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

Cal MediConnect Contract Number:	13-90490
Three-Way Contract Effective Dates:	August 22, 2017 January 1, 2018
Audit Period:	November 1, 2017 through September 30, 2018
Report Issued:	April 12, 2019

TABLE OF CONTENTS

I. INTRODUCTION

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

In 1987, the SMHC founded the Health Plan of San Mateo (HPSM or the "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 Health Plan of San Mateo. Board members are appointed by the San Mateo County Board of Supervisors. The Plan received its Knox-Keene license as a full service plan on July 31, 1998.

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

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

Members enrolled in CMC receive all Medicare and Medi-Cal benefits, including medical care, behavioral health services, long-term services and supports, such as in-home support services, community based adult services, and multipurpose senior services program, in addition to non-emergency transportation services and care in nursing facilities.

As of August 31, 2018, Health Plan of San Mateo's total enrollment for its Cal MediConnect line of business was 9,023.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS Cal MediConnect audit for the period November 1, 2017 through September 30, 2018. The onsite review was conducted from October 9, 2018 through October 19, 2018. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on March 8, 2019 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the exit conference. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior Department of Managed Health Care (DMHC) Cal MediConnect medical survey for the audit period of April 1, 2014 through March 31, 2015 was issued on December 31, 2015. It identified deficiencies, which were addressed in a corrective action plan (CAP). The CAP closeout letter was dated August 3, 2016.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to ensure that routine authorizations are processed within five working days from receipt of information reasonably necessary to render a decision. The Plan did not review routine prior authorizations within five working days, as required by the contract. The Plan was following the timeframe of 14 calendar days listed on Chapter 13 of the Medicare Managed Care Manual. However, the contract takes precedence in the event of any conflict among documents such as the Medicare Managed Care Manual.

The Plan is required to ensure that its pre-authorization, concurrent review and retrospective review procedures meet minimum requirements. The Plan did not process retrospective review of authorizations for CMC members. The Plan stated this was not done as it was not a Centers for Medicare and Medicaid Services (CMS) requirement in the Medicare Managed Care Manual.

Category 2 – Case Management and Coordination of Care

Non-emergency medical transportation (NEMT) services are subject to prior authorization, with exceptions. The Plan did not require prior authorizations for NEMT services as described in Duals Plan Letter 18-001. The Plan conducted retrospective authorization review of non-emergency basic life support and advanced life support ambulance transportation but did not have any procedures in place to review wheelchair and gurney van medical transportation services. The Plan also did not use a DHCS approved Physician Certification Statement form nor did they have a mechanism to capture and submit data for NEMT services to DHCS.

Category 3 – Access and Availability of Care

The Plan is required to ensure an up-to-date copy of the provider/pharmacy network directory is available on the Plan's website. The Plan did not maintain an accurate online and printed provider directory.

Category 4 – Member's Rights

The Plan is required to resolve each grievance and provide notice of resolution to the member within 30 calendar days from receipt of the grievance. In the event a grievance resolution is not reached within 30 days, the Plan is required to notify members in writing the status and estimated completion date of the grievance resolution. The Plan did not resolve grievances within 30 calendar days of receipt due to insufficient staffing.

Category 5 – Quality Management

No findings.

Category 6 – Administrative and Organizational Capacity

No findings.

III. AUDIT SCOPE/PROCEDURES

SCOPE:

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

PROCEDURES:

The onsite review was conducted from October 9, 2018 through October 19, 2018. 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: 3 medical prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 3 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Continuity of Care (COC): 10 Plan COC case files were reviewed to confirm the performance of services and 10 case files for health risk assessments.

Non-Emergency Medical Transportation: 7 claims were reviewed to confirm compliance with the Non-Emergency Medical Transportation requirements.

Non-Medical Transportation: 8 claims were reviewed to confirm compliance with the Non-Medical Transportation requirements.

Category 3 – Access and Availability of Care

Appointment Availability Verification: 8 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.

Category 4 – Member's Rights

Grievance Procedures: 7 standard, 3 quality of care, and 3 exempt grievances were reviewed for timely resolution and response to complainant.

Confidentiality Rights: 2 Protected Health Information (PHI) breach and security incidents were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

Potential Quality of Care Issues: 3 samples were reviewed for appropriate reporting and proper resolution.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: 6 fraud and abuse cases were reviewed for appropriate reporting and processing.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

CATEGORY 1 – UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION AND APPEALS REQUIREMENTS

Cal MediConnect Three-Way Contract

Prior Authorization and Review Procedures:
2.11. Enrollee Access to Service

2.11.6.3. Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

2.11.6.3.1. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

2.11.6.3.2. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Contractor's medical director, in collaboration with the Contractor's pharmacy and therapeutics committee or its equivalent.

