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State of California—Health and Human Services Agency
Department of Health Care Services



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GOVERNOR GOVERNOR

Ian Johansson
Compliance Officer/Director of Regulatory Affairs
Health Plan of San Mateo
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

RE: Department of Managed Health Care Seniors and Persons with Disabilities
Enrollment Survey

Dear Mr. Johansson:

The Department of Managed Health Care conducted an on-site enrollment survey of Health Plan of San Mateo, a Managed Care Plan (MCP), from November 3, 2014 through November 6, 2014. The survey covered the review period of January 1, 2014 through July 31, 2014.

On November 9, 2015, the MCP provided DHCS with its Corrective Action Plan (CAP). At this time, all deficiencies have been reviewed and either closed or provisionally closed.

Provisionally closed deficiencies indicate that DHCS has conditionally accepted the MCP's plan of action being proposed and/or implemented in order to bring a deficiency into compliance. For this CAP, approximately two (2) deficiencies have been provisionally closed. DHCS will continue to monitor and/or follow up on deficiencies that have been provisionally closed.

The CAP is hereby closed. The enclosed report will serve as DHCS's official response to the MCP's CAP.

Please be advised that in accordance with Health and Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

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If you have any questions, contact Joshua Hunter, Analyst, Compliance Unit, at (916)449-5108 or CAPMonitoring@dhcs.ca.gov.

Sincerely,

Originally Signed by Dana Durham

Dana Durham, Chief
Contract Compliance Section

Enclosure

cc: Stephanie Issertell, Contract Manager
Department of Health Care Services
Managed Care Operations Division
P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413

**ATTACHMENT A
Corrective Action Plan Response Form
Health Plan of San Mateo**



Review/Audit Type: DMHC 115 Medicaid Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey
Review Period: January 1, 2014 through July 31, 2014

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP via email in word format which will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require long term corrective action or a period of time longer than 30 days to remedy or operationalize, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

CORRECTIVE ACTION PLAN FORMAT

Deficiency Number and Finding	Action Taken	Implementation and Documentation	Completion/Expected Completion Date	DHCS Comments
1. Utilization Management				
1. The Plan does not ensure that its Utilization Management Program effectively detects under- and over-utilization of health care services.	1. Updated Over and Underutilization Policy 2. Restructured and convened Utilization Management Committee to actively monitor and take action on identified over and underutilization issues	1. Policy: UM-31 Over and Under Utilization 2. Utilization Management Committee Meeting Minutes for August and September 2015 Agenda for October 2015	1. June 2015 2. August 2015	The Plan made modifications to its Over and Under Utilization Policy. The Plan also submitted agenda and minutes from multiple UM Committee meetings showing that over and under utilization issue are being monitored and discussed. This item is closed.
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.	1. Develop policy on inter rater reliability 2. Perform inter rater reliability: Medical Directors 3. Begin inter rater reliability: Nurses	1. Policy: UM-11 Inter Rater Reliability 2. File: Medical Directors Report_9_29_15 3. Sample evaluations of nurses (6 files)	1. July 2015 2. Sept 2015 3. Sept-Nov 2015	The Plan developed Policy UM-11 Inter Rater Reliability To ensure consistent application of standardized utilization criteria and decision making among personnel within the Utilization Management (UM) Department. The Plan also submitted examples of inter rater reliability evaluations for Medical Directors and nurses. This item is closed.

<p>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.</p>	<p>1. Develop Report on appeals 2. Review report during Utilization Management Committee 3. Review report during Pharmacy and Therapeutics Committee</p>	<p>1. File: Q2 2015_Authorization Appeals Report_10_27_2015 2. Agenda: UM Committee Meeting Agenda_10_27_2015</p>	<p>1. Sept 2015 2. Oct 27, 2015</p>	<p>The Plan developed and submitted a report on Authorization Appeals. The Plan submitted the agenda to the October 27, 2015 UM Committee meeting showing that the report was discussed. This item is closed.</p>
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2. Case Management and Coordination of Care

