screening appointments, and a CAP for providers with deficiencies related to blood lead screening. Despite the Plan's CAP for the outreach requirement for blood lead level testing, non-compliance was identified throughout the audit period.

When the Plan does not ensure that providers conduct and document outreach attempts for blood lead screening, members under six years of age may not receive medically necessary blood lead testing and follow-up care for elevated lead levels.

This is a repeat finding of the prior year's finding 2023 - 2.1.4 Blood Lead Screening Member Outreach Attempts for Pediatric Members.

Recommendation: Revise and implement policies and procedures, including providers' documentation of outreach attempts, to ensure members under six years of age receive blood lead screening tests.

2.2 COMPLEX CASE MANAGEMENT

2.2.1 Care Management Plans for Members Enrolled in Complex Case Management

CCM services are provided by the Plan in collaboration with the PCP and shall include at a minimum basic case management services, management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team, intense coordination of resources to ensure the member regains optimal health or improved functionality, and with member and PCP input, development of care plans specific to individual needs and updating of these plans at least annually. *(2023 Contract 08-85213, Exhibit A, Attachment 11 (2)(B))*

The Plan's CCM program is required to include a comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a CMP with performance goals, monitoring, and follow-up; complete a CMP for all members receiving CCM consistent with the member's goals in consultation with the member. The CMP must:

- Address a member's health and social needs, including needs due to social determinants of health;
- Be reviewed and updated at least annually, upon a change in member's condition or level of care, or upon request of the member;
- Be in an electronic format and a part of the member's medical record, and document all of the member's services and treating providers;
- Be developed using a person-centered planning process that includes identifying, educating, and training the member's parents, family members, legal guardians, ARs, caregivers, or authorized support persons, as needed; and
- Include referrals to community-based social services and other resources even if they are not covered services under this Contract.

(2024 Contract 23-30238, Exhibit A, Attachment III 4.3.7 (A) and (B))

Plan policy, *CC-01 Care Coordination and Case Management Program* (revised 11/30/23), stated that the care coordinator is responsible for developing an appropriate individualized plan of care [CMP] that addresses the specific care management and care coordination needs of the member. CMPs are developed with input from the member. Essential elements of this process include prioritized member goals and preferences, ability to self-direct care, and ability to opt-out of the individualized care process. Additional CMP elements include measurable objectives and time frames to meet the member's medical, psychosocial, behavioral health, and long-term support service needs. The CMP includes a timeframe for re-assessment of these elements. Timeframes are determined based on whether or not members are meeting individualized care planning goals when there is a change in health status, or at the request of the member.

Finding: The Plan did not develop and implement CMPs that addressed CCM member health needs or review the CMP when there was a change in a member's condition.

A verification study of ten samples showed that the Plan did not develop and implement person-centered CMPs for four members. Examples of deficiencies include:

- In one sample, the member had multiple medical conditions and reported having challenges with incontinence and unmanaged pain which diminished their quality of life. The member had a CMP initiated with the goals of setting up appointments with a pain management clinic, dentist, and eye doctor. The member had no progress toward meeting the goals for several months, yet no further interventions were indicated by the CM. The member was eventually discharged from the CCM program despite the member's goal progression not being reflected in the CMP for some goals, such as an appointment with an eye doctor.
- In another sample, the member wanted assistance with managing their chronic conditions. The member's medical conditions included congestive heart failure, diabetes, and bilateral knee osteoarthritis. The member was considered high risk due to several hospital admissions. The member had a CMP initiated with goals to manage the member's heart condition and knee pain; however, the member's diabetes was not directly addressed. Several months later, the member reported feeling upset that their knee surgery had been postponed due to the PCP not recommending knee surgery because of difficulty controlling the diabetes. The CMP was not updated to reflect the member's change in condition of their health and the member was then discharged from the CCM program.

In a written response, the Plan stated that through the Plan's level of service screening process, members are identified for other case management programs. Members can be referred to a lower-level program as a step down from CCM when members no longer need high touch services with all or most care plan goals met, but still need or prefer to continue to receive ongoing care management.

