MEDICAL REVIEW – NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

San Mateo Health Commission dba Health Plan of San Mateo

2021

Contract Number: 08-85213

Audit Period: November 1, 2019
Through
July 31, 2021

Report Issued: January 6, 2022

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 of 1986, as a local, independent public entity.

In 1987, the SMHC founded the 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.

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 July 31, 2021, the Plan had 155,544 members of which 111,423 (71.63 percent) were Medi-Cal and 6,932 (4.46 percent) were Seniors and Persons with Disabilities (SPD), 25,797 (16.59 percent) were Access and Care for Everyone Program, 8,824 (5.67 percent) were Cal MediConnect, 1,350 (0.87 percent) were Whole Child Model Program, and 1,218 (0.78 percent) were HealthWorx.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of November 1, 2019 through July 31, 2021. The review was conducted from August 30, 2021 through September 10, 2021. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on December 10, 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 Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of November 1, 2018 through October 30, 2019 was issued on March 3, 2020. The medical audit identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP closeout letter dated September 21, 2021 noted that all findings were closed. This audit examined the Plan's compliance with its DHCS Contract and assessed implementation of its prior year's CAP.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 includes a review of the Plan's UM program, delegation of UM, prior authorization process, and the appeal process.

The Plan is required to maintain a full time physician as Medical Director. The Plan did not ensure that its Chief Medical Officer (CMO) was a full time physician.

The Plan is required to report to DHCS any changes in the status of the Medical Director within ten calendar days. The Plan did not report to DHCS the change in status of the CMO during the audit period within ten calendar days. They had a change in December 2019 as well as May 2021.

The Plan is required to ensure its member informing materials, including Notice of Action (NOA) letters are written at a sixth grade reading level and include clear and concise explanations of Plan decisions. The Plan did not ensure that NOA letters included clear and concise explanations of the decisions.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to provide mental health and substance abuse services.

The Plan is required to develop and implement policies and procedures to define and describe what mental health care services are to be provided by a Primary Care Provider (PCP) or licensed mental health care provider, including Alcohol Misuse Screening and Counseling (AMCS) for alcohol use disorders. The Plan did not have policies and procedures to ensure PCP documentation of alcohol misuse screening services.

The Plan is required to develop and implement a written internal policy and procedure to ensure that members who need Specialty Mental Health Services (SMHS) are referred to and are provided mental health services by an appropriate Medi-Cal Fee-for-Service (FFS) mental health provider or to the county Mental Health Plan (MHP) for SMHS. The Plan did not ensure the provision of SMHS by the county MHP.

The Plan is required to execute a Memorandum of Understanding (MOU) with the MHP to delineate Plan and MHP responsibilities when covering mental health services. The Plan's MOU with the county MHP did not meet all the requirements specified in All Plan Letter (APL) 18-015 *MOU Requirements for Medi-Cal Managed Care Plans*.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding Access to Care, Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for medically necessary services, and the adjudication of claims for emergency services and family planning services.

The Plan is required to communicate, enforce, and monitor network providers' compliance with accessibility and availability requirements. When the timeframe for an appointment is extended by a qualified health care professional, it must be documented within the member's medical record that a longer timeframe will not have a detrimental impact on the member's health. The Plan did not ensure that members' medical records documented that delays in obtaining appointments would not have detrimental impacts on their health.

The Plan is required to subject NEMT services to prior authorization. The Plan is required to use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate mode of transportation for Medi-Cal members. The Plan did not subject non-COVID related NEMT services to prior authorization and did not require providers to use the PCS form.

The Plan is required to ensure that contracting providers are enrolled in the Medi-Cal program. The Plan did not ensure that NEMT providers were enrolled in the Medi-Cal program.

Category 4 – Member's Rights

Category 4 includes requirements to protect member's rights by properly handling grievances.

The Plan is required to submit grievance and appeal reports for Medi-Cal members in a format approved by DHCS which include an explanation for each grievance and appeal that was not resolved within 30 calendar days of receipt of the grievance or request for an appeal. The Plan did not submit to DHCS quarterly grievance and appeal reports for Medi-Cal grievances that exceeded the required 30 calendar day timeframe.

Category 5 – Quality Management

Category 5 includes requirements to maintain an effective Quality Improvement System (QIS), including delegation of quality improvement and provider training.

The Plan is required to collect and review its subcontractors' ownership and control disclosure information. The Plan did not consistently collect ownership and disclosure information from its credentialing delegates. The Plan collected incomplete ownership and disclosure information from two of nine credentialing delegates and did not collect any information from the other seven delegates.

The Plan is responsible and accountable for any functions and responsibilities delegated to subcontractors and must meet the subcontracting requirements. All subcontracts shall be in writing and in accordance with the requirements. The Plan did not specify provider training responsibilities in its written agreements with the delegated entities. The Plan is also required to ensure all new providers receive training regarding the Medi-Cal Managed Care program and operate in full compliance with the Contract. The Plan did not ensure new providers who were part of delegated entities received training.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to implement and maintain the compliance program.

The Plan is required to conduct, complete, and report to DHCS, the results of a preliminary investigation of any suspected fraud or abuse within ten working days of the date the Plan first becomes aware of such activities. The Plan did not complete and report to DHCS the results of its preliminary investigation of suspected fraud and abuse incidents timely.

The Plan is required to implement and maintain procedures to detect and prevent Fraud, Waste, and Abuse (FWA). The procedures must include establishment and implementation of routine internal monitoring and auditing of compliance risks; promptly responding to compliance issues as they are raised; investigation of potential compliance problems as identified in the course of self-evaluation and audits. The Plan did not conduct investigations of all suspected fraud, waste and abuse issues raised or identified through its monitoring procedures.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The review was conducted from August 30, 2021 through September 10, 2021. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. Documents were reviewed and interviews were conducted with the Plan's administrators, staff, and delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 15 medical prior authorization requests including five SPD cases were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 15 medical prior authorization appeals including five SPD cases were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Health Risk Assessment (HRA): Ten files were reviewed to confirm coordination of care and fulfillment of HRA requirements.

Complex Case Management: Six medical records which include one SPD member were reviewed for coordination of care.

Behavioral Health Treatment: Ten SPD medical records were reviewed to confirm the coordination of care.

Continuity of Care (COC): 11 member files which include nine SPD members 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.

NEMT: 25 claims were reviewed to confirm compliance with the NEMT requirements.

NMT: 25 claims were reviewed to confirm compliance with the NMT requirements.

Category 4 – Member's Rights

Grievances Procedures: 37 grievances including 27 standard, five quality of care, and five exempt were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. Ten grievances were reviewed for SPD members.

Confidentiality Rights: Eight protected health information breaches and security incidents were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

Potential Quality of Care Issues: Five samples were reviewed for appropriate reporting, timely evaluation, and proper resolution.

