

CONTRACT AND ENROLLMENT 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**

2022

Contract Number: 08-85213

Audit Period: August 1, 2021
Through
June 30, 2022

Dates of Audit: July 25, 2022
Through
August 3, 2022

Report Issued: December 14, 2022

TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	EXECUTIVE SUMMARY	2
III.	SCOPE/AUDIT PROCEDURES	5
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 – Utilization Management	7
	Category 2 – Case Management and Coordination of Care	11
	Category 3 – Access and Availability of Care	13
	Category 4 – Member’s Rights	18
	Category 5 – Quality Management	21

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 June 30, 2022, the Plan had 165,064 members of which 123,647 (74.91 percent) were Medi-Cal and 8,175 (4.95 percent) were Seniors and Persons with Disabilities (SPD), 21,856 (13.24 percent) were Access and Care for Everyone Program, 8,792 (5.33 percent) were Cal MediConnect, 1,403 (0.85 percent) were Whole Child Model Program, and 1,191 (0.72 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 August 1, 2021 through June 30, 2022. The audit was conducted from July 25, 2022 through August 3, 2022. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on November 17, 2022. 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, 2019 through July 31, 2021, was issued on January 6, 2022. This audit examined documentation for Contract compliance and assessed implementation of the Plan's 2021 Corrective Action Plan (CAP).

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

The summary of the findings by category follows:

Category 1 – Utilization Management

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

The Plan is required to provide fully translated member informing materials, including Notice of Action (NOA) letters. The Plan is required to provide translated written informing materials to members that speak the identified threshold or concentration standard languages. The Plan did not send fully translated NOA letters for prior authorization denials to members with a primary threshold language other than English.

In accordance with federal and state law, appeals may be filed either verbally or in writing by a member, a provider acting on behalf of the member, or an authorized representative. Appeals filed by the provider on behalf of the member require written consent from the member. The Plan did not ensure that members' written consent was received when providers filed standard appeals on the members' behalf.

Category 2 – Case Management and Coordination of Care

Category 2 covers requirements to provide coordination of care including Initial Health Assessment (IHA).

The Plan is required to cover and ensure the provision of an IHA. The Plan did not ensure the provision of a complete IHA to each new member.

Category 3 – Access and Availability of Care

Category 3 covers requirements regarding access to care and Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) for members.

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times for providers to answer and return telephone calls, and time to obtain various types of appointments including availability of first prenatal appointment within ten business days of request. The Plan did not monitor members' waiting times for network providers to answer telephone calls and the availability of first prenatal appointments.

For NEMT services, the Plan is required to utilize NEMT providers that are enrolled in the Medi-Cal program and to implement a prior authorization process including use of a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate mode of transportation for members. The Plan did not implement a prior authorization process or require providers to use PCS forms prior to providing NEMT services. The Plan did not ensure that NEMT providers were enrolled in the Medi-Cal program.

Category 4 – Member's Rights

Category 4 covers requirements to protect member's rights by proper handling of grievances.

The Plan is required to provide a notice of resolution to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. The Plan did not resolve standard grievances within the timeframe of 30 calendar days.

In the event the resolution is not reached within 30 calendar days, the Plan is required to notify the member in writing of the status of the grievance and the estimated date of resolution. The Plan did not notify members in writing of the status of the grievance and the estimated date of resolution when the resolution was not reached within 30 calendar days.

Category 5 – Quality Management

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

The Plan is responsible and accountable for any functions and responsibilities delegated to subcontractors and must meet the subcontracting requirements. The Plan is required to collect and review its subcontractors' ownership and control disclosure information. The Plan did not ensure that its subcontractors delegated with credentialing functions submitted complete ownership and control disclosure information.

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 subcontractors. 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 that all network providers received new provider training.

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 audit was conducted from July 25, 2022 through August 3, 2022. 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 seven SPD members were reviewed for timeliness, consistent application of criteria, and appropriate review.

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

Category 2 – Case Management and Coordination of Care

Health Risk Assessment: 20 files were reviewed to confirm coordination of care and fulfillment of Health Risk Assessment requirements.

IHA: 15 files including four SPD members were reviewed to confirm the performance of assessment.