Review of the Plan's *Program Guide Desk Procedure for Care Plan Implementation* showed that the Plan used an acuity tool which was completed for CCM members upon 90 days and 180 days after development of a CMP. The tool was used to measure the level of support needed by the member to address remaining care plan goals. However, for these samples, the care plan goals had not been met prior to discharge from the program. In an interview, the Plan stated it monitors care plans through direct supervision and a case review process that is conducted on a routine basis. In a written response, the Plan stated that CMs contact members regularly to identify barriers and revise or update care plans to meet care plan goals. However, these samples did not have care plan revisions done by the CM when progress towards goals were not met.

During the audit period, the Plan conducted an Annual Satisfaction Survey for the CMP with a goal of achieving an 80 percent agreement in satisfaction with the program. However, the Plan did not achieve this goal as indicated by low satisfaction scores in the 2023 survey results. For example, only 60 percent of members felt that their CM created a care plan to help meet their goals.

If the Plan does not ensure that members' CMPs address complex medical needs, then members may not receive case management services to improve or maintain health conditions.

Recommendation: Revise and implement policies and procedures to ensure that members' CMPs are fully developed and implemented to include medical needs and are updated to reflect changes in health conditions.

2.3 BEHAVIORAL HEALTH TREATMENT

2.3.1 Behavioral Health Treatment Plan Criteria

BHT services are required to be based upon a treatment plan that is reviewed no less than every six months by a qualified autism service provider as defined by the California Health and Safety (H&S) Code section 1374.73(c)(3) and by the federally approved State Plan. *(2023 Contract 08-85213, Exhibit A, Attachment 10 (G)(3))*

The member's behavioral treatment plan must be reviewed, revised, and/or modified no less than every six months by a BHT service provider. *(2024 Contract 23-30238, Exhibit A, Attachment III, 5.3.4 (F)(2))*

BHT services are required to be provided, observed, and directed under a Plan-approved behavioral treatment plan. The behavioral treatment plan must be person-centered and based on individualized, measurable goals and objectives over a specific timeline for the specific member being treated. The approved behavioral treatment plan must also meet the following criteria including but not limited to an estimated date of mastery and a crisis plan. *(APL 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21)*

Plan policy, *Peds-02 Behavioral Health Treatment* (revised 5/20/24), stated that BHT services are medically necessary and provided and supervised in accordance with a Plan-approved behavioral treatment plan, which includes a crisis plan and estimated dates for goal mastery that is developed by a BHT service provider who meets the requirements in California's Medicaid State Plan.

Finding: The Plan did not include all required criteria for BHT plans, including a crisis plan and estimated dates for goal mastery.

A verification study showed that 2 of the 15 samples did not have all the required criteria. One sample did not have an estimated date of mastery for goals and another sample did not have a crisis plan included in their BHT plan.

In an interview, the Plan stated that its delegate, Magellan, reviews BHT plans every six months and that this process includes ensuring that members' treatment plans contain particular areas such as a crisis plan and date of mastery. However, the Plan was unable to explain the reason Magellan did not identify and address the missing elements of the BHT plans in the two verification study samples.

As part of its CAP to the prior audit deficiency (2.3.1 Behavioral Health Treatment Plan Criteria), the Plan initiated and finalized the de-delegation of Magellan a month after the end of the audit period (October 1, 2024). Additionally, eight months into the audit period (May 2024), the Plan began its monitoring of Magellan through monthly reviews of ten BHT case files. The Plan's review of Magellan revealed that for ten members' BHT plans:

- One did not contain dates of mastery.
- Two did not contain a crisis plan.

Despite the monthly review process as part of the Plan's CAP, non-compliance was identified during the initial six-month portion of the audit period.

When the Plan does not ensure that BHT plans contain all the required criteria, members may not receive individualized and complete treatment that addresses their behavioral health needs.

This is a repeat finding of the prior year's finding 2023 - 2.3.1 Behavioral Health Treatment Plan Criteria.

Recommendation: Revise and implement policies and procedures to ensure BHT plans contain all the required criteria including an estimated date of mastery for goals and a crisis plan.

