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

Contract Number: 08-85213

Audit Period: November 1, 2018 Through October 31, 2019

Report Issued: March 3, 2020

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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.

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 October 31, 2019, the Plan had 134,732 members of which 99,231 (74.65 %) Medi-Cal, 23,775 (17.65%) Access and Care for Everyone (ACE) Program, 8,873 (6.59%) Cal MediConnect, 1,695 (1.26%) Whole Child Model Program, and 1,158 (.86%) 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, 2018 through October 31, 2019. The onsite review was conducted from November 4, 2019 through November 14, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on January 31, 2020. 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.

During the audit period, the Plan participated in the California Children's Services Whole Child Model Program. An evaluation of the Plan's compliance with requirements specified in *All Plan Letter (APL) 18-023 California Children's Services Whole Child Model Program,* was also included in the audit scope.

The prior DHCS medical audit for the period of November 1, 2017 through September 30, 2018, was issued on April 12, 2019. This audit examined the Plan's compliance with its DHCS contract and assessed implementation of its prior year's Corrective Action Plan.

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, including delegation of UM, prior authorization process, and the appeal process.

The Plan is required to maintain policies and procedures for imposing corrective action and financial sanctions on subcontractors upon discovery of non-compliance. The Plan is also required to report any significant instances of non-compliance, imposition of corrective actions, or financial sanctions on subcontractors to their DHCS Contract Manager within three business days. The Plan did not have the required policies or procedures and did not report a significant instance of non-compliance to DHCS. During the audit period, the Plan terminated its delegation of UM to a subcontractor as a result of significant deficiencies identified.

The Plan is required to cover and ensure the provision of screening, preventive and medically necessary diagnostic, and treatment services for members under 21 years of age, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services. The Plan may not impose benefit limitations on EPSDT services such as speech therapy, occupational therapy, and physical therapy when medically necessary to correct or ameliorate defects discovered by screening services. The Plan's prior authorization process imposed benefit limitations in cases that indicated medical necessity or the correction or amelioration of the condition for a child.

The Plan is required to follow the criteria delineated in *APL 15-012 Dental Services-Intravenous Sedation and General Anesthesia Coverage* for prior authorization review of medical services requested in support of dental procedures. The Plan's prior authorization criteria for decisions regarding dental Intravenous (IV) sedation and general anesthesia was not consistent with the requirements and criteria in the APL.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to provide coordination of care including non-emergency medical transportation and non-medical transportation for members.

The Plan is required to ensure network providers are enrolled in the Medi-Cal Program. The Plan did not ensure that contracted Non-Emergency Medical Transportation (NEMT) providers' are enrolled in the Medi-Cal program.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding access to care and pharmaceutical services for members.

The Plan is required to have written policies and procedures to ensure that emergency medication dispensing requirements are met and monitored. The Plan did not have written procedures to monitor access to pharmaceuticals in emergency situations.

Category 4 – Member's Rights

Category 4 includes requirements to protect member's rights by properly handling grievances and Protected Health Information (PHI).

The Plan is required to establish and maintain a Grievance System that processes and resolves all member grievances. The Plan's Grievance System did not capture all complaints and expressions of dissatisfaction reported by members.

The Plan is required to notify and provide a complete report of the investigation to DHCS upon the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI within the required timeframes. The Plan did not consistently report suspected security incidents and privacy breaches to DHCS within the contractual timeframes.

The Plan is required to produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of Health Insurance Portability and Accountability Act (HIPAA). The Plan did not include the required DHCS Privacy Officer contact information on its NPP.

Category 5 – Quality Management

Category 5 includes requirements to deliver adequate quality of care to members and take effective action to address needed improvements in quality of care delivered by providers.

The Plan is required to collect and review its delegated subcontractors' ownership and control disclosure information. The Plan did not collect all of the required ownership and control disclosure information for its delegated subcontractors.

The Plan is required to conduct training for all providers within ten working days after the Plan places a newly contracted provider on active status. The Plan did not ensure provider training was conducted within the required timeframe.

Category 6 – Administrative and Organizational Capacity

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

The Plan is required to report all overpayments identified or recovered to DHCS, specifying the overpayments due to potential fraud. Although the Plan identified and recovered overpayments during the audit period, the Plan did not report them to DHCS.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the DHCS Medical Review Branch 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

The onsite review was conducted from November 4, 2019 through November 14, 2019. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 18 medical (ten medical and eight behavioral health) prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

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

Category 2 – Case Management and Coordination of Care

California Children's Services: Ten medical records were reviewed to verify the implementation of Whole Child Model Program.