2.11.6.3.3. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

2.11.6.3.4. Reasons for decisions are clearly documented.

2.11.6.3.5. Notification to Enrollees regarding denied, deferred or modified referrals is made as specified in Section 2.11.6. *[Section 2.11.6.1.6]*

2.11.5.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261, and must:

2.11.5.5.1. Be produced in a manner, format, and language that can be easily understood;

2.11.5.5.2. Be made available in Threshold Languages, upon request;

2.11.5.5.3. Include information, in Threshold Languages about how to request translation services and alternative formats. Alternative formats shall include materials which can be understood by persons with limited English proficiency: and

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

1.2	PRIOR AUTHORIZATION AND APPEALS REQUIREMENTS

2.11.5.5.4 In any written communication to a physician or other health care provider of a denial, delay or modification of a request, include the name and telephone number of the health care professional responsible for the denial, delay or modification.

2.11.6.3.6. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

2.11.6.3.7. Prior Authorization requirements shall not be applied to Emergency Services, urgently needed services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

2.11.6.3.8. Records, including any NOA, shall meet the retention requirements described in Section 5.4 Records Retention, Inspection, and Audit.

2.11.6.3.9. Contractor must notify the requesting provider or Enrollee of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

2.7.1.1.2. To determine medical necessity for Drug Medi-Cal Benefits, Contractor and counties will follow California Code of Regulations Title 22 sections 51303 and 54301. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in California Code of Regulations Title 22 section 51159.

2.11.7. Timeframes for Authorization:

2.11.7.1 Emergency and Urgently Needed Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

2.11.7.2. Concurrent review of authorization for treatment regimen already in place: Within five (5) business days or less, consistent with urgency of the Enrollee's medical condition and in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

2.11.7.3. Retrospective review: Within thirty (30) calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

2.11.7.4. Non-Part D covered pharmaceuticals: Twenty-four (24) hours on all drugs that require prior authorization in accordance with WIC Section 14185 or any future amendments thereto.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

1.2	PRIOR AUTHORIZATION AND APPEALS REQUIREMENTS

2.11.7.5 Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the state for the need for additional information and how it is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.7.6 Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires and not later than seventy-two (72) hours after receipt of the request for services. The Contractor may extend this period by up to fourteen (14) calendar days if the Enrollee requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.7.7 LTSS Authorization as follows:

2.11.7.7.1 Must include the PCP or case manager signature on any nursing facility authorization or reauthorization request.

2.11.7.7.2 Must include the PCP or case manager signature on any CBAS authorization or reauthorization request.

2.11.7.7.3 Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for MSSP to MSSP providers for authorization into the MSSP. MSSP providers and the Contractor shall collaborate and coordinate MSSP care management services (see Section 2.6.3). [Section 2.6.1.2]

2.11.7.7.4 Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for IHSS to County Social Services Agency responsible for IHSS service authorization. County IHSS eligibility worker may participate on the ICT whenever IHSS services are involved in the care of the Enrollees.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

1.2	PRIOR AUTHORIZATION AND APPEALS REQUIREMENTS

2.11.5.6. The Contractor must make authorization decisions in the following timeframes

2.11.5.6.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires, within five (5) working days from receipt of the information reasonably necessary to render a decision, and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.5.6.1.1. The Enrollee or the Provider requests an extension, or

2.11.5.6.1.2. The Contractor can justify (to the satisfaction of DHCS and/or CMS upon request) that:

2.11.5.6.1.2.1. The extension is in the Enrollee's interest; and

2.11.5.6.1.2.2. There is a need for additional information where:

2.11.5.6.1.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.11.5.6.1.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.6.2. For expedited service authorization decisions, where the provider indicates or the Contractor determines that following the standard timeframe in Section 2.11.4.7.1 *[Section 2.11.5.7.1]* could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.5.6.2.1. The Enrollee or the provider requests an extension; or

2.11.5.6.2.2. The Contractor can justify (to DHCS and/or CMS upon request) that:

2.11.5.6.2.2.1. The extension is in the Enrollee's interest; and

2.11.5.6.2.2.2. There is a need for additional information where:

2.11.5.6.2.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.11.5.6.2.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.6.3. In accordance with 42 C.F.R. §§ 438.3(i), 438.210(e), and 422.208, compensation to individuals or entities that conduct utilization management activities for the Contractor must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖ Three-Way Contract (Cal MediConnect)
PLAN: San Mateo Health Commission dba Health Plan of San Mateo
AUDIT PERIOD: November 1, 2017 through September 30, 2018 **DATE OF AUDIT:** October 9, 2018 through October 19, 2018

1.2	PRIOR AUTHORIZATION AND APPEALS REQUIREMENTS
2.11.6.	**Referral Tracking System of Prior Authorization:**
2.11.6.1.6.	An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor shall ensure that all contracted Network Providers and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

SUMMARY OF FINDINGS:

1.2.1 Timeframe for Processing Routine Authorizations

The Plan is required to ensure that timeframes for routine authorizations are followed. The timeframe for routine authorizations is five (5) working days from receipt of the information reasonably necessary to render a decision in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request *(Contract, Section 2.11.7.5).*

In the event of any conflict among the documents that are a part of this contract, the contract terms and conditions, including all appendices takes precedence *(Contract, Section 5.7.2)*.

The *Medicare Managed Care Manual* stated that nothing in this manual should be construed to alter the contractual obligations between cost plans or health care prepayment plan (HCPP) and CMS except that cost plans and HCPPs must conform to the regulatory requirements at 42 CFR Part 422, Subpart M.