New Provider Training: 11 new training records were reviewed for timely 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.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: San Mateo Health Commission dba Health Plan of San Mateo
AUDIT PERIOD: November 1, 2019 through July 31, 2021 **DATE OF AUDIT:** August 30, 2021 through September 10, 2021

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	MEDICAL DIRECTOR AND MEDICAL DECISIONS

1.1.1 Medical Director

The Plan shall maintain a full time physician as Medical Director. *(Contract, Exhibit A, Attachment 1(6))*

The Plan's 2020 and 2021 UM program descriptions outlined the CMO's roles and responsibilities but it did not state that they were required to be full-time.

Finding: The Plan did not ensure that its CMO was a full time physician.

In a written statement, the Plan stated that the CMO was not currently full-time but expected to be full time by 2022. When asked who covered their responsibilities when they were not available, the Plan stated that the Senior Medical Director would be available to Plan staff.

The CMO is responsible for overall regulation of all medical facets that may affect the health plan. If a full time CMO is not in place to carry out all the required duties effectively, this may lead to poor quality of care and potential harm to the Plan's members.

Recommendation: Develop and implement policies and procedures to ensure that the Plan's CMO is a full time physician.

1.1.2 DHCS Notification of Changes in Status of the Medical Director

The Plan shall report to DHCS any changes in the status of the Medical Director within ten calendar days. *(Contract, Exhibit A, Attachment 1(7))*

The 2020 and 2021 UM program descriptions outlined the CMO's roles and responsibilities but there was no discussion of the Plan's responsibility to notify DHCS of any changes in the status of the CMO.

Finding: The Plan did not report to DHCS the change in status of the CMO during the audit period within ten calendar days. They had a change in December 2019 as well as May 2021.

The Plan's previous CMO left in December 2019 and they had an interim CMO until May 2021 when the current CMO was hired. There was no documentation that the Plan notified DHCS of the changes within the required timeframe. The Plan did not share the current CMO's information until DHCS requested it in an email dated July 15, 2021.

A CMO is a trained physician who oversees the operations of a health plan. They coordinate teams of physicians, nurses as well as non-medical staff to ensure the goals of the Plan are being met. If the Plan does not notify DHCS of changes in the status of the CMO, the Plan may inadvertently allow this position to go unfilled.

Recommendation: Develop and implement policies and procedures to ensure that the Plan reports to DHCS any changes in the status of its CMO within ten calendar days.

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Medical Notice of Action (NOA) Letters

The Plan shall ensure that all member information is provided to members at a sixth grade reading level or as determined appropriate through the Plan's Group Needs Assessment and approved by DHCS. *(Contract, Exhibit A, Attachment 13(4)(C))*

APL 17-006, "Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments" effective July 1, 2017 stated that the written NOA shall contain a clear and concise explanation of the reasons for the decision.

Plan policy *UM.004 Prospective Prior Authorization Reviews* (revised 4/26/2021) stated that NOA for Medi-Cal members are formal letters informing a member and provider, within a specified timeframe, of adverse benefit determinations taken by the Plan. It did not outline the content requirements of the NOA.

Finding: The Plan did not ensure that NOA letters included clear and concise explanations of the decisions.

A verification study of 17 prior authorizations was performed which included six members who were enrolled in California Children's Services (CCS). CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. Three of the six CCS cases demonstrated the following:

- In one case, the NOA to the member and provider included information of a phone call to the member's mother with incorrect grammar and nurse initials, which was part of the Plan's internal documentation.

- Another case included multiple dates of when notes were written and when the service authorization expired which made the NOA wordy and confusing.

- In one other case, again the NOA included information that was part of the Plan's internal documentation process.

During interviews, the Plan stated that they were not sure why that specific language that was part of internal Plan documentation was included in the NOAs. The Plan's compliance department conducted quarterly audits of UM denials, which included CCS cases. In quarter one of 2021 there was one CCS case where the member letter did not have an appropriate or clear reason for the denial or a reference to any criteria used for the decision. In quarter two of 2021 there was only one CCS denial and this case had an issue with timeliness. The Plan stated that CCS staff had just participated in training on CCS denial letters in June 2021. This training included medical necessity review, denial letter requirements, and a review of letter templates and when to use each one. The auditor requested CCS cases for the month of July 2021 to see if the changes had been implemented, but the Plan only had one denial for that month and therefore a post training verification study could not be performed.

If written information to members is not clear and concise, members will not understand the health plan processes and this may affect their ability to make informed health decisions.

Recommendation: Develop and implement policies and procedures to ensure that NOAs contain clear and concise explanations of the reasons for the Plan's decisions.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: San Mateo Health Commission dba Health Plan of San Mateo
AUDIT PERIOD: November 1, 2019 through July 31, 2021 **DATE OF AUDIT:** August 30, 2021 through September 10, 2021

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.5	MENTAL HEALTH AND SUBSTANCE ABUSE

2.5.1 Provision of Specialty Mental Health Services (SMHS)

The Plan is required to develop and implement a written internal policy and procedure to ensure that members who need SMHS are referred to and are provided mental health services by an appropriate Medi-Cal FFS mental health provider or to the county MHP for SMHS. *(Contract, Exhibit A, Attachment 10(8)(D)(3))*

Plan policy *HS-05: Medi-Cal Mental Health and Substance Use Disorder (SUD) Services Referral and Coordination of Services* (revised 5/30/2021) stated that the Plan is not responsible for SUD or SMHS services as those services are the responsibility of the MHP. The Plan is responsible for coordinating medical care for members who also need or receive treatment for SUD or Serious Mental Illness (SMI) even though the SUD and SMI services are the responsibility of the MHP.

Finding: The Plan did not ensure the provision of SMHS by the county MHP.

All referrals for mental health or substance abuse assessment or treatment services, whether by a PCP, self-referral by a member, Plan member services staff, or Plan care coordination staff, are directed to the county MHP. For members enrolled in case management, the Plan tracks referrals to ensure that SMHS are provided by the county MHP. For members not enrolled in case management, the Plan did not track the referrals made to the county MHP.

During the interview, the Plan explained they refer members to the county MHP's call center and follow the referral when the member is enrolled in care management. The Plan does not track member self-referrals when members call the county directly. In a written response, the Plan stated their role ends once a referral is made for SMHS services. Members are encouraged to call into the integrated care management team if they encounter any issues or have any additional needs and the Plan team will troubleshoot as needed. Plan informing materials such as member handbook and its website did not have information which encouraged members to call the Plan's integrated care management team.

The Plan's provider manual had limited information regarding the provision of SMHS. The manual stated the provider is contacted if they initiated the call to the county MHP and if medical evaluations or tests are required during outpatient treatment. The manual instructed providers to refer members to the county or to provide the member with the toll-free phone number so the member can contact the county directly. There was no further information for what occurs after the referral is made.

If the Plan does not ensure members are provided mental health services by the county MHP, then members may miss opportunities to receive services and treatment for their conditions.

Recommendation: Develop and implement policies and procedures to ensure that members who need SMHS are provided mental health services by the county MHP.