Complex Case Management: Ten medical records including five SPD members were reviewed for coordination of care.

Category 3 – Access and Availability of Care

NEMT: 30 records were reviewed to confirm compliance with the NEMT requirements.

NMT: 20 records were reviewed to confirm compliance with the NMT requirements.

Category 4 – Member’s Rights

Grievances Procedures: 72 grievances including 45 standard, 15 quality of care, ten exempt and two expedited were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. Eighteen grievances were reviewed for SPD members.

Category 5 – Quality Management

Potential Quality of Care Issues: Ten medical records were reviewed for appropriate reporting, timely evaluation, and proper resolution.

New Provider Training: 15 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Ten 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: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Medical NOA Letters

The Plan is required to provide fully translated member information, including but not limited to the member services guide, welcome packets, marketing information, and form letters including NOA letters and Grievance and Appeal (G&A) acknowledgement and resolution letters. The Plan shall provide translated written informing materials to all monolingual or limited English proficient members that speak the identified threshold or concentration standard languages. *(Contract, Exhibit A, Attachment 9(13)(C))*

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

The Plan is required to fully translate NOA letters, including the clinical rationale for the Plan's decision, into the Plan's threshold languages by February 28, 2022. If the Plan mails a partially translated NOA with the clinical rationale written in English, it must provide a fully translated written notice, including a fully translated clinical rationale as soon as possible but not later than 30 calendar days from the date the partially translated notice was sent. *(APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Finding: The Plan did not send fully translated NOA letters for prior authorization denials to members with a primary threshold language other than English.

- A verification study showed that 11 of 15 cases reviewed involved members who had a primary language other than English. The NOA letters in these 11 cases were partially translated into the member's primary language, which included clinical information in English.
- Nine of these 11 cases involved members who spoke Spanish as their primary language. Two cases involved members who spoke Cantonese as their primary language.
- During the audit period, the threshold languages for San Mateo County were English, Spanish, Tagalog, and Chinese (Chinese is the combination of Cantonese, Mandarin, and other Chinese Language).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

- Five of these 11 cases occurred after the *APL 21-011* implementation date of February 28, 2022. The Plan did not send a fully translated NOA letter to the member in any of these five cases.

As observed in the verification studies the Plan does partially translate the NOA letters into the member's primary threshold language, except for the clinical information section. In an interview, the Plan stated that partially translated NOA letters are sent to members to meet timeliness standards. The Plan also pointed to its policy and procedures manual, *PH.205 Translation Procedures* (revised 6/30/2022), which states that the member can request full translations from the Plan if necessary at no cost to the member. The Plan does not have a process to automatically send a fully translated letter subsequent to the partially translated NOA letter.

Failure to send fully translated NOA letters to members may result in delay of care due to a member not being fully informed of their rights and medical care.

Recommendation: Develop and implement policy and procedures to ensure that NOA letters are fully translated, including any clinical information, into a member's threshold language.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

1.3

PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Written Consent from the Member for Appeals Filed by a Provider

The Plan is required to comply with all existing final PLs and APLs issued by DHCS. (*Contract, Exhibit E, Attachment 2(1)(D)*)

In accordance with federal and state law, appeals may be filed either verbally or in writing by a member, a provider acting on behalf of the member, or an authorized representative. Appeals filed by the provider on behalf of the member require written consent from the member. (*Contract, Exhibit A, Attachment 14(5)(A); Code of Federal Regulations (CFR), Title 42, section 438.402(c)(1)(ii); and APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (IV)(B)*)

Plan policy, *GA.08 Member Appeals Procedure for Medi-Cal, HealthWorx, and ACE* (revised 3/28/2022), stated the Plan cannot proceed in processing appeals filed by providers on behalf of members without first obtaining the member's verbal consent and requesting the member's written consent. The Plan must make at least three attempts to contact the member by phone to obtain verbal consent. All three attempts must be made within 14 calendar days of receiving the appeal. In addition to obtaining verbal consent, the G&A Coordinator also asks the member to send the Plan a letter with a written statement confirming that they want their provider to file the appeal on their behalf. If the G&A Coordinator is unable to reach the member and additional medical records have been submitted by the provider, the G&A Coordinator proceeds with the appeal and submits the appeal and the additional records to the Plan's Medical Director for clinical review. If the G&A Coordinator is unable to obtain verbal consent after three attempts, the Coordinator dismisses the appeal.