2.3.2 Provision of Behavioral Health Treatment Services

The Plan is required to provide medically necessary BHT services as stated in the member's treatment plan and continuation of BHT services under COC with the member's BHT provider. *(2023 Contract 08-85213, Exhibit A, Attachment 10 (G)(1))*

For members less than 21 years of age, the Plan is required to cover medically necessary BHT services regardless of diagnosis in compliance with *APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services*, and APL 23-010*, Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21. (2024 Contract 23-30238, Exhibit A, Attachment III (F))*

For members under the age of 21, Plans are required to provide and cover, or arrange, as appropriate, all medically necessary EPSDT services, including BHT services, when they are covered under Medicaid. BHT services must be provided, observed, and directed under a Plan-approved behavioral treatment plan. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary. *(APL 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21)*

Plan policy, *Peds-02 Behavioral Health Treatment* (revised 5/20/24,) stated that the provision of BHT services is the responsibility of Magellan Health Services and includes an assessment to determine the BHT needs, care plan, and BHT services. Examples include but are not limited to behavioral interventions, comprehensive behavioral treatment, and parent/guardian training.

The delegation agreement between the Plan and Magellan stated that if Magellan is unable to provide a necessary and covered service to a member in-network, Magellan must adequately and timely cover these services OON, for as long as Magellan is unable to provide the service.

Finding: The Plan did not ensure the provision of BHT services for members under 21 years of age in accordance with their BHT plans.

A verification study demonstrated that in 3 of 15 samples, the Plan did not provide BHT services as authorized on the BHT plans.

- In one sample, the member was authorized to receive 15 hours of one-to-one direct service a week but only received 6 hours a week from a BHT provider during part of the treatment period due to staffing shortages.
- In another sample, the member had authorized 20 hours of one-to-one direct service a week. Due to scheduling difficulties, the member had received 12 hours a week for part of the treatment period.
- In another sample, the member had 16 hours of one-to-one direct service a week authorized. However, the member received only up to eight hours a week for part of the treatment period.

In a written response, the Plan provided a list of the authorized BHT hours during the audit period which showed that not all hours were utilized by these members. In an interview, the Plan stated that a challenge to BHT service delivery was due to scheduling difficulties such as members needing BHT services in the evening hours when enough staff may not be available.

As part of the CAP to the prior audit deficiency (2.3.2 Provision of Behavioral Health Treatment Services), the Plan initiated the de-delegation of Magellan which became effective a month after the end of the audit period (October 1, 2024). Additionally, the Plan developed a process to evaluate if members were offered and received the appropriate services in accordance with approved behavioral treatment plans. Despite the Plan's CAP, non-compliance was identified throughout the audit period.

When the Plan does not ensure members receive all approved BHT services, members may not receive medically necessary treatment to improve or maintain behavioral health conditions.

This is a repeat finding of the prior year's finding 2023 - 2.3.2 Provision of Behavioral Health Treatment Services.

Recommendation: Revise and implement policies and procedures to ensure that members receive BHT services according to their approved BHT plans.

2.4 CONTINUITY OF CARE

2.4.1 Continuity of Care Request Completion within Required Timeframes

If the Plan's network is unable to provide necessary medical services covered under the Contract to a particular member, the Plan is required to adequately and timely cover these services OON for the member, for as long as the entity is unable to provide them. *(2023 Contract, Exhibit A, Attachment 9 (16)(A)(B))*

The Plan is required to deliver quality care that enables all its members to maintain health and improve or manage a chronic illness or disability. The Plan is required to ensure quality care and have mechanisms to continuously monitor, review, evaluate, and improve coordination and COC services to all members. *(2024 Contract 23-30238, Exhibit A, Attachment III (2.2)(A)(6)(2.2.6)(P))*

The Plan must meet the following requirements when processing COC requests: The COC process begins when the Plan receives the COC requests. The Plan is required to begin to process non-urgent requests within five working days following the receipt of the COC request. Additionally, each COC request must be completed within the following timelines from the date the Plan received the request: 30 calendar days for non-urgent requests; 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or as soon as possible, but no longer than 3calendar days for urgent requests (i.e., there is identified risk of harm to the member). *(APL 23-022 Continuity of Care For Medi-Cal Beneficiaries Who Newly Enroll In Medi-Cal Managed Care From Medi-Cal Fee-For-Service, On Or After January 1, 2023)*