2.5.2 Memorandum of Understanding (MOU) with the Mental Health Plan (MHP)

The Plan is required to execute a MOU with the MHP as stipulated in the Contract. *(Contract, Exhibit A, Attachment 12(3)(A))*

APL 18-015, "MOU Requirements for Medi-Cal Managed Care Plans" effective September 19, 2018 stated the Plan is responsible for updating, amending, or replacing existing MOUs with MHPs to delineate Plan and MHPs responsibilities when covering mental health services.

For MHPs, California Code of Regulations, title 9, chapter 11, Medi-Cal SMHS Regulations (Attachment 1) outlines MOU requirements including, but not limited to:

- *Section 1810.415*, Coordination of Physical and Mental Health Care.
- *Section 1850.505*, Request for Resolution.

APL 18-015 outlines the MOU elements including, but not limited to care coordination. The required elements are described in greater detail in Attachment 1 and Attachment 2 of the APL.

Finding: The Plan's MOU with the county MHP did not meet all the requirements specified in *APL 18-015*.

The MOU did not include the following elements from Attachments 1 and 2:

- The entire dispute resolution process including but not limited to the timeframes for submittal, notification and documentation

- The notification process between the Plan and the MHP within 24 hours for the admission and discharge of inpatient mental health treatment to arrange for appropriate follow-up services. A process for reviewing and updating care plans for members as clinically indicated

During the interview, the Plan stated the missing elements are included in the original MOU from 2004. The missing elements were not in the original MOU or the addendum to the MOU from 2021.

Subsequent to the Exit Conference, the Plan submitted the MOU addendum between Plan and MHP (effective 1/1/2021) and highlighted Dispute Resolution Process of the document, however, it did not specify the timeframes for dispute submittal, notification and documentation. The Plan also referred to policy *CC-01 Care Coordination* (revised 4/26/21) but the policy did not include a notification process for admission and discharge or a process for reviewing and updating the care plans of members.

If the Plan does not ensure the MOU contains all required elements, then Plan and MHP staff may not be aware of their responsibilities.

Recommendation: Revise and implement the MOU with the county MHP to include all required elements as specified in *APL 18-015* Attachments 1 and 2.

2.5.3 Alcohol Misuse Screening and Counseling (AMSC)

The Plan is required to develop and implement policies and procedures for mental health services provided by a PCP, including AMCS, formerly known as screening, brief intervention, referral and treatment for alcohol use disorders. *(Contract, Exhibit A, Attachment 21(4)(E))*

APL 18-014, "Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care" effective September 14, 2018 stated the Plan is required to annually screen adult members 18 years of age and older for alcohol misuse. Additional screenings must be provided when medically necessary. Medical necessity must be documented by the member's PCP or primary care team. The Plan is also required to maintain policies and procedures to ensure that providers in primary care settings offer and document alcohol misuse screening services required by this *APL 18-014* and the Preventative Services Medi-Cal Provider Manual.

Plan policy *HS-05: Medi-Cal Mental Health and SUD Services Referral and Coordination of Services* (revised 5/30/2021) stated the Plan's contracted PCPs are responsible for screening, brief interventions, and treatment referral to Behavioral Health and Recovery Services for alcohol use disorder services; however, the policy did not describe how the Plan monitors the provision and documentation of screenings, brief interventions, and referrals to treatment.

Finding: The Plan did not have policies and procedures to ensure PCP documentation for alcohol misuse screening services.

During the interview, the Plan stated the providers offer screening and brief intervention and then refer to the county for referral and treatment services. In a written response, the Plan stated there is no policy about this and all PCPs are expected to do the behavioral health screenings with all members annually, and talk to members about scores that are positive. The Plan also stated they incentivize the provision of behavioral health screening services by PCPs by including substance misuse screening and follow up in the PCP Pay-for-Performance program.

The Plan's provider manual stated the PCP is responsible for providing all primary health care services that do not require specialized care. These include but are not limited to routine preventive health screenings and physical examinations. There was no additional information regarding PCP responsibility to document alcohol misuse screening services.

If the Plan does not ensure PCP documentation of AMCS services provided by the PCP, then providers and members may miss opportunities for alcohol misuse intervention.

Recommendation: Develop and implement policies and procedures to ensure AMSC services are provided and documented by the PCPs.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 Extended Waiting Time for Appointments

The Plan shall establish acceptable accessibility standards in accordance with *California Code of Regulations, title 28, section 1300.67.2*. The Plan shall communicate, enforce, and monitor network providers' compliance with these standards. *(Contract, Exhibit A, Attachment 9(3))*

The Plan is required to ensure members are offered appointments within timeframes appropriate for their condition, and if clinically appropriate, that timeframes are shortened or extended by a qualified health care professional. If the timeframe is extended, it must be documented within the member's medical record that a longer timeframe will not have a detrimental impact on the member's health. Current standard to obtain non-urgent primary care appointment is within ten business days of request. *(Contract, Exhibit A, Attachment 9(3)(A)(2)(c)(3))*

Plan policy *PS.06-01 Timely Access and Network Adequacy* (revised 6/15/2021) stated the applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee. However, the policy did not include procedures on how the Plan will monitor providers' compliance with documentation requirements when an appointment is extended.

Finding: The Plan did not fully implement its policy to ensure that if appointment waiting times are extended, there is documentation supporting that a longer timeframe will not have a detrimental impact on the member's health.

A verification study of grievances showed three cases when providers informed members of appointments having extended waiting times, for up to six weeks. The members were informed by the providers with an extended waiting time for an appointment up to six weeks. In the Plan's investigation of these grievances, the providers responded and confirmed the extended waiting time for an appointment of up to six weeks in all three cases. The Plan did not request documentation for the extended waiting time and did not issue any corrective actions toward these providers.

- In one grievance case, the member had to wait six weeks for a routine appointment. The member changed PCP.

- In another grievance case, the member had to wait four to six weeks for a new patient appointment. The diabetic member had their prescription refilled the same day and scheduled an appointment with another provider.

- In one grievance case, the member had to wait three to six weeks for an initial visit appointment. The member secured an appointment and was seen by another provider a week after filing the grievance.

If the Plan does not ensure documentation of the impact on members' health related to extended appointment wait times, the Plan cannot confirm that a qualified professional completed an assessment to determine appointment scheduling based on health care priorities.

Recommendation: Revise and implement policies and procedures to ensure documentation of extended timeframes for member appointments will not have a detrimental impact on the member's health.

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION AND NON-MEDICAL TRANSPORTATION

3.8.1 Non-Emergency Medical Transportation Prior Authorization

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

The Plan is required to comply with all Policy Letters and APL issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

APL 17-010, "Non-Emergency Medical and Non-Medical Transportation Services" effective July 10, 2017 stated NEMT services are subject to a prior authorization. Plans are required to use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members.

The *2020 DHCS Memo, "Updated COVID-19 Screening and Testing"* dated March 16, 2020 stated the Plan is required to waive prior authorization requests for services, including screening and testing, related to COVID-19. The Plan is responsible for determining the appropriate mode of transportation required to meet the members' medical needs.