Plan policy *UM 07 Standard Medicare Pre-Service Organization Determinations,* dated 5/23/2017 stated, “Standard organization determination decisions must be rendered and member notified within 14 calendar days of receipt of the request, unless an extension has been taken.”

The Plan’s process for reviewing routine prior authorizations did not meet the contract requirement of adjudicating within five working days.

During the interviews, the Plan stated that they were following the guidelines on Chapter 13 of the Medicare Managed Care Manual issued 4/20/2012, which stated, "When an enrollee has made a request for a service, the Medicare health plan must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination." The Plan also stated that they had a Centers for Medicare and Medicaid Services (CMS) validation audit in the summer of 2017 and there was no mention of a change in timeframe for processing routine prior authorizations. The three-way contracts between CMS, DHCS, and the Plan effective August 31, 2017 and January 1, 2018, both state that the requirement for processing routine prior authorizations is five working days.

If routine prior authorization requests are not processed within the required timeframe of five working days, there is a risk of not providing members the necessary care in a timely manner, which could lead to poor health outcomes.

1.2.2 Retrospective Reviews

The Plan is required to ensure that its pre-authorization, concurrent review and retrospective review procedures meet minimum requirements as well as specific timeframes for authorization *(Contract, Sections 2.11.6.3 and 2.11.7)*. Retrospective reviews shall be processed within thirty (30) calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto *(Contract, Section 2.11.7.3).*

The Plan is required to deliver and coordinate all components of Medicare and Medi-Cal covered services for members. The Plan is required to comply with all provisions set in the contract as well as all applicable provisions of federal and state laws and the Memorandum of Understanding between CMS and the State of California titled the Capitated Financial Alignment Model - Memorandum of Understanding (CFAM-MOU) *(Contract, Section 2.1)*.

In the event of any conflict among the documents that are a part of this contract, the contract terms and conditions, including all appendices takes precedence. In addition, the CFAM-MOU takes precedence over all applicable federal and state regulations and laws as well as CMS guidance. *(Contract, Section 5.7.2)*.

Where there is overlap between Medicare and Medicaid benefits, coverage and rules will be delineated in the three-way contract; the benefits will maintain coverage as outlined in both state and federal rules. Participating Plans will be required to abide by the more generous of the applicable Medicare and California Medi-Cal standards *(Capitated Financial Alignment Model - Memorandum of Understanding).*

The *Medicare Managed Care Manual* stated that nothing in this manual should be construed to alter the contractual obligations between cost plans or health care prepayment plan (HCPP) and CMS except that cost plans and HCPPs must conform to the regulatory requirements at 42 CFR Part 422, Subpart M.

Plan policy *HS-01 Retrospective Review of Authorizations,* documented the Plan's procedure for retrospective review requests. The policy did not include the Cal MediConnect (CMC) line of business.

The Plan did not process retrospective review of authorizations for CMC members.

In an interview, when asked about processing of retrospective reviews for CMC members, the Plan stated that this was not a CMS requirement pursuant to Chapter 13 of the Medicare Managed Care Manual, and therefore not done. The Plan also stated in follow up communications that although they had verified the requirement in the three-way contract, they were clarifying with CMS on its applicability beyond Medi-Cal-only decisions. According to the Plan, "Because retrospective reviews are not required by Medicare, they (CMS) believe the three-way contract language would only apply to Medi-Cal primary services." However, response received from CMS only applied to Medicare members, not CMC members who are beneficiaries of both Medicare and Medi-Cal.

If the Plan does not review retrospective requests for CMC members, this may lead to a denial of covered benefits without a medical necessity review by a physician, as well as inappropriate denial of payment to providers.

1.2.3 Provider Manual

The provider manual shall be a comprehensive online reference tool for the provider and staff regarding topics such as members' rights *(Contract, Section 2.9.10.5)*. Member, the member's authorized representative, or a provider with the member's written consent, may file the oral or written member appeal with the Plan within sixty (60) calendar days after the date of the Integrated Notice of Action *(Contract, Section 2.15.3.2; Code of Federal Regulations, Title 42, Section 422.582)*.

Chapter 13 of the *Medicare Managed Care Manual*, issued on 4/20/2012, stated "…a party must file the request for reconsideration within 60 calendar days from the date of the notice of the organization determination."

Plan policy *GA-05 Medicare Part C Appeals,* last revised 8/15/2014, stated that the Grievance and Appeals Coordinator verifies that the complaint was filed within 60 days of the date of the denial.

The Plan did not update its provider manual to include the new timeframe of 60 days for filing an appeal.

In an interview, Plan staff confirmed that the provider manual had not been updated because they were following the Medicare Managed Care Manual guideline of 90 days. However, as stated above, the timeframe specified in the Medicare Managed Care Manual was 60 days.

If the provider manual is not updated with current information, such as with new timeframes on when to file an appeal, members may not receive timely care, which can lead to poor health outcomes.

RECOMMENDATIONS:

1.2.1 Develop and implement policies and procedures to ensure that the correct timeframe for processing routine prior authorizations is followed by UM staff.

1.2.2 Revise and implement policies and procedures to ensure that retrospective review of authorizations includes the CMC line of business.