Finding: The Plan did not ensure that members' written consent was received when providers filed standard appeals on the members' behalf.

A verification study of 15 prior authorization member appeals revealed the following:

- In five of five standard appeals where a provider filed an appeal on the member's behalf, the Plan did not receive written member consent.
- Four of these five cases were able to proceed after verbal consent was obtained and the members were requested to submit a written consent to the Plan.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

- In one of these five cases, the Plan was not able to reach the member and did not obtain verbal consent nor did it request the member send in a written consent. However, this case was able to proceed due to additional medical records being submitted by the provider.
- All five cases were resolved without a written member consent on file.

In a written response as to why there were no member written consent on file, the Plan stated that according to their *MC Appeals Filed by Providers Workflow*, the Plan's process is to call the member to request both verbal and written consent. However, verification studies demonstrated that the Plan did not receive any written consents and Plan policy allows for processing of appeals without member's written consent.

When the Plan does not ensure written member consent is received for standard appeals filed by providers on members' behalf, it may lead to delays in service and care for members.

Recommendation: Revise and implement policies and procedures to ensure the Plan receives written member consent for standard appeals when a provider files on behalf of a member.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1 INITIAL HEALTH ASSESSMENT

2.1.1 Provision of IHA

An IHA consists of a comprehensive history, physical and mental status examination, an Individual Health Education Behavioral Assessment (IHEBA), identified diagnoses, and plan of care. The IHA enables a provider of primary care services to comprehensively assess and manage the member's current acute, chronic and preventive health needs, and identify those members whose health needs require coordination with appropriate community resources and other agencies for services not covered under the Contract. The Plan is required to cover and ensure the provision of an IHA, which includes an IHEBA, to each member within 120 days of enrollment. (*Contract, Exhibit A, Attachment 10(3)(A)(B)*).

The Plan is required to provide at a minimum preventive services based on the latest edition of the *Guide to Clinical Preventive Services* published by the U.S. Preventive Services Task Force (USPSTF). The USPSTF is used to determine the provision of clinical preventive services to asymptomatic, healthy adult members age 21 or older. All preventive services identified as USPSTF "A" and "B" recommendations must be provided (*Contract, Exhibit A, Attachment 10(6)(B)*).

The USPSTF A and B recommendations including but not limited to screening for depression in the general adult population, hepatitis C virus infection in adults aged 18 to 79 years, and tobacco smoking cessation in adults (*U.S. Preventive Services Task Force, A & B Recommendations*).

Plan policy, *QI-107 IHA & Initial Health Education Behavioral Assessment* (revised 6/28/2021), stated that a primary care physician is required to perform an IHA with a Medi-Cal member within 120 days of enrollment. The IHA will be comprised of:

- comprehensive history
- preventive services
- comprehensive physical and mental status exam
- diagnosis and plan of care
- IHEBA

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

Plan policy, *QI-107*, also stated the Plan adheres to the current edition of the Guide to Clinical Preventive Services of the USPSTF, specifically USPSTF “A” and “B” recommendations for providing preventative screening, testing, and counseling services.

Finding: The Plan did not ensure the provision of a complete IHA to each new member.

In a verification study, 20 members were selected from a list of newly enrolled members identified by the Plan as having received an IHA. The verification study revealed that the Plan did not document the provision of an IHA for all 20 members as noted in the following:

- The Plan did not submit medical records supporting IHA completion for five of 20 members.
- For 15 of 20 member records, the Plan’s documentation did not meet all IHA requirements as identified in the following deficiencies: Ten of 15 records did not meet requirements for timeliness since the IHA was not provided within 120 days of enrollment with the Plan; Nine of 15 records did not include an IHEBA; and four of 15 records did not have all applicable preventive services identified as USPSTF “A” and “B” recommendations offered to members who qualified based on condition and age, or that the status of services was recorded such as tobacco smoking cessation, hepatitis C virus infection, and depression screenings.

