

DEPARTMENT OF
**Managed
Health Care**
Help Center

DIVISION OF PLAN SURVEYS

1115 WAIVER

SENIORS AND PERSONS WITH DISABILITIES

**MEDICAL SURVEY REPORT OF
HEALTH PLAN OF SAN MATEO**

A COUNTY ORGANIZED HEALTH SYSTEM PLAN



DATE ISSUED TO DHCS: AUGUST 27, 2015

**1115 Waiver SPD Medical Survey Report
Health Plan of San Mateo
A County Organized Health System Plan
August 27, 2015**

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EXECUTIVE SUMMARY

The California Department of Health Care Services (“DHCS”) received authorization (“1115 Waiver”) from the federal government to conduct mandatory enrollment of seniors and persons with disabilities (“SPD”) into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The DHCS then entered into an Inter-Agency Agreement with the Department of Managed Health Care (the “Department”)¹ to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California’s strong patient-rights laws. Mandatory enrollment of SPDs into managed care began in June 2011.

On August 22, 2014, the Department notified San Mateo Health Commission, dba Health Plan of San Mateo (the “Plan”), that its medical survey had commenced and requested the Plan to provide all necessary pre-onsite data and documentation. The Department’s medical survey team conducted the onsite portion of the medical survey from November 3, 2014 through November 6, 2014.²

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreement, the Department provides the 1115 Waiver SPD Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the SPD population. This medical survey evaluated the following elements specifically related to the Plan’s delivery of care to the SPD population as delineated by the DHCS-HPSM Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations:

I. Utilization Management

The Department evaluated Plan operations related to utilization management, including implementation of the Utilization Management Program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting over- and under-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

II. Continuity of Care

The Department evaluated Plan operations to determine whether medically necessary services are effectively coordinated both inside and outside the network, to ensure the

¹ The Inter-Agency Agreement (Agreement Number 10-87255) was approved on September 20, 2011.

² Pursuant to the Knox-Keene Health Care Service Plan Act of 1975, codified at Health and Safety Code section 1340, *et seq.*, Title 28 of the California Code of Regulations section 1000, *et seq.* and the Department of Health Care Services Two-Plan, GMC, and COHS Boilerplate Contracts. All references to “Section” are to the Health and Safety Code unless otherwise indicated. All references to the “Act” are to the Knox-Keene Act. All references to “Rule” are to Title 28 of the California Code of Regulations unless otherwise indicated. All references to “Contract” are to the Two-Plan, GMC, or COHS Boilerplate contracts issued by the Department of Health Care Services.

coordination of special arrangement services, and to verify that the Plan provides for completion of covered services by a non-participating provider when required.

III. Availability and Accessibility

The Department evaluated Plan operations to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes, and are addressing reasonable patient requests for disability accommodations.

IV. Member Rights

The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for Primary Care Physician (PCP) selection and assignment, and to evaluate the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

V. Quality Management

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care.

The scope of the medical survey incorporated review of health plan documentation and files from the period of January 1, 2014 through July 31, 2014³.

³ The survey review period spans seven months rather than one full year because the Plan's SPD amendments did not go into effect until January 1, 2014.

SUMMARY OF FINDINGS

The Department identified **11** potential survey deficiencies during the current medical survey.

2014 MEDICAL SURVEY POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT	
#1	<p>The Plan does not ensure that its Utilization Management Program effectively detects under- and over-utilization of health care services. DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 4 – Review of Utilization Data.</p>
#2	<p>The Plan does not ensure that decisions to approve, modify, delay, or deny health care service requests based in whole or in part on medical necessity are based on a set of written criteria or guidelines that are consistently applied. DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(B) – Pre-Authorizations and Review Procedures; Section 1367.01(b).</p>
#3	<p>The Plan does not ensure that its Utilization Management Program includes the integration of utilization management activities into the Quality Improvement System and procedures for continuously reviewing the utilization of services. DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management, Provisions 1(G) and (H) – Utilization Management (UM) Program; Section 1367.01(j); Rule 1300.70(c).</p>
CONTINUITY OF CARE	
#4	<p>The Plan does not maintain effective procedures for monitoring the coordination of care for its members to ensure that problems are being identified and effective action is taken to improve care. DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 1(F) – Utilization Management (UM) Program; DHCS-HPSM Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3(A)(2)(d) – Access Requirements; DHCS-HPSM Contract, Exhibit A, Attachment 10 – Scope of Services, Provisions 3(A) and (E)(1) – Initial Health Assessment (IHA); DHCS-HPSM Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care, Provision 1 – Case Management Services, and Provision 2(A)(1) – Comprehensive Case Management Including Coordination of Care Services; Rule 1300.70(a)(1) and (3); Rule 1300.70(b)(1)(B).</p>

AVAILABILITY & ACCESSIBILITY OF SERVICES	
#5	<p>The Plan does not ensure adequate oversight of accessibility and availability of services by its governing body and its Quality Assessment and Improvement Committee.</p> <p>DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 2 – Accountability, and Provision 3(C) and (D) – Governing Body, and Provision 4 – Quality Improvement Committee; Rule 1300.67.2.2(d)(2)(D).</p>
#6	<p>The Plan does not ensure that during normal business hours, the waiting time for a member to speak by telephone to a customer service representative does not exceed ten minutes.</p> <p>DHCS-HPSM Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 4(D) – Contract Performance; Rule 1300.67.2.2(c)(10); Rule 1300.67.3(a)(2).</p>
MEMBER RIGHTS	
#7	<p>The Plan does not consistently resolve each grievance and provide written notice of resolution to the member within 30 calendar days from receipt of the grievance.</p> <p>DHCS-HPSM Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System, and Provision 5(B) – Member Appeal Process; Section 1368.01(a); Rule 1300.68(d)(3).</p>
QUALITY MANAGEMENT	
#8	<p>The Plan does not consistently ensure that quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.</p> <p>DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-HPSM Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(E) – Grievance System Oversight; Rule 1300.70(a)(1); Rule 1300.70(b)(1).</p>
#9	<p>The Plan does not maintain effective oversight procedures to ensure that its delegate, San Mateo County Behavioral Health and Recovery Services, is fulfilling all delegated quality improvement functions and responsibilities.</p> <p>DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, and Provision 6(A) and (B)(1)(3) – Delegation of Quality Improvement Activities; Rule 1300.70(b)(2)(C); Rule 1300.70(b)(2)(G)(2) and (3); Rule 1300.70(b)(2)(H)(1).</p>
#10	<p>The Plan does not maintain a system of accountability which includes adequate participation and oversight by its governing body and Quality Assessment and Improvement Committee.</p> <p>DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, Provision 2 – Accountability, Provision 4 – Quality Improvement Committee, and Provision 7(I) – Written Description; Rule 1300.70(b)(2)(C).</p>

#11	<p>The Plan does not demonstrate that it has adequate administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out quality assurance activities.</p> <p>DHCS-HPSM Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 4(D) – Contract Performance; DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; Rule 1300.67.3(a)(2); Rule 1300.70(b)(2)(F).</p>
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OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD MEMBERS

The Plan is a County Organized Health System (COHS), and as such, the SPD population has been enrolled in the Plan since inception in 1987. Therefore, SPDs were not included in the mandatory enrollment process. Nevertheless, the Plan has undertaken the following activities that address not only the specific needs of its SPD population, but benefit its entire membership at large:

- The Plan is in the process of organizing a team of staff who will be dedicated to supporting members being discharged from skilled nursing facilities. The team will ensure that members have access to housing as well as any critical medical and psychiatric supports needed to foster successful reintegration back into the community.
- The Plan contracted with a PCP who is designated for providing intensive 24/7 care and consultation for a small group of frail members who have complex medical conditions.
- The Plan recognized the need to increase clinical staff to support quality management activities such as identifying potential quality issues and ensuring that appropriate corrective action plans are implemented. The Plan intends to hire a nurse and medical director dedicated to overseeing these functions.
- The Plan's Medical Director reported that the Plan has invested in a new case management computer system which contains enhancements that should result in significant improvements over the existing case management system.

DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

Potential Deficiency #1: The Plan does not ensure that its Utilization Management Program effectively detects under- and over-utilization of health care services.

Contractual/Statutory/Regulatory References: DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 4 – Review of Utilization Data.

DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management

4. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services.

Documents Reviewed:

- 2014 Utilization Management Program
- Policy UM.31: Over-Under Utilization (09/14/14)
- UM Work Group Meeting Minutes (04/17/14; 06/19/14)
- Medical Utilization and IBNR Review Meeting Summary (01/09/14; 02/13/14; 03/13/14; 04/10/14; 05/08/14; 06/11/14; 07/09/14)
- Key Healthcare Expense and Budget Indicators (06/30/14)
- Analysis of Hospital Inpatient Expenses (06/30/14)
- IBNR June Reports (06/30/14)
- Long Stay and Catastrophic Cases (06/30/14)
- Medi-Cal Costs Comparison (01/2014–06/2014 vs. 01/2013–06/2013)
- Medi-Cal Monthly Trends (06/2014)
- 2014 Pharmacy Utilization Summary by Date of Services (04/11/14; 7/18/14)
- DMHC Onsite Document Request #26: Clarification regarding Medical Review Committee (undated)

Assessment: DHCS-HPSM Contract, Exhibit A, Attachment 5, Provision 4 requires the Plan to include within its Utilization Management Program mechanisms to detect both under- and over-utilization of health care services. In order to assess compliance with this standard, the Department reviewed two key Plan documents that speak directly to these processes: 1) 2014 Utilization Management Program, and 2) Policy UM.31: Over-Under Utilization. The Department found that while both of these documents describe robust monitoring processes to detect under- and over-utilization, the Plan is not carrying out these activities as indicated in its own procedures.

1) 2014 Utilization Management Program

The 2014 Utilization Management Program document defines the specific role and responsibilities of the Utilization Management Workgroup in monitoring for under- and over-utilization. Specifically, on page 8, it states:

The Utilization Management Workgroup...monitors the utilization of healthcare services by HPSM members in all programs to *identify areas of under or over utilization* that may adversely impact member care. The Workgroup meets *monthly*.

Role and Responsibility

- Provides coordination of UM functions.
- Provides oversight for appropriateness and clinical criteria used to monitor care.
- Monitors data and reports and identifies opportunities for improvement of internal processes and systems.
- Measures and documents effectiveness of actions taken.
- *Reviews and evaluates data to identify under or over utilization patterns.*
- Reviews care management issues related to continuity and coordination of care, including those services provided through the CCI. [Emphasis added.]

The 2014 Utilization Management Program further identifies various methods the Plan uses to monitor for under- and over- utilization. Specifically, on page 21, it states:

In an effort to review appropriateness of care provided to members, HPSM *tracks and trends various data elements to determine over- and/or under- utilization patterns*. Industry benchmark rates are used as guidelines for comparison. Some of the elements reviewed include:

- Hospital admits/1,000
- Re-admissions within 30 days
- Pharmacy utilization
- Bed days/1,000, using HPSM performance standards
- Emergency room visits
- Encounters per enrollee per year
- Behavioral Health inpatient admissions
- Denials
- Frequency of selected procedures, as determined by utilization patterns
- Medi-Cal Medical Directors Utilization Reports
- Industry Collaborative Effort Utilization Reports
- Cultural/Linguistic reports that reflect barriers for access to care or delivery of care
- Patterns of Utilization of (Coordinated Care Initiative) CCI services, including: CBAS, IHSS, MSSP.

HPSM enacts actions to improve performance as a result of these clinical data analysis, and feedback is provided to both entities and individual practitioners so

that corrective actions can be taken. HPSM continues to monitor for compliance with corrective action plans and improvements in the care delivery process. [Emphasis added.]

In light of the multitude of data reports delineated for review, the Department requested that the Plan provide any utilization reports that were generated and reviewed during the survey review period. The Plan provided the following seven reports to the Department onsite:

- Key Healthcare Expense and Budget Indicators
- Analysis of Hospital Inpatient Expenses
- Incurred But Not Received [IBNR] June Reports
- Long Stay and Catastrophic Cases
- Medi-Cal Costs Comparison
- Medi-Cal Monthly Trends
- Pharmacy Utilization Summary

However, review of these reports revealed that the data captured was primarily limited to hospital and pharmacy expenditures. Therefore, although these reports do address some of the elements listed in the 2014 Utilization Management Program (e.g., hospital admits, pharmacy utilization, bed days per 1000, etc.), many of the other elements delineated in the Plan's procedures (e.g., readmissions, emergency room visits, denials, cultural/linguistic, and patterns of utilization) were not generated for review. Furthermore, while the reports did provide raw data, there was no evidence of analysis or evaluation to identify under- or over- utilization patterns.

The Department additionally requested the Utilization Management Workgroup meeting minutes to assess whether these reports or any additional reports were reviewed by the work group, and if so, what analysis was done, if any, to monitor for under- and over-utilization. The Plan provided only two UM Work Group Committee meeting minutes for the seven-month survey review period. Therefore, the Department determined that meetings were not conducted on a monthly basis as indicated. Furthermore, the minutes themselves failed to include any documented review or evaluation of data to identify under- or over-utilization patterns. For example, the April 17, 2014 minutes indicated that the meeting was dedicated towards informing nursing staff of recent updates and changes to the department, namely, the improvements currently underway to make the authorization process more efficient and less cumbersome. The June 19, 2014 minutes similarly did not address under- or over-utilization but instead included a status report on the Plan's efforts to complete the backlog of treatment authorization requests, an update regarding the conversion to a new care coordination database, direction to management staff to fill vacancies, and the results of a recent audit.

Therefore, neither the Utilization Management Workgroup meeting minutes nor the reports submitted by the Plan provide evidence that the Plan effectively tracks and trends various data elements to determine under- and over-utilization patterns as indicated by the Plan's internal 2014 Utilization Management Program document.

2) Policy UM.31: Over-Under Utilization

Policy UM.31: Under-Over Utilization places responsibility and authority on the Plan's Medical Review Committee to review utilization data, including under- and over-utilization. Specifically, on page 2, it states:

The Health Plan of San Mateo's Medical Review committee monitors for under utilization and over utilization of medical-services by monitoring, tracking and analyzing data from various sources (i.e., claims/payments, encounter data and medical records).

Members of the Medical Review committee include but not limited to: *Medical Director, Health Services Director, Senior Health Services Clinical Manager, Health Services Utilization Manager, Pharmacy Services Manager, and Quality Manager* [Emphasis added.]

...

The Medical Review committee regularly reviews several utilization data sets. These data sets include but are not limited to:

- Acute bed days per thousand,
- Admits per thousand,
- ER visits,
- Average length of acute stay,
- Readmission rate and
- Pharmaceutical utilization

To evaluate compliance with this policy, the Department requested that the Plan provide the Medical Review Committee meeting minutes for the survey review period. The Plan was unable to produce these meeting minutes but in a written response indicated that the "Medical Utilization and IBNR [incurred but not received] Committee" is the same thing as the "Medical Review Committee" and functions in the same capacity. As such, the Plan produced the Medical Utilization and IBNR Committee meeting minutes for each of the seven months of the survey review period. Review of these meeting minutes indicated the Committee is comprised of the following members:

- Claims Operation Manager
- Senior Financial Analyst
- Claims Resource Manager
- Claims Director
- Accounting Manager
- Director of Finance & Administrative Services
- Senior Health Statistician
- Provider Services Manager
- Financial Planning & Analysis Manager
- Medical Director

However, with the exception of the Medical Director, none of the other members listed in the Plan's policy (e.g., Health Services Director, Senior Health Services Clinical Manager, Health Services Utilization Manager, Pharmacy Services Manager, and Quality Manager) participate on the Committee. Instead, the Committee is comprised of staff members who serve in capacities solely related to claims, finance, accounting, or provider services. As such, review of the meeting minutes themselves revealed that discussions predominantly focused on claims-related topics, such as claims processing, claims recovery, and provider billing issues. In addition, the Medical Director, who is on the Committee, attended only two of the seven meetings (05/08/14 and 07/09/2014). In those two meetings, as well as two additional meetings (03/13/14 and 04/10/14⁴), some medical utilization updates were provided. However, these discussions pertained mainly to the high cost drug used to treat Hepatitis C (Sovaldi). There was no documentation to substantiate that the Committee regularly reviewed any of the data sets outlined in the Plan's own internal policy to monitor for under- and over-utilization of medical services.