Coordination of Care and Initial Health Assessment (IHA): Five medical records were reviewed to confirm coordination of care and fulfillment of IHA requirements.

Non-Emergency Medical Transportation (NEMT): 17 claims were reviewed to confirm compliance with the NEMT requirements.

Non-Medical Transportation (NMT): 15 claims were reviewed to confirm compliance with the NMT requirements.

Category 3 – Access and Availability of Care

Appointment Availability Verification: 34 providers of routine, urgent, specialty, and prenatal care from the Plan's Directory were reviewed. The first next available appointments were used to measure access to care.

Claims: 20 emergency services and 15 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 50 standard, ten quality of care, and ten exempt grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: 18 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 and proper resolution.

New Provider Training: 24 new primary care provider training records were reviewed for timely Medi-Cal Managed Care 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) ❖

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

AUDIT PERIOD: November 1, 2018 through October 31, 2019
DATE OF AUDIT: November 4, 2019 through November 14, 2019

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM REFERRAL TRACKING SYSTEM / DELEGATION OF UM MEDICAL DIRECTOR AND MEDICAL DECISIONS

1.1.1 UM Delegates Non-Compliance and Financial Sanction Imposition

All Policy Letters and APL issued by Managed Care Quality and Monitoring Division (MCQMD) and Managed Care Operations Division (MCOD) shall be complied with by the Plan. *(Contract A18, Exhibit E, Attachment 2 (1) (D))*

APL 17-004 Subcontractual Relationships and Delegation, stated the Plan is required to maintain policies and procedures for imposing corrective action and financial sanctions on subcontractors upon discovery of non-compliance with the subcontract or other Medi-Cal requirements. The Plan is required to report any significant instances of non-compliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the Contract with DHCS to their Contract Manager within three business days of discovery or imposition.

Finding: The Plan did not have any policies or procedures for imposing financial sanctions on its subcontractors and delegated entities. The Plan did not have any policies or procedures for reporting significant non-compliance, or financial sanctions of its subcontractors and delegated entities to its DHCS Contract Manager within three business days.

Plan policy *CP.023 Delegation Oversight,* stated the Delegation Oversight Committee will act on instances of non-compliance concerning the delegates, including but not limited to the issuance of a Corrective Action Plan. However, there is no mention of financial sanctions nor reporting to DHCS Contract Manager within three business days of significant non-compliance, or financial sanctions of Plan subcontractors and delegated entities.

During the audit period, the Plan terminated its delegation of UM to an entity on May 1, 2019, as a result of significant deficiencies found during the Plan's annual audit. Deficiencies included UM decisions were made by unqualified professionals and authorizations not processed within the required timeframe. While the Plan did perform corrective action, it did not report to the DHCS Contract Manager the significant non-compliance identified or corrective action imposed.

When the Plan does not have any policies or procedures to impose financial sanctions on noncompliant subcontractors, the Plan cannot ensure current and future subcontractors will comply with the Contract requirements.

Recommendation: Develop and implement policies and procedures for imposing financial sanctions on subcontractors and delegated entities and reporting significant non-compliance or financial sanctions to the Plan's DHCS Contract Manager within three business days.

1.2	**PRIOR AUTHORIZATION REVIEW REQUIREMENTS**

1.2.1 EPSDT Services Prior Authorization

The Plan is required to cover and ensure the provision of screening, preventive and medically necessary diagnostic, and treatment services for members under 21 years of age, including EPSDT supplemental services. (*Contract A18, Exhibit A, Attachment 10 (5)*)

EPSDT supplemental services requested as a result of EPSDT screening services are exempt from the benefit limitations in section 51304. (*California Code of Regulations (CCR), Title 22, section 51340*).

The EPSDT benefit includes a comprehensive array of preventive, diagnostic, and treatment services. The Plan shall provide speech therapy, occupational therapy, and physical therapy services when medically necessary to correct or ameliorate defects discovered by screening services, whether or not such services or items are covered under the State Plan unless otherwise specified in the Contract. The Plan must determine what level of service (if any) is being provided by other entities, and then coordinate the provision of services with the other entities to ensure that the Plan and the other entities are not providing duplicative services. (*APL 18-007 Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21*).