1.2.3 Develop and implement policies and procedures to ensure that the correct timeframe to file an appeal is reflected in the provider manual.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4	NON EMERGENCY MEDICAL TRANSPORTATION/NON-MEDICAL TRANSPORTATION

Non-Emergency Medical Transportation Requirements
NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when it is prescribed in writing by a physician, dentist, or podiatrist. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 12501.
Duals Plan Letter 18-001

NEMT Physician Certification Statement Forms
MMPs (Medicare-Medicaid Plans) and transportation brokers must use a DHCS-approved Physician Certification Statement (PCS) forms to determine the appropriate level of service for MMP members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization.
Duals Plan Letter 18-001

Non-Medical Transportation Requirements
MMPs must provide NMT for their members to obtain medically necessary services, including those not covered by the Contract. Services not covered under the Contract include, but are not limited to, those delineated as excluded services in Section A.2 and Appendix A of the Contract.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with State and local statutes, ordinances, or regulations. MMPs may authorize NMT for a member who uses a wheelchair, but whose limitation is such that the member is able to ambulate without assistance from the driver. The NMT requested must be the least costly method of transportation that meets the member's needs.
Duals Plan Letter 18-001

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

2.4	NON EMERGENCY MEDICAL TRANSPORTATION/NON-MEDICAL TRANSPORTATION

Non-Medical Transportation Authorization
MMPs may apply prior authorization requirements to NMT services. If an MMP chooses to require prior authorization for NMT services, then it is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely manner. The MMP's prior authorization process must be consistently applied to medical/surgical, mental health, and substance use disorder services as required by CMS-2333-F.
Duals Plan Letter 18-001

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards
MMPs are contractually required to meet Access to Care Standards contained in the Contract. MMPs that have a Knox-Keene license are also required to meet the Timely Access Standards contained in Cal. Code Regs., Tit. 28, Section 1300.67.2.2. A member's need for NMT and NEMT services does not relieve the MMP from complying with Timely Access Standard obligations.
Duals Plan Letter 18-001

Conditions for Non-Medical Transportation Services:

- MMPs may use prior authorization processes for approving NMT services and for re-authorizing services every 12 months, when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at the time of the initial NMT authorization request.
- NMT does not cover trips to non-medical locations or for appointments that are not medically necessary.
- Members may not drive themselves under the private conveyance policy. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to the MMP in person, electronically, or over the phone, stating that all other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
  - Has no valid driver's license.
  - Has no working vehicle available in the household.
  - Is unable to travel or wait for medical or dental services alone.
  - Has a physical, cognitive, mental, or developmental limitation.

Duals Plan Letter 18-001

SUMMARY OF FINDINGS:

2.4.1 Non-Emergency Medical Transportation Services

The Plan is required to cover medical transportation subject to utilization controls *(Welfare and Institutions Code, Section 14132(i)).*

The *Duals Plan Letter 18-001 Non-Emergency Medical and Non-Medical Transportation Services,* dated 4/26/2018, stated that the Plan is required to provide non-emergency medical transportation (NEMT) services when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care, hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care pursuant to Health Safety Code, Section 1250.

Plan policy *UM-16 Medical Transportation* stated that authorization is required for non-emergency ambulance transport. However, the policy did not include an authorization review procedure to review all requested NEMT services.

The Plan did not require prior authorizations for NEMT services as described in Duals Plan Letter 18-001.

A verification study of 7 NEMT services found that authorization reviews were not performed. The study included 6 gurney van and 1 Basic Life Support (BLS) transportation services.

In an interview, Plan staff stated that they did not require a prior authorization to process the requested NEMT services. Members would contact transportation services directly and the providers would send claims to the Plan. The Plan's desktop procedures *Authorization for Non-Emergent Ground Transportation* stated that BLS transportation and non-emergency Advanced Life Support transportation are subject to retrospective review. Wheelchair van and gurney van transportation services were not subjected to authorization review. The Plan's policy and desktop procedures are not consistent with the Duals Plan Letter requirement of requiring prior authorization for NEMT services.

When no utilization controls are implemented, the Plan may not be aware of the types of transportation services needed by members and if the most reasonable costs are applied.

2.4.2 Physician Certification Statement

The Plan is required to use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of transportation service for Medi-Cal members. The PCS forms must include at a minimum: function limitations justification, dates of service needed, mode of transportation needed, and certification statement. The Plan is required to have a mechanism to capture and submit data from the PCS form to DHCS *(Duals Plan Letter 18-001 Non-Emergency Medical and Non-Medical Transportation Services).*

Plan policy *UM-16 Medical Transportation* stated that authorization is required for non-emergency ambulance transport. However, the policy did not include procedures to obtain a PCS form and the required data as listed in Duals Plan Letter 18-001.

The Plan did not use a DHCS approved PCS form nor did they have a mechanism to capture and submit data for NEMT services.

A verification study found that in 6 of 7 samples, there were no PCS forms available or maintained by the Plan. A process to obtain information on the PCS was not in place by the Plan or required by the Plan.

In an interview, Plan staff stated that PCS forms were not required as they did not want to impose a barrier in claim processing.

If PCS forms are not required, the Plan may not provide the appropriate type of transportation to members or submit the data to DHCS.

