

MEDICAL REVIEW – NORTHERN SECTION I
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

**San Mateo Health Commission
dba Health Plan of San Mateo**

Contract Number: 08-85213

Audit Period: November 1, 2015
Through
October 31, 2016

Report Issued: March 2, 2017

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I. INTRODUCTION

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

In 1987, the SMHC founded the Health Plan of San Mateo (HPSM or the “Plan”) to provide county residents with access to a network of providers and a benefits program that promotes preventive care.

The SMHC is the governing board for the Health Plan of San Mateo. Board members are appointed by the San Mateo County Board of Supervisors. The Plan received its Knox-Keene license as a Full Service Plan on July 31, 1998.

HPSM’s provider network includes independent providers practicing as individuals, small and large group practices, community clinics, and San Mateo Medical Center (SMMC), which operates multiple clinic sites.

As of October 31, 2016, Health Plan of San Mateo served 136,286 members through the following programs:

| Line of Business | Membership |
|------------------|------------|
| CalMediConnect | 9,315 |
| D-SNP | 606 |
| Healthy Kids | 710 |
| HealthWorx | 1,049 |
| Medi-Cal | 124,606 |
| Total | 136,286 |

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of November 1, 2015 through October 31, 2016. The on-site review was conducted from November 28, 2016 through December 2, 2016. The audit consisted of document review, verification studies, and interviews with Plan personnel.

The audit evaluated four categories of performance: Utilization Management (UM), Access and Availability to Care, Members' Rights and Quality Management (QI).

The prior DHCS medical audit (for the period of November 1, 2014 through October 31, 2015 with onsite review conducted from November 2, 2015 through November 13, 2015) was issued on June 17, 2016. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized their corrective action plan (CAP). Repeat findings were identified and appear in the body of the report.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan did not process standard prior authorizations within five business days, retrospective reviews within 30 calendar days, and concurrent reviews within 24 hours. The Plan did not send appeals acknowledgment letters within five calendar days, and did not resolve appeals within the required 30 calendar days. The Plan encountered multiple challenges associated with the implementation of the new prior authorization system and the new appeals system. The amount of time spent training staff on the new system and shortage of staff led to delays in the processing times.

The Plan's notice of action (NOA) letters did not clearly and completely explain the reason for denial of the chronic hepatitis C treatment. The Plan faced challenges with the chronic hepatitis C treatment resolution letters because of the lengthy criteria, making it difficult to be concise yet provide all the necessary information the patient and provider would need.

Category 2 – Case Management and Coordination of Care

Not reviewed. Prior findings for areas not reviewed in the 2016 audit will be reviewed in a future audit.

Category 3 – Access and Availability of Care

The Plan did not consistently take appropriate corrective action despite identifying deficiencies in its access monitoring measures. The Plan did not investigate or identify the causes of the timely access deficiencies nor did it request a corrective action plan from all non-compliant providers. The Plan did not provide any evidence that it had followed-up with deficient providers or that the Plan had taken any additional actions as a result of the Plan's access monitoring measures. The Plan did not have a procedure to monitor the wait times for providers to return member calls or to monitor wait times at providers' offices.

The Plan did not ensure that contracted emergency departments provide members access to at least a 72-hour supply of drugs in emergency situations.

Category 4 – Member's Rights

The Plan's grievance department encountered multiple challenges associated with the implementation of the new grievance system, shortage of staff, and an increase in the number of grievances filed during the first quarter of 2016, which led to delays in the grievance processing time. The Plan did not process or send required correspondence for grievances timely and did not translate its correspondence to the Plan's threshold languages.

Category 5 – Quality Management

No findings.

Category 6 – Administrative and Organizational Capacity

Not reviewed. Prior findings for areas not reviewed in the 2016 audit will be reviewed in a future audit.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

The on-site review was conducted from November 28, 2016 through December 2, 2016. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 15 medical and 15 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 15 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 3 – Access and Availability of Care

Appointment availability verification study: 25 providers from the Plan's in-network providers of routine, urgent, specialty, and prenatal care were surveyed. The third next available appointment was used to measure access to care.

Category 4 – Member's Rights

Grievance procedures: 60 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level of review.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

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

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements... (as required by Contract)

COHS Contract A.5.2.A, B, C, F, H, I

Exceptions to Prior Authorization:

Prior Authorization requirements are not applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

COHS Contract A.5.2.G

Timeframes for Medical Authorization

Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).