Services that maintain (i.e., support, sustain, or prevent from worsening) the child's health condition are also covered under EPSDT because they ameliorate a condition. The common definition of ameliorate is to "make more tolerable." *(APL 19-010 Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21*).

During the audit period, both APLs described above were applicable.

Plan policy *HS.050 Pediatric Physical, Occupational, Speech Therapy Authorization Review and Case Management*, dated May 6, 2019, stated, "Pediatric therapy providers will submit a request for authorization prior to providing therapy services to members under 21 years old. Therapy services would take place after the initial evaluation. The request must include a current physician's prescription, pertinent documentation indicating the need for therapy, therapy notes if already receiving outpatient therapy and if the member is enrolled in Early Start or receiving services through the school district, and the Current Individualized Family Service Plan or Individualized Education Program (IEP)."

The Plan policy further stated that both Milliman Care Guidelines (MCG) and Medi-Cal guidelines would be used in determining therapy requests. "Twelve follow up therapy visits are generally approved for routine initial therapy requests. Additional visits may be authorized based on member's medical condition and documentation submitted. Members could receive outpatient and school therapy simultaneously if therapeutic goals are distinct and not duplicative (therapy notes and IEP would clarify this). Over-utilization of therapy will be reduced through consistent application of MCG and Medi-Cal guidelines in order to reduce the timeframes between prescription, evaluation, authorization, and therapy."

Finding: The Plan's prior authorization process imposed benefit limitations in cases that indicated medical necessity or the correction or amelioration of the condition for that child, without consideration as EPSDT service.

The verification study showed that in three of three prior authorization requests for speech therapy the Plan set limits on the amount of sessions to approve using MCG criteria.

- One case involved a six year old with a moderate mixed language disorder and severe phonological disorder. An oral mechanism exam showed difficulty with tongue elevation and decreased oral motor patterns for speech production. The member's speech therapist, therefore, recommended the continuation of speech therapy sessions. The Plan denied the request and in the Notice of Action (NOA) letter stated, "According to MCG A-0561, Developmental Language Disorders Rehabilitation, 31 speech therapy visits should be enough to treat your condition. Our records show that you have already been approved for 24 speech therapy visits. Therefore, we will approve an additional seven speech therapy visits to total 31 approved visits. During these therapy visits, your provider should teach you all of the exercises that you can do at home."

- Another case involved a five year old with a receptive language disorder, expressive language delay and a sensory process disorder. According to the speech therapist the member was making progress but was still struggling with following directions, working memory, and sentence construction. Therefore, it was "highly recommended" to continue with sessions. The Plan denied the request and in the NOA letter stated, "We cannot approve this treatment the way it is: 12 individual speech therapy visits were requested, eight visits are denied. This is because based on our records, you have been authorized for 48 speech therapy visits since February 27, 2018. According to MCG *A-0561, Developmental Language Disorders Rehabilitation*, 17 speech therapy visits should be enough to treat your condition. During these treatment visits, your therapist should be teaching you all of the exercises to be practicing at home."

- A third case involved a seven year old who was receiving speech and language therapy due to a mixed expressive/receptive language disorder and a motor speech disorder in the presence of a diagnosis of autism spectrum disorder. The speech therapist's evaluation stated that the member was making progress but would continue to benefit from weekly individual therapy because care at the child's school had been inconsistent. The Plan denied the request and in the NOA letter stated that according to MCG "32 speech therapy visits should be enough to treat your condition. Based on our records, you have already received 64 speech therapy visits." It was also denied because outpatient goals were similar to the IEP goals. Although the Plan can deny requests when the services are already provided by other entities, the Plan is not allowed to deny requests based on the number of sessions the member already received.

The first two cases were overturned on appeal. However, the Plan continued to apply MCG limitations and only added additional visits up to the number allowed by MCG.

During interviews, the Plan described their process for reviewing pediatric speech therapy prior authorizations. The Plan stated that they review the member's IEP, MCG criteria, diagnosis and how it correlates to MCG criteria, and they also use their policy above. The Plan stated that they get many requests for speech therapy, therefore, they have to look at the whole picture to make a decision. However, they could not provide a valid rationale for limiting visits for EPSDT services, which are exempt from the benefit limitations set forth under *CCR, Title 22, section 51304*.

After the Exit Conference, the Plan submitted additional documentation in support of its policy. However, resources cited by the Plan were not consistent with California EPSDT guidelines which state, "MCPs are prohibited from imposing service limitations on any EPSDT benefit other than medical necessity."