In an onsite interview, the Medical Director acknowledged that the Plan's current process for detecting under- and over-utilization of health care services was limited. She explained that while a review is performed, it is conducted more informally and on an ad hoc basis. Although the Plan has the capability of generating various utilization metrics (e.g., data on approved and denied services, overturned denials, inpatient and pharmacy utilization, etc.), reports are not reviewed on a routine basis to detect for under- and over-utilization.

Plan staff further indicated that it does not specifically review the utilization patterns of its SPD population. Other than generating the required SPD reports for submission to the DHCS, Plan staff did not see the need to separate SPD data from that of the rest of the Medi-Cal population. Plan staff reasoned that historically, as a COHS plan, SPDs have always been integrated, and therefore, the Plan's existing programs have already been geared towards the SPD population as well. The Department noted, however, that reviewing utilization patterns of SPDs is beneficial as the characteristics of this population are unique, indicating that the root causes for under- and over- utilization may be different as well. For example, SPDs predictably utilize certain specialists (e.g., cardiologists) more often than non-SPDs, in large part because cardiovascular diseases are more prevalent among the SPD population. In order for the Plan to identify opportunities for improving the overall health of its SPDs, analyzing SPD-specific utilization patterns to detect potential over- and under-utilization of services is essential. In this way, the Plan can identify disease management initiatives and programs that will minimize hospitalization and emergency room visits.

Conclusion: DHCS-HPSM Contract Exhibit A, Attachment 5, Provision 4 requires the Plan to include within its UM program mechanisms to detect both under- and over-utilization of health care services. The Department found that while the Plan does have two key documents that describe robust monitoring processes in compliance these requirements, the Plan is not carrying out these activities as indicated in its own procedures. Specifically, neither meeting minutes

⁴ An Associate Medical Director was present at the April 10, 2014 Medical Utilization and IBRN Committee meeting.

from the Plan's Utilization Management Workgroup nor the Medical Utilization and IBNR Committee provide documentation to substantiate that the Plan effectively tracks and trends various data elements to determine under- and over-utilization patterns. Therefore, the Department finds the Plan in violation with this contractual requirement.

Potential Deficiency #2: The Plan does not ensure that decisions to approve, modify, delay, or deny health care service requests based in whole or in part on medical necessity are based on a set of written criteria or guidelines that are consistently applied.

Contractual/Statutory/Regulatory References: DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 2(B) – Pre-Authorizations and Review Procedures; Section 1367.01(b).

DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management

2. Pre-Authorizations and Review Procedures

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

B. 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. [Emphasis added.]

Section 1367.01(b)

A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes....

Documents Reviewed:

- 2014 Utilization Management Program
- Policy HS-03: Utilization Review Program (09/10/14)

Assessment: Section 1367.01(b) requires the Plan's written policies and procedures to ensure that decisions based on medical necessity are consistent with criteria or guidelines that are supported by clinical principles and processes. DHCS-HPSM Contract, Exhibit A, Attachment 5 additionally requires that the Plan's set of written criteria or guidelines for utilization review be consistently applied. In order to assess compliance with these standards, the Department reviewed two key Plan documents that speak directly to these processes: 1) 2014 Utilization Management Program, and 2) Policy HS-03: Utilization Review Program. The Department found that while the Plan does utilize a set of written criteria or guidelines that is supported by clinical principles and processes, no monitoring is done to ensure that the criteria or guidelines are consistently applied among reviewers.

Both the 2014 Utilization Management Program and Policy HS-03: Utilization Review Program documents describe the Plan's protocols for processing a variety of prospective, concurrent, or retrospective health care service requests. In addition to outlining general procedures for submitting requests as well as standard timeframes for processing, the documents also name the specific criteria and guidelines used for making medical necessity determinations. For example:

- Policy HS-03: Utilization Review program indicates that the Plan uses the following criteria and guidelines, including, but not limited to:
 - Manual of Criteria for Medi-Cal Authorization (State of California, DHCS)
 - Milliman Care Guidelines
 - Medi-Cal Medical, Allied Health and Inpatient/Outpatient Provider Manuals
 - California Code of Regulations, Title 22
- The 2014 Utilization Management Program document similarly lists many of the same criteria and guidelines used. Specifically, on page 22, it states:

Approved HPSM Guidelines shall be used for all medical necessity determinations. HPSM uses the following criteria sets: Medi-Cal Manual of Criteria, published by the State of California, American Academy of Pediatric Guidelines (AAP), Milliman Care Guidelines, Medicare Coverage manual and the HPSM Medical Policy and Medi-Cal Benefits Guidelines (Medi-Cal Provider manuals – Allied Health, Inpatient/Outpatient, Medical, Vision, Pharmacy).

Therefore, both documents indicate that the Plan relies on a given set of written criteria or guidelines (e.g., Medi-Cal Manual, Milliman Care Guidelines) when making medical necessity determinations. The 2014 Utilization Management Program document additionally addresses monitoring provisions for consistent review and application of the criteria or guidelines. Specifically, on page 23, it states:

The Health Services Clinical Manager and Senior Clinical Manager perform ongoing monitoring of UM nurse reviewer application of criteria/guidelines to:

- Measure the reviewers' comprehension of the review criteria and guideline application process.
- Ensure accurate and consistent application of the criteria among staff reviewers, and ensure criteria and guidelines are utilized per policy/procedure.
- Ensure a *peer review process for inter-rater reliability*. [Emphasis added.]

Despite these written provisions, the Department found no evidence that the Plan performs ongoing monitoring to ensure that reviewers, including physician reviewers, use appropriate

criteria or guidelines when making medical necessity determinations, and that the criteria or guidelines are consistently applied by all reviewers. For instance, no inter-rater reliability (IRR) testing is performed. This would assist the Plan with monitoring not only the individual performance of reviewers for accurate and consistent application of criteria or guidelines, but would also include a measure for ensuring consistency for all reviewers as well. During onsite interviews, Plan staff confirmed that the Plan has not implemented any monitoring tasks or tools, such as IRR testing, to ensure that that clinical criteria or guidelines are consistently and accurately applied amongst its utilization management staff or physician reviewers. The Medical Director explained that the Plan is recruiting a trainer who will be tasked with developing IRR tracking tools.

Conclusion: Section 1367.01(b) requires the Plan’s written policies and procedures to ensure that decisions based on medical necessity are consistent with criteria or guidelines that are supported by clinical principles and processes. DHCS-HPSM Contract, Exhibit A, Attachment 5, Provision 2 requires the Plan to have a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. The Department’s review of two key Plan documents that speak directly to these processes revealed that while the Plan does utilize a set of written criteria or guidelines that is supported by clinical principles and processes, no monitoring is done to ensure that the criteria or guidelines are consistently applied among reviewers. Therefore, the Department finds the Plan in violation of these contractual and statutory requirements.

Potential Deficiency #3: The Plan does not ensure that its Utilization Management Program includes the integration of utilization management activities into the Quality Improvement System and procedures for continuously reviewing the utilization of services.

Contractual/Statutory/Regulatory References: DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management, Provisions 1(G) and (H) – Utilization Management (UM) Program; Section 1367.01(j); Rule 1300.70(c).

DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70.

DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management

1. Utilization Management (UM) Program

⁵ Inter-rater reliability (IRR) testing measures the degree to which different reviewers agree or disagree in their assessment decisions. To ensure that clinicians are making appropriate and consistent determinations based on their clinical judgment and/or applied use of established criteria or guidelines, a second reviewer assesses a sample (or even the universe) of cases. Results from the two reviewers are then compared, discrepancies are analyzed, and corrective actions (e.g., reviewer education, clarification of criteria, etc.) are implemented as needed.

Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:
G. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

H. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

Section 1367.01(j)

A health care service Plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the Plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health Plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

Rule 1300.70(c)

In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department.

Documents Reviewed:

- 2014 Utilization Management Program
- Policy GA-08: Member Appeal Procedure – Non-Medicare Lines of Business (09/09/14)
- DMHC Onsite Document Request #47: SPD Denials and Pharmacy Appeals (11/14/14)

Assessment: DHCS-HPSM Contract, Exhibit A, Attachment 5, Provisions 1(G) and (H), Rule 1300.70(c), and Section 1367.01(j) require the Plan's Utilization Management Program to include the integration of utilization management activities into the Quality Improvement System and procedures for continuously reviewing the utilization of services. Based on onsite interviews and a review of the Plan's responses to the Department's onsite and post-onsite inquiries related to pharmacy appeals, the Department determined that the Plan fails to meet these requirements. Specifically, the Plan fails to review its pharmacy overturn rates (on appeals) to assess for trends. As a result, potential problems are not communicated to appropriate staff so that corrective actions can be implemented.

The 2014 Utilization Management Program document places responsibility on the Plan's Grievance and Appeals staff to carry out the appeals process. Specifically, on page 24, it states:

HPSM has a comprehensive review system to address matters when members or providers (on behalf of members for services yet to be provided) wish to exercise

their rights to appeal an organizational determination that denied, deferred or modified a request for services.

The administration of HPSM's reconsideration of an organization determination and appeals process is the responsibility of the Grievance and Appeals staff...

Policy GA-08: Member Appeal Procedure – Non-Medicare Lines of Business similarly places responsibility on the Plan's Grievance and Appeals staff for appeals processing. Specifically, on pages 1-2, it states:

- The Grievance and Appeals Manager is responsible for the day-to-day oversight of the Appeals Process.
- The Grievance and Appeals Coordinators are responsible for implementing this Appeals Process in accordance with the timeframes and procedures.

During onsite interviews, the Department inquired with the Plan's Grievance and Appeals staff to see whether any reports on appeals are generated, specifically those regarding the outcome of appeal determinations (i.e., the decision to uphold or overturn the initial denial). Plan staff indicated that reports are generated on an ad hoc basis only and explained that although reports are shared with the Grievance and Appeals Committee, they are not shared with the Utilization Management Department. Interviews with Utilization Management staff confirmed that they do not review reports regarding appeals, and as such, are not made aware of the rationales behind overturned decisions (e.g., further information was submitted by the provider, pertinent information was not considered during the initial review, the incorrect criteria was initially applied, etc.).

In an effort to assess whether or not there were any noteworthy trends regarding appeals that Utilization Management staff should have been made aware of, the Department requested that the Plan provide the total number of SPD health service denials, appeals, and pharmacy-related appeals for the survey review period. The Plan submitted the following data in response:

Total number of SPD Health Services Denials: 226
Number of SPD Appeals: 68
Number of Appeals that were Pharmacy-Related: 53

Due to the high percentage of pharmacy-related appeals (78%), the Department further inquired about the reasons for these denials. The Plan submitted the following data in response:

Of the 53 Pharmacy-related appeals, how many were initially denied due to lack of or incomplete information? 20

Of these [20] denials due to incomplete information, how many were overturned/approved on appeal? 5

Of the remaining [33] denials (due to reasons other than incomplete information), how many were overturned/approved on appeal? 20

Based on the above data, 20 of 33 (61%) pharmacy-related appeals denied initially for reasons *other than incomplete information* were overturned upon appeal. While it might be common to overturn a denial that was based on a lack of information when new medical information is submitted at the time of appeal (since such information provided at the time of initial review might have resulted in an authorization rather than a denial), it is less common to overturn a denial that was based on the exact same medical information that was already available at the time of the initial review. Therefore, unless the Plan's reporting mechanisms are inaccurate, a 61% overturn rate in the absence of new medical information submitted is concerning because it suggests a potentially flawed initial review process (e.g., pertinent information was not considered during the initial review, the incorrect criteria was applied, the correct criteria was misapplied, reviewers do not consistently apply criteria or guidelines⁶, etc.). Such a high overturn rate would warrant further investigation to uncover any trends worthy of communicating to relevant Plan staff so that corrective actions could be implemented if necessary. However, since the Plan's Grievance and Appeals Department, who is responsible for processing all appeals, neither generates routine reports nor conveys this information to the Utilization Management Department, if problems do exist, no action is taken to prevent undue delay in the provision of medically necessary services as members would have to appeal potentially wrongful initial denial determinations in order to get the services authorized.

Conclusion: Rule 1300.70(c) requires the Plan to design and implement reasonable procedures for continuously reviewing the utilization of services and demonstrate to the Department the reasonableness of the procedures and the adequacy of the implementation. DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 1 requires compliance with this rule. Section 1367.01(j) requires the Plan to establish as part of its quality assurance program a process that includes provisions for the assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health Plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance. DHCS-HPSM Contract, Exhibit A, Attachment 5, Provisions 1(G) and (H), encompass the requirements of both Rule 1300.70(c) and Section 1367.01(j) and similarly require the Plan's Utilization Management Program to include the integration of utilization management activities into the Quality Improvement System, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate staff and procedures for continuously reviewing the utilization of services.

Through its evaluation of data regarding SPD appeals and the Plan's pharmacy overturn rates, the Department determined that the Plan overturned 61% of all pharmacy-related appeals that were initially denied for reasons other than incomplete information during the survey review

⁶ Please reference Deficiency #3 for a further discussion regarding the Plan's failure to implement any monitoring tasks or tools, such as IRR testing, to ensure that that clinical criteria or guidelines are consistently and accurately applied amongst its utilization management staff or physician reviewers.

period. Such a high overturn rate in the absence of new medical information submitted is concerning because it suggests a potentially flawed initial review process which would warrant further investigation to uncover any trends worthy of communicating to relevant Plan staff. However, since the Plan's Grievance and Appeals Department, who is responsible for processing all appeals, neither generates routine reports nor conveys this information to the Utilization Management Department, if problems exist, no corrective action is taken to prevent undue delay in the provision of medically necessary services as members would have to appeal potentially wrongful initial denial determinations in order to get the services authorized. Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

CONTINUITY OF CARE

Potential Deficiency #4: The Plan does not maintain effective procedures for monitoring the coordination of care for its members to ensure that problems are being identified and effective action is taken to improve care.

Contractual/Statutory/Regulatory References: DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 1(F) – Utilization Management (UM) Program; DHCS-HPSM Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3(A)(2)(d) – Access Requirements; DHCS-HPSM Contract, Exhibit A, Attachment 10 – Scope of Services, Provisions 3(A) and (E)(1) – Initial Health Assessment (IHA); DHCS-HPSM Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care, Provision 1 – Case Management Services, and Provision 2(A)(1) – Comprehensive Case Management Including Coordination of Care Services; Rule 1300.70(a)(1) and (3); Rule 1300.70(b)(1)(B).

DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. ...

DHCS-HPSM Contract, Exhibit A, Attachment 5 – Utilization Management

1. Utilization Management (UM) Program

Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

F. An established system to track and monitor services requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified prior authorizations, and the timeliness of the determination.