COHS Contract A.5.F

Routine authorizations: five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

COHS Contract A.5.H

Denial, Deferral, or Modification of Prior Authorization Requests:

Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative... This notification must be provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

COHS Contract A.13.8.A

SUMMARY OF FINDINGS:

1.2.1 Timeframes for medical prior authorizations

The Plan is required to make decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the Plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination. Concurrent review decisions pertaining to care that is underway, shall be communicated to the enrollee's treating provider within 24 hours. (*Contract A18, Exhibit A, Attachment 5 (3)(D)(E)(H) and HSC Section 1367.01(h)(1)(3)*).

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The Plan's Policy #: *UM-02: Pre-Service and Concurrent Determination Timeframes for Medi-Cal* states that a five business day time frame from receipt of information to decision is applied to standard or routine requests. For concurrent reviews the Plan will notify the facility or provider of the authorization decision within 24 hours of rendering the decision. The Plan's 2016 UM Program also confirms these time frames and it states that retrospective reviews will be handled within 30 calendar days from receipt of request.

The Plan exceeded the time frames for resolution of standard, concurrent, and retrospective review of medical prior authorizations. A total of 15 medical prior authorizations were reviewed. Two concurrent reviews were not resolved within the required 24-hour time frame. Four routine authorizations were not adjudicated within the required time frame of five working days. One retrospective review was not adjudicated within the required time frame of 30 calendar days. The Plan was not in compliance with the requirements for time frames for medical prior authorizations.

Interviews with the Plan confirmed timeliness of processing medical prior authorizations was affected due to a few obstacles including staffing shortages due to illness, resignations, and vacancies. The Plan implemented a new prior authorization system and spent most of 2016 training staff.

If medical prior authorizations are not processed in a timely manner, there will be a delay in delivering the necessary treatments needed by the members.

1.2.2 Medical prior authorization notice of action (NOA) letter rationale

The Plan is required to send enrollees NOA letters with a clear and concise explanation of the reasons for the Plan's decision. The detail must contain a description of the criteria or guidelines used, including a citation of the specific regulations or plan authorization procedures supporting the action and the clinical reason for the decision regarding medical necessity. (*Contract A18, Attachment 13 (8)(a), MMCD All Plan Letter No. 04006 November 1, 2004, and Title 22 CCR Section 53894 (d)*).

The Plan's Policy #: *UM-02: Pre-Service and Concurrent Determination Timeframes for Medi-Cal* states that the Plan will ensure that member notification will include clear and concise denial, deferral, or modification reason and that appropriate criteria or guideline used in the decision is cited.

The Plan's NOA letters did not clearly and completely explain the reason for denial of the chronic hepatitis C treatment. In four cases of pharmacy prior authorizations, the Plan's NOA letters stated "the California Department of Health Care Services require that certain criteria be documented. The information submitted by your physician did not meet the prior authorization criteria of having evidence of Stage 2 or greater hepatic fibrosis/cirrhosis." However, the DHCS Treatment Policy for the Management of Chronic Hepatitis C effective July 1, 2015 lists 15 clinical conditions that identify candidates for treatment. Although Stage 2 or greater hepatic fibrosis is one of the 15 clinical conditions, it is not the only criteria for which the medication can be prescribed. Members would fit criteria if any of these clinical conditions are met. On review of medical records there was no evidence of inappropriate use of criteria, however the NOA letter did not have clarity.

The interviews confirmed that the Plan faced challenges with the chronic hepatitis C treatment resolution letters because of the lengthy criteria, making it difficult to be concise yet provide all the necessary information the patient and provider would need. The Plan has started working on making some changes to the letter templates.

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If members and providers receive notice of action letters with incorrect criteria for chronic hepatitis C treatment, members will not receive the necessary treatment and providers will not be able to fully treat the patients' condition.

RECOMMENDATIONS:

- 1.2.1** Resolve standard prior authorizations within five business days, concurrent reviews within 24 hours, and retrospective reviews within 30 calendar days. Continue to resolve staffing shortages in order to comply with contract requirement of time frames.

- 1.2.2** Ensure all NOA letters provide clear and concise language to explain the reasons for the Plan's decision.