The DHCS notice, "Information about Novel Coronavirus (COVID-19) for Medi-Cal Transportation Providers" dated April 22, 2020 stated during the Public Health Emergency (PHE), DHCS is waiving the requirement for a prescription, from a provider, for eligible beneficiaries to utilize NEMT transportation. While the prescription requirement is waived, a Treatment Authorization Request is still required for NEMT and providers are instructed to incorporate the statement, "Patient impacted by COVID-19" within the miscellaneous information field. These flexibilities will remain in effect through the end of the COVID-19 PHE.

Plan policy *UM.013 Non-Emergency Medical Transportation* (revised 7/26/2021) stated the Plan will authorize the following modes of NEMT services: ambulance, litter van, wheelchair van, and air. PCS forms must be completed before NEMT will be provided.

Finding: 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 did not determine the appropriate mode of transportation to meet members' medical needs.

A verification study revealed 15 of 30 approved NEMT service requests did not require prior authorization and PCS forms.

In a provider notice, the Plan informed NEMT providers that prior authorization would be waived for NEMT services as of 3/1/2020 until further notice but it did not limit it to COVID-19 related conditions. During the interview, the Plan revealed the mode of transportation was determined by the transportation providers when they coordinated the rides. Since the prior authorization requirement was waived for all NEMT services, medical necessity determination was not performed and the Plan did not require providers to submit PCS forms.

When the Plan does not review and determine the appropriate mode of transportation for NEMT services, the Plan cannot ensure that it complies with DHCS requirements to provide justification for medically necessary services.

Recommendation: Implement policies and procedures to required prior authorization and use of PCS forms, and to ensure appropriate mode of transportation for NEMT services.

3.8.2 Non-Emergency Medical Transportation Provider Enrollment

The Plan is required to comply with all Policy Letters and APL issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

APL 19-004, "Provider Credentialing / Recredentialing and Screening / Enrollment" effective June 12, 2019, in accordance to *Code of Federal Regulations (CFR), title 42, section 438.608 (b)*, the state is required to screen and enroll, and periodically revalidate, all network providers of managed care organizations, aligning with the FFS enrollment requirements described in *CFR, title 42, part 455, subpart B and E*. These requirements apply to both existing contracting network providers as well as prospective network providers.

Plan policy *CR-01 Credentialing of Physician and Non-Physician Medical Practitioners / Other Services Providers* (revised 5/22/2019) stated all physician and non-physician medical practitioners/other services provider applicants will be evaluated to ensure that providers accepted into contracted network comply with Plan's credentialing criteria. Provider's credentialing application must include documentation of initial California State Medi-Cal program certification process or active certification and in good standing to provide service under the California State Medi-Cal program.

Finding: The Plan did not ensure that NEMT providers complied with Medi-Cal screening and enrollment requirements.

Review of the Plan's NEMT log revealed the following:

- The NEMT provider with the highest volume of completed rides provided 25,248 of 82,899 total completed rides, about 30 percent of the total completed rides in the audit period, was not contracted with the Plan and not enrolled in Medi-Cal.

- Another NEMT provider provided 4,406 of 82,899 total completed rides, about five percent of the total completed rides, was not contracted with the Plan and not enrolled in Medi-Cal.

The NEMT provider with the highest volume of completed rides was identified in the last audit as not being enrolled in the Medi-Cal program and not contracted with the Plan. However, the Plan continued to utilize this provider. In the interview, the Plan stated that they were actively recruiting providers to join the network. The determination to use contracted versus non-contracted provider was based on availability. The Plan acknowledged using non-contracted providers when there were no in-network providers available to provide the service.

If the Plan does not utilize contracted NEMT providers who are enrolled in Medi-Cal, members may be subjected to inadequate and unsafe transportation conditions.

Recommendation: Revise and implement processes to ensure NEMT providers comply with Medi-Cal screening and enrollment requirements.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Quarterly Grievance Report

The Plan is required to submit grievance and appeal reports for Medi-Cal members only as set forth in *California Code of Regulations, title 28, section 1300.68(f)* or in a format approved by DHCS, with the additional information required by DHCS in accordance with *Code of Federal Regulations, title 42, section 438.416.* The report should include an explanation for each grievance and appeal that was not resolved within 30 calendar days of receipt of the grievance or request for an appeal.

For the Medi-Cal category of the report, the Plan is required to provide the following additional information:

- The total number of grievances and appeals received
- The average time it took to resolve grievances and appeals, which includes providing written notification to the member
- The date Plan received the grievance or appeal
- A general description of the reason for the grievance or appeal
- The date(s) of Plan's review of the grievance or appeal, or if applicable, a review meeting
- The resolution and date of resolution, at each level of the grievance or appeal
- A listing of the zip codes, ethnicity, gender, and primary language of the member who filed the grievance or appeal
- The name of the member for whom review of a grievance or appeal was requested

(Contract, Exhibit A, Attachment 14(3)(B))

Plan policy *GA-10 Overview of Member Complaints Process* (revised 3/1/2021) stated complaints not resolved within 30 days are reported on a quarterly basis to the Department of Managed Health Care (DMHC).

Finding: The Plan did not submit to DHCS quarterly grievance and appeal reports for Medi-Cal grievances that exceeded the required 30 calendar day timeframe.

In a written response, the Plan stated any grievances that exceeded the 30 day timeframe would be included in the summary data on the quarterly Consumer Advisory Committee (CAC) reports that correspond with the time period the grievance was received; however, late grievances were not included in the CAC reports or in other quarterly reports submitted to DHCS.

If the Plan does not submit quarterly grievance and appeal reports for grievances that exceed the required timeframe, then the Plan may miss the opportunity to identify factors that prolong the grievance process.

Recommendation: Develop and implement policies and procedures to ensure submittal of quarterly grievance and appeal reports to DHCS include grievances and all required information elements that exceed the required timeframes.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: San Mateo Health Commission dba Health Plan of San Mateo
AUDIT PERIOD: November 1, 2019 through July 31, 2021 **DATE OF AUDIT:** August 30, 2021 through September 10, 2021

CATEGORY 5 – QUALITY MANAGEMENT

5.2	DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

5.2.1 Ownership and Control Disclosure Reviews

The Plan is accountable for all quality improvement functions and responsibilities (e.g. UM, Credentialing and Site Review) that are delegated to subcontractors. The Plan may delegate credentialing and re-credentialing activities. If the Plan delegates these activities, the Plan shall comply with delegation of quality improvement functions and responsibilities. *(Contract, Exhibit A, Attachment 4 (6)(A),(12)(C))*

The Plan is required to comply with *CFR, title 42, section 455.104*. 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. The Plan is also required to disclose the name, address, date of birth, and social security number of any managing employee of the disclosing entity. *(Contract, Exhibit A, Attachment 1(2)(B))*

APL 17-004, "Subcontractual Relationships and Delegation" effective April 18, 2017 stated 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*.