Plan policy, *MS.01-10 Member Services Handling of Continuity of Care Requests* (revised 6/2/23) stated that newly enrolled Plan members have the right to request COC with a provider with whom the member has an existing relationship (the member has seen the provider at least once during the 12 months prior to the date of the member's initial enrollment in the Plan for a non-emergency visit). The member may be allowed to continue to receive services from the OON provider for a period of up to 12 months.

Plan policy, *PS-05 Provider Terminations and Continuity of Care* (revised 11/1/23), stated that upon receiving a request for COC from a member, their AR, or provider, a UM nurse reviews the request within two business days to determine the level of urgency.

Timeframes for adjudication by levels of urgency include, 30 calendar days for routine requests; 15 calendar days for urgent requests; 3 calendar days if there is risk of harm to the member.

Plan policy, *PSJA-01 Monitoring Continuity of Care Requests* (revised 5/10/24), stated that on a weekly basis, the Plan staff reviews the dashboard for open COC requests. For COC cases that are nearing its due date, the responsible provider services staff and the provider services manager, or designee, will discuss the details of the case and any actions required. On a monthly basis, COC request timeliness is reviewed; and the monthly COC report is generated and reviewed for request timeliness.

Finding: The Plan did not ensure that COC requests from members were completed within the required timeframes.

In a verification study of ten sample COC requests, four samples had routine COC requests not completed within 30 days. The completion times of these requests were delayed between 33 and 49 days.

In an interview, the Plan stated that an internal ticket system was utilized for COC requests. The Plan further stated that the delayed timeframes to complete the four sample COC requests were due to staff error in not closing the COC tickets timely. However, the documents reviewed as part of the audit determined that the COC request was not due to a closure error and that the COC request was not completed timely.

As part of its CAP to the prior audit deficiency (2.4.1 Continuity of Care Request Completion within Required Timeframes), the Plan developed a new policy detailing the monitoring of COC cases. This new policy, *PSJA-01*, was revised in May 2024. The Plan stated that it was looking into a solution to pull the timeframes from the ticketing system into the tracker. Currently, there is a manual calculation component to the monitoring process. During the interview, the Plan confirmed that the new CAP process was implemented eight months into the audit period (May 2024). Despite its CAP, non-compliance was identified in meeting COC completion timelines during the initial six-month portion of the audit period.

When the Plan does not complete COC requests within the required timeframe, members may experience delays in receiving ongoing medical services to manage and treat their health conditions.

This is a repeat finding of the prior year's finding 2023 - 2.4.1 Continuity of Care Request Completion within Required Timeframes.

Recommendation: Implement policies and procedures to ensure members' COC requests are completed within the required timeframes.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member Rights

4.2 Cultural and Linguistics

4.2.1 Interpreter Services during Behavioral Health Treatment Service Delivery

The Plan is required to ensure equal access to health care services for its members without regards to a member's proficiency in the English language. The Plan is required to provide interpreter services adequate to communicate the medical, social, and psychological issues of its members when necessary. *(2023 Contract 08-85213, Exhibit A, Attachment 9 (13)(A))*

The Plan is required to ensure equal access to the provision of high-quality interpreter and linguistic services for LEP members and potential members, and for members and potential members with disabilities, in compliance with federal and state law, and APL 21-004, *Standards for Determining Threshold Languages, Nondiscrimination Requirements, And Language Assistance Services*. The Plan is required to ensure that any lack of interpreter services does not impede or delay a member's timely access to care. *(2024 Contract 23-30238, Exhibit A, Attachment III, (5.2.10) (A)(B)(2))*

Subcontractor and downstream subcontractors must provide interpreter services for members and comply with language assistance standards developed pursuant to H&S Code section 1367.04. *(2024 Contract 23-30238, Exhibit A, Attachment III (3.1.5) (B) (25))*.