If benefit limitations are placed on services such as speech therapy, there is a risk of delaying the correction or improvement of certain conditions, which in turn could result in poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure that service limitations are not placed on any EPSDT benefit including speech therapy.

1.2.2 Dental Anesthesia Prior Authorizations

The Plan may require prior authorization for medical services required in support of dental procedures. (*Contract A18, Exhibit A, Attachment 11 (16)*).

The Plan must provide prior authorization for IV sedation and general anesthesia for dental services and must assist providers and beneficiaries with the prior authorization process as a form of care coordination to avoid situations where services are unduly delayed. (*APL 15-012 Dental Services-Intravenous Sedation and General Anesthesia Coverage).*

The Plan must ensure that anesthesia providers submit documentation outlining the patient's need for IV sedation or general anesthesia, and they must receive approval prior to delivering the requested sedation or anesthesia services. Additionally, the Plan must also ensure that dental providers meet the requirements for chart documentation, which includes a copy of a complete history and physical examination, diagnosis, treatment plan, radiological reports and images, the indication for IV sedation or general anesthesia, and documentation of perioperative care (preoperative, intraoperative and postoperative care) for the dental procedure pertinent to the request. (*APL 15-012 Dental Services-Intravenous Sedation and General Anesthesia Coverage).*

Plan policy *MG-01 Medical Guideline for Intravenous Sedation and General Anesthesia Coverage, Dental Services,* dated June 5, 2015, stated that the dental provider must meet general requirements for chart documentation that includes the indication for IV or general anesthesia and documentation of perioperative care for the dental procedure. If the provider documents both failure of local anesthesia to control pain and failure of conscious sedation, either inhalation or oral then the patient shall be considered for IV sedation or general anesthetic. If the provider documents failure of effective communicative techniques and the inability for immobilization or any condition specified in the APL then the patient shall be considered for IV sedation or general anesthetic.

Finding: The Plan did not apply the correct requirements and criteria to make decisions on dental IV sedation and general anesthesia prior authorization requests. The Plan's prior authorization criteria for dental IV sedation and general anesthesia was not consistent with the requirements and criteria in the APL.

A verification study showed that in three of three prior authorization requests for dental general anesthesia the decision maker did not use the correct requirements and criteria listed in the APL.

- In all three cases, the Plan did not ensure that dental providers met the requirements for chart documentation, which includes a complete history and physical examination, radiological reports and images, and documentation of perioperative care (preoperative, intraoperative, and postoperative care).

- In two cases, the Plan used the criteria listed in the Medi-Cal Manual.

- In one case, the Plan used both the criteria listed in the Medi-Cal Manual and MCG.

During interviews, the Plan stated that they use Medi-Cal and MCG criteria to make dental IV sedation and general anesthesia determinations, which was outlined in their policy. The Plan's policy did not align with the APL.

If incorrect or outdated requirements and criteria are used to make medical determinations, there is a risk that members will be inappropriately approved or denied services. This could lead to poor health outcomes as well as over and underutilization.

Recommendation: Revise and implement policies and procedures to ensure correct requirements and criteria are used to make decisions on dental IV sedation and general anesthesia prior authorization requests.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICALTRANSPORTATION

2.4.1 Non-Emergency Medical Transportation Provider

The Plan is required to comply with All Policy Letters and APL issued by MCQMD and MCOD. APLs provide clarification of the Plan's obligations pursuant to this Contract, and inform the Plan regarding mandated changes in state or federal law or regulations, or pursuant to judicial interpretation. *(Contract A18, Exhibit E, Attachment 2 (1) (D))*

In accordance to *Code of Federal Regulations (CFR), Title 42, section 438.608 (b),* the State, through its contracts with a Managed Care organization entity must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of part 455, subparts B and E of this chapter.

Plans are required to maintain contracts with their network providers and develop and implement a Managed Care provider screening and enrollment process that meets the requirements of *APL 19-004,* or direct their network providers to enroll through DHCS. (*APL 19-004 Provider Credentialing/Re-credentialing and Screening/Enrollment*)

The Plan elected to direct their network providers to enroll through DHCS.

Plan policy *CR-01 Credentialing of Physician and Non Physician Medical Practitioners/ Other Services Providers,* 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 application process or active enrollment, and in good standing to provide service under the California State Medi-Cal Program.

Finding: The Plan did not ensure that contracted NEMT network providers' are enrolled in the Medi-Cal program.