In an interview, the Plan stated that ensuring the provision of a complete IHA is a continuous challenge due to the Covid-19 public health emergency.

When the Plan does not ensure the provision of a complete IHA, members may not receive essential behavioral and medical health screenings that can help identify and prevent illnesses.

Recommendation: Implement policies and procedures to ensure the provision of a complete IHA to each new member within 120 calendar days of enrollment.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1 APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 Telephone Call Wait Times

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in network providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments. (*Contract, Exhibit A, Attachment 9(3)(C)*)

Plan policy, *PS06-01 Timely Access and Network Adequacy* (revised 4/29/2022), stated that the Plan ensures all services required for delivery of basic health care services are readily available at reasonable times by conducting ongoing monitoring of provider network geographic access, reviewing and responding to access and availability grievances, and assisting members with appointment scheduling as needed by referral to the Plan's Integrated Care Management team. The Plan's contracted providers are required to provide triage and/or screening 24/7 by telephone within 30 minutes.

Finding: The Plan did not monitor members' waiting times for network providers to answer telephone calls.

In the 2021 Enrollee Satisfaction Survey conducted by the Plan, the survey monitored how long it took for providers to return a member's telephone call, but the survey did not monitor how long it took for providers to answer incoming telephone calls from members. In an interview, the Plan stated it did not monitor the wait times for answering the initial telephone calls from members to providers.

If the Plan does not monitor wait times for answering telephone calls, the Plan cannot verify that calls from members are being answered in a timely manner.

Recommendation: Develop and implement procedures to ensure that the wait times for answering telephone calls from members are monitored.

3.1.2 Monitoring Access to First Prenatal Appointments

The Plan is required to have the first prenatal visit for a pregnant member available within ten business days upon request. (*Contract, Exhibit A, Attachment 9(3) (B)*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

The Plan shall implement and maintain a written description of its QIS that shall include a description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards. (*Contract, Exhibit A, Attachment 4(7)(G)*)

Plan policy, *PS 06-01 Timely Access and Network Adequacy* (revised 4/29/2022), stated that the first prenatal visit must be offered within two weeks upon request. The policy also stated that the Plan measures adherence to timely access standards using Provider Appointment Availability Survey (PAAS) and the quarterly timely access survey.

Finding: The Plan did not monitor the availability of first prenatal appointments.

In an interview, the Plan stated they monitor first prenatal appointment through the PAAS. The 2021 PAAS survey did not have questions regarding access or availability of the first prenatal appointment. The Plan explained that the PAAS does not distinguish if an appointment is the first prenatal appointment or not.

If the Plan does not monitor access to and availability of the first prenatal appointment, the Plan cannot ensure pregnant members have timely access to first prenatal appointments which can detect pregnancy complications sooner and promote a healthy pregnancy.

Recommendation: Revise and implement policy and procedures to ensure that the Plan monitors the access to and availability of first prenatal appointments.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

3.8

**NON-EMERGENCY MEDICAL TRANSPORTATION
NON-MEDICAL TRANSPORTATION**

3.8.1 NEMT Prior Authorization Process

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 existing final PLs and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

The Plan is required to ensure 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. PCS forms must also include the function limitations, dates of service needed, and the prescribing PCS *(APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)*.

The Plan is required to determine the appropriate mode of transportation required to meet members' medical needs. Plans are not exempt from arranging transportation services for members to access Medi-Cal covered services *(APL 20-004 Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19)*.

Plan policy, *UM.013 Non-Emergency Medical Transportation* (revised 12/14/2020), stated that PCS forms must be completed before NEMT services will be provided. PCS forms will include the mode of transportation: ambulance, litter van, wheelchair van, and air.

Finding: The Plan did not implement a prior authorization process or require providers to use PCS forms prior to providing NEMT services.