DHCS-HPSM Contract, Exhibit A, Attachment 9 – Access and Availability

3. Access Requirements

Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

A. Appointments

(2) Standards for Timely Appointments:

(d) Appointment with a specialist – within 15 business days of request.

DHCS-HPSM Contract, Exhibit A, Attachment 10 – Scope of Services

3. Initial Health Assessment (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 this contract.

A. Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with Title 22 CCR Section 53851 (B)(1) and 53910.5(a)(1) to each new Member within 120 days of enrollment.

E. Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA.

1) Contractor shall make at least three (3) documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA. Contact methods must include at least one (1) telephone and one (1) mail notification.

DHCS-HPSM Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care

1. Case Management Services

Contractor shall ensure contracted providers provide basic Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.

2. Comprehensive Case Management Including Coordination of Care Services

A. Basic Case Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include:

1) Initial Health Assessment (IHA)

Rule 1300.70(a)(1) and (3)

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

Rule 1300.70(b)(1)(B)

To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

(B) quality of care problems are identified and corrected for all provider entities.

Documents Reviewed:

- Policy CC 01: Care Coordination and Case Management Program (10/10/13)
- Policy QAI-01: Quality Assessment and Improvement Protocol, Policy and Procedure (07/30/14)
- Policy QAI-07: Initial Health Assessment (IHA) & Initial Health Education Behavioral Assessment (IHEBA) (08/13/14)
- Policy QAI-11: Pay for Performance Program (09/26/11)
- Policy MS.04-02: PCP Selection Assignment (11/22/13)
- Policy HS-03: Utilization Review and Care Coordination/Case Management Program (04/22/12)
- Policy PS.06-01: Timely Access and Member Access to Services and Network Sufficiency (12/06/13)
- 2013-2014 Quality Improvement System
- IHA Monthly Compliance Report (through Q1, 2014)
- DMHC Pre-Onsite Request: DMHC_QMCC.2_Reports on Continuity and Coordination of Care (undated)
- DMHC Onsite Request #10: Out-of-Network Referral Tracking (undated)

Assessment: DHCS-HPSM Contract, Exhibit A, Attachment 11, Provision 1 requires the Plan to maintain procedures for monitoring the *coordination of care* provided to its members, including all medically necessary services delivered both within and outside the Plan's provider network. Rule 1300.70(a)(1) and (3) additionally requires the Plan's quality assurance program to address services elements, including *continuity of care*, and to document that care is being reviewed, problems are being identified, and effective action is taken to improve care. To assist with measuring the Plan's compliance with these contractual and regulatory requirements, the Department's pre-onsite request includes a request for any reports that demonstrate monitoring. However, in its written response, the Plan stated, "There are no reports on continuity and coordination of care for the audit period." Therefore, during the onsite review, the Department interviewed Plan staff to conduct further investigation. Through its review, the Department determined that the Plan does not monitor the following key aspects pertaining to continuity or coordination of care: 1) Changes in Primary Care Provider, 2) Completion of Initial Health Assessments (IHA), or 3) Tracking of Out-of-Network Specialist Referrals.

1) Changes in Primary Care Provider

Policy MS.04-02: PCP Selection Assignment emphasizes the role of the PCP and on page 1 states, "The PCP is the Member's main provider and will take care of most of the Member's health care needs..." The 2013-2014 Quality Improvement System document further defines the role of the PCP and on page 2 states, "PCPs have case management responsibility for their caseloads." Given the critical role of the PCP in coordinating care, the Plan has an obligation to monitor PCP changes to ensure continuity of care for its members. By monitoring for any

noteworthy trends regarding PCP changes, the Plan has the opportunity to ensure that problems are being identified and effective action is be taken to improve care if necessary. Therefore, the Department inquired about Plan processes for when: 1) A member requests a change in PCP, and 2) A PCP requests member reassignment.

- *Member Requests a Change in PCP*

During onsite interviews, Plan staff explained the process for when a member initiates a change in PCP. When the member contacts the Plan, the Member Services Representative (MSR) inquires about the reason for the change. Depending on the reason, a particular code is inputted into the system and the MSR proceeds with assisting the member with selecting a new PCP. Although staff reported that the Plan produces reports which contain the codes used to categorize the PCP change reasons, the reports are not specifically reviewed to detect trends such as how many PCP changes are due to dissatisfaction with care or access issues. In addition, no analysis is performed to identify other patterns such as providers who receive a high number of requests for PCP changes. The Plan's Medical Director acknowledged that the Plan recognizes this as an area of opportunity for improvement and indicated that the Plan is currently recruiting an additional nurse whose duties may include assessing new ways of categorizing and processing PCP changes so that the data flows into the quality management system for review.

- *PCP Requests Member Reassignment*

The Department reviewed a case⁷ that the Plan had identified as a potential quality issue⁸ (PQI) during the survey review period. A PCP had terminated the member due to the complexity of co-occurring medical issues and inability to manage the member's care. Therefore, during onsite interviews, the Department inquired about scenarios for when a PCP might initiate reassignment of a member to another PCP. Plan staff noted that a common reason for this would be patients who repeatedly go to their PCPs displaying drug-seeking behaviors. However, the Plan indicated that this data has not been quantified as they do not formally track reasons for why PCPs initiate member reassignments. Therefore, no evaluation has been performed to determine the appropriateness of these requests or to identify trends that might warrant further follow-up and intervention.

2) Initial Health Assessments

DHCS-HPSM Contract, Exhibit A, Attachment 10, Provision 3(A) establishes both the purpose and required timeframe for completion of the Initial Health Assessment (IHA). The IHA, which must be completed within 120 days of enrollment for new members, is a comprehensive assessment designed to enable the PCP to manage the member's current acute, chronic and preventive health needs, and identify those members whose health needs require coordination

⁷ Please see Deficiency #8 for the Department's quality concerns regarding File #5.

⁸ Cases, providers, processes, or concerns identified through member grievances, sentinel events (e.g., mortalities), data analysis, provider site visits, and other sources as having *potential quality issues* that require investigation are often referred to as PQIs.

with appropriate community resources and other agencies for services. DHCS-HPSM Contract, Exhibit A, Attachment 10, Provision 3(E)(1) requires the Plan to make at least three documented attempts to demonstrate unsuccessful efforts to contact the member to schedule the IHA. Given the critical role the IHA plays in assisting the PCP with managing the member's care, the Department evaluated the Plan's processes for monitoring IHA completion.

Policy QAI-07: Initial Health Assessment (IHA) & Initial Health Educational Behavioral Assessment (IHEBA) addresses how the Plan monitors for completion of the IHA. Specifically, on page 4, it states, "QAI [Quality Assessment and Improvement] Nurses monitor compliance with IHA and use of the IHEBA during site and medical review audits every three years or as needed (e.g. with focused reviews, etc.)." While verification studies are useful, using retrospective review only every three years as the sole method for ongoing monitoring to ensure that *all* new members receive the IHA is insufficient. Nevertheless, the Plan did produce an IHA Monthly Compliance Report which demonstrates that IHA completion rates are in fact being tracked on a monthly basis, although not delineated in policy. In onsite interviews, Plan staff explained that data for these reports is derived from select CPT codes⁹ designated to signify completion of the IHA and that the Plan tracks how many times those codes appear in patient billing. However, the Plan has not verified the accuracy of this methodology (e.g., comparing claims encounter data with results from the periodic site audits). Regardless, the IHA Monthly Compliance Report indicated that the IHA completion rates fell below the Plan's average target rate of 69.80%. Pertinent to the survey review period, the IHA completion rates for January, February, and March 2014, were 75.11%, 58.25%, and 60.81%, respectively. Therefore, for the months of February and March 2014, the IHA completion rates fell below this goal.

During onsite interviews, the Department inquired about the Plan's efforts to increase IHA completion rates. Plan staff explained that they do have a Pay for Performance Program that provides PCPs with incentives for completing the IHA within the required timeframes. The Department also noted that Policy QAI-07: Initial Health Assessment (IHA) & Initial Health Educational Behavioral Assessment (IHEBA) states that completion of a member's IHA can be waived when the "PCP has made two diligent attempts to contract the patient, including a phone call and a written attempt, and has documented this in the patient's record." This is in conflict with the contractual requirement of three documented attempts. Nevertheless, Plan staff confirmed that the Plan does not conduct monitoring to verify that PCPs are either consistently making or documenting these attempts.

3) Out-of-Network Specialist Referrals

Policy HS-03: Utilization Review and Care Coordination/Case Management Program defines the process for when PCPs refer members to out-of-network specialists and requires that PCPs first obtain prior authorization from the Plan. Specifically, on page 5, it states:

While HPSM has a broad network of specialty providers, there may be cases where a PCP recommends that a member go to a specialty provider that is not

⁹ CPT (Current Procedural Terminology) codes are five-digit numeric codes used to describe all services provided to a patient including medical, surgical, and diagnostic services. They are used to determine the amount of reimbursement that a provider will receive to ensure industry-wide uniformity.

available within the network. These referral requests are reviewed by the Medical Director on a case-by-case basis and authorized if deemed medically necessary.

...

Referral Authorization Forms (RAFs) are generated by the Primary Care Physician (PCP) as he/she identifies needs based on the patient's clinical status. RAFs are used by the PCP to authorize referral for specialist provider services.

DHCS-HPSM Contract, Exhibit A, Attachment 5, Provision 1(F) requires the Plan's UM program to track and monitor services requiring prior authorization (e.g., specialist referrals). However, in its response to the Plan's onsite request for any reports that show tracking of out-of-network specialist referrals, the Plan stated, "We do not formally track referrals for out of network providers or for specialists." By not monitoring out-of-network specialist referrals, the Plan does not have access to valuable data (e.g., volume of requests, specialists by type, wait times, etc.) that would assist the Plan in determining whether PCPs experience challenges in coordinating timely referrals for members. Therefore, the Plan cannot ensure that problems are being identified or that effective action is taken to improve care where indicated.

Conclusion: DHCS-HPSM Contract, Exhibit A, Attachment 11, Provision 1 requires the Plan to maintain procedures for monitoring the coordination of care provided to its members. DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 1, Rule 1300.70(a)(1) and (3), and Rule 1300.70(b)(1)(B) incorporate the requirement for continuous monitoring with the Plan's quality assurance program to ensure that problems are being identified and effective action is taken to improve care. However, the Department determined that the Plan does not monitor several key aspects pertaining to continuity or coordination of care. Specifically, despite the PCP's critical role in coordinating members' care, the Plan does not monitor for any noteworthy trends regarding any reasons for PCP changes, whether initiated by the member or the PCP.

DHCS-HPSM Contract, Exhibit A, Attachment 11, Provision (2)(1) requires basic case management to include provision of the IHA. DHCS-HPSM Contract, Exhibit A, Attachment 10, Provision (3)(A) further establishes the importance of the IHA in enabling the PCP to manage the member's health needs and identify those members who require coordination with other agencies for services. DHCS-HPSM Contract, Exhibit A, Attachment 10, Provision (3)(E)(1) requires completion of the IHA within 120 days of enrollment or else have at least three documented attempts to demonstrate unsuccessful efforts. Yet, the Plan has not verified the accuracy of the methodology that it uses to capture IHA completion rates (e.g., comparing claims encounter data with result from the periodic site audits) and regardless, its reported rates fell below the Plan's average target rate of 69.80%, despite its Pay for Performance Program that provides PCPs with incentives for completing the IHA within the required timeframes. Plan staff also confirmed that no monitoring is conducted to verify that PCPs are either consistently making or documenting follow-up attempt efforts.

Finally, DHCS-HPSM Contract, Exhibit A, Attachment 5, Provision 1(F) requires the Plan to track and monitor services requiring prior authorization, and DHCS-HPSM Contract, Exhibit A, Attachment 9, Provision 3(A)(2)(d) requires that appointments with specialists be granted within

15 business days of the request. Based on the Plan's policies, out-of-network specialist referrals require prior authorization, yet Plan staff indicated that they do not formally track these referrals.

Because the Plan fails to monitor the coordination of care provided to its members as it pertains to PCP changes, IHA completion, and out-of-network referrals, it also cannot ensure that problems are being identified so that effective action is taken to improve care as necessary. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

AVAILABILITY AND ACCESSIBILITY

Potential Deficiency #5: The Plan does not ensure adequate oversight of accessibility and availability of services by its governing body and its Quality Assessment and Improvement Committee.

Contractual/Statutory/Regulatory References: DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 2 – Accountability, and Provision 3(C) and (D) – Governing Body, and Provision 4 – Quality Improvement Committee; Rule 1300.67.2.2(d)(2)(D).

DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System

2. Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the Medical Director, and the inclusion of contracting Physicians and Contracting Providers in the process of QIS development and performance review. Participation of non-contracting providers is at the Contractor's discretion.

3. Governing Body

Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following:

- C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.
- D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

4. Quality Improvement Committee

Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the Medical Director or a physician designee shall actively participate on the committee. Contractor must ensure that subcontractors, who are representative of the composition of the contracted provider network including but not limited to subcontractors who provide health care services to Seniors and Persons with Disabilities or

chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to QIC.

The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

Rule 1300.67.2.2(d)(2)(D)

(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:

(D) Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services.

Documents Reviewed:

- San Mateo Health Commission and San Mateo Community Health Authority Meeting Minutes (02/12/14, 04/09/14, 05/14/14, 07/09/14)
- Quality Assessment and Improvement Committee (QAIC) Meeting Minutes (02/19/14)
- DMHC Onsite Request #14: Q2 2014 Missing QAIC Meeting (undated)
- Quality Improvement System (2013 – 2014)
- Description of Committees and Membership List (2013 – 2014)
- Provider Network Update – Evolving Network Capabilities (03/26/14; 06/06/14)
- Quarterly Provider Services Network Updates – List of Attendees (July 2013 – June 2014)
- HPSM Accessibility Monitoring (2013 results)

Assessment: DHCS-HPSM Contract, Exhibit A, Attachment 4, Provisions 2, 3, and 4 require the Plan to maintain a system of accountability which includes the participation of the governing body and designation of a quality improvement committee. The governing body must routinely receive written progress reports from the quality improvement committee on activities, findings, recommendations, and actions.

The Plan's Quality Improvement System document is consistent with these contractual requirements and on page 10 states, "[T]he Quality Assessment Improvement Committee (QAIC) provide[s] insight and recommendations about HPSM's quality initiatives. Reports from all these activities are provided at least quarterly to the San Mateo Health Commission (SMHC), HPSM's governing body."

However, there was no documentation to demonstrate that the SMHC either regularly received or reviewed reports from the QAIC. The Department discovered that the QAIC met only once

during the seven-month review period on February 19, 2014. The meeting scheduled for May 21, 2014 was cancelled due to the inability to reach a quorum. Therefore, quarterly reports were not provided to the SMHC as required since the QAIC failed to meet quarterly as well.

Furthermore, the Department's review of existing meeting minutes from both the SMHC and the QAIC showed minimal evidence to demonstrate that these committees received or discussed data on issues relating to accessibility and availability of services. During interviews, Plan staff described analyses performed regarding appointment availability survey results and geographic distribution of providers in relation to members. However, discussions regarding these analyses were not recorded in either the SMHC or QAIC meeting minutes. Minutes included no documented discussion of key aspects of accessibility and availability such as appointment wait times or geographic distribution of key specialties, and those few references made toward accessibility and availability were brief and lacked detail. For example:

SMHC Minutes (02/12/14)

- Item 5.2 includes a discussion on the impact of Assembly Bill 85, including the expansion of Medi-Cal in California. Specifically, on page 2, it states:

Commissioner [name] asked if there has been any change to the network of Medi-Cal PCPs in terms of availability or increase in contracted PCPs. [Name], Provider Network Director, answered that there is no new influx of providers as of yet; however, there is adequate capacity throughout the network and quite a bit of competition for Medi-Cal members in some parts of the county.