RECOMMENDATIONS:

2.4.1 Revise and implement policies and procedures to establish utilization controls for NEMT services.

2.4.2 Develop and implement policies and procedures to utilize PCS forms and have a mechanism to capture and submit data for NEMT services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	ACCESS TO CARE

Cal MediConnect Three-Way Contract

2.9. Provider Network

2.9.1. The Contractor must demonstrate annually that it has an adequate network as approved by CMS and the state to ensure adequate access to medical, Behavioral Health, pharmacy, and LTSS, excluding IHSS, providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access.

2.9.2. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including Behavioral Health services, other specialty services, and all other services required in 42 C.F.R. §§ 422.112, 423.120, and 438.206 and under this Contract (see Covered Services in Appendix A).

2.9.10.5. The Provider Manual shall be a comprehensive online reference tool for the Provider and staff regarding, but no limited to, administrative, prior authorization, and referral processes, claims and encounter submission processes, continuity of care requirements, and plan benefits.

2.10. Network Management

2.10.1. General requirements. The Contractor shall establish, maintain, and monitor a network that is sufficient to provide adequate access to all Covered Services in the Contract. Section 2.9.1 discusses the annual network review and approval requirement.

2.10.1.1. Taking into consideration:

2.10.1.1.1. The anticipated number of Enrollees;

2.10.1.1.2. The expected utilization of services, in light of the characteristics and health care needs of Contractor's Enrollees;

2.10.1.1.3. The number and types of providers required to furnish the Covered Services;

2.10.1.1.4. The number of Network Providers who are not accepting new patients; and

2.10.1.1.5. The geographic location of Network Providers and Enrollees, taking into account distance, travel time, the means of transportation and whether the location provides physical access for Enrollees with disabilities.

2.10.2. Access to Care Standards. The Contractor must demonstrate annually that its Provider Network meets the stricter of the following standards:

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

3.1	ACCESS TO CARE
2.10.2.3.	For Medi-Cal providers and facilities, the Contractor contract with a sufficient number of LTSS providers, including but not limited to SNFs (distinct part and free-standing), MSSP, CBAS and County Social Services Agencies located in the Contractor's Service Area.
2.10.2.3.1.	If the LTSS provider within the Service Area cannot meet the Enrollee's medical needs, the Contractor must contract with the nearest LTSS provider outside of the covered Service Area. Contractor is responsible for all Covered Services, pursuant to WIC section 14186.3(c).
2.10.2.3.2.	Contractor shall ensure the provision of acceptable accessibility standards in accordance with 42 CFR 438.206(c) and Title 28 CCR Section 1300.67.2.2 and as specified below.
2.10.2.4.	Ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or comparable to Medi-Cal fee-for-service, if the provider serves only Medi-Cal Enrollees.
2.11.	**Enrollee Access to Services**
2.11.1.	General. The Contractor must provide services to Enrollees as follows:
2.11.1.1.	Authorize, arrange, coordinate and provide to Enrollees all Covered Services that are Medically Necessary;
2.11.1.2.	Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services from the Contractor…
2.11.1.3.	The Contractor must identify to DHCS the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The Contractor must also establish and execute a work plan to achieve and maintain ADA compliance; and
2.11.1.4.	If the Contractor's Provider Network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

3.1	ACCESS TO CARE
2.11.1.5.	When a PCP or medical, Behavioral Health or LTSS provider is terminated from the Contractor's plan or leaves the Provider Network for any reason, the Contractor must make a good faith effort to give written notification of termination of such provider, within fifteen (15) days after receipt or issuance of the termination notice, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the Contractor must also report the termination to DHCS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the Contractor shall ensure that there is no disruption in services provided to the Enrollee.
2.11.1.6.	Contractor shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of vacation, illness, or other unforeseen circumstances.
2.11.2.	Contractor shall ensure Enrollee access to specialists for Covered Services that are Medically Necessary. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through subcontracts, sufficient to assure that health services will be provided in accordance with Section 2.10.2 and consistent with all specified requirements.
2.11.2.1.	Contractor shall establish acceptable <u>accessibility</u> requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below…Contractor shall communicate, enforce, and monitor Network Providers' compliance with these requirements.
2.11.2.1.6.	Unusual Specialty Services: Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined medically necessary.
2.11.4.	The Contractor must have a mechanism in place to allow Enrollees with special health care needs to have direct access to a specialist as appropriate for the Enrollee's condition and identified needs, such as a standing referral to a specialty Provider.
2.11.10.	Availability of Services

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

3.1	ACCESS TO CARE

2.11.10.1. Access to Services for Emergency Conditions and Urgent Care. The Contractor must ensure access to twenty-four (24) hour emergency services for all Enrollees, whether they reside in institutions or in the community.

2.17. Marketing, Outreach, and Enrollee Communications Standards

2.17.5. Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

2.17.5.1.1. An Evidence of Coverage (EOC)/Member Handbook document that is consistent with the requirements at 42 C.F.R. § 438.10, 42 C.F.R. § 422.111, and 42 C.F.R. § 423.128; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMSM and DHCS.