During the audit period, the Case Management Team handled requests for NEMT services and coordinated NEMT services. The Case Management Team used their own assessment to confirm the reason for NEMT services instead of re-implementing the prior authorization process and requiring providers use PCS forms. In the verification study of 30 samples, the Plan did not apply the assessment consistently. The Plan applied the assessment to seven samples; three of the seven samples were missing the patient diagnosis and demographic information, and appointment information while one sample was a care goal discussion. The Plan did not complete the assessment for the 23 other samples.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

In an interview, the Plan acknowledged they have not reinstated the prior authorization process or the use of PCS forms for NEMT services as outlined in the CAP supporting documentation statement for 2021 finding 3.8.1 Non-Emergency Medical Transportation Prior Authorization. The Plan explained they are still developing a new methodology, including universal authorization for contracted providers. However, the new process is not yet implemented.

This is a repeat finding of the 2021 finding 3.8.1 Non-Emergency Medical Transportation Prior Authorization.

If the Plan does not have a prior authorization process or require providers complete the PCS forms prior to providing NEMT services, members may not receive the appropriate level of transportation for their clinical conditions.

Recommendation: Develop and implement policy and procedures to ensure NEMT services are subject to a prior authorization process that includes PCS forms.

3.8.2 NEMT Medi-Cal Enrollment

The Plan is required to comply with all existing final PLs and APLs issued by DHCS. (*Contract, Exhibit E, Attachment 2(1)(D)*)

The Plan is required to ensure all NEMT providers must comply with the enrollment requirements set forth in *APL 19-004* or any superseding APL. The Plan may allow NEMT providers to participate in its network for up to 120 days, pending the outcome of the enrollment process. However, the Plan must terminate its Contract with a NEMT provider upon expiration of the one 120-day period. If the NEMT providers are unable to successfully enroll in Medi-Cal, the Plan cannot continue to contract with the providers. (*APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses*)

The Plan is required to screen and enroll, and periodically revalidate, all network providers of Managed Care organizations, aligning with the Fee for Service 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. (*APL 19-004 Provider Credentialing / Recredentialing and Screening / Enrollment*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

Plan policy, *CR-4 Health Delivery Organization (HDO) Credentialing* (revised 8/25/2021), identified NEMT as a contracted organizational provider or HDO. This policy stated the Plan's Contracting Department conducts initial and ongoing assessments of HDO providers to ensure compliance with the Plan credentialing criteria. NEMT providers are required to submit applicable documentation, including proof of Medi-Cal enrollment; their credentialing documentation is reviewed by a credentialing specialist to ensure completion and accuracy.

Finding: The Plan did not ensure NEMT providers were enrolled in the Medi-Cal program.

In an interview, the Plan stated two NEMT providers were not enrolled in the Medi-Cal program. These two transportation providers service a majority of the rides providing 18,538 rides or 42.75 percent of total rides combined. One NEMT provider submitted the Medi-Cal application on 6/27/2022, after the audit period, while the other transportation provider is not contracted and remains unable to complete the enrollment application. The Plan cited the potential negative impact to members for continuing to utilize NEMT providers who are not enrolled in Medi-Cal.

Plan policy, *UM.013 Non-Emergency Medical Transportation* (revised 12/14/2020), did not include any information regarding the screening and enrollment of NEMT providers. The Plan stated policy *UM.013* is currently in the process of being updated with the requirements outlined in the CAP supporting documentation statement for 2021 finding 3.8.2 Non-Emergency Medical Transportation Provider Enrollment and new APL language including provider enrollment.

If the Plan does not require NEMT providers to enroll in Medi-Cal then unqualified providers may inadvertently service member rides and this may put members at risk for injuries or accidents.

This is a repeat finding of the 2021 finding 3.8.2 Non-Emergency Medical Transportation Provider Enrollment.

Recommendation: Revise and implement policy and procedures to ensure all NEMT providers are screened, and enrolled in Medi-Cal prior to providing NEMT services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

CATEGORY 4 – MEMBER’S RIGHTS

4.1 GRIEVANCE SYSTEM

4.1.1 Grievance Resolution Timeframe

The Plan must provide a notice of resolution to the member as quickly as the member’s health condition requires, within 30 calendar days from the date the Plan receives the grievance. (*Contract, Exhibit A, Attachment 14(1)(B)*)

The Plan must comply with the state’s established timeframe of 30 calendar days for grievance resolutions. (*APL 21-011 Grievances and Appeal Requirements, Notice and “Your Rights” Templates*)

Plan policy, *GA.07 Member Grievance Procedure for Medi-Cal, HealthWorx, and ACE* (revised 5/31/2022), stated the Plan will reach a resolution to the grievance as expeditiously as the case requires but no later than 30 calendar days after the date the Plan received the member’s original grievance.