- Item 5.3 includes a discussion on the Plan's approval of a subcontract with San Mateo County Behavioral Health and Recovery Services (BHRS). Specifically, on page 4, it states:

HPSM staff is working closely with BHRS [San Mateo County Behavioral Health and Recovery Services] to ensure there is access to treatment. However, developing appropriate access will take time.

QAIC Minutes (02/19/14)

- Item 5.6 includes a discussion on one of the Plan's access-related internal quality improvement projects [IQIP]. Specifically, on page 4, it states:

[QI Specialist] reported we are required by the State of California to have an internal quality improvement project (IQIP) as well as a statewide project (the current topic is readmissions). The last 10 years for our IQIP has been early access for prenatal care. Going forward, we will evaluate the effectiveness of each intervention. Note: the State has allowed us to extend the prenatal project. Our Quality staff has been working to re-establish with our community partnerships. Our rates have been in the 50th percentile. We are hoping to increase our percentile to the 75th

percentile by direct member outreach, engaging the provider network, and work closely with our IT Dept. to capture data. Continue follow up at the next quarterly QAIC meeting.

The Department inquired about the lack of discussion related to accessibility and availability of services in both the SMHC and QAIC meeting minutes. In interviews, Plan staff explained that its Provider Network Quarterly Review Committee (PNQRC) is charged with reviewing data on access and availability. The nine-member committee is comprised of Plan staff, including the CEO, the Director of Member Services, the Director of Provider Network Development and Services, and the Medical Director. Upon the Department's request, the Plan submitted PowerPoint presentations for the March and June 2014 meetings of this group. The presentations included a variety of data on pertinent access-related topics such as network enrollment, provider capacity, specialty data, medical group data, recruiting initiatives, and work plans. However, the group did not keep minutes of its discussions. As such, the Department was unable to determine what discussions took place regarding the information presented to see whether any committee determinations or recommendations were made. Plan staff confirmed that information within the PowerPoint presentations was funneled upward to either the SMHC or the QAIC but that in the absence of any PNQRC minutes, there was no documentation to substantiate that anything had been submitted to either of these bodies. Nevertheless, given that the QAIC does not itself meet to review accessibility and availability of services, it does not fulfill its responsibility to report activities, findings, recommendations, and actions to the governing body.

Conclusion: DHCS-HPSM Contract, Exhibit A, Attachment 4, Provisions 2, 3(C) and (D), and 4 require the Plan to maintain a system of accountability which includes the participation of the governing body and designation of a quality improvement committee. The governing body must routinely receive written progress reports from the quality improvement committee on activities, findings, recommendations, and actions. Rule 1300.67.2.2(d)(2)(D) requires the Plan to review and evaluate, on not less than a quarterly basis, the information available to the Plan regarding accessibility and availability of services. The Department's review of meeting minutes for the Plan's governing body (SMHC) and QAIC for the survey review period demonstrate only minimal discussion of access-related issues. Furthermore, the Plan's QAIC did not meet on a quarterly basis as required and therefore did not submit reports to the SMHC for review. Although the Plan has established a PNQRC that does present data on a variety of access-related topics, there was no documentation to substantiate that information was funneled upward to either the SMHC or QAIC for review. As such, there is no evidence to suggest that the QAIC itself reviews accessibility and availability of services. Therefore, the QAIC does not fulfill its responsibility to report activities, findings, recommendations, and actions to the governing body. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Potential Deficiency #6: The Plan does not ensure that during normal business hours, the waiting time for a member to speak by telephone with a customer service representative does not exceed ten minutes.

Contractual/Statutory/Regulatory References: DHCS-HPSM Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 4(D) – Contract Performance; Rule 1300.67.2.2(c)(10); Rule 1300.67.3(a)(2).

DHCS-HPSM Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan

4. Contract Performance

Contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with Title 28 CCR Section 1300.67.3. Contractor shall ensure the following:

D. Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the Contractor’s business.

Rule 1300.67.2.2(c)(10)

Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee’s questions and concerns *shall not exceed ten minutes*. [Emphasis added.]

Rule 1300.67.3(a)(2)

(a) The organization of each plan shall provide the capability to furnish in a reasonable and efficient manner the health care services for which subscribers and enrollees have contracted. Such organization shall include:

(2) staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

Documents Reviewed:

- Policy MS.04-03: Overview & Scope of Member Services (08/19/14)
- Policy PS.06-01: Timely Access and Member Access to Services and Network Sufficiency (12/06/13)
- Health Plan of San Mateo – Call Center Report (Q1 and Q2)

Assessment: Rule 1300.67.2.2(c)(10) requires that during normal business hours, the waiting time for a member to speak by telephone with a customer service representative does not exceed ten minutes. Policy PS.06-01: Timely Access and Member Access to Services and Network is consistent with this standard. To assess the Plan’s compliance with this requirement, the Department placed ten calls to the Plan’s Member Services line over the course of a two-month time span on varying days and times during normal business hours. The results were as follows:

- *Calls #1 & #2:* Two calls were placed on November 5, 2014, one in the morning and one in the afternoon. During both calls, the results were the same. Upon pick-up, the caller heard a voice recorded standard greeting in English (“thank you for calling the Health Plan of San Mateo, etc. ...”), which was followed by the same greeting in Spanish and

Tagalog, and included instructions on how to access each of the alternate language options. The caller chose to stay on the line with the English option. Dead air briefly followed the greeting and the language prompt, and then another recording stated that the call may be recorded for quality/training purposes, and that all representatives were currently busy and to please hold. More dead air followed, and then another recording repeated that all representatives were still busy, and a voicemail option was offered. More dead air followed, and then another recording notified the caller that s/he was being transferred to the Plan's voicemail. There was no longer an option to wait on hold offered. An automated message advised the caller that s/he would receive a call back within one business day and the caller was provided the means to leave a message on the voicemail system. The total time spent on the morning call was 3 minutes, 34 seconds, and the total time spent on the afternoon call was 3 minutes.

- *Calls #3, #4, & #5:* Three calls were placed on November 10, 2014.
 - For the first call, the caller selected the English language option and an English-speaking MSR came on the line after a wait time of 2 minutes and 48 seconds.
 - For the second call, the caller selected the Spanish option and an English-speaking MSR came on the line after a wait time of 1 minute and 52 seconds and offered to transfer the caller to a Spanish-speaking MSR.
 - For the third call, the caller selected the Tagalog option, and an English-speaking MSR came on the line after four rings but immediately put the caller on hold for one minute and 30 seconds. When the MSR came back on the line, the caller requested a Tagalog translator. The MSR put the caller on hold for an additional 2 minutes until a Tagalog speaker came on the line.
- *Call #6:* One call was placed during the morning of December 3, 2014. The wait time for the call was 1 minute and 38 seconds, after which an MSR came on the line.
- *Call #7:* One call was placed during the afternoon of December 24, 2014. The wait time for the call was 15 seconds, after which an MSR came on the line.
- *Call #8:* One call was placed on January 6, 2015. After the voice recorded greeting, the caller selected the Spanish option. An initial recording stated that all representatives were busy and the caller was placed on hold. A subsequent recording stated that all representatives were still busy and the caller was going to be transferred to voicemail. At that point, an English-speaking MSR came on the line. When the caller explained that the Spanish option had been requested, the MSR then spoke in Spanish. The MSR explained that the Spanish-speaking MSRs customarily answer the phone in English, but upon hearing a request for Spanish, has the capability of switching to Spanish. The total wait time was 2 minutes.

- *Call #9:* One call was placed during the morning of January 7, 2015. The wait time for the call was 1 minute and 45 seconds, after which an MSR came on the line.
- *Call #10:* One call was placed in the morning of January 8, 2015. The caller was first offered voicemail but chose to stay on the line. After a total wait time of 3 minutes and 20 seconds, the caller was automatically transferred to voicemail and told that the call would be returned in one business day.

A summary of the call wait times and responses can be found in the table below:

TABLE 1
Member Services Call Center Wait Times & Responses

CALL #	DATE	WAIT TIME ¹⁰ (MINUTES : SECONDS)	LANGUAGE	PLAN RESPONSE (VOICEMAIL OR MSR)
1	11/05/14	03:34	English	Voicemail
2	11/05/14	03:00	English	Voicemail
3	11/10/14	02:48	English	MSR
4	11/10/14	01:52	Spanish	MSR
5	11/10/14	01:30 + 02:00	Tagalog	MSR
6	12/03/14	01:38	English	MSR
7	12/24/14	00:15	English	MSR
8	01/06/15	02:00	Spanish	MSR
9	01/07/15	01:45	English	MSR
10	01/08/15	03:20	English	Voicemail

In total, wait times ranged from as short as 15 seconds, to as long as 3 minutes and 34 seconds. Although all ten calls were well within the ten-minute wait time standard, only seven calls were answered by a live MSR. For the three calls that were not answered by a live MSR, the caller was automatically transferred to voicemail with no option of waiting to speak to a live MSR. Therefore, although the call was terminated well within the ten-minute wait time standard, because the member was never able to speak to a live representative, the Plan is in violation of Rule 1300.67.2.2(c)(10). Furthermore, the automated message indicated that a return call would occur within one business day, and not within ten minutes.

The Department evaluated the Plan’s 2014 Call Center Report to gain further insight into call center activity patterns. The report indicated that during the first and second quarters of 2014, 67% and 73% of calls were answered directly by MSRs, while 21% and 16%¹¹ of calls went to

¹⁰ Please note that wait times are approximate due to manual tracking.

¹¹ The Plan’s 2014 Call Center Report does not capture the percentage of calls that went to voicemail but instead includes the raw data only. During the first and second quarters, 525 of 2,556 (21%) and 359 of 2,231 (16%) of calls were “flow out calls” that went to voicemail, respectively. The Department manually calculated the percentages using the raw data.

voicemail, respectively. Of the calls that were answered directly by MSRs, 62% and 70% of calls were answered within 60 seconds, and 38% and 30% of calls took longer than 61 seconds to answer, with average wait times of 48 seconds and 40 seconds, respectively. Despite low average wait times with the majority of calls answered within 60 seconds, there was no measure of how many calls were answered beyond the ten-minute required timeframe as the Plan only measured the percentage of calls answered beyond 61 minutes. The Plan further did not measure how long it took for MSRs to return phone calls for members who are routed to voicemail.

Conclusion: Rule 1300.67.2.2(c)(10) requires the Plan to ensure that during normal business hours, the waiting time for a member to speak by telephone with a customer service representative knowledgeable and competent regarding the member's questions and concerns does not exceed ten minutes. DHCS-HPSM Contract, Exhibit A, Attachment1, Provision 4 and Rule 1300.67.3(a)(2) require the Plan to ensure sufficient staffing in medical and administrative services to effectively conduct the Plan's business. The Department's review of ten random phone calls placed to the Plan's Member Services Department revealed that in three calls, members were involuntarily transferred to voicemail without given the option of continuing to wait on the line to speak to a live MSR. Furthermore, the recorded message indicated that a call back would be made within one business day, and not within ten minutes. Evaluation of the Plan's 2014 Call Center Report was consistent with the Department's findings and confirmed that during the first and second quarters of 2014, 21% and 16% of respective calls received by the Member Services Department went to voicemail. This suggests that that Plan does not have sufficient staffing in its call center to effectively conduct business. Furthermore, although the Plan's report does capture a variety of useful data including the volume of calls, average wait times, and call types, there is no measurement of compliance for calls answered within the required ten-minute standard to speak to a live customer service representative. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

MEMBER RIGHTS

Potential Deficiency #7: The Plan does not consistently resolve each grievance and provide written notice of resolution to the member within 30 calendar days from receipt of the grievance.

Contractual/Statutory/Regulatory References: DHCS-HPSM Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System, and Provision 5(B) – Member Appeal Process; Section 1368.01(a); Rule 1300.68(d)(3).

DHCS-HPSM Contract, Exhibit A, Attachment 14 – Member Grievance System

1. Member Grievance System

Contractor shall implement and maintain a Member Grievance system in accordance with Title 28 CCR Section 1300.68.... Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

5. Member Appeal Process

Contractor shall implement and maintain a Contractor-level appeal process as described below to resolve Member appeals.

B. Contractor must provide a Member notice, as expeditiously as the Member's health condition requires, within 45 days from the day Contractor receives the Contractor-level appeal. A Member notice, at a minimum, must include the result and date of the appeal resolution.

Section 1368.01(a)

The grievance system shall require the plan to resolve grievances within 30 days.

Rule 1300.68(d)(3)

The plan shall respond to grievances as follows:

(3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in Subsection (d)(8).

Documents Reviewed:

- 47 Standard Grievance and Appeal files (01/01/14 – 07/31/14)
- Policy GA-07: Member Grievance Procedure for Non-Medicare Lines of Business (07/05/13; 09/09/14)

Assessment: Section 1368.01(a), Rule 1300.68, and DHCS-HPSM Contract, Exhibit A, Attachment 14, Provision 1, require the Plan to resolve each grievance and provide written notice of resolution to the member within 30 calendar days from receipt of the grievance. Policy GA-07: Member Grievance Procedure for Non-Medicare Lines of Business is consistent with this requirement. To assess the Plan's compliance with this standard, the Department reviewed a random sample of 47 standard grievance and appeal files¹². In 13 of 46 (28%) files, the Plan failed to provide written resolution of the grievance to the member within 30 calendar days as required. The following table includes a summary of the files that were found to be deficient in this standard:

TABLE 2
Grievance Resolution Letters Not Sent Within 30 Calendar Days

FILE #	PLAN ID	GRIEVANCE RECEIPT DATE	RESOLUTION LETTER DATE	CALENDAR DAYS FOR RESOLUTION
6	201402606	03/31/14	05/01/14	31
8	201404182	05/19/14	07/07/14	49 ¹³

¹² One file was excluded from review because the member withdrew the grievance after the acknowledgment letter was sent and therefore a resolution letter was no longer required. As a result, 46 files were measured against the standards of DHCS-HPSM Contract, Exhibit A, Attachment 14, Provision 1, Section 1368.01(a), and Rule 1300.68.

¹³ File #8 is a grievance regarding a previously denied service (appeal). DMHC Contract DHCS-HPSM Contract, Exhibit A, Attachment 14, Provision 5(B) requires the Plan to send the member written resolution within 45 days from receipt of the request (rather than 30 days). However, the Plan's policy indicates the more stringent 30-calendar day standard. Nevertheless, the resolution letter was sent beyond both the 30-day and 45-day standard.