2.17.5.3. A combined provider and pharmacy directory that includes all providers of Medicare, Medi Cal, and Flexible Benefits and is consistent with the requirements in Section 2.17.5.10, or a distinct and separate notice on how to access this information online and how to request a hard copy.

2.17.5.10. Provider/Pharmacy Network Directory*****

2.17.5.10.1. The Contractor must comply with the following maintenance and distribution requirements:

2.17.5.10.1.1. Maintain a combined Provider/Pharmacy Network directory that uses the model document developed by CMS and DHCS;

2.17.5.10.1.2. Provide either a print copy or a distinct and separate notice about how to access this information online or request a hard copy, as specified in Chapter 4 of the Medicare Managed Care Manual and the Marketing Guidance for California Medicare-Medicaid Plans, to all new Enrollees at the time of enrollment and annually thereafter;

2.17.5.10.1.3. When there is a significant change to the network, the Contractor must send a special mailing to Enrollees, as specified in Chapter 4 of the Medicare Managed Care Manual, immediately;

2.17.5.10.1.4. The Contractor must ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d);

*[*****Refer to Sections 2.17.5.11 & 2.17.5.12 - for minimum requirements of Content of Provider and Pharmacy Network Directories, respectively]*

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖ Three-Way Contract (Cal MediConnect)
PLAN: San Mateo Health Commission dba Health Plan of San Mateo
AUDIT PERIOD: November 1, 2017 through September 30, 2018 **DATE OF AUDIT:** October 9, 2018 through October 19, 2018

3.1	ACCESS TO CARE
2.17.5.11.	Content of Provider/Pharmacy Network Directory. The Provider/Pharmacy Network directory must include, at a minimum, the following information for all providers in the Contractor's Provider Network:
2.17.5.11.1.	The names, addresses, and telephone numbers of all current Network Providers, and the total number of each type of provider, consistent with 42 C.F.R.§422.111(h).

Applicable References for the review period:

- *Three-Way Contract – Appendix B: Enrollee Rights*
- *Applicable federal and State regulations and laws*
- *All current and Applicable DPLs issued by DHCS. http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanLetters.aspx*

SUMMARY OF FINDING:

3.1.1 Accuracy of Provider Directory

The Plan must ensure an up-to-date copy of the provider/pharmacy network directory is available on the Plan's website, consistent with 42 C.F.R. §§ 422.111(h) and 423.128(d*) (Contract, Section 2.17.5.10.1.4).* The provider/pharmacy network directory must include, at a minimum, the following information for all providers in the Plan's Provider Network: the names, addresses, and telephone numbers of all current Network Providers, and the total number of each type of provider, consistent with 42 C.F.R. § 422.111(h) *(Contract, Section 2.17.5.11.1).*

The Plan is required to provide, upon request, a list of contracting providers and update this information at least quarterly. The Plan is required to ensure the accuracy of the provider directory information by updating the online directory at least weekly or more frequently and when informed of and upon confirmation by the Plan of any information that affects the content or accuracy of the provider directory. Health Plans shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the Plan's provider directory in accordance with this section, and shall, at least annually, review and update the entire provider directory for each product offered *(Health & Safety Code, Section 1367.27).*

Plan policy *PS-04 PRIME Provider Data Auditing, Report, and Provider Directories Production*, stated that the Plan weekly monitors the provider office information by Provider Services representatives. The Plan annually reviews and updates all directories, including notification to each contracted provider by mail monthly. Providers not responding within the 10-day removal notice period will be removed from the directory in the next update.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

The Plan did not maintain an accurate provider directory.

DHCS conducted an appointment availability verification study of 8 providers which consisted of 3 Primary Care Providers, 2 specialists, and 3 OB/GYNs. This study measured the Plan's average days of member wait times to obtain an appointment and verified the accuracy of the Plan's provider directory information. The following deficiencies related to the Plan's printed and online provider directory information were identified:

- 3 of 8 providers had inaccurate office hours and days of operations.
- 2 of 8 providers had incorrect phone numbers.
- 3 of 8 providers had the incorrect address listed.
- 1 of 8 provider was not accepting new patients but was listed on the Plan's directory as accepting new patients.

In an interview, Plan staff stated that they were in the process of transitioning into a new system for the auditing and validation of data in the provider network database. The Plan will add a web portal for providers to update their directory information; however, a definite date was not set to implement the new changes. The Plan did not provide an explanation for the inaccuracies in the provider directory.

Inaccurate information in the provider directory may increase barriers for members' access to care.

RECOMMENDATION:

3.1.1 Implement policies and procedures to update provider directory to reflect accurate and complete information.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Cal MediConnect Three-Way Contract

2.14. Enrollee Grievances

2.14.1. Grievance Filing -- The Contractor shall inform Enrollees that they may file a grievance through either the Contractor or Cal Medi-Connect Ombuds Program for complaints relating to Medicare and Medi-Cal covered benefits and services. Medicare beneficiaries may also file a grievance through 1-800 Medicare. The Contractor must display a link to the electronic grievance form on the Medicare.gov Internet Web site on the Contractor's main web page pursuant to 42 C.F.R. § 422.504 (a)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee grievance regarding Medicare and Medi-Cal covered benefits and services may be filed. Authorized representatives may file grievances on behalf of Enrollees to the extent allowed under applicable federal or state law.