Finding: The Plan did not resolve standard grievances within the timeframe of 30 calendar days.

The verification study showed nine cases exceeded the 30 calendar day timeframe. Four quality of service grievances and five quality of care grievances were not resolved within the 30 calendar day timeframe. The resolutions exceeded the timeframe between one to 53 days.

In an interview and written response, the Plan stated the resolution for these cases were late because of a G&A Manager who underperformed during the audit period. The Manager who was responsible for the untimely cases received ongoing feedback and oversight while working these cases, but ultimately left the Plan on 05/13/2022; cases were reassigned. The date range of cases whose timelines were negatively impacted were due between 2/28/2022 and 5/14/2022. All of these cases were marked as untimely and tracked in the Plan’s quarterly G&A Report. The Plan was aware of the untimely cases as they were coming due and when they became overdue.

If the Plan does not ensure timely resolution of all grievances then members’ health may be harmed if they do not receive the appropriate service and care.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

Recommendation: Implement policy and procedure to ensure standard grievances are resolved within 30 calendar days.

4.1.2 Written Notification of Delay

The Plan is required to ensure timely acknowledgement for grievances and provide a notice of resolution to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. (*Contract, Exhibit A, Attachment 14(1)(B)*)

The Plan must notify the member in writing of the status of the grievance and the estimated date of resolution in the event the resolution is not reached within 30 calendar days. (*APL 21-011, Grievances and Appeal Requirements, Notice and "Your Rights" Templates*)

Plan policy, *GA.07 Member Grievance Procedure for Medi-Cal, HealthWorx, and ACE* (revised 5/31/2022), stated that if the Plan cannot resolve a grievance within the regulatory timeframe, the G&A Coordinator will notify the member of the delay in writing within 30 days of receiving the grievance. This notification will include the estimated resolution date, the reason for the delay and a notice of the member's right to file an expedited grievance if they do not agree with the delay, and a notice that the member may file the grievance directly with the Department of Managed Health Care (DMHC). Delays must not exceed 14 calendar days from the original due date.

Finding: The Plan did not notify the members in writing of the status of their grievances and the estimated date of resolution when the resolution was not reached within 30 calendar days.

The verification study showed eight cases did not have letters indicating that grievance resolutions would be delayed. In three quality of service grievances and five quality of care grievances, the Plan did not notify the member in writing of the status of the grievance or the estimated date of resolution. The delay ranged from one to 53 days.

In a written response, the Plan acknowledged there were no delay notification letters because these cases were handled by the G&A Manager who was underperforming during the audit period. After the termination of the Manager, their priority was to close the cases as soon as possible, thus the Plan did not send out delay notification letters to the affected members.

If the Plan does not provide written notification for grievances that exceed the resolution timeframe, members may not be aware of their grievance status, which may negatively impact their health care decisions.

❖ **COMPLIANCE AUDIT FINDINGS (CAF)** ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

Recommendation: Implement policy and procedure to ensure members receive in writing, the status of their grievance and the estimated date of resolution when the resolution exceeds the 30 calendar day timeframe.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

CATEGORY 5 – QUALITY MANAGEMENT

5.2

DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

5.2.1 Ownership and Control Disclosure Reviews

The Plan is required to comply with *CFR, Title 42, section 455.104, Disclosure by Medicaid providers and fiscal agents: Information on ownership and control*. The Plan must require each subcontractor 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 shall also require its subcontractors to disclose the name, address, date of birth, and social security number of any managing employee of all subcontractors. (*Contract, Exhibit A, Attachment 1(2)(B)*)

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 17-004, Subcontractual Relationships and Delegation)*

Finding: The Plan did not ensure that its subcontractors submitted complete ownership and control disclosure information.