<p>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.</p>	<p>1. Coordinate with member services for health services to receive and review primary care provider change log monthly</p> <p>2. a) Quarterly sample audit (Q1 complete) by FSR nurses of select providers noting if members of the sample have a current IHA on file. b) Pilot clinic provided all new pediatric members (0-17 yrs old) for outreach efforts- Documentation of attempts are noted. c) MMR site reviews include audit of IHA component completion. FSR Nurses use the opportunity to review with provider and/or staff – internal corrective action plans are given to providers to improve IHA completion d) Pilot program with 4 providers documenting IHA outreach efforts for MCE members e) IHA Policy and Procedure updated to include QI efforts to increase compliance f) Targeted messaging of importance of seeing provider within 120 days for all new members implemented in new identification card letters sent out to members g) Targeted messaging included on website</p> <p>3. Develop report on open referrals</p>	<p>1. File: COC_PCP_Deletion Tracking</p> <p>2. Files: a.) &b) Study IHA. c) Example_MRR CAP Closure. d) MCE Pilot Reporting Requirements e.) IHA P&P.pdf f) Letters by age group: MC_ID_ENGL_revised 0-4yrs, 5-11yrs, 12-17 yrs, adult, senior g) https://www.hpsm.org/members/medical/new-members.aspx</p> <p>3. 201510 Open Referrals</p>	<p>1. October 2015 2. September 2015 3. October 2015 and monthly</p>	<p>The Plan has created a monthly primary care provider change log to monitor PCP changes. The Plan also submitted documentation showing that IHA completion and outreach are being monitored and developed a report showing that open referrals are being monitored. This item is closed.</p>
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3. Access and Availability of Care

<p>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.</p>	<p>1. QIC reviews access and services issues</p>	<p>1. Files: QAIC Minutes_6_24_2015 and And QIC Minutes_9_16_2015</p>	<p>1. June 2015</p>	<p>The Plan submitted QIC and QAIC meeting minutes that show access availability of services are discussed. This item is closed.</p>
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<p>6. 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>1. HPSM is upgrading its phone system in Q1 or Q2 2016. The phone system will include an enhanced automated call distribution system. One of the new system's features is an automatic call-back function. Callers will have the option to get an automatic call-back rather than wait in the queue for the next available representative without losing their place in the call queue. When the next available representative is available to take a call, the system will automatically call that caller back. This feature should eliminate the callers opting to select voice mail during business hours. The upgraded telephone system should improve the overall capabilities of the ACD system.</p> <p>2. The Director, Member Services and Outreach, Member Services Manager and Member Services Supervisor review the Automated Call Distribution system on a daily, weekly, monthly and quarterly basis. The average speed to answer in Q2 and Q3 was 58 seconds; the % of flow out calls to voice mail was 5% in Q2 2015 and 6% in Q3, indicating a significant decrease in calls transferring to voice mail. The report also includes the maximum Delay which is the average speed to answer the longest call in queue; the maximum delay in Q2 and Q3 2015 was 9:28.</p> <p>3. Member Services management recognizes that additional staffing is needed in the call center and has submitted a request to add two FTE Member Services Representatives in the 2016 HPSM budget. The request was submitted in September 2015; the 2016 HPSM budget has not yet been approved by the HPSM Governing Body. As an interim measure, Member Services is hiring a Temporary Member Services Representative.</p>	<p>1. DMHC Potential Deficiency #6_Email Re Telephone System</p> <p>2. DMHC Potential Deficiency #6_ACD Comparison.xlsx</p>	<p>1. Phone system upgrade is expected to be completed by Q2 2016</p> <p>2. ACD reports through September 2015 have been completed. ACD reporting will continue.</p> <p>3. Positions will be available for hire at the start of the HPSM fiscal year in January 2016.</p>	<p>The Plan is upgrading its phone system that will have additional features such as automatic call-back enabling members to receive a call-back rather than waiting in the queue for the next available representative. The Plan will also hire additional staff at the start of the fiscal year in January 2016. This item is provisionally closed pending the activation of the new phone system. Please notify DHCS when the new phone system is operational with the new features and when the new permanent Member Services staff has been hired.</p>
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<p>4. Members' Rights</p>				
<p>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.</p>	<p>1. Two additional Grievance and Appeals (G&A) Coordinators hired to decrease Coordinator caseload.</p> <p>2. Administrative Assistant hired for Grievance and Appeals Unit to assist with clerical duties previously performed by G&A Coordinators, to decrease Coordinator workload.</p> <p>3. Weekly timeliness report reviewed by G&A Manager and shared with G&A staff.</p> <p>4. Confirmation of timely closure of Medi-Cal grievances and appeals. Note: closure date is the date of written notification to Member and can be used as a proxy for the date resolution letter was sent to Member.</p>	<p>1. Summary of Position Changes_2015 Salary Budget; Position Change Request Form for G&A_2015; Personnel Requisition Form.</p> <p>2. Summary of Position Changes_2015 Salary Budget; Position Change Request Form for G&A_2015</p> <p>3. G&A Staff Meeting Agenda and Sign-In Sheets from first report (08/03/14) and most recent (10/05/15)</p> <p>4. Timeliness Report</p>	<p>1. Hire dates 02/2/15 and 09/21/15</p> <p>2. Hire date 02/2/15</p> <p>3. Began 08/03/14, continued weekly</p> <p>4. 10/15/15</p>	<p>The Plan hired additional staff to assist with grievance workload. Weekly timeliness reports are reviewed by the G&A Manager and are shared with staff. This item is closed</p>