2.14.2. Internal (plan level) Grievance: An Enrollee may file an Internal Enrollee grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Contractor or its providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee grievances, including grievances regarding reasonable accommodations and access to services under the ADA.

2.14.2.1. Reporting of plan level grievances: Contractor shall track and report to DHCS the number and types of inquiries, complaints, grievances, appeals, and resolutions related to Cal MediConnect, in compliance with 42 C.F.R. § 438.416 and as described in WIC Section 14182.17(e)(4)(E), in the format specified by DHCS in accordance applicable DPL(s) as indicated in Section 2.1.5. DHCS will then make the required information publicly available on DHCS' internet web site.

2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, consistent with the Knox-Keene Act, and the regulations promulgated thereunder, Welfare and Institutions Code Section 14450 and CCR, Title 22, Section 53260.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

4.1	GRIEVANCE SYSTEM

2.14.2.1.2. The Contractor must maintain written records of all grievance activities, and notify CMS and DHCS of all internal grievances. The system must meet the following standards:

2.14.2.1.2.1. Timely acknowledgement of receipt of each Enrollee grievance;

2.14.2.1.2.2. Timely review of each Enrollee grievance;

2.14.2.1.2.3. Response, electronically, orally or in writing, to each Enrollee grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the grievance;

2.14.2.1.2.4. Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the grievance to each Enrollee grievance whenever Contractor extends the Appeals timeframe or Contractor refuses to grant a request for an expedited Appeal; and

2.14.2.1.2.5. Availability to Enrollees of information about Enrollee Appeals, as described in Section 2.15, including reasonable assistance with Enrollee Grievances and Appeals in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

2.14.2.1.2.6. Procedures to ensure that decision makers on grievances were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

2.14.2.1.2.6.1. A grievance regarding denial of expedited resolutions of an appeal.

2.14.2.1.2.6.2. Any grievance or appeal involving clinical issues.

2.14.2.1.2.7. *****In addition to grievance logs required by Medicare and Medi-Cal rules, pursuant to CA Health & Safety Code section 1368(a)(4)(B) and Title 28 CCR 1300.68(d)(8), the Contractor shall maintain a log of all Exempt Grievances. The log shall be periodically reviewed by the plan and shall include the following information for each Exempt Grievance:

2.14.2.1.2.7.1. The date of the call

2.14.2.1.2.7.2. The name of the complainant

2.14.2.1.2.7.3. The complainant's member identification number

2.14.2.1.2.7.4. The nature of the grievance

2.14.2.1.2.7.5. The nature of the resolution

2.14.2.1.2.7.6. The name of the plan representative who took the call and resolved the grievance

*[***** This section is not applicable prior to January 1, 2018]*

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

4.1	GRIEVANCE SYSTEM

2.14.3. External Grievance: The Contractor shall inform Enrollees that they may file an external grievance for Medicare only covered benefits and services through 1-800- Medicare or for Medicare and Medi-Cal covered benefits and services through the Cal MediConnect Ombudsman program. The Contractor must display a link to the electronic grievance form on the Medicare.gov Internet Web site on the Contractor's main web page pursuant to 42 C.F.R. § 422.504(a)(15)(ii).

2.14.3.1. The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee grievance may be filed.

2.14.3.2. *****Consistent with Health & Safety Code Section 1368(b), Contractor, except for non-Knox Keene Act Licensed COHS plans, shall inform Enrollees that they may file an External Grievance for Medi-Cal only covered benefits and services through DMHC's consumer complaint process. Contractor shall inform Enrollees of the DMHC's toll-free telephone number, DMHC's TDD line for the hearing and speech impaired, and DMHC's website address pursuant to Health & Safety Code Section 1368.02.

*[***** This section is not applicable prior to January 1, 2018]*

Expedited Grievance Review:

2.15.3.4.2. Standards for expedited review of grievances involving an imminent and serious threat to the health of the Enrollee: Title 28, CCR, Sections 1300.68 and 1300.68.01;

2.12.4. Enrollee Advisory Committee:

2.12.4.1. The Contractor shall establish an Enrollee advisory committee that will provide regular feedback to the Contractor's governing board on issues of Demonstration management and Enrollee care. The Contractor shall ensure that the Enrollee advisory committee:

2.12.4.1.1. Meets at least quarterly throughout the Demonstration.

2.12.4.1.2. Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the Demonstration population, including individuals with disabilities. CMS and DHCS reserve the right to review and approve Enrollee membership.

2.12.4.2. The Contractor shall also include Ombudsman reports in quarterly updates to the Enrollee advisory committee and shall participate in all statewide stakeholder and oversight convenings as requested by DHCS and/or CMS.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
Three-Way Contract (Cal MediConnect)

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

4.1	GRIEVANCE SYSTEM

Members Handbook

2.17.5. Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

2.17.5.1.1. An Evidence of Coverage (EOC)/Member Handbook document that is consistent with the requirements at 42 C.F.R. § 438.10, 42 C.F.R. § 422.111, and 42 C.F.R. § 423.128; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMSM and DHCS.