The Plan collected disclosure forms from seven of nine subcontractors delegated for credentialing. A review of seven disclosure forms revealed the following deficiencies:

- Seven disclosure forms did not contain the name, address, social security number and date of birth of individuals with controlling interest such as directors and managing employees.
- Four disclosure forms did not contain the tax identification number of the corporation.
- One disclosure form did not contain the subcontractor's address.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

In an interview, the Plan explained that much of the required information on the disclosure forms are not applicable to its subcontractors because of the type of entity. The Plan relied on the subcontractor's Compliance Department's interpretation of applicability for each section of the ownership and control disclosure form. The Plan also explained that they developed policy, *CP.030 Oversight Responsibilities for Medi-Cal Delegates*, which has information about ownership and control disclosures, however, the policy is still in a draft form. Review of the draft policy *CP.030* did not address how the Plan will ensure collecting complete ownership and control disclosure information.

In addition, the Plan is currently working with the Managed Care Quality and Monitoring Division on a CAP to the 2021 audit finding 5.2.1 Ownership and Control Disclosure Reviews.

This is a repeat finding from prior years 2019 - 5.1.1 Ownership and Control Disclosure Reviews and 2021 - 5.2.1 Ownership and Control Disclosure Reviews.

When the Plan does not collect and review the required ownership and control disclosure information of all subcontractors, it cannot ensure that subcontractors and controlling entities are in compliance and have no potential violations of the ownership and control disclosure requirements.

Recommendation: Develop and implement policies and procedures to ensure complete collection of all subcontractors' ownership and control disclosure information.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

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 is required to maintain policies and procedures, approved by DHCS, to ensure that subcontractors fully comply with all terms and conditions of this Contract. The Plan shall evaluate the prospective subcontractor's ability to perform the requested services, 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)*. (*Contract, Exhibit A, Attachment 6(13)*)

All contracts or written arrangements between the Plan and subcontractor 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 Plan's Contract obligations. (*CFR, Title 42, section 438.230 (c)(1)(i)-(iii)*)

Plan policy, *CP.023 Delegation Oversight* (revised 7/17/2019), stated that at the time of 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 & Medicaid Services (CMS), DHCS, or DMHC that pertains to the function(s) being delegated.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

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

The written delegation agreements for eight of nine subcontractors did not include language on provider training as a responsibility. In an interview, the Plan stated that additional amendments to add provider training language to the delegation agreements are awaiting approvals.

This is a repeat finding of 2021 finding 5.3.1 Delegation of Provider Training.

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

Recommendation: Revise and implement delegated agreements to include and specify all delegated activities and responsibilities of the subcontractors.

5.3.2 Provider Training

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities, which includes the continuous monitoring, evaluation and approval of the delegated functions. (*Contract, Exhibit A, Attachment 4(B)*)

The Plan is required to 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 5/16/2022), stated that the Provider Services Department will monitor provider compliance with this Contract requirement. Delegated providers are required to report training completion dates for network providers as requested and no less frequently than twice annually. Delegated credentialing providers will retain documentation of training completion date and make this available to the Plan upon request for oversight and monitoring purposes. Providers who do not comply with the new provider training requirement will be subject to corrective action and escalation to the Plan's Peer Review Committee.

Finding: The Plan did not ensure that all network providers received new provider training.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: August 1, 2021 through June 30, 2022

DATES OF AUDIT: July 25, 2022 through August 3, 2022

The Plan submitted a Provider Training Delegation Oversight Committee Report for the status of its 2021 audit of subcontracted providers. Deficiencies were identified for eight of the eight subcontractors including not having attestations available, leadership not aware of the requirement, and only partial training implemented. As of July 2022, the Plan had not received CAPs for four of eight subcontractors.

In the CAP to 2021 finding 5.3.2 Provider Training, the Plan updated its *PS01-03 Provider Training Procedure* and proposed to increase the frequency of its monitoring to twice annually. However, as of this audit the finding has not been closed and the new process has not been implemented.

This is a repeat finding of 2021 finding 5.3.2 Provider Training.

Without adequate monitoring of provider training, the Plan cannot ensure that subcontractor provider training was completed.

Recommendation: Implement procedures to ensure that all network providers receive provider training.