10	201402499	03/27/14	04/29/14	33
13	201403500	04/25/14	06/26/14	62
14	201404436	05/28/14	07/22/14	55
21	201401297	02/18/14	06/23/14	125
27	201403322	04/18/14	06/26/14	69
37	201403554	04/29/14	05/31/14	32
39	201404026	05/13/14	07/16/14	64
40	201400792	01/30/14	03/03/14	32
41	201403762	05/05/14	06/27/14	53
43	201402250	03/18/14	05/08/14	51
44	201403525	04/28/14	07/09/14	72

Two examples are discussed below:

- *File #21:* This file is of particular concern to the Department due to the Plan’s prolonged delay (125 days) in resolving the member’s grievance. The following is a chronological summary of the case:
 - *02/18/14:* The Plan received a handwritten grievance letter from the daughter/caretaker of a 77-year-old partially paralyzed and wheelchair bound female member who suffered a third cerebral vascular accident. The letter explained that the member had spent six months a skilled nursing facility before the daughter took her home to care for her herself. The daughter/caretaker was requesting a full electric hospital bed due to safety concerns and difficulties operating the existing semi-electric bed.
 - *02/25/14:* The Plan timely acknowledged receipt of the grievance indicating the grievance would be resolved within 30 days.
 - *03/20/14:* The Plan extended the timeframe for resolving the grievance and in a letter to the member stated, “Based upon our review, we are extending the timeframe for making a decision until April 7, 2014 because we will need a DME [durable medical equipment] consultant to go to your house and do an evaluation.”
 - *04/10/14:* The Plan once again extended the timeframe for resolving the grievance and in a letter to the member stated:

Based upon our review, we are extending the time frame for making a decision until April 21, 2014. I understand that it is taking a long time for a resolution to be made but we have been communicating with DME Consultants to do

an evaluation. We understand that the appointment has been scheduled for April 12, 2014. HPSM will communicate with DME Consultants and provide us with a report. We thank you so much for your patience.

- *04/14/14:* The DME Consulting Group completed its report. The physical therapist who conducted the evaluation stated in the report, “While it is understandable that the caretaker and member wish to receive this device and it would provide greater convenience, it is not a covered benefit. **Based on the information on the following pages, the current request does not meet the criteria for medical necessity at this point in time.**”
- *04/18/14:* The Plan’s physician reviewer reviewed the case and noted the following denial determination:

Request for full-electric hospital bed denied. 77 yo F [year-old female] with recent third CVA, non-ambulatory and needing diaper changes up to four time a day. Current semi-automatic hospital bed, being provided in 12/2013, adequately meets member’s ADL [activities of daily living] needs per 4/14/14 on-site RPT assessment; the purpose of the request is to alleviate the care-giver’s shoulder pain. Daughter is appointed IHSS [In-Home Supportive Services] provider. Total electric bed not reasonable and necessary. LCD L11572. CM [case management] to approve for pressure relieving mattress to prevent pressure sores and refer the case SW [social work] for community resources.

- *04/21/14:* The physician reviewer sent an email to the Health Services nurse assigned to the case informing her of the denial determination. The email stated, “I denied this request for total-electric bed. Approved for pressure relieving mattress and SW (social worker) referral.”

Case notes further indicate that the member’s daughter/caretaker was notified by phone and informed of the denial determination.

- *06/23/14:* 125 days following the receipt of the grievance, the Plan sent the member a written notice of resolution that stated:

The durable medical equipment (DME) evaluation conducted at your mother’s home and the review of this evaluation by HPSM’s Associate Medical Director did not medically justify the need for a new bed. Your request for a new bed has therefore been denied. However, as you know, HPSM’s Associate Medical Director recommended

that your mother be given a different mattress to meet her needs. In order to provide you with this mattress, HPSM must receive a TAR from a DME company contracted with HPSM, such as M&M Medical Supply. To obtain a TAR, the DME company must first get a prescription for the appropriate mattress from your mother's primary care physician, [doctor's name]. We have tried to assist you with coordinating this process, but have not received confirmation that your mother has seen [doctor's name] to obtain this prescription. If your mother is still in need of a new mattress, please follow up with [doctor's name] directly. We apologize for the delay in processing your mother's case and for any difficulty or inconvenience either you or your mother may have experienced.

The file included documentation to indicate that the Plan had made repeated coordination efforts with the member's PCP office to see whether the request for the new mattress had been made. Nevertheless, it still took the Plan 125 days to send out the resolution letter which falls outside of the 30-day required timeframe to resolve grievances. Furthermore, there still was no indication that the Plan had actively followed-up with the member's daughter/caretaker to ensure that the mattress had in fact been provided and the grievance was adequately resolved.

- *File #14* This file demonstrates the Plan's delay in promptly requesting records to investigate the case, resulting in a 55-day timeframe for grievance resolution. The following is a chronological summary of the case:
 - *05/28/14:* The Plan received the grievance by telephone when the member's daughter contacted the Plan reporting that during a follow-up visit, her father's PCP became very upset and yelled at him because he went to the emergency room twice within two weeks. The member's daughter explained that the member went to the emergency room because of severe back pain and was having trouble walking. The daughter reported that they had been trying to find out what was wrong but the PCP would not tell them what the diagnosis was but would instead continue prescribing pain medications.
 - *05/30/14:* The Plan timely acknowledged receipt of the grievance indicating the grievance would be resolved within 30 days.
 - *07/16/14:* 49 days from receipt of the member's grievance, the Plan's Grievance and Appeals Coordinator contacted the patient advocate at the member's medical center, requesting provider response regarding the grievance.
 - *07/18/14:* The patient advocate at the medical center responded to the Plan's Grievance and Appeals Coordinator and in a written message and stated, "I will

provide you with further detail when available. *I have questions as to when the Health Plan received this complaint as the patient's visits to the emergency were in March and May, see notes in report.*" [Emphasis added.]

- 07/21/14: The patient advocate at the medical center resolved the member's grievance within three days from the Plan's request for provider response and in a written message to the Plan's Grievance and Appeals Coordinator stated:

I have attached a copy of the letter that will be going out to the patient, it is currently being translated to Spanish. I will be closing this complaint at this time. *I would still like to speak with you or your manager on how we can get concerns related to care at the Medical Center or our clinics sent to us in a more timely way.* [Emphasis added.]

Additionally, the patient advocate's resolution letter to the member stated:

You had contacted the HPSM on May 28th regarding concerns you had with your care. *We would like to apologize for our late reply to these issues as they were just provided to us on July 16th....* After receiving your concerns they were immediately forwarded to [doctor's name], Medical Director... [Emphasis added.]

- 07/22/14: 55 days following the receipt of the grievance, the Plan sent the member its own written notice of resolution. Based on the investigation conducted by the patient advocate at the medical center, the Plan's resolution letter indicated that the member's concerns regarding the PCP were being addressed, the member had been assigned to a new PCP, and the member had since been seen by a specialist and is awaiting a surgery appointment.

In this case, it was evident that the delay in resolving the grievance had to do with the Plan's failure to promptly contact the patient advocate at the medical center to initiate an investigation. The initial request for information was not submitted until 49 days following receipt of the grievance. Documentation indicates that the patient advocate expressed concerns two times to the Grievance and Appeals Coordinator regarding the delay in being notified of the grievance by the Plan, and in her own resolution letter to the member indicated that the case was processed immediately on her end upon notification of grievance.¹⁴

Conclusion: Section 1368.01(a), Rule 1300.68, and DHCS-HPSM Contract, Exhibit A, Attachment 14, Provision 1, require the Plan to resolve each grievance and provide written notice

¹⁴ Please see Deficiency #8 for further examples of grievances that demonstrate the Plan's delay in initiating requests for medical records from the provider. These particular grievances contained potential quality of care issues and were referred to the Plan's Medical Director for review.

of resolution to the member within 30 calendar days from receipt of the grievance. DHCS-HPSM Contract, Exhibit A, Attachment 14, Provision 5 requires the Plan to resolve member appeals within 45 days from receipt of the appeal. In 13 of 46 (28%) grievance files reviewed, the Department found that the Plan failed to provide written resolution of the grievance to the member within 30 calendar days as required. Therefore, the Department finds the Plan in violation of these contractual, statutory, and regulatory requirements.

QUALITY MANAGEMENT

Potential Deficiency #8: The Plan does not consistently ensure that quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Contractual/Statutory/Regulatory References: DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; DHCS-HPSM Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(E) – Grievance System Oversight; Rule 1300.70(a)(1); Rule 1300.70(b)(1).

DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

DHCS-HPSM Contract, Exhibit A, Attachment 14 – Member Grievance System

2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below to monitor the Member's Grievance system and the expedited review of grievances required under Title 28 CCR Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.

E. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Contractor's Medical Director.

Rule 1300.70(a)(1)

The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Rule 1300.70(b)(1)

To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that a level of care which meets professionally recognized standards of practice is being delivered to all enrollees.

Documents Reviewed:

- Policy GA-07: Member Grievance Procedure for Non-Medicare Lines of Business (07/05/13; 09/09/14)
- Policy QAI-01: Quality Assessment and Improvement Protocol, Policy and Procedure (07/30/14)
- Policy QAI-03: Review and Handling of Quality of Care Complaints and Concerns (03/25/14)
- 2013-2014 Quality Improvement System
- 5 Potential Quality Issue (PQI) files (01/01/2014 – 07/31/2014)
- 47 Standard Grievance and Appeal files (01/01/14 – 07/31/14)

Assessment: Policy QAI-03: Review and Handling of Quality of Care Complaints and Concerns states on page 3, “The most common way that clinical quality of care concerns are identified is via grievances that are filed by members, on behalf of members or by providers.” Indeed, the Plan identified five PQI files during the survey review period, all of which initially came to the Plan through the member grievance process. The Department’s evaluation of these five files, along with the Plan’s processes for identifying and handling PQIs, revealed the following concerns:

- 1) The Plan does not consistently identify grievances related to medical quality of care issues and refer them to the Medical Director.
- 2) The Plan does not consistently document that quality of care provided is being reviewed prior to closing PQI cases.
- 3) The Plan does not consistently document that quality of care problems are being identified.
- 4) The Plan does not consistently document that effective action is taken to improve care where deficiencies are identified and follow-up is planned where indicated.
- 5) The Plan does not consistently complete its investigation of PQIs in a timely manner.

1) *The Plan does not consistently identify grievances related to medical quality of care issues and refer them to the Medical Director.*

DHCS-HPSM Contract, Exhibit A, Attachment 14, Provision 2 requires grievances related to medical quality of care issues to be referred to the Plan’s Medical Director. Policy QAI-03: Review and Handling of Quality of Care Complaints and Concerns is consistent with this requirement. Specifically, on page 3, it states:

All grievances that could potentially involve clinical quality of care concerns are noted by the Grievance and Appeals Coordinators as soon as they arrive and promptly brought to the attention of one of the Medical Directors.

...

For cases that initially come to the attention of HPSM via Member Services/Care Navigators staff or Provider Services Staff: such cases are referred to one of the Grievance and Appeals Coordinators, who will bring the case to one of the Medical Directors.

The Department noted that the Plan identified only five PQI files during the survey review period. To assess whether the Plan consistently identified and referred all cases that merited clinical review to the Medical Director, the Department reviewed a random sample of 47 grievance and appeal files. Of the 47 files reviewed, the Department identified five files that involved potential medical quality of care issues. One of these files¹⁵ had been identified by the Plan as a PQI and was referred for clinical review for investigation by the Medical Director. Two files¹⁶ were not formally classified as PQIs but were nevertheless referred to the Medical Director for clinical review. However, the remaining two files¹⁷ (40%) that merited clinical review were not referred to the Medical Director for investigation.¹⁸ For example:

- *File #14:* The Plan received the grievance by telephone when the member's daughter contacted the Plan reporting that during a follow-up visit, her father's PCP became very upset and yelled at him because he went to the emergency room twice within two weeks. The member's daughter explained that the member went to the emergency room because of severe back pain and was having trouble walking. The daughter reported that they had been trying to find out what was wrong but the PCP would not tell them what the diagnosis was but would instead continue prescribing pain medications.

The Plan's Grievance and Appeals Coordinator initiated an investigation by contacting the patient advocate at the member's medical center, requesting the provider's response regarding the grievance. The referral form indicates that the following two boxes were checked for the type of complaint that was received: "Quality of Care" and "Communication."

The patient advocate at the medical center ultimately resolved the member's grievance by requesting medical records and following up with the member's care. In a resolution letter to the member, the patient advocate wrote:

After receiving your concerns they were immediately forwarded to [doctor's name], Medical Director [medical center] for review. You had been seen by your primary care provider and in the emergency several times after apparently having back pain from moving some heavy wood. Care progressed with an MRI being ordered, a review of the MRI findings was conducted with you, a pain management plan was discussed, which

¹⁵ File #15

¹⁶ File #4; 21

¹⁷ File #14; 17

¹⁸ Please see Table 3.

included pain medications and a referral to [spine clinic] was provided. When we received your concerns last week we noted that you had been seen at [spine clinic]. Clinic staff contacted you and found you are awaiting a surgery appointment through [spine clinic]. Care can take time as we wait to see if treatment plans are working. We also understand that during this time you continued to have pain which we apologize for. We are glad that the plan for care that has been moving forward appears to be working for you. We will continue to provide and follow up with you for your primary care.

Your concerns regarding the behavior or your provider are being address[ed]. I am unable to provide you with the outcome of this review as it is considered a personnel issue. We apologize if your visit was not to the high standards we expected you to receive. We have assigned you to a new primary care provider, [doctor's name], per your request. You are scheduled to be seen by [doctor's name] on July 25th at 10:00 AM.

The following day, the Plan sent its own written notice of resolution to the member, summarizing the same events noted in the patient advocate's resolution letter. However, although the patient advocate's letter indicated that the grievance was forwarded to the medical center's Medical Director for review, the case was never referred to the Plan's own Medical Director, despite the clear indication of potential quality of care issues as noted in its referral form. Furthermore, although the Plan's resolution letter indicated that the concerns regarding the behavior of the PCP were being addressed, other than receipt of the patient advocate's resolution letter, there was no documentation that the Plan had conducted its own investigation to determine whether the member received appropriate pain management care from the PCP, or whether the member's claim that the PCP refused to disclose a diagnosis was substantiated. Due to the Plan's initial failure to identify this as a case that warranted clinical review by the Medical Director, the Department was unable to determine whether substandard care or other quality problems existed, necessitating implementation of a corrective action plan (CAP).

2) The Plan does not consistently document that quality of care provided is being reviewed prior to closing PQI cases.

Rule 1300.70(a)(1) requires the Plan to document that the quality of care provided is being reviewed. The Department reviewed all five PQI files identified by the Plan during the survey review period and determined that two of five files¹⁹ (40%) were not adequately investigated. Documentation revealed that the lack of investigation was due to the providers' unresponsiveness to the Plan's requests for medical information. For example:

- *File #1:* This file documents closure of the case despite repeated attempts by the Plan to obtain necessary information for investigation without success. The following is a chronological summary of the case:

¹⁹ File #1; 2

- *01/14/14:* The member contacted the Plan through its telephone grievance process and reported multiple complaints regarding a recent seven-day stay at a rehabilitation facility following a month-long hospitalization due to heart failure. The reported allegations reflect a combination of both quality of service and quality of care concerns which are summarized below:

Quality of Service concerns:

- The member did not receive a wristband when she was admitted at the facility.
- The sheets from another bed were removed and placed on the member's bed.
- The nurse did not put on gloves while administering the member's medications. The nurse became upset and told the member that she was paranoid and was a difficult patient.
- The member felt ignored, isolated, and that the staff wanted her out of the facility.
- The member was never provided a calendar of events.

Quality of Care concerns:

- The member arrived at the facility at approximately 10:00 a.m. and was hungry but was not provided food until later that evening.
 - The member was not assisted with bathing by the nurse.
 - No one came in to check-in on the member.
 - The member was only provided one hour of physical and occupational therapy throughout the course of her seven-day stay and was told that she was fine and could go home.
 - The doctor at the facility told the member that he would be present when she was discharged to make sure everything was okay but he was not there.
 - Upon discharge, the member was released with the wrong medication. The medication prescribed was one the member could not take due to side effects and her past medical history. (This is the most disturbing allegation that would warrant further investigation to determine who prescribed the medications and whether avoidable mistakes were made. If quality of care issues were confirmed, an immediate CAP would need to be implemented.)
- *01/15/14:* The Plan timely acknowledged receipt of the grievance indicating the grievance would be resolved within 30 days.
 - *01/31/14:* The Plan faxed a request for written response to the rehabilitation facility indicating a five-day timeframe to submit records.
 - *02/10/14:* The Plan left a voice message at the rehabilitation facility indicating that a provider response had not been received.