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1.4 PRIOR AUTHORIZATION APPEAL PROCESS

Appeal Procedures:

There shall be a well-publicized appeals procedure for both providers and Members.
COHS Contract A.5.2.E

SUMMARY OF FINDINGS:

1.4.1 Time frames for appeals notification and resolution

The Plan is required to resolve each grievance and provide notice to the member as quickly as the Member's health condition requires, within 30 calendar days from receipt. The Plan is required to send a written acknowledgment notice to the member within five calendar from receipt and a written resolution within 30 calendar days of receipt. "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including an appeal made by an enrollee or the enrollee's representative. (*Contract A18, Exhibit A, Attachment 14 (1) and (2)(A) and CCR, Title 28 1300.68(a)(1)(d)(1)(3)*).

The Plan's Policy #: *GA-08: Member Appeal Procedure for Non-Medicare Lines of Business* states that the deadline for processing standard appeals is 30 calendar days from the date the appeal was filed. It also states that within five calendar days of the filing of the appeal an acknowledgment letter is mailed to the member and attaches it to the database case file.

The Plan exceeded the time frame for notification and resolution of appeals. A total of 15 appeal files were reviewed. Three acknowledgment letters were not sent within the five calendar day time frame. Four appeals were not resolved within 30 calendar days and therefore a resolution letter was not sent to members within the required time frame. The Plan was not in compliance with the requirements for appeals notification and resolution time frames.

Interviews with the Plan confirmed timeliness of processing appeals was affected due to a few obstacles including staffing shortages due to illness, resignations, and vacancies. The Plan implemented a new appeals system and spent most of 2016 training staff.

If appeals are not processed in a timely manner, there will be a delay in delivering the necessary treatments needed by the members.

1.4.2 Appeals resolution letter rationale

The Plan is required to implement and maintain a member Grievance system in accordance with *Title 28 CCR Section 1300.68*. The regulations specify that the written response shall contain a clear and concise explanation of the plan's decision. (*Contract A18, Exhibit A, Attachment 14 (1) and CCR, Title 28 1300.68(d)(3)*).

The Plan's Policy #: *GA-08: Member Appeal Procedure for Non-Medicare Lines of Business* states that the resolution letter will include an explanation in clear and concise language explaining how any exclusion applies to the specific health care service or benefit requested by the member.

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The Plan's resolution letters did not clearly and completely explain the reason for denial of the chronic hepatitis C treatment. In five appeals for chronic hepatitis C treatment, the Plan's resolution letters stated the California Department of Health Care Services (DHCS) require these treatments to be approved only for members with stage 2 fibrosis or above. However, the DHCS Treatment Policy for the Management of Chronic Hepatitis C effective July 1, 2015 lists 15 clinical conditions that identify candidates for treatment. Although Stage 2 or greater hepatic fibrosis is one of the 15 clinical conditions, it is not the only criteria for which the medication can be prescribed. Members would fit criteria if any of these clinical conditions are met. On review of medical records there was no evidence of inappropriate use of criteria, however the NOA letter did not have clarity.

The interviews confirmed that the Plan faced challenges with the chronic hepatitis C treatment resolution letters because of the lengthy criteria, making it difficult to be concise yet provide all the necessary information the patient and provider would need. The Plan has started working on making some changes to the letter templates.

If members and providers receive resolution letters with incorrect criteria for chronic hepatitis C treatment, members will not receive the necessary treatment and providers will not be able to fully treat the patients' condition.

RECOMMENDATIONS:

- 1.4.1 Send appeal acknowledgment letters to members within the five calendar days and resolution letters within 30 calendar days. Resolve appeals within 30 calendar days. Continue to resolve staffing shortages in order to comply with contract requirement of time frames.
- 1.4.2 Ensure all resolutions letters provide clear and concise language to explain the reasons for the Plan's decision.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1 APPOINTMENT PROCEDURES AND WAITING TIMES

Appointment Procedures:

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
COHS Contract A.9.3.A

Members must be offered appointments within the following timeframes:

- c) Non-urgent primary care appointments – within ten (10) business days of request;
- d) Appointment with a specialist – within 15 business days of request;

COHS Contract A.9.3.A.2

Prenatal Care:

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within 10 business days upon request.

COHS Contract A.9.3.B

Waiting Times:

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Subprovision A, Appointments, above.

COHS Contract A.9.3.C

SUMMARY OF FINDINGS:

3.1.1 Corrective action plan for providers non-compliant with timely access standards

The Plan is required to communicate, enforce and monitor providers' compliance with acceptable accessibility standards in accordance with *CCR, Title 28, section 1300.67. 2* and as specified in the Contract (*Contract A18, Exhibit A, attachment 9 (3)*). The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access, which includes but is not limited to taking all necessary and appropriate action to identify the causes underlying identified timely access deficiencies and to bring its network into compliance (*CCR, Title 28, section 1300 67. 2. 2 (d)(3)*).