APL 19-004, "Provider Credentialing / Recredentialing and Screening / Enrollment" effective June 12, 2019 stated the Plan's screening and enrollment requirements are separate and distinct from their credentialing and re-credentialing processes. The credentialing and re-credentialing process is one component of the comprehensive QIS required in all Plan's Contracts.

Finding: The Plan did not collect ownership and disclosure forms from seven of nine credentialing delegates. The Plan collected incomplete ownership and disclosure information from two of nine credentialing delegates.

Review of Plan disclosure forms collected from the two delegates revealed the following deficiencies:

- One disclosure form did not contain the names of the delegated entities' managing employees in leadership positions such as directors and executives.

- One disclosure form did not contain the tax identification number of the corporation.

As a CAP to the 2019 audit finding, 5.1.1 Ownership and Control Disclosure Reviews, the Plan revised its policy *CP.23 Delegation Oversight* to include the review of delegate's ownership and control disclosures, however, this policy had not been approved. During interviews, the Plan explained that the cause of delay for approval was due to lack of oversight but was scheduled to be presented at the September 2021 compliance committee meeting. The policy was not completed, so the new process was also not implemented during the audit period.

Furthermore, in a written response the Plan explained that they do not collect disclosure forms from credentialing delegates because they considered credentialing activity as part of the overall network provider agreement. The Plan classified the seven credentialing delegates as network providers and not as subcontractors hence ownership and disclosure information were not collected. Although the delegates' had executives and board of directors, the Plan did not collect these managing employees name, address, date of birth, and social security number. The Plan continued to subject and demand other delegation requirements such as reporting and monthly meetings with the delegates.

This is a repeat of prior year finding 5.1.1 – Ownership and Control Disclosure Reviews.

When the Plan does not collect and complete the required ownership and control disclosure information of all delegates, it cannot ensure that delegates' owners and controlling interest individuals are eligible for program participation.

Recommendation: Implement policies and procedures to ensure complete collection of all delegates' ownership and control disclosure information.

5.3	PROVIDER QUALIFICATIONS

5.3.1 Delegation of Provider Training

The Plan may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. The Plan shall maintain policies and procedures, approved by DHCS, to ensure that the subcontractors fully comply with all terms and conditions of this Contract. When doing so, the Plan shall oversee and remain responsible and accountable for any functions and responsibilities delegated, and shall meet the subcontracting requirements as stated in *CFR, title 42, section 438.230(b)(1).* All subcontracts shall be in writing and in accordance with the requirements of the *CFR, title 42, section 438.230 (c)(1)(i)-(iii). (Contract, Exhibit A, Attachment 6 (13))*

All contracts or written agreements between the Plan and delegates must meet the following requirements:

I. The delegated activities or obligations, and related reporting responsibilities, are specified in the Contract or written agreement.

II. The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Plans entity's Contract obligations.

(CFR, title 42, section 438.230 (c)(1)(i)-(ii))

Plan policy *CP.023 Delegation Oversight* (revised 7/17/2019) stated that at the time of the pre-delegation audit, the delegation agreement will also be reviewed to ensure it contains the following provisions:

- Delineates the duties and responsibilities of both the Plan and the proposed delegate.
- Outlines the services to be performed by the delegate, including reporting responsibilities that shall occur at least quarterly.
- Specifies that performance of the delegate is monitored on an ongoing basis by the Plan, and that the Plan retains the right to audit the delegate with adequate notice.
- States that delegate must comply with all applicable Medicare and Medi-Cal laws and regulations and National Committee for Quality Assurance accreditation standards, as applicable, and any guidance or instructions from Centers for Medicare and Medicaid Services, DHCS, or DMHC that pertains to the functions being delegated.

Finding: The Plan did not specify provider training responsibilities in its written agreements with the delegated entities.

In interviews, the Plan reported that provider training responsibilities had been delegated to nine entities that were also delegated credentialing functions. The written delegation agreements for the nine delegated entities did not include verbiage on provider training as a responsibility. The Plan stated it was in the process of working with the delegated entities, however, no revisions have been finalized in the delegation agreements to address provider training.

Without identifying specific responsibilities in the written agreements, the Plan cannot ensure its delegates will fulfill delegated obligations as contractually required.

Recommendation: Revise and implement delegate agreements to include and specify all delegated activities and responsibilities to delegated entities.

5.3.2 Provider Training

The Plan shall ensure that all network providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations. *(Contract, Exhibit A, Attachment 7(5))*

Plan policy *PS.01-03 Provider Training* (revised 5/20/2020) stated the Plan will provide new provider training materials to delegated credentialing provider groups to incorporate into their new provider onboarding process and conduct the training within ten working days and completion within 30 calendar days of becoming an active provider with the group. Delegated credentialing providers will retain documentation of training completion date and make this available to the Plan upon request for oversight and monitoring purposes. Delegated credentialing providers are required to report training completion dates for network providers as requested.

Finding: The Plan did not ensure that all new network providers received training. The Plan did not acquire provider training attestations or other documentation from providers who were part of delegated entities.

In the verification study, three of 12 samples did not have provider training attestations available for review. The three samples were providers of delegated entities. In interviews, the Plan acknowledged that it has not collected all provider training attestations from providers of delegated entities.

Prior DHCS audits from 2019 (finding 5.2.1) and 2018 (finding 5.2.3) found that the Plan did not ensure that provider training was conducted for all new providers. As a CAP to the 2019 audit finding, 5.2.1 Provider Training, the Plan revised its policy *PS-01-03: Provider Training* to include a section on New Provider Training for the required training of all new providers. However, the revised policy was not fully implemented during the audit period.

This is a repeat of prior finding 5.2.1 Provider Training in 2019 and 5.2.3 Provider Training in 2018.

Without provider training attestations from delegated entities, the Plan cannot ensure that provider training was completed.

Recommendation: Implement policies and procedures to ensure and document that all network providers receive provider training within the required timeframe.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: San Mateo Health Commission dba Health Plan of San Mateo
AUDIT PERIOD: November 1, 2019 through July 31, 2021 **DATE OF AUDIT:** August 30, 2021 through September 10, 2021

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD AND ABUSE

6.2.1 Fraud and Abuse Reporting

The Plan shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days of the date the Plan first becomes aware of, or is on notice of, such activity. *(Contract, Exhibit E, Attachment 2 (27)(B)(7))*

Plan policy *CP-DP.002 Fraud, Waste, and Abuse (FWA) Incident Investigation and Reporting* (revised 9/6/2019) stated the compliance staff file all suspected FWA cases to DHCS using the MC609 reporting template. Reports are made no later than ten working days after the Plan is first aware or is noticed of FWA activity. The Chief Compliance Officer is responsible for overseeing the Plan's Compliance Program, including the FWA Program. The Compliance Manager is delegated day-to-day operational oversight of the FWA program.

Finding: The Plan did not complete and report to DHCS the results of preliminary investigations of suspected fraud and abuse incidents within ten working days.