Language assistance services must be provided free of charge, be accurate and timely, and protect the privacy and independence of the LEP individual. Plans are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, And Language Assistance Services)*

The delegation agreement between the Plan and Magellan stated that based on the linguistic needs of its members, Magellan provides interpreter or bilingual services in its member services department and telephone functions. This includes all points of service, including visits with providers. The Plan reviews Magellan's interpreter services reports and materials in order to ensure service levels, quality, and compliance with regulatory requirements. The Plan retains overall authority for this activity.

Plan policy, *HE.102 Member Access to Interpreter Services* (revised 12/1/23), stated the Plan member and their medical decision makers who expresses a preference for a non-English language or who demonstrates a need for interpreter services, are offered the use of qualified interpreter services at no cost to the member. To avoid denial and delay of a service to individuals with LEP, the Plan provides interpreter services without appointment at all medical and non-medical points of contact. The Plan does not delegate interpreter services to providers. The Plan contracts interpreter services vendors, available on demand or by appointment, for all members.

Finding: The Plan did not ensure the provision of interpreter services for members during BHT service delivery.

A verification study of 15 sample members, showed that 4 samples of members who were receiving BHT services from Magellan did not have documentation that interpreter services were available to members.

- In three of the four samples, the members spoke Spanish or Tagalog and had authorized BHT services. The member's BHT plan contained a crisis plan that stated a parent or caregiver is required to be at home throughout treatment sessions, and it is required that the designated caregiver speak English at a basic competency level for staff to communicate around any potential health and safety issues. The Plan did not provide an explanation as to the reasons these members were not offered interpreter services.
- In the fourth sample, the member had authorized BHT services. However, the member's progress report noted that barriers to progress included that the parents spoke in Spanish with the member, and the member may have more functional communication in Spanish than English, so some parts of treatment were put on hold until care coordination was conducted.
- None of the sample files contained documentation of the BHT provider, Magellan, or the Plan offering or coordinating interpreter services for members.

In an interview the Plan did not provide information about interpreter services usage or monitoring for these four members. The Plan stated that it promotes the availability of interpreter services but does not have a monitoring process in place for BHT services.

In a written response, the Plan stated that Magellan tracks and monitors language assistance requests quarterly. However, this reporting is not at the member level, so there is no information regarding individual interpreter usage. In addition, as of October 1, 2024, a month after the end of the audit period, the Plan finalized de-delegation of Magellan.

When the Plan does not ensure interpreter availability for members, members may not receive linguistic assistance to understand how to manage or improve their health conditions.

Recommendation: Develop and implement policies and procedures to ensure interpreter services are provided and monitored for members, including those receiving BHT services.

COMPLIANCE AUDIT FINDINGS

Category 6 – Administrative and Organizational Capacity

6.2 FRAUD AND ABUSE

6.2.1 Quarterly Reports of Investigation

The Plan is required to submit a quarterly report to DHCS PIU on all FWA investigative activities ten working days after the close of every calendar quarter. *(2024 Contract 23-30238, Exhibit A, Attachment III, 1.3.2 (D)(3))*

Plan policy, *CP-DP.002 Fraud, Waste, and Abuse Incident Investigation and Reporting* (revised 7/20/22), stated that on a quarterly basis, the Plan will submit a report to DHCS PIU on all FWA investigative activities within ten working days of the close of every calendar quarter. The quarterly report will include the status of all preliminary, active, and completed investigations, and include both referrals initiated by the Plan and DHCS.

Finding: The Plan did not submit quarterly reports to DHCS PIU on all FWA investigative activities.

Review of Plan documents revealed that the Plan did not demonstrate implementation of policy *CP-DP.002*. The Plan did not submit evidence that it submitted quarterly reports to DHCS of FWA investigative activities during the audit period.

In a written statement, the Plan stated that they have not been reporting quarterly to DHCS and have only been submitting the MC609 Confidential Medi-Cal Complaint Report for individual FWA incidents. Subsequent to the audit interviews, the Plan reported that quarterly reports for the first and second quarters were submitted to DHCS in October 2024, which were six months and three months late.