The Plan's Policy#: *PS-08: Timely Access and Network Adequacy Monitoring* states that providers who are identified to be out of compliance with the timely access standards shall be required to undertake corrective measures.

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The Plan did not consistently take appropriate action to address timely access deficiencies identified through its monitoring procedures. Although the Plan identified 18 providers that were non-compliant with the Plan's 2015 Access and Availability survey conducted in December 2015. The Plan sent access standards reminder letters to three provider groups and worked directly with one non-compliant provider, which the Plan restricted from acquiring new members. However, the Plan did not investigate or identify the causes of the timely access deficiencies nor did it request a corrective action plan from all non-compliant providers. The Plan did not provide any evidence that it has followed-up with deficient providers or that the Plan has taken any additional actions as a result of the survey. This is an ongoing finding.

3.1.2 Monitoring of wait times in providers' offices for telephone call returns

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in the provider's office, telephone calls (to answer and return), and the time to obtain various types of appointments (*Contract A18, Exhibit A, Attachment 9 (c)*).

The Plan did not have a procedure to track whether members' request for a return call were actually returned by providers. The Plan included a question that asked on its 2016 Group Needs Assessment (GNA) survey whether members received a call back within 24 hours. 10.6% of adults and 8.4% of children responded that they did not get a call back within 24 hours. The Plan's monitoring did not measure how long it took the provider to return a member's call.

The 2015 DHCS audit found that the Plan's access survey did not track whether a telephone call was returned. As part of the corrective action plan to address the prior audit finding, the Plan stated it would initiate a project with eight partnering clinics to track returned phone call wait times with each clinic and it would also track returned telephone calls during the 2016 Access Survey. The Plan is still in the process of developing its project with the eight partnering clinics. The Plan did not track returned phone calls in the 2016 timely access survey. The Plan continues to work with the partnering clinics but did not have an effective start date for the project. This is an ongoing finding.

3.1.3 Monitoring of wait times at provider's offices

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in the provider's office (*Contract A18, Exhibit A, Attachment 9 (c)*).

The Plan did not have a procedure to monitor wait times in provider's offices. The DHCS 2015 audit found the Plan had started a program with a clinic to collect data on wait times in provider offices. However, the Plan did not provide any evidence that this data was collected. As part of the corrective action plan to address the prior year's audit findings, the Plan stated it would continue its partnership with the clinic to obtain reporting from the clinic's electronic health records system related to wait times and it would also start a new project with eight additional partnering clinics. The Plan did not monitor wait times at collaborating clinics during the audit period or collected data on wait times. The Plan is still in the process of developing its new wait time monitoring process with the eight partnering clinics. The Plan did not have an effective start date for the project. **This is a repeat finding.**

❖ COMPLIANCE AUDIT FINDINGS ❖

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3.1.4 Accuracy and completeness of provider directory

The Plan is required to distribute a provider directory that includes the following information: name, NPI number, and telephone number of each service location. In case of a medical group/foundation or IPA, the medical groups name, NPI number, and telephone number shall appear for each physician provider. (*Contract A18, Exhibit A, Attachment 13 (4)*). The Plan is required to provide, upon request, a list of contracting providers. This list is required to indicate which providers have notified the Plan that they have closed practices or are otherwise not accepting new patients at that time. The Plan is required to update this information at least quarterly. The Plan may satisfy this update requirement by providing an insert or addendum to any existing provider listing. (*H&S Code §1367. 26*).

The Plan's Policy #: *PS-04 Prime Provider Data Auditing, Report and Provider Directories* states that the Plan annually reviews and updates all directories, including notification to each provider by mail monthly. Providers not responding by the 10-day removal notice period will be removed from the directory in the next update.

The Plan's provider directory did not accurately reflect the status of providers accepting new members. As a result of the 2015 DHCS audit findings, the Plan created a work plan and a desktop procedure to ensure provider updates were revised in the directory timely. In the new process, the Plan would conduct weekly monitoring of provider office information, send out quarterly requests for updates to providers, and investigate any reports of inaccuracy. Providers, members and members of the public could report directory inaccuracies through the Plan's website, member service line or email. Directory inaccuracies were changed during the next scheduled update, but no longer than five business days from the date reported.