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

- Three of 11 contracted NEMT providers were not enrolled in Medi-Cal program.

- The NEMT provider with the highest volume of transportation services provided during the audit period was neither contracted with the Plan nor enrolled in the Medi-Cal program.

In an interview, the Plan confirmed that these NEMT providers were not enrolled in Medi-Cal and the Plan did not provide credentialing documentation. The Plan explained that it considered concern for unconstrained NEMT access and better NEMT rates in its decision to utilize non-contracted and non-Medi-Cal enrolled providers.

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: Implement processes to ensure the Plan utilizes contracted NEMT providers who are enrolled in Medi-Cal.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.4	ACCESS TO PHARMACEUTICAL SERVICES

3.4.1 Monitoring of Drugs Prescribed in Emergency Situations

The Plan is required to ensure access to at least 72-hour supply of a covered outpatient drug in an emergency situation. The Plan is required to have written policies and procedures, which describe the method that are used to ensure that emergency medication dispensing are met and policies and procedures must describe how the Plan will monitor compliance with the requirements. *(Contract A18, Exhibit A, Attachment 10 (8) (F) (1)(a))*

Plan policy *HS.011 Ensuring Access to Drugs in Emergency Situations,* stated the Plan monitor/track drug access requests pertaining to emergency situations. It also stated the Plan evaluate any negative trends identified from complaints and grievances pertaining to drug access in emergency situations and determine next steps as applicable.

Finding: The Plan did not have written procedures for monitoring access to pharmaceuticals in emergency situations.

Although the Plan maintained a pharmacy override log to document all the prescriptions requested in emergency situations, the Plan did not have evidence that the data captured in the log was tracked and trended or analyzed to determine any barriers to access to drugs in emergency situations.

As a corrective action to the prior audit finding, 3.4.1 Members' Access to Drugs in Emergency Situations, the Plan revised policies *HS.011 Ensuring Access to Drugs in Emergency Situations* and *RX.025 Emergency Fills.* The revised policies and procedures did not include a description of how the Plan will monitor compliance with access to pharmaceuticals in emergency situations.

When the Plan does not have a written monitoring procedure, the Plan cannot determine if consistent access to medication was available in emergency situations.

This is a repeat of prior year finding 3.4.1 - Members' Access to Drugs in Emergency Situations.

Recommendation: Revise and implement policies and procedures to include description of the method to monitor access to drugs in emergency situations.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Capturing All Grievances

The Plan shall implement and maintain a Member Grievance System in accordance with *CCR, Title 28, section 1300.68*. *(Contract A18, Attachment 14 (1))*

The Plan is required to establish and maintain written procedures for submittal, processing, and resolution of all grievances. *(CCR, Title 22, section 53858(a))*

The Plan's provider agreement template states that if a member files a complaint with a provider, the provider agrees to notify the Plan of said complaint and work with the Plan for resolution. The provider training materials, Provider Manual, and Plan website did not educate contracted provider facilities to notify the Plan of member complaints.

Plan policy *GA.10 Overview of Member Compliant Process,* included an overview of the Plan's system for processing and addressing member complaints. The policy did not address handling of complaints filed at contracted provider facilities.

Finding: The Plan's grievance system did not capture and resolve all grievances. Grievances filed at network provider facilities were not captured and addressed by the Plan.

During the interview, the Plan stated they do not have a way to monitor grievances filed at provider facilities. DHCS conducted onsite visits with four providers and found that provider facilities were not notifying the Plan of grievances. Four of four providers stated they keep an internal log of grievances filed in their office but do not notify the Plan of all grievances. One of four providers only notified the Plan of severe grievances.

When the Plan does not capture all member expressions of dissatisfaction, member complaints may not be addressed, investigated, and resolved appropriately. Additionally, grievances may not be tracked and trended because the Plan is not capturing all grievances.

Recommendation: Develop and implement a policy and procedure to capture all member grievances and expressions of dissatisfaction.

4.3	CONFIDENTIALITY RIGHTS

4.3.1 Notification and Reporting of Breaches

The Plan is required to (1) notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, and use or disclosure of PHI or Personal Information, (2) immediately investigate within 72 hours of the discovery and submit an updated Privacy Incident Report (PIR), and (3) provide a complete report of the investigation to the DHCS Privacy Officer within ten working days of the discovery of the breach or unauthorized use or disclosure. *(Contract A18, Exhibit G (III) (J)(1)(2)(3))*

Plan desktop procedure *CP-DP.001 Privacy Incident Investigation and Reporting,* stated that reports to DHCS must be made initially within 24 hours of discovery, an updated PIR must be sent to DHCS within 72 hours of discovery, and complete report must be made within ten working days of the discovery.