- 02/12/14: The Plan faxed a second request for written response to the rehabilitation facility. The rehabilitation facility confirmed receipt of the request.
- 02/13/14: The rehabilitation facility contacted the Plan requesting a one-week extension to submit medical records. The Plan agreed to an extension of 14 days after informing the member of the delay in the case and obtaining her consent. The Plan's Grievance and Appeals Coordinator sent an email to the Associate Medical Director requesting assistance with obtaining medical records.
- 02/21/14: Case notes from the Plan's Grievance and Appeals Coordinator indicated that no response had been received by the provider and that she would send an email to the Plan's Medical Director requesting that he communicate directly with the rehabilitation facility.
- 02/28/14: The Grievance and Appeals Coordinator contacted the rehabilitation facility and spoke with a staff member who indicated that the person in charge of gathering the medical records was not there. The staff member was instructed by the Grievance and Appeals Coordinator to email the medical records directly to the Plan's Associate Medical Director.
- 03/03/14: Case notes indicated that the Plan's Associate Medical Director had still not received medical records from the rehabilitation facility.
- 03/04/14: The Plan's Grievance and Appeals Coordinator documented a late entry call indicating that a voice message from the rehabilitation facility was received on March 3, 2014. The voice message indicated that the rehabilitation facility had tried to submit the medical records, but the email came back. The Plan's Grievance and Appeals Coordinator left a return voice message indicating the correct email address.

The Plan's Associate Medical Director issued a written message to the Grievance and Appeals Coordinator with his final determination which stated:

HPSM acknowledges the grievance submitted by member [member's name] concerning the care she received during her stay at: [name, address, and phone number of rehabilitation facility]

To conduct a quality-of-care assessment and to evaluate a patient's/member's concern, [I] must review the written documentation provided by and/or the response from the involved facility to make a determination.

The Grievance and Appeals Department at HPSM and I as an associate medical director have made multiple attempts requesting a response and medical records from [rehabilitation facility name], with the first attempt on January 31, 2014. *To date, HPSM has not*

received a response from [rehabilitation facility name]. Therefore, this grievance will be closed at this time; however, as this is a violation of their contractual obligation, further action will be pursued:

- The member will be advised that she may file a complaint with the Ombudsman Program.
- HPSM will attempt to contact the medical director of [rehabilitation facility name].
- The case will be discussed at HPSM's Physician Review Committee. [Emphasis added.]

Case notes from the Grievance and Appeals Coordinator stated:

I spoke to [member's name] and explained that we did not obtain a response back from the provider or the medical records. I explained to her that we recommend for her to file a complaint with the Ombudsman Office. I told her that she will be receiving a resolution letter with this information. She thank[ed] us for trying to obtain a response from the provider.

Resolution letter will be mailed to the member. I will no longer be calling [rehabilitation facility name] for additional information.

The Plan closed the case on March 4, 2014 without having ever received or reviewed medical records from the rehabilitation facility. The grievance resolution letter sent to the member stated, "Because we have not received your records, we cannot evaluate your case for issues regarding the quality of the care that you received. Therefore, this grievance will be closed." The letter informed the member that further action would be pursued regarding the rehabilitation facility's contractual obligation to provide the Plan with medical records, and recommended that the member file a complaint with the Ombudsman Program. However, there was no documentation in file to substantiate that the Plan had indeed pursued further follow-up action beyond March 4, 2014. In addition, no CAPs were implemented related to the facility's lack of cooperation to produce medical records.

- *File #2:* This file documents closure of a case prior to receiving pertinent medical records from the PCP's office. The following is a chronological summary of the case:
 - *02/11/14:* The member, a cancer patient in remission for the past few years, reported the following concerns regarding his PCP, the nurses at the clinic, as well as the laboratory:
 - On January 17, 2014, the member completed a urine test for which he was told was a drug test by the nurses. The member was told he would be

called back. However, after waiting weeks without contact, on February 6 or 7, 2014, the member reached out to the PCP's office to inquire. At that time, he received discrepant information from the nurses which was concerning. The nurses first told him that the laboratory had tested for other things besides drugs and that he had an infection. However, they then retracted the statement indicating that he did not have an infection after all. Nevertheless, the laboratory made a mistake and dumped his urine so he would need to repeat the test again when he comes in for his February 13, 2014 appointment. Based on the results, he would then be able to continue with his narcotic pain medication.

- The member further alleged that his PCP has never examined him to check if his breathing was okay or to confirm an ear infection. Therefore, he wanted to change his PCP.
- *3/11/14*: The Plan's Grievance and Appeals Coordinator submitted a faxed request to the member's clinic requesting all medical records from January 1, 2014 to the present.

The Plan's Grievance and Appeals Coordinator contacted the member to assist with processing the PCP change. The member indicated that he had yet to take the second urine test but needed to in order to obtain his medication. The member indicated that he was willing to take it again, but maintained that someone "dropped the ball" with his first urine test and lost or misplaced it.

The Plan's Grievance and Appeals Coordinator also spoke with the nurse at the clinic who clarified that there was a new Food and Drug Administration regulation that required members on narcotics to be drug tested. The nurse explained that on January 17, 2014, the laboratory had conducted only one test (culture of the urine to detect infection) rather than two tests (including the drug screening). The nurse indicated that the member had an appointment with the PCP "not so long ago," and that the necessity of the urine test was explained to the member, but that he refused to come in for repeat urine testing.

The clinic submitted portions of the requested medical records to the Plan for review but did not include medical notes from the member's PCP. Notes from other providers, including the laboratory tests, were included. There was no explanation regarding the absence of PCP notes.

Case notes from the Plan's Grievance and Appeals Coordinator indicated that the records would be forwarded to the Medical Director for review.

- *3/13/14*: The Plan's Associate Medical Director issued a written message to the Grievance and Appeals Coordinator with his final determination which stated:

I have reviewed the complaint and the records submitted.

To conduct a quality-of-care assessment and to evaluate a patient's/member's concern, I have only the written documentation submitted along with my clinical experience to make a determination.

The member's complaints are regarding the care provided by [PCP's name]. The records provided by San Mateo Medical Center include notes by [neurologist's name], MD, the neurologist, and urine culture results, but do not include any notations by [PCP's name]. Therefore, no opinion can be rendered regarding the care provided by [PCP's name]. Member stated he will change primary care physicians and he is encouraged to do so.

In regards to the urine test, it is unfortunate that the urine collected was not tested as per the member's stated intention and it appears that the urine was lost or discarded. Only a urine culture was performed which demonstrated no evidence of infection. I understand that expressions of apology were given to the member. I also understand that the member is willing to provide another urine sample to run the requested test. I am in agreement with the member's frustration that the requested test was not performed on his original urine sample and appreciated the expressed acknowledgement and apologies from the laboratory and the physician's office. In my clinical experience, this scenario has, unfortunately, occurred on occasion and has involved tests to be performed on both urine and blood samples. A small consolation is that the lost or discarded specimen did not require a venipuncture (needlestick) which would have to be repeated.

The parties involved are aware of this mishap, and should review their systems for areas that require improvement. [Emphasis added.]

The Plan closed the case and sent the member written notification of resolution on March 13, 2014 despite the absence of essential PCP records needed to investigate the case. PCP notes would have been needed to confirm or refute the member's allegations regarding the PCP's failure to examine the member. Although the Plan assisted the member with changing his PCP, there was no documentation to substantiate that the Plan had attempted to obtain the additional information from the clinic prior to closing the case or ran a query to see whether the PCP had a history of member complaints.

As described in the two case examples above, the Plan's failure to initially obtain pertinent medical records needed to fully investigate PQI cases hindered the Plan's ability to then confirm

whether or not quality of care problems existed. As result, the Plan was therefore unable to implement corrective actions if necessary.

3) The Plan does not consistently document that quality of care problems are being identified.

Rule 1300.70(a)(1) requires the Plan to demonstrate that not only quality of care is being reviewed, but that problems are being identified. As noted in concern #2 in the section above, the Plan did not fully investigate two of the five cases identified as PQIs due to an absence of, or incomplete medical records. Therefore, without sufficient review, the Plan was unable to ensure that all quality of care problems were identified. For the remaining three files, the Plan did conduct an adequate investigation by requesting, receiving, and reviewing all pertinent medical information from the provider. However, one case was of particular concern to the Department as the Plan did not identify all quality of care issues, despite conducting a thorough investigation. For example:

- *File #5:* This file represents a particularly challenging case concerning a member with at least 18 complex, co-occurring medical issues. On July 1, 2014, the member filed a grievance against her PCP raising multiple quality of service and quality of care issues including, but not limited to, poor bedside manner, not returning phone calls, refusing to return her In-Home Supportive Services paperwork, telling her to “be quiet because it’s quiet time,” pushing her to the door telling her she had been dismissed from the office, and difficulties obtaining specialist referrals and medications. Follow-up phone calls with the member generated further complaints against other providers as well as a complaint against one of the Plan’s MSRs.

Prior to the member’s filing of the grievance, the PCP had sent a notification to the Plan on June 29, 2014 requesting that the member be terminated from his practice and stated, “I am requesting the above named be removed from my patient list as her medical condition is beyond my expertise.” As part of the investigation, the Plan’s Grievance and Appeals Coordinator later interviewed the PCP who stated:

She’s been to the ER, I’ve seen her in the office for about 20 years or less. She is a long time patient. That’s why I’m giving her up because she is beyond my expertise. She has multiple needs.

...

I referred her to the lymphedema clinic. She needs extensive equipment that she can not afford. She goes to the ER and they tell her that she needs many things, just by seeing her one time. I’m her Dr. and I know what she needs. I referred her to Stanford and also referred her to the Psychiatrist and psychologist also.

Case notes documented extensive efforts by the Plan to investigate the multiple quality of service and quality of care allegations associated with the grievance. The Plan’s Grievance and Appeals Coordinator worked collaboratively with various internal

departments including Provider Services (to obtain timely medical records for review), Care Coordination (to refer the member to case management), as well as Member Services (to facilitate the PCP termination and change request).

Ultimately, the Plan's Associate Medical Director reviewed 117 pages of medical records and on July 16, 2014 issued a written message to the Grievance and Appeals Coordinator with his final determination which stated:

In evaluating this member's concerns and a detailed review of the medical records, I find no quality issues in the provision of care. A multitude of referrals to specialists have been made over the period included in my record review, not only from [PCP's name], but also while an in-patient or from the specialists themselves. ...

The Associate Medical Director's review went on to address each of the allegations raised by the member. However, despite the Plan efforts to conduct a thorough investigation of the case, the Plan failed to identify a single quality of care issue regarding the member's care, such as the lack of care coordination given the member's intensive need for case management, even prior to filing of the grievance. The member's ongoing need for case management and mental health/substance abuse services (as a result of a dependency on opiates which were prescribed by the PCP) had been evident. The health record indicated that the PCP recommended that the member receive treatment at the Stanford Pain Clinic. However, there was no follow-up regarding treatment of the member's medical co-morbidities, referral to case management, or participation in the pain clinic. The PCP did not address the member's opioid dependence and as a result of the member's demands for pain medication (which distracted from other medical treatment), the member's multiple co-morbidities were not addressed.

4) The Plan does not consistently document that effective action is taken to improve care where deficiencies are identified and follow-up is planned where indicated.

Rule 1300.70(a)(1) requires the Plan to demonstrate that not only quality of care is being reviewed and problems are being identified, but that effective action is taken to improve care where deficiencies are identified and follow-up is planned where indicated. As noted in concerns #2 and #3 in the sections above, the Plan did not fully investigate two²⁰ of the five cases identified as PQIs due to an absence of, or incomplete medical records, and was thereby unable to ensure that all quality of care problems were identified. For the remaining three files where a thorough investigation was conducted, the Department identified one case²¹ where the Plan did not identify all quality of care issues. The following case summaries below demonstrate how in three of five files (60%), the Plan's failure to identify problems hindered the Plan from taking effective action or follow-up to improve care. For example:

²⁰ File #1; File 2

²¹ File #5

- *File #1:* The Plan closed the case on March 4, 2014 without having ever received or reviewed the requested medical records from the provider despite repeated follow-up attempts. The grievance resolution letter informed the member that further action would be pursued regarding the provider's contractual obligation to provide the Plan with medical records. However, there was no documentation in file to substantiate that the Plan had indeed pursued further follow-up action beyond March 4, 2014.
- *File #2:* The Plan closed the case on March 13, 2014 after receiving some but not all of the necessary medical records needed to confirm any quality of care issues. The Plan's Associate Medical Director issued a written message to the Grievance and Appeals Coordinator with his final determination which stated:

The member's complaints are regarding the care provided by [PCP's name]. The records provided by San Mateo Medical Center include notes by [neurologist's name], MD, the neurologist, and urine culture results, but do not include any notations by [PCP's name]. Therefore, no opinion can be rendered regarding the care provided by [PCP's name]. Member stated he will change primary care physicians and he is encouraged to do so.

In regards to the urine test, it is unfortunate that the urine collected was not tested as per the member's stated intention and it appears that the urine was lost or discarded. Only a urine culture was performed which demonstrated no evidence of infection. I understand that expressions of apology were given to the member. I also understand that the member is willing to provide another urine sample to run the requested test. I am in agreement with the member's frustration that the requested test was not performed on his original urine sample and appreciated the expressed acknowledgement and apologies from the laboratory and the physician's office. In my clinical experience, this scenario has, unfortunately, occurred on occasion and has involved tests to be performed on both urine and blood samples. A small consolation is that the lost or discarded specimen did not require a venipuncture (needlestick) which would have to be repeated.

The parties involved are aware of this mishap, and should review their systems for areas that require improvement. [Emphasis added.]

The Associate Medical Director indicated that he could not confirm the existence of any quality of care issues in regards to the care provided by the PCP without essential records from the PCP. Nevertheless, the Plan closed the case without further follow-up action requesting those records. Regarding the laboratory issue which the Associate Medical Director identified and confirmed as a "mishap," no corrective action, follow-up, or oversight was implemented to ensure the prevention of similar incidents from occurring.

Rather, the Associate Medical Director simply indicated that the parties involved should review their systems for areas that require improvement.

- *File #5:* The Plan closed the case on July 21, 2014 but yet failed to identify a single quality of care issue despite the member's evident need for intensive case management and mental health/substance abuse services. Due to the Plan's failure to identify any quality of care concerns, no follow-up action was taken to ensure that all members with complex co-occurring medical issues are appropriately referred to case management so that all needs are addressed.

5) The Plan does not consistently complete its investigation of PQIs in a timely manner.

The Plan's policies do not delineate any specific timeframes regarding processing of PQIs. However, the Department's review of timeframes regarding these cases identified overall delays in investigation of the quality of care component due to sometimes-excessive lag times in requesting medical information from the provider. As indicated previously, all five of the Plan's PQI files identified during the survey review period originated as grievances. Delays in investigating the case were not attributed to how long it took the Associate Medical Director to review the case once records were received (this always took less than one week), rather, how long it took the Grievance and Appeals Department to initiate a request for medical records upon receipt of the grievance (this took anywhere from ten days up to two months)²². For example:

- *File #1:* The Plan initiated a request for medical records 17 days from receipt of the grievance. The Associate Medical Director made a determination on the same day it was decided that records could not be obtained from the provider (after multiple attempts).
- *File #2:* The Plan initiated a request for medical records 28 days from receipt of the grievance. The Associate Medical Director made a determination within 2 days of receipt of records reviewed.
- *File #3:* The Plan initiated a request for medical records 30 days from receipt of the grievance. The Associate Medical Director made a determination within 6 days of receipt of records reviewed.
- *File #4:* The Plan initiated a request for medical records 58 days from receipt of the grievance. The Associate Medical Director made a determination within 4 days of receipt of records reviewed.
- *File #5:* The Plan initiated a request for medical records 10 days from receipt of the grievance. The Associate Medical Director made a determination within 6 days of receipt of records reviewed.