During the DHCS appointment availability verification study, nine PCPs, six specialists, and 10 OB /GYN providers were contacted. These were the inaccuracies reported:

- 1 PCP and 2 specialist providers were no longer working at the location listed on the provider directory.
- 2 OB/GYN providers were not contracted with the Plan but were listed on the Plan's provider directory as accepting new members.
- 2 OB/GYN providers do not accept new members but are listed on the Plan's directory as accepting new members.

Although the Plan has implemented a new process to update the provider directory and has created new tools for members and providers to submit updated information, the Plan continues to have some inaccuracies listed on its directory. This is an ongoing finding.

RECOMMENDATIONS:

- 3.1.1 Conduct prompt investigation and corrective action when compliance monitoring discloses access deficiencies.
- 3.1.2 Develop, implement, and maintain a process to monitor wait times at provider offices to return member telephone calls.
- 3.1.3 Develop, implement, and maintain a process to monitor wait times at provider offices.
- 3.1.4 Improve provider directory updating process to reflect accurate provider information.

❖ COMPLIANCE AUDIT FINDINGS ❖

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3.6 ACCESS TO PHARMACEUTICAL SERVICES

Pharmaceutical Services and Prescribed Drugs:

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours. Contractor shall develop and implement effective drug utilization reviews and treatment outcomes systems to optimize the quality of pharmacy services.

Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. Contractor shall meet this requirement by doing all of the following: ... (as required by Contract).
COHS Contract A.10.8.F.1

SUMMARY OF FINDINGS:

3.6.1 Monitoring of members' access to a 72-hour supply of drugs in emergency situations

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

The Plan's Policy #: *HS-11 Oversight of Emergency Department's Methods for Ensuring Adequate Dispensing of Drugs* states that in order to ensure members have appropriate access to emergency department (ED) discharge medication, the following monitoring activities will take place:

- The Plan will randomly select hospital based EDs on a periodic basis and ask their medical director or designee to submit a statement that they have a policy and procedure which ensures members who receive emergency services are provided a sufficient quantity of drugs to last until they can reasonably have a prescription filled.
- The Plan may perform audits of EDs with respect to these policies and procedures if required.
- Quarterly, the Plan will review ED visit at the identified hospital EDs and related pharmacy fills within seven days of the ED visit. The Plan will select a sample of 30 visits for chart review on ED visits without a pharmacy fill within seven days to determine whether medications were indicated and if indicated, provided.
- This review will be presented to the Utilization Management Committee.

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Although the Plan had policies and procedures to monitor whether emergency departments (ED) dispense an adequate supply of drugs in emergency situations, these monitoring procedures were not performed during the audit period as specified in its policy or in the corrective action plan submitted to DHCS. The DHCS 2014 and 2015 audits found that the Plan did not perform its monitoring procedures. The Plan did not request a statement from emergency departments that they had a policy of adequate access to drugs nor did the Plan conduct any audits of emergency departments with respect to their policies and procedures. As a corrective plan to the prior findings, the Plan revised its policy to also include quarterly review of ED visit charts and present that review to the Utilization Management Committee (UM). The Plan reviewed 30 ED visit charts during the first and second quarters of 2016 with no findings. However, the Plan still does not request a statement from emergency departments that they had a policy of adequate access to drugs or conduct any audits of emergency departments with respect to their policies and procedures. The Plan did not present the review of the ED chart review to the UM Committee. **This is repeat finding.**

RECOMMENDATION:

3.6.1 Implement policy and procedure to ensure provision of prescribed drugs dispensed in emergency situations.

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CATEGORY 4 – MEMBER’S RIGHTS

4.1 GRIEVANCE SYSTEM

Member Grievance System and Oversight:

Contractor shall implement and maintain a Member Grievance system in accordance with Title 28 CCR Section 1300.68 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph D.13, and 42 CFR 438.420(a)(b) and (c). 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.

COHS Contract A.14.1

Contractor shall implement and maintain procedures...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.... (as required by Contract)

COHS Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

COHS Contract A.14.3.A

SUMMARY OF FINDINGS:

During the audit period, the grievance department encountered multiple challenges associated with the implementation of the new grievance system, shortage of staff, and an increase in the number of grievances filed during the first quarter of 2016 which led to delays in the grievance processing time. Grievances related to quality of care or access were prioritized and processed first while grievances for issues such as billing were processed later.