Finding: The Plan did not consistently notify and report suspected security incidents and privacy breaches to DHCS within the contractual timeframes.

A verification study of 15 cases found that five cases exceeded the contractual timeframes for discovery, investigation, and/or complete report to DHCS. The Plan explained the effort to obtain more information and compile more data along with an admitted lack of oversight contributed to missing the timeframes.

- Four of 15 suspected security incidents and breach incidents were not initially reported to DHCS within 24 hours of discovery.

- Two of 15 suspected security incidents and breach incidents did not have updated PIRs submitted within 72 hours of discovery.

- One of 15 complete report of investigation was not submitted within ten days of the discovery.

The lack of oversight poses a threat to the members' right to confidentiality and prevents the Plan from being able to successfully perform in accordance with the terms of the Contract.

Recommendation: Implement policies and procedures to ensure consistency in meeting the established timeframes for initial report, investigation, and complete report of suspected security incidents and privacy breaches.

4.3.2 Notice of Privacy Practices

The Plan shall develop, implement, maintain written policies that address the member's rights and responsibilities, and shall communicate these to its members and providers. The Plan shall implement and maintain policies and procedures to ensure the members' right to confidentiality of medical information. *(Contract A18, Exhibit A, Attachment 13, (1) (A) (B))*

The Plan is required to produce a NPP in accordance with standards and requirements of HIPAA that include the DHCS Privacy Officer contact information. This Contact is an alternative means for Medi-Cal beneficiaries to lodge privacy complaints. The Plan must update their NPP to reflect the current address of the DHCS Privacy Officer as soon as reasonably possible. (*APL 06-001 Health Insurance Portability and Accountability Act (HIPAA): Plan's Reporting Responsibilities)*

Plan policy *HP.014 Notice of Privacy Practices,* stated that members may complain to the Plan and to the Secretary of the Federal Health and Human Services Department (HHS) if a member believes their privacy rights have been violated. However, it did not include the option to contact the DHCS Privacy Officer and neither did the NPPs.

Finding: The Plan did not include the DHCS Privacy Officer contact information on the NPPs.

The Plan confirmed the NPP on the Plan's website was the most updated version. Review of the Plan's NPP found it did not include the DHCS Privacy Officer contact information.

The member's ability to report suspected security incidents and privacy breaches is limited if members do not have the current contact information for the DHCS Privacy Officer.

Recommendation: Revise and implement policies and procedures to ensure all required information is included in the NPPs.

CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

5.1.1 Ownership and Control Disclosure Reviews

The Plan is required to comply with *CFR, Title 42, 455.104. (Contract A18, Exhibit A, Attachment 1 (2) (B))*

In accordance to, *CFR, Title 42, 438.608(c)(2)*, the Plan is required to collect and review their subcontractors' ownership and control disclosure information as set forth in *CFR, Title 42, section 455.104.* The Plan must make the subcontractors' ownership and control disclosure information available, and upon request, this information is subject to audit by DHCS. *(APL 17-004 Subcontractual Relationships and Delegation)*

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 address and other tax identification number of each corporation with an ownership or control interest in the disclosing entity. *(CFR, Title 42, section 455.104)*

Finding: The Plan only collected ownership and control disclosure information for three of nine credentialing subcontractors. However, the Plan did not collect all required information for these subcontractors.

Review of three Plan disclosure forms revealed the following deficiencies:

- Three of three disclosure forms did not contain all owners or individuals with control interest.

- One of three disclosure forms did not contain addresses, date of birth, and social security numbers of all owners and individuals with control interest.

The Plan did not collect ownership and control disclosure information for six subcontractors, because it stated it was not required for network providers. *APL 17-004,* stated that network providers are not subcontractors by virtue of the network provider agreement. However, as soon as a Plan delegates any activity or obligation, including credentialing, the Plan enters into an agreement, and the network provider becomes a subcontractor, which is required to provide subcontractor ownership and control disclosure information.

When the Plan does not collect and review ownership and control disclosure information of its subcontractors, they cannot ensure that the subcontractors' owners and controlling interest individuals are eligible for program participation.