A review of the suspected FWA incidents revealed:

- Five of the nine suspected incidents were not reported to DHCS within ten working days after the Plan became aware or notified of suspected incidents. These suspected incidents exceeded the reporting timeframe by four to 27 days. Similar findings were found in the other line of business.

During interviews, the Plan stated that it lost a Compliance Investigator position since February 2020. The Compliance Investigator was responsible for FWA investigation and reporting. In a written response, the Plan stated it has not replaced the position because of a hiring freeze instituted by the Plan due to funding uncertainty brought on by the PHE.

If the Plan does not complete and report suspected fraud and abuse incidents timely, it could delay detection and prevention of FWA incidents.

Recommendation: Implement policies and procedures to ensure all suspected incidents of fraud and abuse are investigated and reported within the required timeframe.

6.2.2 Investigation of Suspected Fraud, Waste and Abuse

The Plan shall implement and maintain procedures that are designed to detect and prevent FWA. The procedures must include establishment and implementation of a system with dedicated staff for: routine internal monitoring and auditing of compliance risks; promptly responding to compliance issues as they are raised; investigation of potential compliance problems as identified in the course of self-evaluation and audits; correction of such problems promptly and thoroughly, or coordination of suspected criminal acts with law enforcement agencies to reduce the potential for recurrence; and ongoing compliance with the requirements under this Contract. *(Contract, Exhibit E, Attachment 2(27)(B)(1)(g))*

Plan policy *CP.016 Investigating and Reporting Fraud, Waste, Abuse and Neglect* (revised 1/26/2021) stated all potential cases of fraud or abuse reported to the compliance department are investigated. Under the direction of the Chief Compliance Officer, Compliance Department staff gathers information regarding the case. Investigations for all cases begin as quickly as possible, but no later than ten business days after the date the potential noncompliance or FWA is identified or reported.

Plan policy *CP.000 Compliance Program 2020* stated that compliance and operational staff perform auditing and monitoring functions to ensure compliance with applicable law and the compliance program. They report, investigate and, if necessary and appropriate, correct, any inconsistencies, suspected violations or questionable conduct. Monitoring is an on-going process completed by the department staff. To ensure processes are working as intended, ongoing checking and measuring are performed daily, weekly, or monthly or on an ad hoc basis.

Finding: The Plan did not conduct investigations of all suspected FWA.

The Plan utilizes two sources of data to look for fraud: non-drug and drug. Non-drug data is reviewed by a vendor which identifies trends and outliers for types of heath care fraud. In a written response, the Plan explained they received individual reports whenever a provider alert was triggered in their system. Review of the reports showed 90 providers were triggered for paid claims between $1,046.60 and $2,409,384.39. In interviews, the Plan stated they continued to receive the report from its vendor, however, the Plan did not conduct an investigation of the providers identified on the report. The Plan stated that the Compliance Manager reviewed them and believed that they were mostly low risk, however, there was no evidence of the review.

If the Plan does not implement its investigation procedures, there is a risk of failure to detect heath care FWA.

Recommendation: Implement policies and procedures to ensure all suspected cases of FWA are investigated.

MEDICAL REVIEW – NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

San Mateo Health Commission
dba Health Plan of San Mateo

2021

Contract Number:	08-85220 State Supported Services
Audit Period:	November 1, 2019 Through July 31, 2021
Report Issued:	January 6, 2022

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the audit finding of San Mateo Health Commission dba Health Plan of San Mateo (Plan) State Supported Services Contract No. 08-85220. The State Supported Services Contract covers contracted abortion services with the Plan.

The onsite review was conducted from August 30, 2021 through September 10, 2021. The audit period was November 1, 2019 through July 31, 2021. The audit consisted of document review of materials supplied by the Plan, verification study, and interviews conducted onsite.

The following verification study was conducted:

State Supported Services

Claims: 20 State Supported Services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: San Mateo Health Commission dba Health Plan of San Mateo

AUDIT PERIOD: November 1, 2019 through July 31, 2021
DATE OF AUDIT: August 30, 2021 through September 10, 2021

STATE SUPPORTED SERVICES

SUMMARY OF FINDING:

There were no deficiencies identified in this audit.

RECOMMENDATION(S):

N/A

MEDICAL REVIEW – NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

San Mateo Health Commission dba Health Plan of San Mateo

2021

Cal MediConnect Contract Number:	13-90490 Cal MediConnect Three-Way Contract
Audit Period:	November 1, 2019 through July 31, 2021
Report Issued:	January 6, 2022

TABLE OF CONTENTS

I. INTRODUCTION

The California Legislature in 1983 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. San Mateo County Board of Supervisors created the San Mateo Health Commission (SMHC) in June of 1986, as a local, independent public entity.

In 1987, the SMHC founded the 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.

Starting in April 2014, in collaboration with the Centers for Medicare and Medicaid Services (CMS), the State of California Department of Health Care Services (DHCS) began operation of a program called Cal MediConnect (CMC), to integrate care for beneficiaries who are eligible for both Medicare and Medi-Cal.

The CMC contract is a three-way contract between CMS, DHCS, and Medicare-Medicaid health plans to coordinate the delivery of care for covered Medicare and Medicaid services for CMC members.

Members enrolled in CMC receive all Medicare and Medi-Cal benefits, including medical care, behavioral health services, long-term services and supports, such as In-Home Support Services, community based adult services, and multipurpose senior services program, in addition to Non-Emergency Transportation Services and care in nursing facilities.

As of July 31, 2021, the Plan had 8,824 CMC members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS CMC audit for the period November 1, 2019 through July 31, 2021. The review was conducted from August 30, 2021 through September 10, 2021. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on December 10, 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 our 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, and Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS CMC audit for the period of November 1, 2017 through September 30, 2018 was issued on April 12, 2019. The CMC audit identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP closeout letter dated November 3, 2020 noted that all findings were closed.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 includes a review of the Plan's UM program, prior authorization process, and the appeal process.

The Plan is required to notify CMC members' appeal rights through a single notice. The notice must explain how to file an appeal and the procedures for exercising the member's rights including appropriate timeframes. The Plan did not include correct timeframes to file an appeal and to request a State Fair Hearing in its denial notices to members.

The Plan is required to provide a member notice of resolution for appeal, as expeditiously as the member's health condition requires. Written material must use easily understood language and format. The Plan did not ensure that notice of resolution letters included easily understood language when explaining the reason for denial.

Category 2 – Case Management and Coordination of Care

There were no findings in this category.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding Access to Care, Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for medically necessary services.

The Plan is required to subject NEMT services to a prior authorization and to provide medically appropriate NEMT services utilizing DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for members. 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 is required to screen and enroll, and periodically revalidate, all NEMT providers aligning with the Fee-for-Service (FFS) enrollment requirements. The Plan did not ensure NEMT providers complied with Medi-Cal screening and enrollment requirements.

Category 4 – Member's Rights

Category 4 includes requirements to protect member's rights by properly handling grievances.