4.1.1 Grievance acknowledgment time frames

The Plan is required to ensure timely acknowledgment and feedback to the member. The Plan is required to send a written acknowledgment notice to the member within five calendar days from receipt. The acknowledgment letter will advise the member that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance. (*Contract A18, Exhibit A, Attachment 14 (2) (A) and CCR, Title 28 § 1300.68(d) (1)*).

The Plan’s Policy #: *GA-07 Member Grievance Procedure for Non-Medicare Lines of Business* states that within five calendar days of the filing of the grievance, the grievance and appeals coordinator mails an acknowledgment letter to the member.

The Plan exceeded the time frame for notification of grievances. A review of 60 grievance files found 26 acknowledgment letters were not sent within the five calendar day time frame. The Plan was not in compliance with the requirements for grievance notification. The DHCS 2014 and 2015 audits found that the Plan exceeded the time frames for notification of grievances. The Plan’s corrective action plan stated that it would hire additional temporary staff and train the new staff on the grievance procedures but despite that the Plan continues to be late in sending acknowledgment letters. **This is a repeat finding.**

❖ COMPLIANCE AUDIT FINDINGS ❖

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

AUDIT PERIOD: November 1, 2015 through October 31, 2016

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4.1.2 Grievance resolution time frames

The Plan is required to resolve each grievance and provide notice to the member as quickly as the member's health condition requires, within 30 calendar days from receipt. The Plan is required to send a written resolution within 30 calendar days of receipt. (*Contract A18, Exhibit A, Attachment 14 (1) and CCR, Title 28 § 1300.68(d) (3)*).

The Plan's Policy #: *GA-07 Member Grievance Procedure for Non-Medicare Lines of Business* states that the deadline for processing standard grievances is 30 calendar days from the date the grievance was filed. Inability of the Grievance and Appeal (G&A) coordinator to contact the member to clarify or verify information regarding the member's grievance does not change the 30-day deadline for resolution of the grievance.

The Plan exceeded the time frame for resolution of grievances. A review of 60 grievance files found that 40 grievances were not resolved and did not have resolution letters sent to the members within 30 calendar days. The DHCS 2014 and 2015 audits also found that the Plan exceeded the time frames for notification of grievances. The Plan's corrective action plan stated that it would hire additional temporary staff and train the new staff on the grievance procedures but despite that the Plan continues to resolve grievances in excess of the 30 calendar day requirement. **This is a repeat finding.**

4.1.3 Grievance status notification letters

In the event a resolution is not reached within 30 calendar days, the Plan is required to send a notification in writing to the member of the status of the grievance and an estimated completion date of resolution as per *CCR, Title 22, §53858(g)(2)*.

The Plan's Policy #: *GA-07-Member Grievance Procedure for Non-Medicare Lines of Business* states that if the Plan extends the 30-day time frame, the G&A coordinator will notify the member in writing within 30 days of receiving the grievance. This notification will include an explanation of how the extension is in the best interest of the member, a notice of the member's right to file an expedited grievance if the member does not agree with the extension, and a notice that the member may file a grievance directly with the Department of Managed Health Care.

The Plan did not send notification letters to members when a resolution was not reached within 30 days. A review of 60 grievances files found that 40 grievances were processed beyond the 30 calendar day time frame. The Plan did not send a status notification letter to the member with an explanation of how the extension was in the best interest of the member, a notice of the member's right to file an expedited grievance if the member did not agree with the extension, a notice that the member may file a grievance directly with the Department of Managed Health Care and an estimated completion date of resolution. The Plan did not send extension letters to members with billing grievances because coordinators were not consistently working on the case and therefore did not meet the extension criteria. The Plan was not in compliance with the requirements for grievance status notification.

4.1.4 Expedited grievance resolution time frame

The Plan is required to provide a written statement to the member on the status of urgent grievances within three calendar days of receipt of the grievance as per *CCR, Title 28 §1300.68.01(a)(2)*.

❖ COMPLIANCE AUDIT FINDINGS ❖

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

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The Plan's Policy #: *GA-07 Member Grievance Procedure for Non-Medicare Lines of Business* states that the Plan has three calendar days from the receipt of the grievance to notify the member verbally and in writing of the resolution of the grievance.

The Plan exceeded the time frame for expedited grievance resolution. A review of 60 grievances found six grievances classified as expedited grievances. None of the six expedited grievances were processed within three calendar days. The Plan was not in compliance with the requirements for expedited grievance processing time frames.