Recommendation: Develop and implement procedures to ensure collection and review of ownership and control disclosure information from entities and individuals with a sub-contractual or delegation relationship with the Plan.

5.2	PROVIDER QUALIFICATIONS

5.2.1 Provider Training

The Plan is required to ensure that all primary care 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. The Plan is required to conduct training for all providers no later than ten working days after the Plan places a newly contracted provider on active status. *(Contract A18, Exhibit A, Attachment 7 (5))*

The Plan is accountable for all quality improvement functions and responsibilities that are delegated to subcontractors. *(Contract A18, Exhibit A, Attachment 4 (6) (A))*

Plan policy *PS.01-03 Provider Training Procedure* stated, “Providers are required to complete an ‘Acknowledgement of Receipt of Training’ form, which must be signed by the provider or a designated staff person at the provider’s practice. Upon notification of a provider’s acceptance in the Plan’s provider network, the provider services representative will also contact the office or facility to schedule (within ten calendar days of contracted date) an orientation meeting with the provider.” Regarding monitoring, the policy stated that the Provider Services Monthly Training Report will indicate the number and listing of providers and/or staff oriented and/or re-educated as pursuant to this procedure.

Finding: The Plan did not ensure provider training was conducted for all new primary care providers.

A verification study revealed 13 of 24 newly contracted primary care providers did not receive new provider training. One of 13 providers was directly contracted with the Plan while 12 of 13 were providers of various subcontractors that were delegated credentialing.

According to the Plan, provider training is delegated to nine subcontractors. However, all nine delegation agreements did not have language for the provision of provider training. In response to last year’s audit finding, the Plan stated it will be revising contract amendments to include provider training requirements. It was not implemented during the audit period.

When new provider training is not completed, the Plan cannot ensure providers operate in full compliance with the contract and all applicable federal and state statutes and regulations to meet program requirements.

This is a repeat of prior year finding 5.2.3 – Provider Training

Recommendation: Ensure newly contracted primary care providers receive new provider training within ten working days of being placed on active status. Revise and implement policies and procedures to ensure delegation agreements include provider training requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: San Mateo Health Commission dba Health Plan of San Mateo
AUDIT PERIOD: November 1, 2018 through October 31, 2019 **DATE OF AUDIT:** November 4, 2019 through November 14, 2019

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD AND ABUSE

6.2.1 Reporting of Overpayments

The Plan shall meet the requirements set forth in *CFR, Title 42, 438.608* by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. *(Contract A18, Exhibit E, Attachment 2, (27) (B))*

The Plan is required to implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State. *(CFR, Title 42, § 438.608(a) (2))*

Plan policy *CL.07-04 Claim Retractions –Processing, Reporting and Recovering Overpayments,* stated overpayments are determined as the result of claim edits, audits, reviews, and analysis from within and outside the Claims Department. After an overpayment has been identified and the specific criteria allowing for retraction are determined, claim retractions are completed. Retraction is the Plan's process of recovering claim overpayment which may be applied as an offset to current and future claims payments. The Claims Operations Manager and Finance Department Managers will review and maintain the recovery report. The policy did not address the procedure for reporting identified or recovered overpayments to DHCS.

Finding: The Plan did not report all overpayments identified or recovered to DHCS.

During the audit period, the Plan identified and recovered overpayments due to coding and pricing discrepancies by a billing provider. The Plan stated there were no overpayments reported to DHCS.

Recommendation: Revise and implement policies and procedures to ensure overpayments are reported to DHCS.

MEDICAL REVIEW – NOTH 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

Contract Number: 08-85220
State Supported Services

Audit Period: November 1, 2018
Through
October 31, 2019

Report Issued: March 3, 2020

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II. COMPLIANCE AUDIT FINDINGS 2

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 November 4, 2019 through November 14, 2019. The audit period was November 1, 2018 through October 31, 2019. 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: 15 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, 2018 through October 31, 2019
DATE OF AUDIT: November 4, 2019 through November 14, 2019

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion
Contractor agrees to provide, or arrange to provide, to eligible members the following State Supported Services:
Current Procedural Coding System Codes*: 59840 through 59857
Health Care Financing Administration Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336

**These codes are subject to change upon the Department of Health Care Services' implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*
State Supported Services Contract Exhibit A.1

SUMMARY OF FINDING(S):

There were no deficiencies identified in this audit.

RECOMMENDATION(S):

N/A