2.17.5.1.4. How to file grievances and internal and external Appeals, including:

2.17.5.1.4.1. Grievance, Appeal and fair hearing procedures and timeframes;

2.17.5.1.4.2. Toll free numbers that the Enrollee can use to file a grievance or an Appeal by phone;

2.17.5.1.4.3. A statement that when requested by the Enrollee, benefits will continue at the Contractor level for all benefits during the Contractor Appeal process, and the Enrollee may be required to pay to DHCS the cost of services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and, how the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

2.17.5.1.4.4. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as DHCS or CMS may identify, including an Ombudsperson;

2.12. Enrollee Services

2.12.1. Enrollee service representatives (ESRs). The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

2.12.1.6. Be available to Enrollees to discuss and provide assistance with Enrollee Grievances and complaints;

2.13. IHSS Related Complaints, Grievances and Appeals

2.13.1. For Enrollee complaints, grievances, or appeals related to IHSS, Contractor must comply with the established grievance and appeal process established by CDSS and by the county agencies responsible for IHSS, in compliance with WIC 10950

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖ Three-Way Contract (Cal MediConnect)
PLAN: San Mateo Health Commission dba Health Plan of San Mateo
AUDIT PERIOD: November 1, 2017 through September 30, 2018 **DATE OF AUDIT:** October 9, 2018 through October 19, 2018

4.1	GRIEVANCE SYSTEM

Applicable References for the review period:

- *Three-Way Contract –*
  - *Appendix A: Covered Services*
  - *Appendix B: Enrollee Rights*
- *Applicable federal and State regulations and laws*
- *All current and Applicable DPLs issued by DHCS. http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanLetters.aspx*
  - *DPL 14-001 – Complaint and Resolution Tracking*
- MMCD All Plan Letter 17-006

SUMMARY OF FINDINGS:

4.1.1 Grievance Resolution Timeframe

The Plan is required to response, electronically, orally or in writing, to each member grievance within a reasonable time, but no later than 30 days after it was received *(Contract, Section 2.14.2.1.2.3).*

The Plan shall comply with the State's established timeframe of 30 calendar days for grievance resolution *(All Plan Letter 17-006).*

Plan policy *GA-04 Member Grievance Procedure for CareAdvantage D-SNP and CareAdvantage CMC*, stated that the Plan will reach a resolution on the grievance as expeditiously as the case requires but no later than thirty (30) calendar days after the date member's original grievance was received.

The Plan did not resolve grievances within 30 calendar days.

A verification study found that 5 of 10 grievances were resolved past 30 days and did not have resolution letters sent to the members within 30 calendar days. The Plan attributed the decline of grievances resolution timeliness to insufficient staffing and changes in its case review process.

Members' health may be negatively affected if grievances are not addressed and resolved timely.

4.1.2 Grievance Filing Timeframe

A member may file a grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Plan or its providers *(Contract, Section 2.14.2)*.

In the event of any conflict among the documents that are a part of this contract, the contract terms and conditions, including all appendices takes precedence *(Contract, Section 5.7.2)*.

The *Medicare Managed Care Manual* stated that nothing in this manual should be construed to alter the contractual obligations between cost plans or health care prepayment plan (HCPP) and CMS except that cost plans and HCPPs must conform to the regulatory requirements at 42 CFR Part 422, Subpart M.

Plan policy *GA-03 Overview of Member Complaint Procedure for CareAdvantage SNP and CareAdvantage CMC Plans,* stated that the timeframe for member to file a grievance is 180 days.

Plan policy *GA-04 Member Grievance Procedure for CareAdvantage D-SNP and CareAdvantage CMC*, stated that the Grievance and Appeals Coordinator verifies that the complaint was filed within 60 days of the date of the service or event in question. If the grievance was not filed timely, the Grievance and Appeals Coordinator notifies the member or Authorized Representative in writing that the Grievance has been filed outside of the allowable timeframe but that the Plan may still accept the appeal if provided with good cause for the delay.

The Plan did not have accurate grievance filing timeframe in its policies and procedures and provided that incorrect information to the providers in its informing materials.

A verification study found that 4 of 10 grievances had requested a provider's response. All of them had attached a provider fact sheet with incorrect grievance filing timeframe of 180 days. However, according to contract requirements, member can file a grievance at any time. In addition, the provider manual also contained the incorrect filing timeframe of 180 days. In an interview, Plan staff confirmed that they did not follow the contract requirement. Instead, they followed Chapter 13 of the Medicare Managed Care Manual, which stated a timeframe of 60 days from the date of event to file a grievance. As a result, the incorrect grievance filing timeframe was stated in Plan policies and procedures and distributed to providers.

When the Plan does not update its policies and procedures, members may receive incorrect information about their rights to file a complaint.

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

AUDIT PERIOD: November 1, 2017 through September 30, 2018
DATE OF AUDIT: October 9, 2018 through October 19, 2018

RECOMMENDATIONS:

4.1.1 Implement policies and procedures to ensure grievances are resolved within 30 calendar days. Ensure the Grievance and Appeals Department is adequately staffed to process grievances timely.

4.1.2 Revise and implement policies and procedures to ensure all informing materials contain current grievance filing timeframe.