4.1.5 Expedited grievance notification

The Plan is required to implement and maintain a member's Grievance system in accordance with Title 28 CCR Section 1300.68, 1300.68.01 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph D.1213, and 42 CFR 438.420(a)(b) and (c). (*Contract A18, Exhibit A, Attachment 14 (1)*). The managed care health plan may extend the timeframes of standard resolution of grievances and appeals, and expedited resolution of appeals by up to 14 calendar days if 1) the enrollee requests the extension, or 2) the managed care organization shows that there is need for additional information and how the delay is in the enrollee's interest (*42 CFR 438.408 (c)(1)*).

The Plan's Policy #: *GA-07 Member Grievance Procedure for Non-Medicare Lines of Business* state that HPSM may extend the time frame for resolution up to 14 days if there is need for additional information and the delay is in the member's interest.

The Plan did not send notification letters to members when an expedited resolution was not reached within three calendar days. A review of 60 grievances found six grievances classified as expedited grievances. One expedited grievances had a notification letter sent to the member that extended the resolution of the grievance up to 17 days. However, that grievance was not resolved by the estimated time given. Five expedited grievances were processed beyond the three calendar days but no notification was sent to the member.

4.1.6 Grievance correspondence in Plan's threshold languages

The Plan is required to fully translate written informing materials, including but not limited to grievance acknowledgment and resolution letters. (*Contract A18, Exhibit A, Attachment 9 (13) (C) (2) and CCR, Title 28, section 1300. 68(b) (3)*).

The Plan did not consistently translate grievance acknowledgment letters to its threshold language. A review of 60 grievances found that 16 grievances were for members with a preferred language other than English. Four of 16 acknowledgement letter were not translated to the Plan's threshold language. **This is a repeat finding**

RECOMMENDATIONS:

- 4.1.1 Implement a process to ensure grievance acknowledgment letters are sent to members within five calendar days. Continue to resolve staffing shortages in order to comply with contract requirement of time frames.
- 4.1.2 Implement a process to ensure grievance resolution letters are sent to members within 30 calendar days. Continue to resolve staffing shortages in order to comply with contract requirement of time frames.

❖ COMPLIANCE AUDIT FINDINGS ❖

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

AUDIT PERIOD: November 1, 2015 through October 31, 2016

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- 4.1.3** Implement a process to ensure written notice of the status of the grievance and estimated completion date of resolution are sent to members when a resolution is not reached within 30 days. Continue to resolve staffing shortages in order to comply with contract requirement of time frames.
- 4.1.4** Implement a process to ensure expedited grievances are resolved within three calendar days. Continue to resolve staffing shortages in order to comply with contract requirement of time frames.
- 4.1.5** Implement a process to ensure written notices of the status of expedited grievances and estimated completion date or resolution are sent to members when a resolution is not reached within three calendar days. Continue to resolve staffing shortages in order to comply with contract requirement of time frames.
- 4.1.6** Implement a process to ensure notification letters sent to members that are fully translated to the Plan's threshold language.

MEDICAL REVIEW - NORTHERN SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

**San Mateo Health Commission
dba Health Plan of San Mateo**

Contract Number: 08-85220
State Supported Services

Audit Period: November 1, 2015
Through
October 31, 2016

Report Issued: March 2, 2017

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INTRODUCTION

This report was created for informational purposes. Department of Health Care Services (DHCS) did not conduct a review of the San Mateo Health Commission dba Health Plan of San Mateo (HPSM) State Supported Services contract No. 08-85220. The State Supported Services contract covers contracted abortion services with HPSM. Prior findings for State Supported Services not reviewed in the 2016 audit will be reviewed in a future audit.

| <input type="checkbox"/> COMPLIANCE AUDIT FINDINGS (CAF) <input type="checkbox"/> | |
|---|--|
| PLAN: Health Plan of San Mateo | |
| AUDIT PERIOD: November 1, 2015 through October 31, 2016 | DATE OF AUDIT: November 28, 2016 through December 2, 2016 |

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion

*Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes*: 59840 through 59857
HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336*

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

SUMMARY OF FINDINGS:

DHCS did not conduct a review of the San Mateo Health Commission dba Health Plan of San Mateo (HPSM) State Supported Services contract No. 08-85220.

RECOMMENDATIONS:

N/A.