If the Plan does not submit the required quarterly reports timely, DHCS may not be aware and informed of all the FWA cases investigated.

Recommendation: Implement policies and procedures to ensure required FWA quarterly reports are submitted to DHCS timely.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF SAN MATEO HEALTH COMMISSION DBA HEALTH PLAN OF SAN MATEO FISCAL YEAR 2024-25

Contract Numbers: 08-85220 and 23-30270

Contract Type: State Supported Services

Audit Period: September 1, 2023 — August 31, 2024

Dates of Audit: September 23, 2024 — October 3, 2024

Report Issued: April 17, 2025

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the results of the audit of San Mateo Health Commission dba Health Plan of San Mateo (Plan) compliance and implementation of the State Supported Services contract numbers 08-85220 and 23-30270 with the State of California. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of September 1, 2023, through August 31, 2024. The audit was conducted from September 23, 2024, through October 3, 2024, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on March 20, 2025. 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 Department of Health Care Services' (DHCS) evaluation of the Plan's response are reflected in this report.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is bound by all applicable terms and conditions of the Primary Contract as of the effective date of the Hyde Contract. (*Hyde Contract 08-85220, Exhibit E (1)(A) and Hyde Contract 23-30270, Exhibit E (1.1) (1.1.1))*

The Plan is required to pay 90 percent of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date the Plan receives the claim, as indicated by the date stamp on the claim. The date of payment shall be the date of the check or other form of payment. *(2023 Contract 08-85213, Exhibit A, Attachment 8 (5)(B))*

The Plan is required to pay clean claims within 30 calendar days of receipt. The Plan must pay at least 90 percent of all clean claims from providers within 30 calendar days of the date of receipt and 99 percent of all clean claims within 90 calendar days. *(2024 Contract 23-30270, Exhibit A, Attachment III (3.3.5)(B))*

The Plan is required to reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after the date of receipt of the complete claim by the Plan, or if the Plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the Plan or the Plan's capitated provider, unless the complete claim or portion thereof is contested or denied. *(California Code of Regulations, Title 28, section 1300.71(g))*

The Plan is required to ensure Proposition 56 payments are made in accordance with timely payment standards in the Contract for clean claims or accept encounters that are received by the Plan or subcontract no later than one year after the date of service. *(All Plan Letter (APL) 23-015, Proposition 56 Directed Payments for Private Services)*

The Plan is required to make payments in compliance with the clean claims requirements and timeframes outlined in the Contract. *(APL 24-003, Abortion Services)*

Plan policy, *CL.29 Processing Claims for Abortion Services* (revised 6/4/24), stated that the Plan pays 100 percent of all clean claims within 45 working days from the date of receipt.

Finding: The Plan did not make payments for abortion services within 45 working days as required by Proposition 56.

In a verification study, 7 of 20 samples were not paid at the full Proposition 56 rate in a timely manner. The seven samples were initially paid the Medi-Cal rate and a subsequent payment was made to add-on the remaining Proposition 56 amount. However, the seven samples were 73 to 141 days late due to not being fully paid and requiring a second payment to reimburse providers at the minimum Proposition 56 amount as required.

In an interview, the Plan stated that Proposition 56 claims are paid at the contracted Medi-Cal base rate, and then the claim is manually reopened to apply the Proposition 56 payment. The Plan tries to make Proposition 56 payments within one month; however, the Plan stated that these samples took longer.

In a written response, the Plan stated that the Proposition 56 payment for the seven samples were paid through an adjustment to the original claim following the original payment. The seven samples were not fully reimbursed timely due to errors in the claims report, which caused the delays in payments. The criteria used by the Plan to generate the report had the incorrect end date of service which resulted in the report not capturing all the claims requiring add on payments, beyond the sampled claims.

If the Plan does not pay Proposition 56 claims timely, provider operations may be impacted due to financial burden and may limit members' access to care.

Recommendation: Revise and implement policies and procedures to ensure that abortion service claims that require Proposition 56 payments are paid within 45 working days of receipt.