5. Quality Management

<p>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.</p>	<ol style="list-style-type: none"> 1. Develop policy and process on potential quality issues 2. Train staff on PQI process 3. Gather, review, and address PQIs 	<ol style="list-style-type: none"> 1. Policy: QI-03_Review and handling of Quality of care complaints and concerns 2. Files: HEALTH SERVICES MONTHLY STAFF MEETING_8_19_2015_CE_MB and HS Monthly Staff_PPT_8_19_2015 Agenda and PQI Training_8_19_2015_MB and RC And sign in_minutes_agenda for Aug 19 2015 3. Sample PQI log: Quality of Care Tracking Log REV 	<ol style="list-style-type: none"> 1. August 2015 2. August 2015 3. August 2015 and ongoing 	<p>The Plan developed policy QI-03 to provide a systematic method for the identification, reporting, and processing of a Potential Quality Issue. The Plan provided the powerpoint for the PQI Process training that was held in August of 2015. PQIs are entered in to a Quality of Care Tracking Log. This item is closed.</p>
<p>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.</p>	<ol style="list-style-type: none"> 1. Regular operations meeting with BHRS established 10/9/2014. Occurring mostly weekly. 2. BHRS and HPSM report out to governing bodies 3. Delegation audit scheduled for December 2015 	<ol style="list-style-type: none"> 1. Sample meeting minutes 2. Files: 20141205 HPSM and BHRS Expansion - Status Update Original And 20150313 Brief HPSM and BHRS Mild to Moderate and BHT Update And 20150610 HPSM and BHRS Expansion - Status Update And Item 4.6 - SMHC Minutes, June 2015 	<ol style="list-style-type: none"> 1. Oct 2014 and ongoing 2. Dec 2014, March 2015, June 2015, Scheduled for Dec 2015 3. Scheduled for Dec 2015 	<p>The Plan submitted workplans and notes for multiple meetings with BHRS and meeting minutes from the San Mateo Health Commission and the San Mateo Community Authority Meeting. The Plan has also scheduled its Delegation Audit for December 2015. This item is provisionally closed. Please submit results of the Delegation Audit once it has been completed.</p>

<p>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.</p>	<p>1. Review and approval of Quality Program Description, Work plan and Evaluation by both Quality improvement Committee (QIC, formerly QAIC) and San Mateo County Health Commission. Plan Quality activities are reviewed and discussed at least quarterly Minutes from the QIC are reviewed by the Commission. Quality improvement outcomes are presented to the Commission.</p>	<p>1. Files: Item 4.6 –SMHC Minutes 7-8-15 Item 4.14 SMCH Minutes 8-12-15 QAIC Minutes_11_19_2014 QAIC Minutes 3_26_2015 QAIC Minutes 6_24_2015 QIC Minutes_9_16_2015</p>	<p>1. Ongoing, quarterly</p>	<p>The Plan submitted QAIC meeting minutes from four consecutive quarters from Q4 2014 through Q3 2015 showing that Plan Quality activities are reviewed and discussed. The Plan submitted SMCH and QAIC minutes that show Review and approval of Quality Program Description, Work plan and Evaluation. The Plan submitted SMHC minutes that show that QAIC minutes were reviewed by the Commission. This item is closed.</p>
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<p>6. Administrative and Organizational Capacity</p>				
<p>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.</p>	<p>1. Increased positions and restructured staff to better meet Utilization Management, Care Coordination, and Quality needs. 2. Medical leadership consists of Chief Medical Officer, Deputy Chief Medical Officer, Medical Director for Utilization Management and Medical Director for Long Term Care 3. Realignment of staff: Prior authorization team and inpatient review/care transitions team under one manager 4. Convened Utilization Management Committee with clinical, quality, and services representation 5. New position of UR Nurse (Grievance and Appeals) to screens grievances for potential quality issues 6. Deputy CMO responsible for delegated relationship with BHRS</p>	<p>1. Organization chart – health services 2. Organization chart – health services 3. Organization chart – health services 4. August 2015 Minutes: UTILIZATION MANAGEMENT COMMITTEE MEETING AGENDA_MINUTES_08_06_2015 5. Organization chart – health services 6. PD DeputyCMO 05.29.2015</p>	<p>1. April 2015 through October 2015 2. April and May 2015 3. August 2015 4. August 2015 and monthly 5. April 2015 6. May 2015</p>	<p>The Plan increased positions and restructured staff to improve in its ability to meet the quality needs of UM and Care Coordination. The Plan also hired additional UR Nurse to screen grievances and appeals for potential quality issues. Prior Authorization and the review/care transition team have been realigned under one manager. This item is closed.</p>
<p>For staffing deficiencies not addressed in deficiency response #11, please see staffing related responses in the Plan's responses to deficiencies 1-10.</p>				