²² Please see Deficiency #7 for a discussion on how the Plan does not resolve grievances within 30 calendar days from receipt of the grievance.

TABLE 3
Potential Quality Issues (PQIs)

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Grievances containing potential medical quality of care issues	5	Referred to the Medical Director for review	3 (60%)	2(40%)
PQIs	5	Quality of care provided is reviewed, problems are identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated	2 (40%)	3 (60%)

Conclusion: Rule 1300.70(a)(1) requires the Plan to document that quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. Rule 1300.70(b)(1) requires the Plan to continuously review the quality of care provided to ensure that a level of care which meets professionally recognized standards of practice is being delivered to all enrollees. DHCS- HPSM Contract, Exhibit A, Attachment 4, Provision 1 requires compliance with these regulations and similarly requires the Plan to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers. DHCS-HPSM Contract, Exhibit A, Attachment 14, Provision 2(E) additionally requires the Plan to ensure that grievances related to medical quality of care issues are referred to the Plan’s Medical Director.

The Department’s review of all five of the PQI files identified by the Plan during the survey review period revealed that three files (60%) did not include documentation to support that quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, or follow-up is planned where indicated. Two PQI files, for example, were prematurely closed by the Plan despite the absence of pertinent medical records requested for review. The Department also discovered that PQIs were not always investigated in a timely matter due to delays in requesting information from the provider. Furthermore, the Department’s evaluation of 47 grievance and appeal files identified five grievances containing medical quality of care concerns. However, two files (40%) were not referred to the Medical Director for clinical review. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Potential Deficiency #9: The Plan does not maintain effective oversight procedures to ensure that its delegate, San Mateo County Behavioral Health and Recovery Services, is fulfilling all delegated quality improvement functions and responsibilities.

Contractual/Statutory/Regulatory References: DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, and Provision 6(A) and (B)(1)(3) – Delegation of Quality Improvement Activities; Rule 1300.70(b)(2)(C); Rule 1300.70(b)(2)(G)(2) and (3); Rule 1300.70(b)(2)(H)(1).

DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70.

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors.

B. Contractor shall maintain a system to ensure accountability for delegated Quality Improvement activities, that at a minimum:

1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

Rule 1300.70(b)(2)(C)

(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.

Rule 1300.70(b)(2)(G)(2) and (3)

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

(2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise, and budgetary resources.

(3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.

1300.70(b)(2)(H)(1)

(H) A plan that has capitation or risk-sharing contracts must:

1. Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the plan shall have systems in place to monitor QA functions.

Documents Reviewed:

- 2014 Contract HPSM/BHRS Medi-Cal Carve-In (10/21/14)
- Process and Procedure for Monitoring Delegated UM by BHRS (undated)
- DMHC Onsite Document Request #7: Inquiry regarding BHRS/HPSM Meeting Minutes (11/03/14)
- Q1 2014 Meeting: HPSM-BHRS Mild-Moderate Medi-Cal Benefit (01/16/14)
- Q2 2014 Meeting: HPSM and BHRS Partnership (04/28/14)
- Q3 2014 Meeting: Medi-Cal Claims Summary, Behavioral Health & Recovery Services (January and February 2014)
- Agenda: BHRS/HPSM Meeting (06/05/14)
- San Mateo County Behavioral Health & Recovery Services Quality Improvement Work Plan (2014 –2015)
- BHRS Delegation Report: HPSM Clients Served at ACCESS Call Center (January 2014 – July 2014)
- BHRS Provider Access to Service Survey Results (2014)
- BHRS Roster Update Mild Moderate Providers (July 2014)

Assessment: Effective January 2014, the Plan was required to provide mental health services to its Medi-Cal members, including SPDs, who have been diagnosed with mental health conditions resulting in mild to moderate impairments of mental, emotional, or behavioral functioning. The Plan contracted with San Mateo County Behavioral Health and Recovery Services (BHRS) to provide these services to its members. Exhibit C, “Division of Operational Responsibility,” of the delegation agreement between the Plan and BHRS, indicates that the following functions are delegated: Network Contracting and Credentialing, Claims Processing and Submission, Utilization Management, Care Coordination, Quality Assurance and Improvement, and Member/Consumer Access (including grievances and appeals). In its evaluation of the Plan’s oversight of these delegated functions, the Department identified concerns regarding the following: 1) Pre-Delegation audit, 2) Required Reporting, and 3) Quarterly Meetings.

1) Pre-Delegation Audit

DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 6(B)(1), Rule 1300.70(b)(2)(G)(2), and Rule 1300.70(b)(2)(H)(1) require the Plan to perform an initial review to assure that the delegate has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities. The delegation agreement includes language that mirrors this requirement and

on page 24 similarly states, “HPSM shall evaluate BHRS’s ability to perform the delegated activities, including an initial review to assure that BHRS has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities under this Agreement.” However, in an onsite interview, Plan staff indicated that the Plan did not conduct a pre-delegation audit for BHRS. Plan staff reported that historically, the Plan has worked closely with BHRS, and due to their pre-existing relationship, the Plan was already familiar with BHRS’ operations due to years of collaboration on various other programs.

2) Required Reporting

DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 6(B)(3) and Rule 1300.70(b)(2)(G)(3) require the Plan to have ongoing oversight procedures in place including continuous monitoring to ensure that the delegate is fulfilling all delegated quality assurance responsibilities. Exhibit 1-F, “Reporting,” of the delegation agreement addresses this requirement and on page 25 states, “HPSM is responsible for the monitoring and oversight of BHRS’s performance under this Agreement. BHRS will provide the following reports to support HPSM’s monitoring and oversight, and facilitate Plan’s compliance with State regulatory agencies or private accreditation requirements.” The following reports required for submission include:

- Monthly Call Center Statistics (monthly)
- Claims Settlement Practices Report (quarterly)
- Provider Network Adequacy Report with additions/deletions and telehealth capabilities (monthly)
- Appointment Access Report (annually)
- Monthly Complaints Log (monthly)
- Quality Improvement Annual Report and Work Plan (annually)
- UM Summary Report (monthly)

Of the seven reports delineated, the Department was able to substantiate that BHRS had submitted three²³ of them. For three²⁴ others, although the Plan did not provide evidence to support that BHRS had submitted these reports specifically, the Department was able to glean from other documentation (i.e., information presented at joint Plan/BHRS meetings), that relevant data was reviewed, although not at the frequency specified in the delegation agreement. For example, the delegation agreement requires the monthly submission of the UM Summary Report. Although the Plan provided no evidence to support *monthly* reports had been submitted, the Plan provided a five-page PowerPoint document titled, “Medi-Cal Claims Summary – Behavioral Health & Recovery Services,” which indicated that monthly data was *utilized* to report overall utilization patterns for January and February 2014. For the remaining single report listed (Monthly Complaints Log), there was no documentation to substantiate that the Plan had obtained this or had reviewed any other grievance-related data.

²³ Monthly Call Center Statistics; Provider Network Adequacy Report; Quality Improvement Annual Report and Work Plan

²⁴ Claims Settlement Practices Report; Appointment Access Report; UM Summary Report

The absence of any grievance-related data is particularly relevant because BHRS submitted a call center report to the Plan which showed a 7.5% rate of abandonment for calls received (621 of 8278 calls received during the survey review period were abandoned). In an onsite interview, Plan staff indicated there were some concerns regarding the low numbers of BHRS grievances given the Plan's member demographics and populations served. As a result, the Plan has taken over many of the tasks related to grievances and appeals handling (e.g., grievance intake, resolution letter generation) although BHRS continues to investigate grievances and appeals on behalf of the Plan. Plan staff indicated that they would be re-evaluating the delegation of certain functions to BHRS and voiced that they had recently hired a Behavioral Health Director who would be tasked with delegation oversight of BHRS to address identified issues such as the high rate of call abandonment.

3) Quarterly Joint Meetings

Appendix 1-E, "Quality Assessment and Improvement," of the delegation agreement specifies BHRS' responsibilities and on page 24 states:

3. Utilization monitoring. BHRS shall regularly monitor utilization to protect against overutilization and underutilization of behavioral health and recovery services, using measures selected by DHCS from HEDIS Use of Service measures and communicated to BHRS by HPSM. *Quarterly meetings involving clinical staff members from BHRS and HPSM shall be held to review encounter data reported on a monthly basis by BHRS.* [Emphasis added.]

However, in its pre-onsite submission to the Department, the Plan indicated that quarterly meetings between the Plan and BHRS did not take place. In its written response, the Plan stated:

On a quarterly basis, BHRS and HPSM meet jointly to review utilization of behavioral health and recovery services by HPSM's Medi-Cal members, to identify issues of over- or under-utilization. Following implementation of the Medi-Cal benefit for mild-to-moderate mental health impairment, *this review did not occur in the first quarter, to allow for the lag in claims data upon which the utilization review is based. The first review occurred in July 2014 and will proceed quarterly hereafter.* [Emphasis added.]

Nevertheless, the Department submitted an onsite request for *any* joint quarterly meeting minutes between the Plan and BHRS during the survey review period. In a somewhat conflicting statement, the Plan stated, "Agenda for these meetings has [*sic*] been provided. Minutes were not kept for the majority of the meetings. **ADDITIONAL DOCUMENTATION:** Attached are email summaries of the meetings that were distributed to participants and interested parties in lieu of free-standing minutes."

Based on the review of the documentation submitted, it appears that the Plan held three joint meetings with BHRS during the seven-month review period. For example:

- *January 16, 2014:* The Plan provided what appears to be a one-page agenda/outline for the meeting. The items indicated on the outline suggest that work plan updates and action items were to be addressed. However, there were no attachments or documentation to confirm what was presented or specifically discussed. There also was no indication of who attended the meeting.
- *April 28, 2014:* The Plan submitted an eight-page PowerPoint document which included an agenda, some data regarding the status on departmental-specific tasks, call center data, utilization data, and future action items. There was no indication of who attended the meeting.
- *June 5, 2014:* The Plan initially provided only a one-page agenda for this meeting. While very brief (only seven short topics were listed), the agenda did include a list of attendees which included clinical staff from both BHRS and the Plan. The Plan subsequently provided a five-page PowerPoint document titled, “Medi-Cal Claims Summary – Behavioral Health & Recovery Services,” as evidence of what was presented at the third quarter 2014 meeting. However, it is unclear whether this attachment was in fact presented at the June 2014 meeting as there was no date on the document other than “January and February 2014” (the Plan could have been reporting on retrospective data from this timeframe). Nevertheless, the PowerPoint document included some claims and utilization data for behavioral health providers by type (e.g., network psychiatrist, network psychologist, network nurse practitioner, etc.).

Although the Plan’s documentation does support that some collaboration and oversight of BHRS is taking place, the lack of clear meeting minutes makes it difficult for the Department to confirm that meetings did in fact take place or ascertain what reports were reviewed and what issues were discussed. It is also unclear whether the meetings that were held were intended to fulfill the requirement for quarterly meetings delineated in the delegation agreement (since the Plan’s response indicated that these did not take place) or to serve a more general function. Furthermore, Rule 1300.70 (b)(2)(C) requires that if the Plan delegates quality assurance activities (which the Plan does delegate to BHRS), the delegate must maintain detailed records of its findings and actions and on at least a quarterly basis report those to the governing body. Despite the evidence presented to suggest that joint meetings likely took place, detailed reports were still not maintained and reported to the governing board as required. In onsite interviews, Plan staff acknowledged the need to improve documentation of its joint meetings with BHRS.

Conclusion: DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision A indicates that the Plan is accountable for all quality improvement functions and responsibilities that are delegated. DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 6(B)(1), Rule 1300.70(b)(2)(G)(2), and Rule 1300.70(b)(2)(H)(1) require the Plan to perform an initial review to assure that the delegate has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities. DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 6(B)(3) and Rule 1300.70(b)(2)(G)(2) and (3) require the Plan to have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated quality assurance responsibilities. Rule 1300.70(b)(2)(C) additionally requires any delegate who is delegated quality assurance

responsibilities to maintain records of its activities and actions and report those detailed findings to the Plan's governing body on at least a quarterly basis. Finally, DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 1, mandates compliance with any aforementioned rules.

The Plan contracts with BHRS to provide mental health services to its members who have been diagnosed with mental health conditions resulting in mild to moderate impairments. The Plan delegates a number of functions to BHRS including quality assurance and improvement. However, in its review of delegation oversight of these functions, the Department discovered that the Plan had not conducted a pre-delegation audit of BHRS. In regards to continuous monitoring, the Department was unable to substantiate that all reports delineated in the delegate agreement were submitted for review based on the frequencies stated. Furthermore, the Plan indicated that it did not conduct the required joint quarterly meetings with BHRS to review utilization data. Although documentation revealed that the Plan appeared to conduct at least three meetings with BHRS during the survey review period, meeting minutes were not maintained and detailed reports were not submitted to the governing body. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Potential Deficiency #10: The Plan does not maintain a system of accountability which includes adequate participation and oversight by its governing body and Quality Assessment and Improvement Committee.

Contractual/Statutory/Regulatory References: DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement, Provision 2 – Accountability, Provision 4 – Quality Improvement Committee, and Provision 7(I) – Written Description; Rule 1300.70(b)(2)(C).

DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70.

2. Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the Medical Director, and the inclusion of contracting Physicians and Contracting Providers in the process of QIS development and performance review. Participation of non-contracting providers is at the Contractor's discretion.

4. Quality Improvement Committee

Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the Medical Director or a physician designee shall actively participate on the committee. Contractor must ensure that subcontractors, who are

representative of the composition of the contracted provider network including but not limited to subcontractors who provide health care services to Seniors and Persons with Disabilities or chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to QIC.

The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis. Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

7. Written Description

I. Description of the activities, including activities used by Members that are Seniors and Persons with Disabilities or persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

Rule 1300.70(b)(2)(C)

(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.

Documents Reviewed:

- San Mateo Health Commission and San Mateo Community Health Authority Meeting Minutes (02/12/14, 04/09/14, 05/14/14, 07/09/14)
- Quality Assessment and Improvement Committee (QAIC) Meeting Minutes (02/19/14)
- DMHC Onsite Request #14: Q2 2014 Missing QAIC Meeting (undated)
- Quality Improvement System (2013 – 2014)
- Description of Committees and Membership List (2013 – 2014)
- Health Plan Pre-Onsite Survey Questionnaire (09/10/14)

Assessment: DHCS-HPSM Contract, Exhibit A, Attachment 4, Provisions 2 and 4 require the Plan to maintain a system of accountability which includes the participation of the governing

body and designation of a quality improvement committee. The Department found the following concerns related to the oversight and monitoring responsibilities of these two bodies:

- 1) The Plan's governing body did not meet monthly as required by its own policy.
- 2) The Plan's QAIC did not meet quarterly as required.
- 3) The Plan's QAIC functioned with vacant seats and member absences during the survey review period.
- 4) The Plan's written description of its Quality Improvement System did not include activities used by SPDs.