The Plan is required to inform members and providers of an accurate grievance filing timeframe. The Plan's provider and member informing materials did not have the correct grievance filing timeframe during the audit period.

Category 5 – Quality Management

There were no findings in this category.

Category 6 – Administrative and Organizational Capacity

There were no findings in this category.

III. AUDIT SCOPE/PROCEDURES

SCOPE:

This audit was conducted by the DHCS Medical Review Branch to ascertain that Medicaid-based medical services provided to CMC members complied with the Three-Way Contract, the federal and state laws and regulations, applicable guidelines, and according to State's Medi-Cal Managed Care under the County Organized Health System Managed Care Contract.

PROCEDURES:

The review was conducted from August 30, 2021 through September 10, 2021. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. Documents were reviewed and interviews were conducted with the Plan's administrators, staff, and delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: Five medical prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: Five medical prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

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

Continuity of Care (COC): Two member files were reviewed to confirm COC and fulfillment of requirements.

Category 3 – Access and Availability of Care

NEMT: Five claims were reviewed to confirm compliance with the NEMT requirements.

NMT: Five claims were reviewed to confirm compliance with the NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: 35 grievances including 25 standard, five quality of care, and five exempt were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: Six Protected Health Information (PHI) breach and security incidents were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

Potential Quality of Care Issues: Five samples were reviewed for appropriate reporting, timely evaluation, and proper resolution.

New Provider Training: One new primary care provider training record was reviewed for timely CMC program training.

Category 6 – Administrative and Organizational Capacity

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

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖ Three-Way Contract (Cal MediConnect)
PLAN: San Mateo Health Commission dba Health Plan of San Mateo
AUDIT PERIOD: November 1, 2019 through July 31, 2021 **DATE OF AUDIT:** August 30, 2021 through September 10, 2021

CATEGORY 1 – UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REQUIREMENTS

1.2.1 Integrated Denial Notices for Prior Authorization

Members will be notified of all applicable CMC, Medicare and Medi-Cal appeal rights through a single notice. The notice must explain the member's, provider's, or authorized representative's right to file an appeal with the Plan and whether exhaustion of the Plan internal appeal process is a prerequisite to additional external review by Medicare, Independent Medical Review (IMR) by Department of Managed Health Care (if applicable), or a State Fair Hearing. It should also explain the procedures for exercising the member's rights to appeal. *(Contract, Sections 2.15.1, 2.15.1.1.4, and 2.15.1.1.5)*

All Plan Letter (APL) 17-006, "Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments" effective July 1, 2017, stated the new federal regulations require members to request a State Hearing within 120 calendar days from the date of the Notice of Appeal Resolution which informs the member that the adverse benefit decision has been upheld.

Chapter 13 of the Medicare Managed Care Manual, issued on 4/20/2012, stated that members must file the request for an appeal within 60 calendar days from the date of the notice of the Plan's determination.

Plan policy *UM.004 Prospective Prior Authorization Reviews* (revised 4/26/2021) stated that an Integrated Denial Notice (IDN) for CMC members are formal letters informing a member and provider, within a specified timeframe, of adverse benefit determinations taken by the Plan. It did not outline the content requirements of the IDN.

Plan policy *GA-05 Medicare Part C Appeals* (revised 2/19/2021) stated that CareAdvantage members may file an appeal within 60 calendar days from the date of the notice of the initial determination and that the grievance and appeals coordinator verifies that the complaint was filed within 60 days of the date of the denial.

Finding: 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.

A verification study of five prior authorizations and five appeals was performed. One of the five prior authorizations and three of the five appeals had integrated denial notices with incorrect information regarding timeframes for filing of appeals and requesting State Fair Hearings.

The integrated denial notices informed the member of their right to appeal the Plan's decision. It further explained that they would need to file the appeal within 60 calendar days of the date of the notice, which was the correct timeframe. However, further down in the letter it stated that the member must request an appeal within 90 days of getting the notice. Furthermore, it stated that the member has up to 90 days to request a State Fair Hearing for Medi-Cal services, instead of the correct timeframe of 120 days. This information was also included in the Plan's letter template.

During interviews, the Plan stated that it was not aware the appeal information included in the IDNs was not up-to-date. The Plan did not provide additional information.

The Plan's Provider Manual, CMC Member Handbook, and website all stated that CMC members have 60 days to file an appeal. The Provider Manual and CMC Member Handbook also stated that for Medi-Cal covered services and items, a member can file a State Hearing within 120 calendar days of an action with which the member is dissatisfied. The auditor did not find information on the timeframe for filing a State Hearing on the Plan's website.

If written member information is not updated with accurate information, such as with the most current timeframes on when to file an appeal, IMR or State Hearing, members may be prevented from exercising their right to file in a timely manner. The potential outcome is denial of services and delayed provision of health care.

Recommendation: Develop and implement policies and procedures to ensure that integrated denial letters contain correct timeframes for filing an appeal and for requesting a State Fair Hearing.

1.3	APPEAL PROCEDURE

1.3.1 Notice of Resolution Letters

The Plan must provide a member notice of resolution, as expeditiously as the member's health condition requires. Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. *(Contract, Sections 2.15.1.2 and 2.15.1.4)*

Plan policy *GA-05 Medicare Part C Appeals* (revised 2/19/2021) stated the resolution letter must include an explanation of the reason for denial in easily understandable language. The clinical review nurse must therefore review all denial letters for clinical accuracy and readability.

Finding: The Plan did not ensure that notice of resolution letters included easily understood language when explaining the reason for denial.

A verification study of five appeals was performed. Of these five, three had notice of resolution letters which included unclear, unnecessary and redundant information making the letters longer than needed. Examples of this information included in the letters were the following:

- "The CMS Manual System is used by CMS program components, partners, and contractors to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives."

- "Per CMS Manual System, Pub 100-08 Medicare Program Integrity, Transmittal 195, 6.2.1 -Suppliers are not eligible to Participate, MFTs are not eligible providers with Medicare and are not allowed to bill Medicare."

- "The request is still denied because mental health counselors and MFTs are not eligible to serve Medicare beneficiaries and are not allowed to bill Medicare."

In a written statement, the Plan stated that the resolution letters included the information listed above to comply with accreditation requirements, which consisted of listing the reference to the source document the Plan used to make the coverage decision. It also clarified that quarterly appeal audits performed by the Compliance Department were Medi-Cal only. CMC audits were less frequent and did not include resolution letters. The audits also did not include criteria for easily understood language for the notice of resolution letters.

If written information to members does not include easily understood language, members may not understand the health plan processes and this may affect their ability to make informed health decisions.