1) The Plan's governing body did not meet monthly as required by its own policy.

The Plan's Quality Improvement System document designates the SMHC as the Plan's governing body and describes its role. Specifically, on page 10, it states:

The San Mateo Health Commission (SMHC) meets monthly. Members are appointed by the San Mateo County Board of Supervisors. SMHC delegates management of the QIS to HPSM's CEO, retaining overall authority and responsibility for program implementation, continuity and effectiveness. SMHC identifies opportunities to improve care and service and directs action to be taken when indicated by QIS reports. [Emphasis added.]

Given the ultimate accountability and responsibility that the SMHC has for the quality of care and services provided to its members, the Department requested the meeting minutes. However, the Department discovered that the SMHC met only four times²⁵ during the seven-month survey review period rather than on a monthly basis as required by its own internal policy.

2) The Plan's QAIC did not meet quarterly as required.

DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 4 requires the Plan's quality improvement committee to meet at least quarterly. The Plan's Committees Description and Membership document reaffirms this requirement and additionally describes the role of the QAIC. Specifically, on page 5, it states:

The QAIC meets on a quarterly basis as an advisory committee for HPSM.... The QAIC is responsible for developing and maintaining the Quality Management Program and developing an annual Quality Management Plan. As part of its responsibilities the committee monitors the quality assessment and improvement processes (evaluates and reviews quality assessment and improvement policies, procedures, standards of care and quality indicators at least annually); analyzes data to identify trends, systems problems and opportunities to improve care; selects routine monitoring and evaluation topics and special studies that are relevant to and will have a potential impact on the membership population served.

²⁵ 02/12/14; 04/09/14; 05/14/14; 07/09/14

Given the QAIC's primary role in improving the quality of care and services provided to its members, the Department requested the meeting minutes for the QAIC. However, the Department discovered that the QAIC met only once during the seven-month survey review period on February 19, 2014. The meeting scheduled for May 21, 2014 was cancelled due to the inability to reach a quorum.

3) The Plan's QAIC functioned with vacant seats and member absences during the survey review period.

The Plan's Committees Description and Membership document describes an 11-member QAIC. Specifically, on page 5, it states, "The QAIC meets on a quarterly basis as an advisory committee for HPSM and consists of 11 members appointed by the Commission. These individuals provide representation from a wide range of providers including primary care, adult and pediatrics, and specialists."

However, at the February 19, 2014 meeting, four of the 11-committee seats were vacant (seats for a pharmacist, an adult PCP, and two [of two] specialists). Of the seven seats remaining that were filled, three physicians (a member physician, an adult PCP, and a pediatric PCP) were absent at the meeting. Therefore, only four committee members attended. In addition, seven Plan staff are listed as members who participant in the meetings. However, four Plan staff, including the Medical Director, were absent at the meeting. Therefore only three Plan members attended. The Plan's failure to fill vacancies and require attendance from its members greatly limits the expertise of the QAIC. Therefore, the Plan's ability to monitor quality processes, analyze data, evaluate progress on initiatives, and conduct quality management program oversight is hindered.

4) The Plan's written description of its Quality Improvement System did not include activities used by SPDs.

DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 7(I), requires the Plan to implement and maintain a written description of its Quality Improvement System including activities used by SPDs. Such activities are to be designed to assure the provision of case management, coordination, and continuity of care services. However, evaluation of the Plan's Quality Improvement System document includes no delineation of special services or programs designed for SPDs. The only mention of SPDs can be found on pages 1 and 4 where it states:

At its inception, the organization's primary focus was to serve the health care needs of San Mateo County Medi-Cal beneficiaries including nearly all Medi-Cal eligible individuals in the county, with membership including people receiving Temporary Aid to Needy Families (TANF) as well as older adults and disabled recipients (Seniors and Persons with Disabilities—SPDs).

...

As of January 24, 2014, HPSM served approximately 85,261 Medi-Cal beneficiaries. As a COHS, HPSM has always covered TANF and SPD populations.

As the Plan did not delineate activities specific for SPDs, it was not surprising then that the Department also found no discussion of SPD data in either the SMHC or QAIC meeting minutes. There was only one brief mention of SPDs in the February 19, 2014 QAIC minutes. Specifically, on page 2, it stated, “The committee discussed the comparison details of DDP, DSNP, SPD requirements; 1) core quality measures; and 2) core quality withholds in conjunction with the Duals Demonstration Project, which also outlines current Medicare/Medi-Cal contract requirements.” However, there were no details included regarding any separate requirements for SPDs or discussion of comparative data or trends.

Conclusion: DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 2 requires the Plan to maintain a system of accountability which includes the participation of the governing body and the designation of a quality improvement committee with oversight and performance responsibility. Rule 1300.70(b)(2)(C) requires the Plan’s governing body and quality assurance committee to each meet on a quarterly basis to oversee their respective program responsibilities. The governing body must routinely receive written progress reports from the quality improvement committee on activities, findings, recommendations, and actions. DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 1 echoes the requirement in regards to the responsibilities of the quality improvement committee. Finally, DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 1, mandates compliance with the rule.

The Department’s review of both the governing body (SMHC) and QAIC minutes revealed that meetings were not held at the frequencies required. The SMHC failed to meet on a monthly basis and met only four times during the seven-month survey review period. The QAIC failed to meet on a quarterly basis and met only once during the seven-month survey review period. The subsequent QAIC meeting scheduled was cancelled due to the inability to reach a quorum and the Department’s review of the sole meeting minutes for the review period indicated that four of 11-committee seats were vacant with three committee members absent from the meeting anyway. Furthermore, because the Plan’s QAIC did not meet on a quarterly basis, it therefore did not submit reports to the SMHC as required.

DHCS-HPSM Contract, Exhibit A, Attachment 4, Provision 7(I), requires the Plan to implement and maintain a written description of its Quality Improvement System including activities used by SPDs. Such activities are to be designed to assure the provision of case management, coordination, and continuity of care services. However, the Plan’s Quality Improvement System document included no delineation of special services or programs designed for the SPDs. The Department consequently found no discussion of SPD data in either the governing board or QAIC meeting minutes.

Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Deficiency #11: The Plan does not demonstrate that it has adequate administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out quality assurance activities.

Statutory/Regulatory/Contract Reference(s): DHCS-HPSM Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 4(D) – Contract Performance; DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement; Rule 1300.67.3(a)(2); Rule 1300.70(b)(2)(F).

DHCS-HPSM Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan
4. Contract Performance

Contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with Title 28 CCR Section 1300.67.3. Contractor shall ensure the following:

D. Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the Contractor's business.

DHCS-HPSM Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70.

Rule 1300.67.3(a)(2)

(a) The organization of each plan shall provide the capability to furnish in a reasonable and efficient manner the health care services for which subscribers and enrollees have contracted. Such organization shall include:

(2) Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

Rule 1300.70(b)(2)(F)

There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the plan and delegated entities.

Documents Reviewed:

- 2014 Utilization Management Program
- Policy UM.31: Over-Under Utilization (09/14/14)
- UM Work Group Meeting Minutes (04/17/14; 06/19/14)
- Medical Utilization and IBNR Review Meeting Summary (01/09/14; 02/13/14; 03/13/14; 04/10/14; 05/08/14; 06/11/14; 07/09/14)
- Utilization Management Department Organization Chart (05/19/15)
- Health Plan of San Mateo – Call Center Report (Q1 and Q2)
- 47 Standard Grievance and Appeal files (01/01/14 – 07/31/14)
- 5 Potential Quality Issues (PQIs) files (01/01/2014 – 07/31/2014)
- 2014 Contract HPSM/BHRS Medi-Cal Carve-In (10/21/14)
- Process and Procedure for Monitoring Delegated UM by BHRS (undated)
- DMHC Onsite Document Request #7: Inquiry regarding BHRS/HPSM Meeting Minutes (11/03/14)
- Q1 2014 Meeting: HPSM-BHRS Mild-Moderate Medi-Cal Benefit (01/16/14)
- Q2 2014 Meeting: HPSM and BHRS Partnership (04/28/14)

- Q3 2014 Meeting: Medi-Cal Claims Summary, Behavioral Health & Recovery Services (January and February 2014)
- Agenda: BHRS/HPSM Meeting (06/05/14)
- San Mateo Health Commission and San Mateo Community Health Authority Meeting Minutes (02/12/14, 04/09/14, 05/14/14, 07/09/14)
- Quality Assessment and Improvement Committee (QAIC) Meeting Minutes (02/19/14)
- DMHC Onsite Request #14: Q2 2014 Missing QAIC Meeting (undated)
- Quality Improvement System (2013 – 2014)
- Description of Committees and Membership List (2013 – 2014)

Assessment: DHCS-HPSM Contract, Exhibit A, Attachment 1, Provision 4 and Rule 1300.67.3 requires the organization of the Plan to provide the capability of furnishing health care services to members in a reasonable and efficient manner. Staffing in medical and other health care services, including fiscal and administrative services must be sufficient to conduct the Plan's business. Rule 1300.70(b)(2)(F) additionally requires the Plan to maintain administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out the Plan's quality assurance activities.

During onsite interviews, existing Plan staff demonstrated the requisite knowledge and expertise in quality assurance matters. However, based on further discussions with Plan staff, observations, and review of documentation submitted, the Department concluded that the Plan does not have sufficient staff to effectively conduct business and carry out required quality assurance activities. The Plan's lack of sufficient administrative and/or clinical staff may have in part attributed to a number of the deficiencies identified by the Department. For example:

- **Utilization Management**
 - The Plan's Utilization Management Workgroup, who is charged with monitoring the utilization of healthcare services by Plan members to identify under- and over-utilization, met only two times during the survey review period rather than on a monthly basis. (Please see Deficiency #1.)
 - The Plan's Medical Review Committee, who is also charged with monitoring for under- and over- utilization by reviewing utilization data, did not hold any meetings during the survey review period. The IBNR Committee, which acts in the capacity of the Medical Review Committee, did meet on a monthly basis. However, with the exception of the Medical Director, no other clinical staff attended the meetings. Furthermore, the Medical Director only attended two of the seven meetings. (Please see Deficiency #1.)
 - The Medical Director has numerous functions and responsibilities, resulting in limited time to commit towards the Utilization Management Program. The Medical Director indicated a need for two additional Medical Directors to assist with utilization management and case management activities. Once those positions are filled, she will have more time to dedicate towards program development and monitoring.

- A review of the Plan's organizational chart for its Utilization Management Department revealed five vacant positions (four care coordination registered nurse positions and one care coordination social work case manager).
- **Availability and Accessibility**
 - Out of ten calls made to the Member Services line, only seven calls were answered by a live MSR. In the remaining three calls, the caller was involuntarily transferred to voicemail when a MSR was not available to answer the phone. The recorded message informed the caller that a return call would be made within one business day. (Please see Deficiency #6.)
- **Member Rights**
 - In 13 of 46 (28%) standard grievance and appeal files reviewed, the Plan failed to provide written resolution of the grievance to the member within 30 calendar days as required. Timeliness with grievance processing appears to be attributed to the Plan's delay in requesting medical records needed to investigate the case. (Please see Deficiency 7#.)
- **Quality Management**
 - The Plan identified only five PQIs during the seven-month survey review period. During onsite interviews, the Associate Medical Director reported being available only approximately 20% of the time to conduct PQI reviews.
 - The Department identified two standard grievance files that involved potential quality of care issues that were not referred to the Medical Director for investigation and review. (Please see Deficiency #8.)
 - The Department identified PQI files that were closed prior to the receipt of pertinent medical information needed to fully investigate the case. Furthermore, Plan staff did not take appropriate follow-up action as needed. (Please see Deficiency #8.)
 - Timeliness with PQI processing appears to be attributed to the Plan's delay in requesting medical records needed to investigate the case. (Please see Deficiency #8.)
 - The Plan did not conduct a pre-delegation audit of BHRS prior to delegating quality improvement functions for the provision of mental health services. (Please see Deficiency #9.)
 - The Plan did not require BHRS to submit monitoring reports at the frequencies specified in the delegation agreement. (Please see Deficiency #9.)
 - The Plan did not keep detailed reports of joint quarterly meetings with BHRS and ensure that information was provided to the governing body as required. (Please see Deficiency #9.)
 - The Plan's governing body met only four times during the survey review period even though Plan procedures mandate monthly meetings. (Please see Deficiency #10.)
 - The Plan's QAIC met only once during the survey review period. (Please see Deficiency #10.)

- During the survey review period, the Plan's 11-member QAIC had four vacant seats. Of seven seats that were filled, three physicians were absent in the sole QAIC meeting that was held during the survey review period. (Please see Deficiency #10.)

Conclusion: DHCS-HPSM Contract, Exhibit A, Attachment 1, Provision 4 and Rule 1300.67.3 requires the organization of the Plan to provide the capability of furnishing health care services to members in a reasonable and efficient manner. Staffing in medical and other health care services, including fiscal and administrative services, must be sufficient to conduct the Plan's business. Rule 1300.70(b)(2)(F) additionally requires the Plan to maintain administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out the Plan's quality assurance activities. DHMC-HPSM Contract, Exhibit A, Attachment 4, Provision 1 requires compliance with this rule. Based on discussions with Plan staff, observations made, and review of documentation submitted, the Department determined that the Plan's lack of sufficient administrative and/or clinical staff may have in part attributed to a number of the deficiencies identified by the Department. Therefore, the Department finds the Plan in violation of contractual and regulatory requirements.

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Jeanette Fong	Medical Survey Team Lead, (916) 255-3367
Cindy Liu	Attorney
MANAGED HEALTHCARE UNLIMITED, INC TEAM MEMBERS	
Marty Glasser, MD	Quality Management and Continuity of Care Surveyor
Patricia Allen-Schano, MEd	Availability & Accessibility Surveyor
Rose Leidl, RN	Utilization Management Surveyor
Bernice Young	Member Rights Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

HEALTH PLAN OF SAN MATEO STAFF	
Maya Altman	Chief Executive Officer
Chris Baughman	Systems Improvement Director
Fiona Donald, MD	Medical Director
Ed Ortiz	Provider Network and Development Director
Ron Robinson	Administration and Finance Director
Carolyn Thon	Member Services Director
Richard Moore, MD	Associate Medical Director
Kesook Lee, MD	Associate Medical Director
Andres Aguirre	Quality Manager
Gabrielle Ault-Riche	Grievances & Appeals Manager
Risa Beckwith	Customer Care Services Manager
Sandy Carlson	Senior Clinical Manager
Barrie Cheung	Pharmacy Manager
Matt Javaheri	Claims Director
Anita Harris	Claims Manager
Paula Heintz	UM Manager
Daisy Liu	Health Educator
Leticia Mora	QI Specialist
David Ries	Network Relations Manager
Katrina Salas	QI Specialist
Jose Santiago	Member Services Manager
Joy Sarraga	Health Services Director

APPENDIX C. LIST OF FILES REVIEWED

Note: The statistical methodology utilized by the Department is based on an 80% Confidence Level with a margin of error of 7%. Each file review criterion is assessed at a 90% compliance rate.

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Standard Grievances and Appeals	47	The Department identified the sample size based upon its standard File Review Methodology and a file universe of 134 files.
Expedited Grievances and Appeals	16	The Department reviewed all 16 expedited grievances and appeals identified by the Plan for the review period.
Exempt Grievances	3	The Department reviewed all 3 exempt grievances identified by the Plan for the review period.
Potential Quality Issues	5	The Department reviewed all 5 PQIs identified by the Plan for the review period.