Recommendation: Develop and implement policies and procedures to ensure notice of resolution letters include easily understood language.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖ Three-Way Contract (Cal MediConnect)
PLAN: San Mateo Health Commission dba Health Plan of San Mateo
AUDIT PERIOD: November 1, 2019 through July 31, 2021 **DATE OF AUDIT:** August 30, 2021 through September 10, 2021

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION AND NON-MEDICAL TRANSPORTATION

3.8.1 Non-Emergency Medical Transportation Prior Authorization

The Contract included NEMT as part of medically necessary covered services for the member. *(Contract, Section A.3.2)*

The Plan is required to comply with all current and applicable Dual Plan Letter (DPL) issued by DHCS and maintain its contract with DHCS for the provision of covered services under the Medi-Cal program. *(Contract, Sections 2.1.5 and 2.1.7)*

DPL 18-001, "Non-Emergency Medical and Non-Medical Transportation Services" effective April 26, 2018, stated the Plan is required to provide NEMT services when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a Skilled Nursing Facility or an intermediate care pursuant to *Health Safety Code, section 1250.*

The *2020 DHCS Memo, "Updated COVID-19 Screening and Testing" dated March 16, 2020,* stated the Plan is required to waive prior authorization requests for services, including screening and testing, related to COVID-19. The Plan is responsible for determining the appropriate mode of transportation required to meet the members' medical needs.

The *DHCS notice," Information about Novel Coronavirus (COVID-19) for Medi-Cal Transportation Providers"* dated April 22, 2020, stated during the Public Health Emergency (PHE), DHCS is waiving the requirement for a prescription, from a provider, for eligible beneficiaries to utilize NEMT transportation. While the prescription requirement is waived, a Treatment Authorization Request (TAR) is still required for NEMT and providers are instructed to incorporate the statement, "Patient impacted by COVID-19" within the miscellaneous information field. These flexibilities will remain in effect through the end of the COVID-19 PHE.

Plan policy *UM.013 Non-Emergency Medical Transportation* (revised 7/26/2021) stated the Plan will authorize the following modes of non-emergency transport services: ambulance, litter van, wheelchair van, and air. PCS forms must be completed before NEMT will be provided.

Finding: The Plan did not subject non-COVID related NEMT services to prior authorization and did not require providers to use the PCS forms.

A verification study revealed two of five approved NEMT service requests did not require prior authorization and PCS forms.

In a provider notice, the Plan informed NEMT providers that prior authorization would be waived for NEMT services as of March 1, 2020, until further notice but it did not limit it to COVID-19 related conditions. During the interview, the Plan revealed the mode of transportation was determined by the transportation providers when they coordinated the rides. Since the prior authorization requirement was waived for all NEMT services, medical necessity determination was not performed and the Plan did not require providers to submit PCS forms.

When the Plan does not review and determine the appropriate mode of transportation for NEMT services, the Plan cannot ensure that it complies with DHCS requirements to provide justification for medically necessary services.

Recommendation: Implement policies and procedures to ensure adherence to prior authorization and PCS form requirements for NEMT services.

3.8.2 Non-Emergency Medical Transportation Provider Enrollment

The Plan is required to comply with all current and applicable DPLs issued by DHCS and maintain its contract with DHCS for the provision of covered services under the Medi-Cal program. *(Contract, Sections 2.1.5 and 2.1.7)*

APL 19-004, "Provider Credentialing / Recredentialing and Screening / Enrollment" effective June 12, 2019, requires both existing contracting network providers as well as prospective network providers to comply with Medi-Cal FFS enrollment requirements as described in *Code of Federal Regulations, Title 42, part 455, subpart B and E.*

Plan policy *CR-01 Credentialing of Physician and Non-Physician Medical Practitioners/Other Services Providers* (revised 5/22/2019), stated that all physician and non-physician medical practitioners/other services provider applicants will be evaluated to ensure that providers accepted into contracted network comply with Plan's credentialing criteria. Provider's credentialing application must include documentation of initial California State Medi-Cal program certification process or active certification and be in good standing to provide service under the California State Medi-Cal program.

Finding: The Plan did not ensure that NEMT providers complied with Medi-Cal screening and enrollment requirements.

Review of the Plan's NEMT log revealed the following:

- The NEMT provider with the highest volume of completed rides provided 12,061 of 48,315 total completed rides, about 25 percent of the total completed rides in the audit period, was not contracted with the Plan and not enrolled in Medi-Cal.

- Another NEMT provider provided 1,953 of 48,315 total completed rides, about four percent of the total completed rides, was not contracted with the Plan and not enrolled in Medi-Cal.

The NEMT provider with the highest volume of completed rides was identified in the 2019 prior year annual medical audit as not being enrolled in the Medi-Cal program and not contracted with the Plan. However, the Plan continued to utilize this provider. In the interview, the Plan stated that they were actively recruiting providers to join the network. The determination to use contracted versus non-contracted provider was based on availability. The Plan would use non-contracted providers when there were no in-network providers available to provide the service.

If the Plan does not utilize contracted NEMT providers who are enrolled in Medi-Cal, members may be subjected to inadequate and unsafe transportation conditions.

Recommendation: Revise and implement processes to ensure NEMT providers comply with Medi-Cal screening and enrollment requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖ Three-Way Contract (Cal MediConnect)
PLAN: San Mateo Health Commission dba Health Plan of San Mateo
AUDIT PERIOD: November 1, 2019 through July 31, 2021 **DATE OF AUDIT:** August 30, 2021 through September 10, 2021

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Filing Timeframe

A member may file an internal grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Plan or its providers by calling or writing to the Plan or provider. *(Contract, Section 2.14.2)*

Plan policy *GA-04 Member Grievances Procedure for CareAdvantage CMC* (revised 12/24/2020), stated CareAdvantage members may file a grievance at any time, without regard for the date of the incident or the time that has elapsed between the date of the incident and the date the member is filing the grievance.

Finding: The Plan did not include the correct time frame to file a grievance in its provider and member informing materials during the audit period.

In two instances, the 2021 CMC Provider Manual incorrectly stated CMC members may file a grievance within 60 days from the date of incident. The 2021 CMC Member Handbook stated if the complaint is about Part D drug, members must file within 60 calendar days after the problem they want to complain about. The Problems and Complaints website page stated CMC members must file within six months of the event.

In a written response, the Plan admitted that the wrong timeframes were listed in the Provider Manual, and Plan website. The Plan stated it discovered that in late fall of 2020 there were multiple versions of the Provider Manual being edited simultaneously due to the large number of edits that were anticipated as a result of the upcoming Medi-Cal pharmacy benefit carve-out. After that program was postponed, the Plan attempted to reconcile the edits across multiple versions of the manual and inadvertently missed incorporating the edit regarding the timeframe for CMC grievances. In regards to the Member Handbook, the Plan stated the language reference is the template language from CMS and the standard is 60 calendar days for Part D complaints.

As a corrective action to the 2019 4.1.2 Grievance Filing Timeframe finding, the Plan updated its policies and procedures and provider fact sheet to include the correct grievance filing timeframe. However, provider and member informing materials, and the Plan's website still contained the incorrect grievance filing timeframe.

If the Plan does not have the correct grievance filing timeframes listed on the Plan's materials, then members may miss opportunities to file a grievance.

Recommendation: Revise and implement policies and procedures to ensure provider and member informing materials are regularly updated to contain current grievance filing timeframe requirements.